..... moves to amend S.F. No. 4410, the second engrossment, as amended, 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 shall 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, 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, 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. 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 144.1501, subdivision 5, is amended to read:

Subd. 5. **Penalty for nonfulfillment.** If a participant does not fulfill the required minimum commitment of service according to subdivision 3, the commissioner of health shall collect from the participant the total amount paid to the participant under the 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 subdivision 2~~ an account in the special revenue fund. The balance of the account does not expire and is appropriated to the commissioner of health for health professional education loan forgiveness awards under this section. The commissioner shall allow waivers of all or part of the money owed the commissioner as a result of a nonfulfillment penalty if emergency circumstances prevented fulfillment of the minimum service commitment.

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 a new rural residency training program;

(7) training site improvements, fees, equipment, and supplies required for a 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 25 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 25 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 registered nurses, clinical nurse specialists, certified registered nurse anesthetists, nurse practitioners, 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 water 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 staffing plans and maintain records demonstrating compliance for each inpatient care unit for five years. Each hospital must provide its hospital 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 shall be 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 organizations, Tribal health organizations, 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 purposes of these assessments, studies, and surveillance system are 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 studies 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) "Commissioner" means the commissioner of health.

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

(d) "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.

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

(f) "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.

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

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 TESTING AND REMEDIATION GRANT PROGRAM; SCHOOLS, CHILD CARE CENTERS, FAMILY CHILD CARE PROVIDERS.**

Subdivision 1. **Establishment; purpose.** The commissioner of health shall establish a grant program to test drinking water in licensed child care centers and licensed family child care providers for the presence of lead and to remediate identified sources of lead in drinking water in schools, licensed child care centers, and licensed family child care providers.

Subd. 2. **Grant awards.** (a) The commissioner shall award grants through a request for proposals process to schools, licensed child care centers, and licensed family child care providers. The commissioner shall award grants in the following order of priority:

(1) statewide testing of drinking water in licensed child care centers and licensed family child care providers for the presence of lead and remediating identified sources of lead in these settings; and

(2) remediating identified sources of lead in drinking water in schools.

(b) The commissioner shall prioritize grant awards for the purposes specified in paragraph (a), clause (1), or paragraph (a), clause (2), to settings with higher levels of lead detected in water samples, with evidence of lead service lines or lead plumbing materials, or that serve or are in school districts that serve disadvantaged communities.

Subd. 3. **Uses of grant funds.** Licensed child care centers and licensed family child care providers must use grant funds under this section to test their drinking water for lead; remediate sources of lead contamination within the building, including lead service lines and premises plumbing; and implement best practices for water management within the building. Schools must use grant funds under this section to remediate sources of lead contamination within the building and implement 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 organizations, 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. **Purposes.** The purposes of the Healthy Beginnings, Healthy Families Act are 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 goals of the Minnesota collaborative to prevent infant mortality program are 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, and 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 subdivision 3, 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 subdivision 10, 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 unify the best practices of the school-based health center and Whole School, Whole Community, Whole Child models.

(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, school-based health centers, and sponsoring organizations to support existing school-based health 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; 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. **Oral health in school settings.** (a) The commissioner of health shall administer a program to provide competitive grants to schools, oral health providers, and other community groups to build capacity and infrastructure to establish, expand, link, or strengthen oral health services in school settings.

(b) Grant funds distributed under this subdivision must be used to support new or existing oral health services in schools that:

(1) provide oral health risk assessment, screening, education, and anticipatory guidance;

(2) provide oral health services, including fluoride varnish and dental sealants;

(3) make referrals for restorative and other follow-up dental care as needed; and

(4) provide free access to fluoridated drinking water to give students a healthy alternative to sugar-sweetened beverages.

(c) Grant recipients must collect, monitor, and submit to the commissioner of health baseline and annual data and provide information to improve the quality and impact of oral health strategies.

Subd. 7. **Whole School, Whole Community, Whole Child grants.** (a) The commissioner of health shall administer a program to provide competitive grants to local public health organizations, schools, and community organizations using the evidence-based Whole School, Whole Community, Whole Child (WSCC) model to increase alignment, integration,

and collaboration between public health and education sectors to improve each child's cognitive, physical, oral, social, and emotional development.

(b) Grant funds distributed under this subdivision must be used to support new or existing programs that implement elements of the WSCC model in schools that:

(1) align health and learning strategies to improve health outcomes and academic achievement;

(2) improve the physical, nutritional, psychological, social, and emotional environments of schools;

(3) create collaborative approaches to engage schools, parents and guardians, and communities; and

(4) promote and establish lifelong healthy behaviors.

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

Subd. 8. **Technical assistance and oversight.** (a) The commissioner shall provide content expertise, technical expertise, and training to grant recipients under subdivisions 6 and 7.

(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) 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) $687 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 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 and to other Indian lands in the state.

(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 nonrefundable registration application fee of ~~$20,000~~ $10,000 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.

(c) The commissioner shall establish and collect an annual 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 mental health practitioners needing supervised hours to become licensed as professionals 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. **NURSING WORKFORCE REPORT.**

The commissioner of health shall provide a public report 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. **LEAD SERVICE LINE INVENTORY GRANT PROGRAM.**

Subdivision 1. **Establishment.** The commissioner of health must establish a grant program to provide financial assistance to municipalities for producing an inventory of publicly and privately owned lead service lines within their jurisdiction.

Subd. 2. **Eligible uses.** A municipality receiving a grant under this section may use the grant funds to:

(1) survey households to determine the material of which their water service line is made;

(2) create publicly available databases or visualizations of lead service lines; and

(3) comply with the lead service line inventory requirements in the Environmental Protection Agency's Lead and Copper Rule.

Sec. 97. **PAYMENT MECHANISMS IN RURAL HEALTH CARE.**

The commissioner of health 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 Health Care Affordability Board.

Sec. 98. **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. 99. **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, 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. 100. **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 boarding 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. 101. **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 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 service 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. 102. **REVISOR INSTRUCTION.**

(a) The revisor of statutes shall codify Laws 2021, First Special Session chapter 7, article 3, section 44, as Minnesota Statutes, section 144.1512. 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.

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 144.1503, 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. 6. Minnesota Statutes 2020, section 144.1911, subdivision 4, is amended to read:

Subd. 4. **Career guidance and support services.** ~~(a)~~ The commissioner shall award grants to eligible nonprofit organizations and eligible postsecondary educational institutions, including the University of Minnesota, to provide career guidance and support services to immigrant international medical graduates seeking to enter the Minnesota health workforce. Eligible grant activities include the following:

(1) educational and career navigation, including information on training and licensing requirements for physician and nonphysician health care professions, and guidance in determining which pathway is best suited for an individual international medical graduate based on the graduate's skills, experience, resources, and interests;

(2) support in becoming proficient in medical English;

(3) support in becoming proficient in the use of information technology, including computer skills and use of electronic health record technology;

(4) support for increasing knowledge of and familiarity with the United States health care system;

(5) support for other foundational skills identified by the commissioner;

(6) support for immigrant international medical graduates in becoming certified by the Educational Commission on Foreign Medical Graduates, including help with preparation for required licensing examinations and financial assistance for fees; and

(7) assistance to international medical graduates in registering with the program's Minnesota international medical graduate roster.

~~(b) The commissioner shall award the initial grants under this subdivision by December 31, 2015.~~

Sec. 7. Minnesota Statutes 2020, section 144.292, subdivision 6, is amended to read:

Subd. 6. **Cost.** (a) When a patient requests a copy of the patient's record for purposes of reviewing current medical care, the provider must not charge a fee.

(b) When a provider or its representative makes copies of patient records upon a patient's request under this section, the provider or its representative may charge the patient or the patient's representative no more than 75 cents per page, plus $10 for time spent retrieving

and copying the records, unless other law or a rule or contract provide for a lower maximum charge. This limitation does not apply to x-rays. The provider may charge a patient no more than the actual cost of reproducing x-rays, plus no more than $10 for the time spent retrieving and copying the x-rays.

(c) The respective maximum charges of 75 cents per page and $10 for time provided in this subdivision are in effect for calendar year 1992 and may be adjusted annually each calendar year as provided in this subdivision. The permissible maximum charges shall change each year by an amount that reflects the change, as compared to the previous year, in the Consumer Price Index for all Urban Consumers, Minneapolis-St. Paul (CPI-U), published by the Department of Labor.

(d) A provider or its representative may charge the $10 retrieval fee, but must not charge a per page fee to provide copies of records requested by a patient or the patient's authorized representative if the request for copies of records is for purposes of appealing a denial of Social Security disability income or Social Security disability benefits under title II or title XVI of the Social Security Act; except that no fee shall be charged to a ~~person~~ patient who is receiving public assistance, or to a patient who is represented by an attorney on behalf of a civil legal services program or a volunteer attorney program based on indigency. For the purpose of further appeals, a patient may receive no more than two medical record updates without charge, but only for medical record information previously not provided. For purposes of this paragraph, a patient's authorized representative does not include units of state government engaged in the adjudication of Social Security disability claims.

Sec. 8. 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. 9. 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. 10. 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. 11. 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. 12. 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. 13. 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. 14. 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. 15. 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. 16. 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. 17. 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. 18. 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. 19. 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. 20. 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.** (a) "Controlling person" 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" 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;

(2) the land on which a nursing home is located;

(3) the structure in which a nursing home is located;

(4) 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) any lease or sublease of the land, structure, or facilities comprising a nursing home.

~~(b)~~ (c) "Controlling person" 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 person 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 person 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. **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. 21. 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 persons, 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 persons, 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 representative copy of the executed lease agreement between the landlord and the licensee, if applicable;

(10) a representative copy of the management agreement, if applicable;

(11) a representative 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 person, 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; or

(v) any felony or misdemeanor under federal or state law relating to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance;

(14) whether the applicant, owner, controlling person, 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 person, 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; and

~~(4)~~ (18) 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 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 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. 22. Minnesota Statutes 2020, section 144A.04, subdivision 4, is amended to read:

Subd. 4. **Controlling person restrictions.** (a) The commissioner has discretion to bar any controlling persons of a nursing home ~~may not include any~~ if the person ~~who~~ was a controlling person 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 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 person under this subdivision, the controlling person has the right to appeal under chapter 14.

Sec. 23. 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. 24. 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 person 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. 25. **[144A.32] CONSIDERATION OF APPLICATIONS.**

(a) Before issuing a 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. 26. Minnesota Statutes 2020, section 144A.4799, subdivision 1, is amended to read:

Subdivision 1. **Membership.** The commissioner of health shall appoint ~~eight~~ 13 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~~

(5) one member representing the Office of Ombudsman for Mental Health and Developmental Disabilities;

~~(5)~~ (6) beginning July 1, 2021, one member of a county health and human services or county adult protection office~~.~~;

(7) 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;

(8) one organization representing long-term care providers, home care providers, and assisted living providers in Minnesota; and

(9) 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. 27. 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. 28. 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. 29. 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. 30. 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. 31. 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. 32. 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. 33. 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. 34. 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. 35. 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. 36. 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. 37. 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. 38. 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. 39. 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. 40. 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. 41. 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 per incident. A fine of $5,000 per incident 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. 42. 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 this chapter 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. 43. 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. 44. 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. 45. 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. 46. 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~~ health facility identification 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.

EFFECTIVE DATE. This section is effective the day following final enactment, except that the amendment to paragraph (a) is effective for assisted living contracts executed on or after August 1, 2022.

Sec. 47. 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. 48. 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. 49. 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. 50. 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. 51. 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 obtains a new service provider 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 that includes:

(1) a detailed explanation of the reasons for the reduction 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 of services;

(3) a statement that if the services being reduced 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 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 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. 52. 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. 53. 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. 54. 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. 55. 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. 56. 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.

(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. 57. 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. 58. 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. 59. 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. 60. 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 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. 61. 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. 62. Minnesota Statutes 2020, section 144G.90, is amended by adding a subdivision to read:

Subd. 6. **Notice to residents.** For any notice to a resident, legal representative, or designated representative provided under this chapter or under Minnesota Rules, chapter 4659, that is required to include information regarding the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities, the notice must contain the following language: "You may contact the Ombudsman for Long-Term Care for questions about your rights as an assisted living facility

resident and to request advocacy services. As an assisted living facility resident, you may contact the Ombudsman for Mental Health and Developmental Disabilities to request advocacy regarding your rights, concerns, or questions on issues relating to services for mental health, developmental disabilities, or chemical dependency."

Sec. 63. 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. 64. 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. 65. 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. 66. 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. 67. 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. 68. **[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. 69. 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. 70. 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. 71. 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. 72. 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. 73. 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. 74. 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. 75. 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 and to other Indian lands 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 destination, and a description and count of the medical cannabis being transported.

Sec. 76. 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. 77. 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. 78. 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. 79. **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. 80. **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 this article to Minnesota Statutes, sections 144A.01; 144A.03, subdivision 1; 144A.04, subdivisions 4 and 6; and 144A.06.

Sec. 81. **REPEALER.**

Minnesota Statutes 2021 Supplement, section 144G.07, subdivision 6, is repealed.

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 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 $50,000. 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 256.01, is amended by adding a subdivision to read:

Subd. 43. **Education on contraceptive options.** The commissioner shall require hospitals and primary care providers serving medical assistance and MinnesotaCare enrollees to develop and implement protocols to provide these enrollees, when appropriate, with comprehensive and scientifically accurate information on the full range of contraceptive options in a medically ethical, culturally competent, and noncoercive manner. The information provided must be designed to assist enrollees in identifying the contraceptive method that best meets their needs and the needs of their families. The protocol must specify the enrollee categories to which this requirement will be applied, the process to be used, and the information and resources to be provided. Hospitals and providers must make this protocol available to the commissioner upon request.

Sec. 10. Minnesota Statutes 2020, section 256.969, is amended by adding a subdivision to read:

Subd. 31. **Long-acting reversible contraceptives.** (a) The commissioner must provide separate reimbursement to hospitals for long-acting reversible contraceptives provided immediately postpartum in the inpatient hospital setting. This payment must be in addition to the diagnostic related group (DRG) reimbursement for labor and delivery.

(b) The commissioner must require managed care and county-based purchasing plans to comply with this subdivision when providing services to medical assistance enrollees.

EFFECTIVE DATE. This section is effective January 1, 2023.

Sec. 11. 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. 12. 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 congressional district or districts 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. 13. 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. 14. 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~~.~~<u>; and</u>

<u>(7) quitline services as described in section 256B.0625, subdivision 68.</u>

(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, 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.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. 16. 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~~ $20,000 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~~ $40,000 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. The amendment to paragraph (a) increasing the asset limits is effective January 1, 2025, or upon federal approval, whichever is later. The amendment to paragraph (a) adding clause (8) 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. 17. 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, and effective January 1, 2025, income up to 133 percent of the federal poverty guidelines. 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. 18. 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. 19. 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.

~~(e)~~ (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 ~~(e)~~ (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 ~~(e)~~ (b), clauses (1) to (3), when provided under sections 256B.69, 256B.692, and 256L.12.

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. 20. 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. 21. 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. 22. Minnesota Statutes 2020, section 256B.0625, subdivision 18h, is amended to read:

Subd. 18h. **Nonemergency medical transportation provisions related to managed care.** (a) The following nonemergency medical transportation subdivisions apply to managed care plans and county-based purchasing plans:

(1) subdivision 17, paragraphs (a), (b), (i), and (n);

(2) subdivision 18; and

(3) subdivision 18a.

(b) A nonemergency medical transportation provider must comply with the operating standards for special transportation service specified in sections 174.29 to 174.30 and Minnesota Rules, chapter 8840. Publicly operated transit systems, volunteers, and not-for-hire vehicles are exempt from the requirements in this paragraph.

(c) Managed care and county-based purchasing plans must provide a fuel adjustment for nonemergency medical transportation payment rates when the price of gasoline exceeds $3.00 per gallon.

Sec. 23. 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. 24. 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.

EFFECTIVE DATE. This section is effective January 1, 2023.

Sec. 25. 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. 26. 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. 27. 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. 28. 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.

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. 29. 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. 30. 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. 31. 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. 32. 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. 33. 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. 34. 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. 35. 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. 36. 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. 37. 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. 38. 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. 39. 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. 40. 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. 41. 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. 42. 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. 43. 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. 44. 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. 45. 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. 46. 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. 47. 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. 48. 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. 49. 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. 50. 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. 51. **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. 52. **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. 53. **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. 54. **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. 55. **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. 56. **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. 57. **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 and interfacility transfers 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 and interfacility transfers 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 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 price of the prescription drug at the time of acquisition and in the calendar year prior to acquisition;~~

~~(2) the name of the company from which the prescription drug was acquired, the date acquired, and the purchase price;~~

~~(3) the year the prescription drug was introduced to market and the price of the prescription drug at the time of introduction;~~

~~(4) the price of the prescription drug for the previous five years;~~

~~(5) 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) 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.

(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 this section.

(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.841, 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~~.~~<u>; and</u>

<u>(25) for a manufacturer, a violation of section 62J.842 or 62J.845.</u>

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. Examples of conditions associated with intractable pain sometimes but do not always include 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 fewer than 200,000 persons in the United States and is chronic, serious, life-altering, or life-threatening;

(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) that is labeled as a rare disease or condition on the Genetic and Rare Diseases Information Center list created by the National Institutes of Health; or

(4) for which a pediatric patient:

(i) has received two or more clinical consultations from a primary care provider or specialty provider;

(ii) has a delay in skill acquisition and development, regression in skill acquisition, failure to thrive, or multisystemic involvement; and

(iii) had laboratory or clinical testing that failed to provide a definitive diagnosis or resulted in conflicting diagnoses.

(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.

ARTICLE 8
COMMUNITY SUPPORTS AND BEHAVIORAL HEALTH POLICY

Section 1. Minnesota Statutes 2021 Supplement, section 62A.673, 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) "Distant site" means a site at which a health care provider is located while providing health care services or consultations by means of telehealth.

(c) "Health care provider" means a health care professional who is licensed or registered by the state to perform health care services within the provider's scope of practice and in accordance with state law. A health care provider includes a mental health professional ~~as defined~~ under section ~~245.462, subdivision 18, or 245.4871, subdivision 27~~ 245I.04, subdivision 2; a mental health practitioner ~~as defined~~ under section ~~245.462, subdivision 17, or 245.4871, subdivision 26~~ 245I.04, subdivision 4; a clinical trainee under section 245I.04, subdivision 6; a treatment coordinator under section 245G.11, subdivision 7; an alcohol and drug counselor under section 245G.11, subdivision 5; and a recovery peer under section 245G.11, subdivision 8.

(d) "Health carrier" has the meaning given in section 62A.011, subdivision 2.

(e) "Health plan" has the meaning given in section 62A.011, subdivision 3. Health plan includes dental plans as defined in section 62Q.76, subdivision 3, but does not include dental plans that provide indemnity-based benefits, regardless of expenses incurred, and are designed to pay benefits directly to the policy holder.

(f) "Originating site" means a site at which a patient is located at the time health care services are provided to the patient by means of telehealth. For purposes of store-and-forward technology, the originating site also means the location at which a health care provider transfers or transmits information to the distant site.

(g) "Store-and-forward technology" means the asynchronous electronic transfer or transmission of a patient's medical information or data from an originating site to a distant site for the purposes of diagnostic and therapeutic assistance in the care of a patient.

(h) "Telehealth" means the delivery of health care services or consultations through the use of real time two-way interactive audio and visual communications 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, 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. Until July 1, 2023, telehealth also includes audio-only communication between a health care provider and a patient in accordance with subdivision 6, paragraph (b). Telehealth does not include communication between health care providers that consists solely of a telephone conversation, e-mail, or facsimile transmission. Telehealth does not include communication between a health care provider and a patient that consists solely of an e-mail or facsimile transmission. Telehealth does not include telemonitoring services as defined in paragraph (i).

(i) "Telemonitoring services" means the remote monitoring of clinical data related to the enrollee's vital signs or biometric data by a monitoring device or equipment that transmits the data electronically to a health care provider for analysis. Telemonitoring is intended to collect an enrollee's health-related data for the purpose of assisting a health care provider in assessing and monitoring the enrollee's medical condition or status.

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. 2. Minnesota Statutes 2021 Supplement, section 148F.11, subdivision 1, is amended to read:

Subdivision 1. **Other professionals.** (a) Nothing in this chapter prevents members of other professions or occupations from performing functions for which they are qualified or licensed. This exception includes, but is not limited to: licensed physicians; registered nurses; licensed practical nurses; licensed psychologists and licensed psychological practitioners; members of the clergy provided such services are provided within the scope of regular ministries; American Indian medicine men and women; licensed attorneys; probation officers; licensed marriage and family therapists; licensed social workers; social workers employed by city, county, or state agencies; licensed professional counselors; licensed professional clinical counselors; licensed school counselors; registered occupational therapists or occupational therapy assistants; Upper Midwest Indian Council on Addictive Disorders (UMICAD) certified counselors when providing services to Native American people; city, county, or state employees when providing assessments or case management under Minnesota Rules, chapter 9530; and ~~individuals defined in section 256B.0623, subdivision 5, clauses (1) to (6),~~ staff persons providing co-occurring substance use disorder treatment in adult mental health rehabilitative programs certified or licensed by the Department of Human Services under section 245I.23, 256B.0622, or 256B.0623.

(b) Nothing in this chapter prohibits technicians and resident managers in programs licensed by the Department of Human Services from discharging their duties as provided in Minnesota Rules, chapter 9530.

(c) Any person who is exempt from licensure under this section must not use a title incorporating the words "alcohol and drug counselor" or "licensed alcohol and drug counselor" or otherwise hold himself or herself out to the public by any title or description stating or implying that he or she is engaged in the practice of alcohol and drug counseling, or that he or she is licensed to engage in the practice of alcohol and drug counseling, unless that person is also licensed as an alcohol and drug counselor. Persons engaged in the practice of alcohol and drug counseling are not exempt from the board's jurisdiction solely by the use of one of the titles in paragraph (a).

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. 3. Minnesota Statutes 2021 Supplement, section 245.467, subdivision 2, is amended to read:

Subd. 2. **Diagnostic assessment.** ~~Providers~~ A provider of services governed by this section must complete a diagnostic assessment of a client according to the standards of section 245I.10~~, subdivisions 4 to 6~~.

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. 4. Minnesota Statutes 2021 Supplement, section 245.467, subdivision 3, is amended to read:

Subd. 3. **Individual treatment plans.** ~~Providers~~ A provider of services governed by this section must complete an individual treatment plan for a client according to the standards of section 245I.10, subdivisions 7 and 8.

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. 5. Minnesota Statutes 2021 Supplement, section 245.4871, subdivision 21, is amended to read:

Subd. 21. **Individual treatment plan.** (a) "Individual treatment plan" means the formulation of planned services that are responsive to the needs and goals of a client. An individual treatment plan must be completed according to section 245I.10, subdivisions 7 and 8.

(b) A children's residential facility licensed under Minnesota Rules, chapter 2960, is exempt from the requirements of section 245I.10, subdivisions 7 and 8. Instead, the individual treatment plan must:

(1) include a written plan of intervention, treatment, and services for a child with an emotional disturbance that the service provider develops under the clinical supervision of a mental health professional on the basis of a diagnostic assessment;

(2) be developed in conjunction with the family unless clinically inappropriate; and

(3) identify goals and objectives of treatment, treatment strategy, a schedule for accomplishing treatment goals and objectives, and the individuals responsible for providing treatment to the child with an emotional disturbance.

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. 6. Minnesota Statutes 2021 Supplement, section 245.4876, subdivision 2, is amended to read:

Subd. 2. **Diagnostic assessment.** ~~Providers~~ A provider of services governed by this section ~~shall~~ must complete a diagnostic assessment of a client according to the standards of section 245I.10~~, subdivisions 4 to 6~~. Notwithstanding the required timelines for completing a diagnostic assessment in section 245I.10, a children's residential facility licensed under Minnesota Rules, chapter 2960, that provides mental health services to children must, within ten days of the client's admission: (1) complete the client's diagnostic assessment; or (2) review and update the client's diagnostic assessment with a summary of the child's current mental health status and service needs if a diagnostic assessment is available that was completed within 180 days preceding admission and the client's mental health status has not changed markedly since the diagnostic assessment.

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. 7. Minnesota Statutes 2021 Supplement, section 245.4876, subdivision 3, is amended to read:

Subd. 3. **Individual treatment plans.** ~~Providers~~ A provider of services governed by this section ~~shall~~ must complete an individual treatment plan for a client according to the standards of section 245I.10, subdivisions 7 and 8. A children's residential facility licensed according to Minnesota Rules, chapter 2960, is exempt from the requirements in section 245I.10, subdivisions 7 and 8. Instead, the facility must involve the child and the child's family in all phases of developing and implementing the individual treatment plan to the extent appropriate and must review the individual treatment plan every 90 days after intake.

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. 8. Minnesota Statutes 2021 Supplement, section 245.735, subdivision 3, is amended to read:

Subd. 3. **Certified community behavioral health clinics.** (a) The commissioner shall establish a state certification process for certified community behavioral health clinics (CCBHCs) that satisfy all federal requirements necessary for CCBHCs certified under this section to be eligible for reimbursement under medical assistance, without service area limits based on geographic area or region. The commissioner shall consult with CCBHC stakeholders before establishing and implementing changes in the certification process and requirements. Entities that choose to be CCBHCs must:

(1) comply with state licensing requirements and other requirements issued by the commissioner;

(2) employ or contract for clinic staff who have backgrounds in diverse disciplines, including licensed mental health professionals and licensed alcohol and drug counselors, and staff who are culturally and linguistically trained to meet the needs of the population the clinic serves;

(3) ensure that clinic services are available and accessible to individuals and families of all ages and genders and that crisis management services are available 24 hours per day;

(4) establish fees for clinic services for individuals who are not enrolled in medical assistance using a sliding fee scale that ensures that services to patients are not denied or limited due to an individual's inability to pay for services;

(5) comply with quality assurance reporting requirements and other reporting requirements, including any required reporting of encounter data, clinical outcomes data, and quality data;

(6) provide crisis mental health and substance use services, withdrawal management services, emergency crisis intervention services, and stabilization services through existing mobile crisis services; screening, assessment, and diagnosis services, including risk assessments and level of care determinations; person- and family-centered treatment planning; outpatient mental health and substance use services; targeted case management; psychiatric rehabilitation services; peer support and counselor services and family support services; and intensive community-based mental health services, including mental health services for members of the armed forces and veterans. CCBHCs must directly provide the majority of these services to enrollees, but may coordinate some services with another entity through a collaboration or agreement, pursuant to paragraph (b);

(7) provide coordination of care across settings and providers to ensure seamless transitions for individuals being served across the full spectrum of health services, including acute, chronic, and behavioral needs. Care coordination may be accomplished through partnerships or formal contracts with:

(i) counties, health plans, pharmacists, pharmacies, rural health clinics, federally qualified health centers, inpatient psychiatric facilities, substance use and detoxification facilities, or community-based mental health providers; and

(ii) other community services, supports, and providers, including schools, child welfare agencies, juvenile and criminal justice agencies, Indian health services clinics, tribally licensed health care and mental health facilities, urban Indian health clinics, Department of Veterans Affairs medical centers, outpatient clinics, drop-in centers, acute care hospitals, and hospital outpatient clinics;

(8) be certified as a mental health ~~clinics~~ clinic under section ~~245.69, subdivision 2~~ 245I.20;

(9) comply with standards established by the commissioner relating to CCBHC screenings, assessments, and evaluations;

(10) be licensed to provide substance use disorder treatment under chapter 245G;

(11) be certified to provide children's therapeutic services and supports under section 256B.0943;

(12) be certified to provide adult rehabilitative mental health services under section 256B.0623;

(13) be enrolled to provide mental health crisis response services under ~~sections~~ section 256B.0624 ~~and 256B.0944~~;

(14) be enrolled to provide mental health targeted case management under section 256B.0625, subdivision 20;

(15) comply with standards relating to mental health case management in Minnesota Rules, parts 9520.0900 to 9520.0926;

(16) provide services that comply with the evidence-based practices described in paragraph (e); and

(17) comply with standards relating to peer services under sections 256B.0615, 256B.0616, and 245G.07, subdivision 1, paragraph (a), clause (5), as applicable when peer services are provided.

(b) If a certified CCBHC is unable to provide one or more of the services listed in paragraph (a), clauses (6) to (17), the CCBHC may contract with another entity that has the required authority to provide that service and that meets the following criteria as a designated collaborating organization:

(1) the entity has a formal agreement with the CCBHC to furnish one or more of the services under paragraph (a), clause (6);

(2) the entity provides assurances that it will provide services according to CCBHC service standards and provider requirements;

(3) the entity agrees that the CCBHC is responsible for coordinating care and has clinical and financial responsibility for the services that the entity provides under the agreement; and

(4) the entity meets any additional requirements issued by the commissioner.

(c) Notwithstanding any other law that requires a county contract or other form of county approval for certain services listed in paragraph (a), clause (6), a clinic that otherwise meets CCBHC requirements may receive the prospective payment under section 256B.0625, subdivision 5m, for those services without a county contract or county approval. As part of the certification process in paragraph (a), the commissioner shall require a letter of support from the CCBHC's host county confirming that the CCBHC and the county or counties it serves have an ongoing relationship to facilitate access and continuity of care, especially for individuals who are uninsured or who may go on and off medical assistance.

(d) When the standards listed in paragraph (a) or other applicable standards conflict or address similar issues in duplicative or incompatible ways, the commissioner may grant variances to state requirements if the variances do not conflict with federal requirements for services reimbursed under medical assistance. If standards overlap, the commissioner may substitute all or a part of a licensure or certification that is substantially the same as another licensure or certification. The commissioner shall consult with stakeholders, as described in subdivision 4, before granting variances under this provision. For the CCBHC that is certified but not approved for prospective payment under section 256B.0625, subdivision 5m, the commissioner may grant a variance under this paragraph if the variance does not increase the state share of costs.

(e) The commissioner shall issue a list of required evidence-based practices to be delivered by CCBHCs, and may also provide a list of recommended evidence-based practices. The commissioner may update the list to reflect advances in outcomes research and medical services for persons living with mental illnesses or substance use disorders. The commissioner

shall take into consideration the adequacy of evidence to support the efficacy of the practice, the quality of workforce available, and the current availability of the practice in the state. At least 30 days before issuing the initial list and any revisions, the commissioner shall provide stakeholders with an opportunity to comment.

(f) The commissioner shall recertify CCBHCs at least every three years. The commissioner shall establish a process for decertification and shall require corrective action, medical assistance repayment, or decertification of a CCBHC that no longer meets the requirements in this section or that fails to meet the standards provided by the commissioner in the application and certification process.

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. 9. Minnesota Statutes 2021 Supplement, section 245A.03, subdivision 7, is amended to read:

Subd. 7. **Licensing moratorium.** (a) The commissioner shall not issue an initial license for child foster care licensed under Minnesota Rules, parts 2960.3000 to 2960.3340, or adult foster care licensed under Minnesota Rules, parts 9555.5105 to 9555.6265, under this chapter for a physical location that will not be the primary residence of the license holder for the entire period of licensure. If a family child foster care home or family adult foster care home license is issued during this moratorium, and the license holder changes the license holder's primary residence away from the physical location of the foster care license, the commissioner shall revoke the license according to section 245A.07. The commissioner shall not issue an initial license for a community residential setting licensed under chapter 245D. When approving an exception under this paragraph, the commissioner shall consider the resource need determination process in paragraph (h), the availability of foster care licensed beds in the geographic area in which the licensee seeks to operate, the results of a person's choices during their annual assessment and service plan review, and the recommendation of the local county board. The determination by the commissioner is final and not subject to appeal. Exceptions to the moratorium include:

(1) foster care settings where at least 80 percent of the residents are 55 years of age or older;

(2) foster care licenses replacing foster care licenses in existence on May 15, 2009, or community residential setting licenses replacing adult foster care licenses in existence on

December 31, 2013, and determined to be needed by the commissioner under paragraph (b);

(3) new foster care licenses or community residential setting licenses determined to be needed by the commissioner under paragraph (b) for the closure of a nursing facility, ICF/DD, or regional treatment center; restructuring of state-operated services that limits the capacity of state-operated facilities; or allowing movement to the community for people who no longer require the level of care provided in state-operated facilities as provided under section 256B.092, subdivision 13, or 256B.49, subdivision 24;

(4) new foster care licenses or community residential setting licenses determined to be needed by the commissioner under paragraph (b) for persons requiring hospital level care; or

~~(5) new foster care licenses or community residential setting licenses for people receiving services under chapter 245D and residing in an unlicensed setting before May 1, 2017, and for which a license is required. This exception does not apply to people living in their own home. For purposes of this clause, there is a presumption that a foster care or community residential setting license is required for services provided to three or more people in a dwelling unit when the setting is controlled by the provider. A license holder subject to this exception may rebut the presumption that a license is required by seeking a reconsideration of the commissioner's determination. The commissioner's disposition of a request for reconsideration is final and not subject to appeal under chapter 14. The exception is available until June 30, 2018. This exception is available when:~~

~~(i) the person's case manager provided the person with information about the choice of service, service provider, and location of service, including in the person's home, to help the person make an informed choice; and~~

~~(ii) the person's services provided in the licensed foster care or community residential setting are less than or equal to the cost of the person's services delivered in the unlicensed setting as determined by the lead agency; or~~

~~(6)~~ (5) new foster care licenses or community residential setting licenses for people receiving customized living or 24-hour customized living services under the brain injury or community access for disability inclusion waiver plans under section 256B.49 and residing in the customized living setting before July 1, 2022, for which a license is required. A customized living service provider subject to this exception may rebut the presumption that a license is required by seeking a reconsideration of the commissioner's determination. The commissioner's disposition of a request for reconsideration is final and not subject to appeal

under chapter 14. The exception is available until June 30, 2023. This exception is available when:

(i) the person's customized living services are provided in a customized living service setting serving four or fewer people under the brain injury or community access for disability inclusion waiver plans under section 256B.49 in a single-family home operational on or before June 30, 2021. Operational is defined in section 256B.49, subdivision 28;

(ii) the person's case manager provided the person with information about the choice of service, service provider, and location of service, including in the person's home, to help the person make an informed choice; and

(iii) the person's services provided in the licensed foster care or community residential setting are less than or equal to the cost of the person's services delivered in the customized living setting as determined by the lead agency.

(b) The commissioner shall determine the need for newly licensed foster care homes or community residential settings as defined under this subdivision. As part of the determination, the commissioner shall consider the availability of foster care capacity in the area in which the licensee seeks to operate, and the recommendation of the local county board. The determination by the commissioner must be final. A determination of need is not required for a change in ownership at the same address.

(c) When an adult resident served by the program moves out of a foster home that is not the primary residence of the license holder according to section 256B.49, subdivision 15, paragraph (f), or the adult community residential setting, the county shall immediately inform the Department of Human Services Licensing Division. The department may decrease the statewide licensed capacity for adult foster care settings.

(d) Residential settings that would otherwise be subject to the decreased license capacity established in paragraph (c) shall be exempt if the license holder's beds are occupied by residents whose primary diagnosis is mental illness and the license holder is certified under the requirements in subdivision 6a or section 245D.33.

(e) A resource need determination process, managed at the state level, using the available reports required by section 144A.351, and other data and information shall be used to determine where the reduced capacity determined under section 256B.493 will be implemented. The commissioner shall consult with the stakeholders described in section 144A.351, and employ a variety of methods to improve the state's capacity to meet the informed decisions of those people who want to move out of corporate foster care or community residential settings, long-term service needs within budgetary limits, including

seeking proposals from service providers or lead agencies to change service type, capacity, or location to improve services, increase the independence of residents, and better meet needs identified by the long-term services and supports reports and statewide data and information.

(f) At the time of application and reapplication for licensure, the applicant and the license holder that are subject to the moratorium or an exclusion established in paragraph (a) are required to inform the commissioner whether the physical location where the foster care will be provided is or will be the primary residence of the license holder for the entire period of licensure. If the primary residence of the applicant or license holder changes, the applicant or license holder must notify the commissioner immediately. The commissioner shall print on the foster care license certificate whether or not the physical location is the primary residence of the license holder.

(g) License holders of foster care homes identified under paragraph (f) that are not the primary residence of the license holder and that also provide services in the foster care home that are covered by a federally approved home and community-based services waiver, as authorized under chapter 256S or section 256B.092 or 256B.49, must inform the human services licensing division that the license holder provides or intends to provide these waiver-funded services.

(h) The commissioner may adjust capacity to address needs identified in section 144A.351. Under this authority, the commissioner may approve new licensed settings or delicense existing settings. Delicensing of settings will be accomplished through a process identified in section 256B.493. Annually, by August 1, the commissioner shall provide information and data on capacity of licensed long-term services and supports, actions taken under the subdivision to manage statewide long-term services and supports resources, and any recommendations for change to the legislative committees with jurisdiction over the health and human services budget.

(i) The commissioner must notify a license holder when its corporate foster care or community residential setting licensed beds are reduced under this section. The notice of reduction of licensed beds must be in writing and delivered to the license holder by certified mail or personal service. The notice must state why the licensed beds are reduced and must inform the license holder of its right to request reconsideration by the commissioner. The license holder's request for reconsideration must be in writing. If mailed, the request for reconsideration must be postmarked and sent to the commissioner within 20 calendar days after the license holder's receipt of the notice of reduction of licensed beds. If a request for

reconsideration is made by personal service, it must be received by the commissioner within 20 calendar days after the license holder's receipt of the notice of reduction of licensed beds.

(j) The commissioner shall not issue an initial license for children's residential treatment services licensed under Minnesota Rules, parts 2960.0580 to 2960.0700, under this chapter for a program that Centers for Medicare and Medicaid Services would consider an institution for mental diseases. Facilities that serve only private pay clients are exempt from the moratorium described in this paragraph. The commissioner has the authority to manage existing statewide capacity for children's residential treatment services subject to the moratorium under this paragraph and may issue an initial license for such facilities if the initial license would not increase the statewide capacity for children's residential treatment services subject to the moratorium under this paragraph.

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

Sec. 10. Minnesota Statutes 2020, section 245D.12, is amended to read:

245D.12 INTEGRATED COMMUNITY SUPPORTS; SETTING CAPACITY REPORT.

(a) The license holder providing integrated community support, as defined in section 245D.03, subdivision 1, paragraph (c), clause (8), must submit a setting capacity report to the commissioner to ensure the identified location of service delivery meets the criteria of the home and community-based service requirements as specified in section 256B.492.

(b) The license holder shall provide the setting capacity report on the forms and in the manner prescribed by the commissioner. The report must include:

(1) the address of the multifamily housing building where the license holder delivers integrated community supports and owns, leases, or has a direct or indirect financial relationship with the property owner;

(2) the total number of living units in the multifamily housing building described in clause (1) where integrated community supports are delivered;

(3) the total number of living units in the multifamily housing building described in clause (1), including the living units identified in clause (2); ~~and~~

(4) the total number of people who could reside in the living units in the multifamily housing building described in clause (2) and receive integrated community supports; and

~~(4)~~ (5) the percentage of living units that are controlled by the license holder in the multifamily housing building by dividing clause (2) by clause (3).

(c) Only one license holder may deliver integrated community supports at the address of the multifamily housing building.

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

Sec. 11. Minnesota Statutes 2021 Supplement, section 245I.02, subdivision 19, is amended to read:

Subd. 19. **Level of care assessment.** "Level of care assessment" means the level of care decision support tool appropriate to the client's age. For a client five years of age or younger, a level of care assessment is the Early Childhood Service Intensity Instrument (ESCII). For a client six to 17 years of age, a level of care assessment is the Child and Adolescent Service Intensity Instrument (CASII). For a client 18 years of age or older, a level of care assessment is the Level of Care Utilization System for Psychiatric and Addiction Services (LOCUS) or another tool authorized by the commissioner.

Sec. 12. Minnesota Statutes 2021 Supplement, section 245I.02, subdivision 36, is amended to read:

Subd. 36. **Staff person.** "Staff person" means an individual who works under a license holder's direction or under a contract with a license holder. Staff person includes an intern, consultant, contractor, individual who works part-time, and an individual who does not provide direct contact services to clients but does have physical access to clients. Staff person includes a volunteer who provides treatment services to a client or a volunteer whom the license holder regards as a staff person for the purpose of meeting staffing or service delivery requirements. A staff person must be 18 years of age or older.

Sec. 13. Minnesota Statutes 2021 Supplement, section 245I.03, subdivision 9, is amended to read:

Subd. 9. **Volunteers.** ~~A~~ If a license holder uses volunteers, the license holder must have policies and procedures for using volunteers, including when ~~a~~ the license holder must submit a background study for a volunteer, and the specific tasks that a volunteer may perform.

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. 14. Minnesota Statutes 2021 Supplement, section 245I.04, subdivision 4, is amended to read:

Subd. 4. **Mental health practitioner qualifications.** (a) An individual who is qualified in at least one of the ways described in paragraph (b) to (d) may serve as a mental health practitioner.

(b) An individual is qualified as a mental health practitioner through relevant coursework if the individual completes at least 30 semester hours or 45 quarter hours in behavioral sciences or related fields and:

(1) has at least 2,000 hours of experience providing services to individuals with:

(i) a mental illness or a substance use disorder; or

(ii) a traumatic brain injury or a developmental disability, and completes the additional training described in section 245I.05, subdivision 3, paragraph (c), before providing direct contact services to a client;

(2) is fluent in the non-English language of the ethnic group to which at least 50 percent of the individual's clients belong, and completes the additional training described in section 245I.05, subdivision 3, paragraph (c), before providing direct contact services to a client;

(3) is working in a day treatment program under section 256B.0671, subdivision 3, or 256B.0943; ~~or~~

(4) has completed a practicum or internship that (i) required direct interaction with adult clients or child clients, and (ii) was focused on behavioral sciences or related fields~~.~~; or

(5) is in the process of completing a practicum or internship as part of a formal undergraduate or graduate training program in social work, psychology, or counseling.

(c) An individual is qualified as a mental health practitioner through work experience if the individual:

(1) has at least 4,000 hours of experience in the delivery of services to individuals with:

(i) a mental illness or a substance use disorder; or

(ii) a traumatic brain injury or a developmental disability, and completes the additional training described in section 245I.05, subdivision 3, paragraph (c), before providing direct contact services to clients; or

(2) receives treatment supervision at least once per week until meeting the requirement in clause (1) of 4,000 hours of experience and has at least 2,000 hours of experience providing services to individuals with:

(i) a mental illness or a substance use disorder; or

(ii) a traumatic brain injury or a developmental disability, and completes the additional training described in section 245I.05, subdivision 3, paragraph (c), before providing direct contact services to clients.

(d) An individual is qualified as a mental health practitioner if the individual has a master's or other graduate degree in behavioral sciences or related fields.

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 2021 Supplement, section 245I.05, subdivision 3, is amended to read:

Subd. 3. **Initial training.** (a) A staff person must receive training about:

(1) vulnerable adult maltreatment under section 245A.65, subdivision 3; and

(2) the maltreatment of minor reporting requirements and definitions in chapter 260E within 72 hours of first providing direct contact services to a client.

(b) Before providing direct contact services to a client, a staff person must receive training about:

(1) client rights and protections under section 245I.12;

(2) the Minnesota Health Records Act, including client confidentiality, family engagement under section 144.294, and client privacy;

(3) emergency procedures that the staff person must follow when responding to a fire, inclement weather, a report of a missing person, and a behavioral or medical emergency;

(4) specific activities and job functions for which the staff person is responsible, including the license holder's program policies and procedures applicable to the staff person's position;

(5) professional boundaries that the staff person must maintain; and

(6) specific needs of each client to whom the staff person will be providing direct contact services, including each client's developmental status, cognitive functioning, and physical and mental abilities.

(c) Before providing direct contact services to a client, a mental health rehabilitation worker, mental health behavioral aide, or mental health practitioner ~~qualified under~~ required to receive the training according to section 245I.04, subdivision 4, must receive 30 hours of training about:

(1) mental illnesses;

(2) client recovery and resiliency;

(3) mental health de-escalation techniques;

(4) co-occurring mental illness and substance use disorders; and

(5) psychotropic medications and medication side effects.

(d) Within 90 days of first providing direct contact services to an adult client, a clinical trainee, mental health practitioner, mental health certified peer specialist, or mental health rehabilitation worker must receive training about:

(1) trauma-informed care and secondary trauma;

(2) person-centered individual treatment plans, including seeking partnerships with family and other natural supports;

(3) co-occurring substance use disorders; and

(4) culturally responsive treatment practices.

(e) Within 90 days of first providing direct contact services to a child client, a clinical trainee, mental health practitioner, mental health certified family peer specialist, mental health certified peer specialist, or mental health behavioral aide must receive training about the topics in clauses (1) to (5). This training must address the developmental characteristics of each child served by the license holder and address the needs of each child in the context of the child's family, support system, and culture. Training topics must include:

(1) trauma-informed care and secondary trauma, including adverse childhood experiences (ACEs);

(2) family-centered treatment plan development, including seeking partnership with a child client's family and other natural supports;

(3) mental illness and co-occurring substance use disorders in family systems;

(4) culturally responsive treatment practices; and

(5) child development, including cognitive functioning, and physical and mental abilities.

(f) For a mental health behavioral aide, the training under paragraph (e) must include parent team training using a curriculum approved by the commissioner.

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. 16. Minnesota Statutes 2021 Supplement, section 245I.08, subdivision 4, is amended to read:

Subd. 4. **Progress notes.** A license holder must use a progress note to document each occurrence of a mental health service that a staff person provides to a client. A progress note must include the following:

(1) the type of service;

(2) the date of service;

(3) the start and stop time of the service unless the license holder is licensed as a residential program;

(4) the location of the service;

(5) the scope of the service, including: (i) the targeted goal and objective; (ii) the intervention that the staff person provided to the client and the methods that the staff person used; (iii) the client's response to the intervention; (iv) the staff person's plan to take future actions, including changes in treatment that the staff person will implement if the intervention was ineffective; and (v) the service modality;

(6) the signature~~, printed name,~~ and credentials of the staff person who provided the service to the client;

(7) the mental health provider travel documentation required by section 256B.0625, if applicable; and

(8) significant observations by the staff person, if applicable, including: (i) the client's current risk factors; (ii) emergency interventions by staff persons; (iii) consultations with or referrals to other professionals, family, or significant others; and (iv) changes in the client's mental or physical symptoms.

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. 17. Minnesota Statutes 2021 Supplement, section 245I.09, subdivision 2, is amended to read:

Subd. 2. **Record retention.** A license holder must retain client records of a discharged client for a minimum of five years from the date of the client's discharge. A license holder who ~~ceases to provide treatment services to a client~~ closes a program must retain ~~the~~ a client's records for a minimum of five years from the date that the license holder stopped providing services to the client and must notify the commissioner of the location of the client records and the name of the individual responsible for storing and maintaining the client records.

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. 18. Minnesota Statutes 2021 Supplement, section 245I.10, subdivision 2, is amended to read:

Subd. 2. **Generally.** (a) A license holder must use a client's diagnostic assessment or crisis assessment to determine a client's eligibility for mental health services, except as provided in this section.

(b) Prior to completing a client's initial diagnostic assessment, a license holder may provide a client with the following services:

(1) an explanation of findings;

(2) neuropsychological testing, neuropsychological assessment, and psychological testing;

(3) any combination of psychotherapy sessions, family psychotherapy sessions, and family psychoeducation sessions not to exceed three sessions;

(4) crisis assessment services according to section 256B.0624; and

(5) ten days of intensive residential treatment services according to the assessment and treatment planning standards in section ~~245.23~~ 245I.23, subdivision 7.

(c) Based on the client's needs that a crisis assessment identifies under section 256B.0624, a license holder may provide a client with the following services:

(1) crisis intervention and stabilization services under section 245I.23 or 256B.0624; and

(2) any combination of psychotherapy sessions, group psychotherapy sessions, family psychotherapy sessions, and family psychoeducation sessions not to exceed ten sessions within a 12-month period without prior authorization.

(d) Based on the client's needs in the client's brief diagnostic assessment, a license holder may provide a client with any combination of psychotherapy sessions, group psychotherapy sessions, family psychotherapy sessions, and family psychoeducation sessions not to exceed ten sessions within a 12-month period without prior authorization for any new client or for an existing client who the license holder projects will need fewer than ten sessions during the next 12 months.

(e) Based on the client's needs that a hospital's medical history and presentation examination identifies, a license holder may provide a client with:

(1) any combination of psychotherapy sessions, group psychotherapy sessions, family psychotherapy sessions, and family psychoeducation sessions not to exceed ten sessions within a 12-month period without prior authorization for any new client or for an existing client who the license holder projects will need fewer than ten sessions during the next 12 months; and

(2) up to five days of day treatment services or partial hospitalization.

(f) A license holder must complete a new standard diagnostic assessment of a client:

(1) when the client requires services of a greater number or intensity than the services that paragraphs (b) to (e) describe;

(2) at least annually following the client's initial diagnostic assessment if the client needs additional mental health services and the client does not meet the criteria for a brief assessment;

(3) when the client's mental health condition has changed markedly since the client's most recent diagnostic assessment; or

(4) when the client's current mental health condition does not meet the criteria of the client's current diagnosis.

(g) For an existing client, the license holder must ensure that a new standard diagnostic assessment includes a written update containing all significant new or changed information about the client, and an update regarding what information has not significantly changed, including a discussion with the client about changes in the client's life situation, functioning, presenting problems, and progress with achieving treatment goals since the client's last diagnostic assessment was completed.

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. 19. Minnesota Statutes 2021 Supplement, section 245I.10, subdivision 6, is amended to read:

Subd. 6. **Standard diagnostic assessment; required elements.** (a) Only a mental health professional or a clinical trainee may complete a standard diagnostic assessment of a client. A standard diagnostic assessment of a client must include a face-to-face interview with a client and a written evaluation of the client. The assessor must complete a client's standard diagnostic assessment within the client's cultural context.

(b) When completing a standard diagnostic assessment of a client, the assessor must gather and document information about the client's current life situation, including the following information:

(1) the client's age;

(2) the client's current living situation, including the client's housing status and household members;

(3) the status of the client's basic needs;

(4) the client's education level and employment status;

(5) the client's current medications;

(6) any immediate risks to the client's health and safety;

(7) the client's perceptions of the client's condition;

(8) the client's description of the client's symptoms, including the reason for the client's referral;

(9) the client's history of mental health treatment; and

(10) cultural influences on the client.

(c) If the assessor cannot obtain the information that this ~~subdivision~~ paragraph requires without retraumatizing the client or harming the client's willingness to engage in treatment, the assessor must identify which topics will require further assessment during the course of the client's treatment. The assessor must gather and document information related to the following topics:

(1) the client's relationship with the client's family and other significant personal relationships, including the client's evaluation of the quality of each relationship;

(2) the client's strengths and resources, including the extent and quality of the client's social networks;

(3) important developmental incidents in the client's life;

(4) maltreatment, trauma, potential brain injuries, and abuse that the client has suffered;

(5) the client's history of or exposure to alcohol and drug usage and treatment; and

(6) the client's health history and the client's family health history, including the client's physical, chemical, and mental health history.

(d) When completing a standard diagnostic assessment of a client, an assessor must use a recognized diagnostic framework.

(1) When completing a standard diagnostic assessment of a client who is five years of age or younger, the assessor must use the current edition of the DC: 0-5 Diagnostic Classification of Mental Health and Development Disorders of Infancy and Early Childhood published by Zero to Three.

(2) When completing a standard diagnostic assessment of a client who is six years of age or older, the assessor must use the current edition of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association.

(3) When completing a standard diagnostic assessment of a client who is five years of age or younger, an assessor must administer the Early Childhood Service Intensity Instrument (ECSII) to the client and include the results in the client's assessment.

(4) When completing a standard diagnostic assessment of a client who is six to 17 years of age, an assessor must administer the Child and Adolescent Service Intensity Instrument (CASII) to the client and include the results in the client's assessment.

(5) When completing a standard diagnostic assessment of a client who is 18 years of age or older, an assessor must use either (i) the CAGE-AID Questionnaire or (ii) the criteria in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association to screen and assess the client for a substance use disorder.

(e) When completing a standard diagnostic assessment of a client, the assessor must include and document the following components of the assessment:

(1) the client's mental status examination;

(2) the client's baseline measurements; symptoms; behavior; skills; abilities; resources; vulnerabilities; safety needs, including client information that supports the assessor's findings after applying a recognized diagnostic framework from paragraph (d); and any differential diagnosis of the client;

(3) an explanation of: (i) how the assessor diagnosed the client using the information from the client's interview, assessment, psychological testing, and collateral information about the client; (ii) the client's needs; (iii) the client's risk factors; (iv) the client's strengths; and (v) the client's responsivity factors.

(f) When completing a standard diagnostic assessment of a client, the assessor must consult the client and the client's family about which services that the client and the family prefer to treat the client. The assessor must make referrals for the client as to services required by law.

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. 20. Minnesota Statutes 2021 Supplement, section 245I.20, subdivision 5, is amended to read:

Subd. 5. **Treatment supervision specified.** (a) A mental health professional must remain responsible for each client's case. The certification holder must document the name of the mental health professional responsible for each case and the dates that the mental health professional is responsible for the client's case from beginning date to end date. The certification holder must assign each client's case for assessment, diagnosis, and treatment services to a treatment team member who is competent in the assigned clinical service, the recommended treatment strategy, and in treating the client's characteristics.

(b) Treatment supervision of mental health practitioners and clinical trainees required by section 245I.06 must include case reviews as described in this paragraph. Every two months, a mental health professional must complete and document a case review of each client assigned to the mental health professional when the client is receiving clinical services from a mental health practitioner or clinical trainee. The case review must include a consultation process that thoroughly examines the client's condition and treatment, including: (1) a review of the client's reason for seeking treatment, diagnoses and assessments, and the individual treatment plan; (2) a review of the appropriateness, duration, and outcome of treatment provided to the client; and (3) treatment recommendations.

Sec. 21. Minnesota Statutes 2021 Supplement, section 245I.23, subdivision 22, is amended to read:

Subd. 22. **Additional policy and procedure requirements.** (a) In addition to the policies and procedures in section 245I.03, the license holder must establish, enforce, and maintain the policies and procedures in this subdivision.

(b) The license holder must have policies and procedures for receiving referrals and making admissions determinations about referred persons under subdivisions ~~14 to 16~~ 15 to 17.

(c) The license holder must have policies and procedures for discharging clients under subdivision ~~17~~ 18. In the policies and procedures, the license holder must identify the staff persons who are authorized to discharge clients from the program.

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. 22. Minnesota Statutes 2021 Supplement, section 254B.05, subdivision 5, is amended to read:

Subd. 5. **Rate requirements.** (a) The commissioner shall establish rates for substance use disorder services and service enhancements funded under this chapter.

(b) Eligible substance use disorder treatment services include:

(1) outpatient treatment services that are licensed according to sections 245G.01 to 245G.17, or applicable tribal license;

(2) comprehensive assessments provided according to sections 245.4863, paragraph (a), and 245G.05;

(3) care coordination services provided according to section 245G.07, subdivision 1, paragraph (a), clause (5);

(4) peer recovery support services provided according to section 245G.07, subdivision 2, clause (8);

(5) on July 1, 2019, or upon federal approval, whichever is later, withdrawal management services provided according to chapter 245F;

(6) medication-assisted therapy services that are licensed according to sections 245G.01 to 245G.17 and 245G.22, or applicable tribal license;

(7) medication-assisted therapy plus enhanced treatment services that meet the requirements of clause (6) and provide nine hours of clinical services each week;

(8) high, medium, and low intensity residential treatment services that are licensed according to sections 245G.01 to 245G.17 and 245G.21 or applicable tribal license which provide, respectively, 30, 15, and five hours of clinical services each week;

(9) hospital-based treatment services that are licensed according to sections 245G.01 to 245G.17 or applicable tribal license and licensed as a hospital under sections 144.50 to 144.56;

(10) adolescent treatment programs that are licensed as outpatient treatment programs according to sections 245G.01 to 245G.18 or as residential treatment programs according to Minnesota Rules, parts 2960.0010 to 2960.0220, and 2960.0430 to 2960.0490, or applicable tribal license;

(11) high-intensity residential treatment services that are licensed according to sections 245G.01 to 245G.17 and 245G.21 or applicable tribal license, which provide 30 hours of clinical services each week provided by a state-operated vendor or to clients who have been civilly committed to the commissioner, present the most complex and difficult care needs, and are a potential threat to the community; and

(12) room and board facilities that meet the requirements of subdivision 1a.

(c) The commissioner shall establish higher rates for programs that meet the requirements of paragraph (b) and one of the following additional requirements:

(1) programs that serve parents with their children if the program:

(i) provides on-site child care during the hours of treatment activity that:

(A) is licensed under chapter 245A as a child care center under Minnesota Rules, chapter 9503; or

(B) meets the licensure exclusion criteria of section 245A.03, subdivision 2, paragraph (a), clause (6), and meets the requirements under section 245G.19, subdivision 4; or

(ii) arranges for off-site child care during hours of treatment activity at a facility that is licensed under chapter 245A as:

(A) a child care center under Minnesota Rules, chapter 9503; or

(B) a family child care home under Minnesota Rules, chapter 9502;

(2) culturally specific or culturally responsive programs as defined in section 254B.01, subdivision 4a;

(3) disability responsive programs as defined in section 254B.01, subdivision 4b;

(4) programs that offer medical services delivered by appropriately credentialed health care staff in an amount equal to two hours per client per week if the medical needs of the client and the nature and provision of any medical services provided are documented in the client file; or

(5) programs that offer services to individuals with co-occurring mental health and chemical dependency problems if:

(i) the program meets the co-occurring requirements in section 245G.20;

(ii) 25 percent of the counseling staff are licensed mental health professionals~~, as defined in section 245.462, subdivision 18, clauses (1) to (6)~~ under section 245I.04, subdivision 2, or are students or licensing candidates under the supervision of a licensed alcohol and drug counselor supervisor and ~~licensed~~ mental health professional under section 245I.04, subdivision 2, except that no more than 50 percent of the mental health staff may be students or licensing candidates with time documented to be directly related to provisions of co-occurring services;

(iii) clients scoring positive on a standardized mental health screen receive a mental health diagnostic assessment within ten days of admission;

(iv) the program has standards for multidisciplinary case review that include a monthly review for each client that, at a minimum, includes a licensed mental health professional and licensed alcohol and drug counselor, and their involvement in the review is documented;

(v) family education is offered that addresses mental health and substance abuse disorders and the interaction between the two; and

(vi) co-occurring counseling staff shall receive eight hours of co-occurring disorder training annually.

(d) In order to be eligible for a higher rate under paragraph (c), clause (1), a program that provides arrangements for off-site child care must maintain current documentation at the chemical dependency facility of the child care provider's current licensure to provide child care services. Programs that provide child care according to paragraph (c), clause (1), must be deemed in compliance with the licensing requirements in section 245G.19.

(e) Adolescent residential programs that meet the requirements of Minnesota Rules, parts 2960.0430 to 2960.0490 and 2960.0580 to 2960.0690, are exempt from the requirements in paragraph (c), clause (4), items (i) to (iv).

(f) Subject to federal approval, substance use disorder services that are otherwise covered as direct face-to-face services may be provided via telehealth as defined in section 256B.0625, subdivision 3b. The use of telehealth to deliver services must be medically appropriate to the condition and needs of the person being served. Reimbursement shall be at the same rates and under the same conditions that would otherwise apply to direct face-to-face services.

(g) For the purpose of reimbursement under this section, substance use disorder treatment services provided in a group setting without a group participant maximum or maximum client to staff ratio under chapter 245G shall not exceed a client to staff ratio of 48 to one. At least one of the attending staff must meet the qualifications as established under this chapter for the type of treatment service provided. A recovery peer may not be included as part of the staff ratio.

(h) Payment for outpatient substance use disorder services that are licensed according to sections 245G.01 to 245G.17 is limited to six hours per day or 30 hours per week unless prior authorization of a greater number of hours is obtained from the commissioner.

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. 23. Minnesota Statutes 2021 Supplement, section 256B.0622, subdivision 2, is amended to read:

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

(b) "ACT team" means the group of interdisciplinary mental health staff who work as a team to provide assertive community treatment.

(c) "Assertive community treatment" means intensive nonresidential treatment and rehabilitative mental health services provided according to the assertive community treatment model. Assertive community treatment provides a single, fixed point of responsibility for treatment, rehabilitation, and support needs for clients. Services are offered 24 hours per day, seven days per week, in a community-based setting.

(d) "Individual treatment plan" means a plan described by section 245I.10, subdivisions 7 and 8.

(e) "Crisis assessment and intervention" means ~~mental health~~ mobile crisis response services ~~as defined in~~ under section 256B.0624~~, subdivision 2~~.

(f) "Individual treatment team" means a minimum of three members of the ACT team who are responsible for consistently carrying out most of a client's assertive community treatment services.

(g) "Primary team member" means the person who leads and coordinates the activities of the individual treatment team and is the individual treatment team member who has primary responsibility for establishing and maintaining a therapeutic relationship with the client on a continuing basis.

(h) "Certified rehabilitation specialist" means a staff person who is qualified according to section 245I.04, subdivision 8.

(i) "Clinical trainee" means a staff person who is qualified according to section 245I.04, subdivision 6.

(j) "Mental health certified peer specialist" means a staff person who is qualified according to section 245I.04, subdivision 10.

(k) "Mental health practitioner" means a staff person who is qualified according to section 245I.04, subdivision 4.

(l) "Mental health professional" means a staff person who is qualified according to section 245I.04, subdivision 2.

(m) "Mental health rehabilitation worker" means a staff person who is qualified according to section 245I.04, subdivision 14.

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. 24. 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~~,~~ or accessible video-based platforms 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. Beginning July 1, 2021, visits provided through telephone may satisfy the face-to-face requirement for reimbursement under these payment methods if the service would have otherwise qualified for payment if performed in person until the COVID-19 federal public health emergency ends or July 1, 2023, whichever is earlier.

~~(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)~~ (e) 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 real-time two-way interactive audio and visual communication 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, 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 a health care provider as defined under section 62A.673, a community paramedic as defined under section 144E.001, subdivision 5f, a community health worker who meets the criteria under subdivision 49, paragraph (a), a mental health certified peer specialist under section ~~256B.0615, subdivision 5~~ 245I.04, subdivision 10, a mental health certified family peer specialist under section ~~256B.0616, subdivision 5~~ 245I.04, subdivision 12, a mental health rehabilitation worker under section ~~256B.0623, subdivision 5, paragraph (a), clause (4), and paragraph (b)~~ 245I.04, subdivision 14, a mental health behavioral aide under section ~~256B.0943, subdivision 7, paragraph (b), clause (3)~~ 245I.04, subdivision 16, a treatment coordinator under section 245G.11, subdivision 7, an alcohol and drug counselor under section 245G.11, subdivision 5, 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.

EFFECTIVE DATE. This section is effective July 1, 2022, or upon federal approval, whichever is later, except that the amendment to paragraph (d) is effective retroactively from July 1, 2021, and expires when the COVID-19 federal public health emergency ends or July 1, 2023, whichever is earlier. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained and when the amendments to paragraph (d) expire.

Sec. 25. Minnesota Statutes 2020, section 256B.0659, subdivision 19, is amended to read:

Subd. 19. **Personal care assistance choice option; qualifications; duties.** (a) Under personal care assistance choice, the recipient or responsible party shall:

(1) recruit, hire, schedule, and terminate personal care assistants according to the terms of the written agreement required under subdivision 20, paragraph (a);

(2) develop a personal care assistance care plan based on the assessed needs and addressing the health and safety of the recipient with the assistance of a qualified professional as needed;

(3) orient and train the personal care assistant with assistance as needed from the qualified professional;

(4) ~~effective January 1, 2010,~~ supervise and evaluate the personal care assistant with the qualified professional, who is required to visit the recipient at least every 180 days;

(5) monitor and verify in writing and report to the personal care assistance choice agency the number of hours worked by the personal care assistant and the qualified professional;

(6) engage in an annual ~~face-to-face~~ reassessment as required in subdivision 3a to determine continuing eligibility and service authorization; and

(7) use the same personal care assistance choice provider agency if shared personal assistance care is being used.

(b) The personal care assistance choice provider agency shall:

(1) meet all personal care assistance provider agency standards;

(2) enter into a written agreement with the recipient, responsible party, and personal care assistants;

(3) not be related as a parent, child, sibling, or spouse to the recipient or the personal care assistant; and

(4) ensure arm's-length transactions without undue influence or coercion with the recipient and personal care assistant.

(c) The duties of the personal care assistance choice provider agency are to:

(1) be the employer of the personal care assistant and the qualified professional for employment law and related regulations including~~,~~ but not limited to~~,~~ purchasing and maintaining workers' compensation, unemployment insurance, surety and fidelity bonds, and liability insurance, and submit any or all necessary documentation including~~,~~ but not limited to~~,~~ workers' compensation, unemployment insurance, and labor market data required under section 256B.4912, subdivision 1a;

(2) bill the medical assistance program for personal care assistance services and qualified professional services;

(3) request and complete background studies that comply with the requirements for personal care assistants and qualified professionals;

(4) pay the personal care assistant and qualified professional based on actual hours of services provided;

(5) withhold and pay all applicable federal and state taxes;

(6) verify and keep records of hours worked by the personal care assistant and qualified professional;

(7) make the arrangements and pay taxes and other benefits, if any, and comply with any legal requirements for a Minnesota employer;

(8) enroll in the medical assistance program as a personal care assistance choice agency; and

(9) enter into a written agreement as specified in subdivision 20 before services are provided.

Sec. 26. Minnesota Statutes 2021 Supplement, section 256B.0671, subdivision 6, is amended to read:

Subd. 6. **Dialectical behavior therapy.** (a) Subject to federal approval, medical assistance covers intensive mental health outpatient treatment for dialectical behavior therapy for adults. A dialectical behavior therapy provider must make reasonable and good faith efforts

to report individual client outcomes to the commissioner using instruments and protocols that are approved by the commissioner.

(b) "Dialectical behavior therapy" means an evidence-based treatment approach that a mental health professional or clinical trainee provides to a client or a group of clients in an intensive outpatient treatment program using a combination of individualized rehabilitative and psychotherapeutic interventions. A dialectical behavior therapy program involves: individual dialectical behavior therapy, group skills training, telephone coaching, and team consultation meetings.

(c) To be eligible for dialectical behavior therapy, a client must:

~~(1) be 18 years of age or older;~~

~~(2)~~ (1) have mental health needs that available community-based services cannot meet or that the client must receive concurrently with other community-based services;

~~(3)~~ (2) have either:

(i) a diagnosis of borderline personality disorder; or

(ii) multiple mental health diagnoses, exhibit behaviors characterized by impulsivity or intentional self-harm, and be at significant risk of death, morbidity, disability, or severe dysfunction in multiple areas of the client's life;

~~(4)~~ (3) be cognitively capable of participating in dialectical behavior therapy as an intensive therapy program and be able and willing to follow program policies and rules to ensure the safety of the client and others; and

~~(5)~~ (4) be at significant risk of one or more of the following if the client does not receive dialectical behavior therapy:

(i) having a mental health crisis;

(ii) requiring a more restrictive setting such as hospitalization;

(iii) decompensating; or

(iv) engaging in intentional self-harm behavior.

(d) Individual dialectical behavior therapy combines individualized rehabilitative and psychotherapeutic interventions to treat a client's suicidal and other dysfunctional behaviors and to reinforce a client's use of adaptive skillful behaviors. A mental health professional or clinical trainee must provide individual dialectical behavior therapy to a client. A mental health professional or clinical trainee providing dialectical behavior therapy to a client must:

(1) identify, prioritize, and sequence the client's behavioral targets;

(2) treat the client's behavioral targets;

(3) assist the client in applying dialectical behavior therapy skills to the client's natural environment through telephone coaching outside of treatment sessions;

(4) measure the client's progress toward dialectical behavior therapy targets;

(5) help the client manage mental health crises and life-threatening behaviors; and

(6) help the client learn and apply effective behaviors when working with other treatment providers.

(e) Group skills training combines individualized psychotherapeutic and psychiatric rehabilitative interventions conducted in a group setting to reduce the client's suicidal and other dysfunctional coping behaviors and restore function. Group skills training must teach the client adaptive skills in the following areas: (1) mindfulness; (2) interpersonal effectiveness; (3) emotional regulation; and (4) distress tolerance.

(f) Group skills training must be provided by two mental health professionals or by a mental health professional co-facilitating with a clinical trainee or a mental health practitioner. Individual skills training must be provided by a mental health professional, a clinical trainee, or a mental health practitioner.

(g) Before a program provides dialectical behavior therapy to a client, the commissioner must certify the program as a dialectical behavior therapy provider. To qualify for certification as a dialectical behavior therapy provider, a provider must:

(1) allow the commissioner to inspect the provider's program;

(2) provide evidence to the commissioner that the program's policies, procedures, and practices meet the requirements of this subdivision and chapter 245I;

(3) be enrolled as a MHCP provider; and

(4) have a manual that outlines the program's policies, procedures, and practices that meet the requirements of this subdivision.

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. 27. Minnesota Statutes 2021 Supplement, section 256B.0911, subdivision 3a, is amended to read:

Subd. 3a. **Assessment and support planning.** (a) Persons requesting assessment, services planning, or other assistance intended to support community-based living, including persons who need assessment ~~in order~~ to determine waiver or alternative care program eligibility, must be visited by a long-term care consultation team within 20 calendar days after the date on which an assessment was requested or recommended. Upon statewide implementation of subdivisions 2b, 2c, and 5, this requirement also applies to an assessment of a person requesting personal care assistance services. The commissioner shall provide at least a 90-day notice to lead agencies prior to the effective date of this requirement. Assessments must be conducted according to paragraphs (b) to (r).

(b) Upon implementation of subdivisions 2b, 2c, and 5, lead agencies shall use certified assessors to conduct the assessment. For a person with complex health care needs, a public health or registered nurse from the team must be consulted.

(c) The MnCHOICES assessment provided by the commissioner to lead agencies must be used to complete a comprehensive, conversation-based, person-centered assessment. The assessment must include the health, psychological, functional, environmental, and social needs of the individual necessary to develop a person-centered community support plan that meets the individual's needs and preferences.

(d) Except as provided in paragraph (r), the assessment must be conducted by a certified assessor in a face-to-face conversational interview with the person being assessed. The person's legal representative must provide input during the assessment process and may do so remotely if requested. At the request of the person, other individuals may participate in the assessment to provide information on the needs, strengths, and preferences of the person necessary to develop a community support plan that ensures the person's health and safety. Except for legal representatives or family members invited by the person, persons participating in the assessment may not be a provider of service or have any financial interest in the provision of services. For persons who are to be assessed for elderly waiver customized living or adult day services under chapter 256S, with the permission of the person being assessed or the person's designated or legal representative, the client's current or proposed provider of services may submit a copy of the provider's nursing assessment or written report outlining its recommendations regarding the client's care needs. The person conducting the assessment must notify the provider of the date by which this information is to be submitted. This information shall be provided to the person conducting the assessment prior to the assessment. For a person who is to be assessed for waiver services under section

256B.092 or 256B.49, with the permission of the person being assessed or the person's designated legal representative, the person's current provider of services may submit a written report outlining recommendations regarding the person's care needs the person completed in consultation with someone who is known to the person and has interaction with the person on a regular basis. The provider must submit the report at least 60 days before the end of the person's current service agreement. The certified assessor must consider the content of the submitted report prior to finalizing the person's assessment or reassessment.

(e) The certified assessor and the individual responsible for developing the coordinated service and support plan must complete the community support plan and the coordinated service and support plan no more than 60 calendar days from the assessment visit. The person or the person's legal representative must be provided with a written community support plan within the timelines established by the commissioner, regardless of whether the person is eligible for Minnesota health care programs.

(f) For a person being assessed for elderly waiver services under chapter 256S, a provider who submitted information under paragraph (d) shall receive the final written community support plan when available and the Residential Services Workbook.

(g) The written community support plan must include:

(1) a summary of assessed needs as defined in paragraphs (c) and (d);

(2) the individual's options and choices to meet identified needs, including:

(i) all available options for case management services and providers;

(ii) all available options for employment services, settings, and providers;

(iii) all available options for living arrangements;

(iv) all available options for self-directed services and supports, including self-directed budget options; and

(v) service provided in a non-disability-specific setting;

(3) identification of health and safety risks and how those risks will be addressed, including personal risk management strategies;

(4) referral information; and

(5) informal caregiver supports, if applicable.

For a person determined eligible for state plan home care under subdivision 1a, paragraph (b), clause (1), the person or person's representative must also receive a copy of the home care service plan developed by the certified assessor.

(h) A person may request assistance in identifying community supports without participating in a complete assessment. Upon a request for assistance identifying community support, the person must be transferred or referred to long-term care options counseling services available under sections 256.975, subdivision 7, and 256.01, subdivision 24, for telephone assistance and follow up.

(i) The person has the right to make the final decision:

(1) between institutional placement and community placement after the recommendations have been provided, except as provided in section 256.975, subdivision 7a, paragraph (d);

(2) between community placement in a setting controlled by a provider and living independently in a setting not controlled by a provider;

(3) between day services and employment services; and

(4) regarding available options for self-directed services and supports, including self-directed funding options.

(j) The lead agency must give the person receiving long-term care consultation services or the person's legal representative, materials, and forms supplied by the commissioner containing the following information:

(1) written recommendations for community-based services and consumer-directed options;

(2) documentation that the most cost-effective alternatives available were offered to the individual. For purposes of this clause, "cost-effective" means community services and living arrangements that cost the same as or less than institutional care. For an individual found to meet eligibility criteria for home and community-based service programs under chapter 256S or section 256B.49, "cost-effectiveness" has the meaning found in the federally approved waiver plan for each program;

(3) the need for and purpose of preadmission screening conducted by long-term care options counselors according to section 256.975, subdivisions 7a to 7c, if the person selects nursing facility placement. If the individual selects nursing facility placement, the lead agency shall forward information needed to complete the level of care determinations and screening for developmental disability and mental illness collected during the assessment to the long-term care options counselor using forms provided by the commissioner;

(4) the role of long-term care consultation assessment and support planning in eligibility determination for waiver and alternative care programs, and state plan home care, case management, and other services as defined in subdivision 1a, paragraphs (a), clause (6), and (b);

(5) information about Minnesota health care programs;

(6) the person's freedom to accept or reject the recommendations of the team;

(7) the person's right to confidentiality under the Minnesota Government Data Practices Act, chapter 13;

(8) the certified assessor's decision regarding the person's need for institutional level of care as determined under criteria established in subdivision 4e and the certified assessor's decision regarding eligibility for all services and programs as defined in subdivision 1a, paragraphs (a), clause (6), and (b);

(9) the person's right to appeal the certified assessor's decision regarding eligibility for all services and programs as defined in subdivision 1a, paragraphs (a), clauses (6), (7), and (8), and (b), and incorporating the decision regarding the need for institutional level of care or the lead agency's final decisions regarding public programs eligibility according to section 256.045, subdivision 3. The certified assessor must verbally communicate this appeal right to the person and must visually point out where in the document the right to appeal is stated; and

(10) documentation that available options for employment services, independent living, and self-directed services and supports were described to the individual.

(k) An assessment that is completed as part of an eligibility determination for multiple programs for the alternative care, elderly waiver, developmental disabilities, community access for disability inclusion, community alternative care, and brain injury waiver programs under chapter 256S and sections 256B.0913, 256B.092, and 256B.49 is valid to establish service eligibility for no more than 60 calendar days after the date of the assessment.

(l) The effective eligibility start date for programs in paragraph (k) can never be prior to the date of assessment. If an assessment was completed more than 60 days before the effective waiver or alternative care program eligibility start date, assessment and support plan information must be updated and documented in the department's Medicaid Management Information System (MMIS). Notwithstanding retroactive medical assistance coverage of state plan services, the effective date of eligibility for programs included in paragraph (k) cannot be prior to the date the most recent updated assessment is completed.

(m) If an eligibility update is completed within 90 days of the previous assessment and documented in the department's Medicaid Management Information System (MMIS), the effective date of eligibility for programs included in paragraph (k) is the date of the previous face-to-face assessment when all other eligibility requirements are met.

(n) If a person who receives home and community-based waiver services under section 256B.0913, 256B.092, or 256B.49 or chapter 256S temporarily enters for 121 days or fewer a hospital, institution of mental disease, nursing facility, intensive residential treatment services program, transitional care unit, or inpatient substance use disorder treatment setting, the person may return to the community with home and community-based waiver services under the same waiver, without requiring an assessment or reassessment under this section, unless the person's annual reassessment is otherwise due. Nothing in this paragraph shall change annual long-term care consultation reassessment requirements, payment for institutional or treatment services, medical assistance financial eligibility, or any other law.

(o) At the time of reassessment, the certified assessor shall assess each person receiving waiver residential supports and services currently residing in a community residential setting, licensed adult foster care home that is either not the primary residence of the license holder or in which the license holder is not the primary caregiver, family adult foster care residence, customized living setting, or supervised living facility to determine if that person would prefer to be served in a community-living setting as defined in section 256B.49, subdivision 23, in a setting not controlled by a provider, or to receive integrated community supports as described in section 245D.03, subdivision 1, paragraph (c), clause (8). The certified assessor shall offer the person, through a person-centered planning process, the option to receive alternative housing and service options.

(p) At the time of reassessment, the certified assessor shall assess each person receiving waiver day services to determine if that person would prefer to receive employment services as described in section 245D.03, subdivision 1, paragraph (c), clauses (5) to (7). The certified assessor shall describe to the person through a person-centered planning process the option to receive employment services.

(q) At the time of reassessment, the certified assessor shall assess each person receiving non-self-directed waiver services to determine if that person would prefer an available service and setting option that would permit self-directed services and supports. The certified assessor shall describe to the person through a person-centered planning process the option to receive self-directed services and supports.

(r) All assessments performed according to this subdivision must be face-to-face unless the assessment is a reassessment meeting the requirements of this paragraph. Remote reassessments conducted by interactive video or telephone may substitute for face-to-face reassessments. For services provided by the developmental disabilities waiver under section 256B.092, and the community access for disability inclusion, community alternative care, and brain injury waiver programs under section 256B.49, remote reassessments may be substituted for two consecutive reassessments if followed by a face-to-face reassessment. For services provided by alternative care under section 256B.0913, essential community supports under section 256B.0922, and the elderly waiver under chapter 256S, remote reassessments may be substituted for one reassessment if followed by a face-to-face reassessment. A remote reassessment is permitted only if the person being reassessed~~, or the person's legal representative, and the lead agency case manager both agree that there is no change in the person's condition, there is no need for a change in service, and that a remote reassessment is appropriate~~ or the person's legal representative provide informed choice for a remote assessment. The person being reassessed, or the person's legal representative, has the right to refuse a remote reassessment at any time. During a remote reassessment, if the certified assessor determines a face-to-face reassessment is necessary ~~in order~~ to complete the assessment, the lead agency shall schedule a face-to-face reassessment. All other requirements of a face-to-face reassessment shall apply to a remote reassessment, including updates to a person's support plan.

Sec. 28. Minnesota Statutes 2021 Supplement, section 256B.0946, subdivision 1, is amended to read:

Subdivision 1. **Required covered service components.** (a) Subject to federal approval, medical assistance covers medically necessary intensive treatment services when the services are provided by a provider entity certified under and meeting the standards in this section. The provider entity must make reasonable and good faith efforts to report individual client outcomes to the commissioner, using instruments and protocols approved by the commissioner.

(b) Intensive treatment services to children with mental illness residing in foster family settings that comprise specific required service components provided in clauses (1) to (6) are reimbursed by medical assistance when they meet the following standards:

(1) psychotherapy provided by a mental health professional or a clinical trainee;

(2) crisis planning;

(3) individual, family, and group psychoeducation services provided by a mental health professional or a clinical trainee;

(4) clinical care consultation provided by a mental health professional or a clinical trainee;

(5) individual treatment plan development as defined in ~~Minnesota Rules, part 9505.0371, subpart 7~~ section 245I.10, subdivisions 7 and 8; and

(6) service delivery payment requirements as provided under subdivision 4.

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. 29. Minnesota Statutes 2021 Supplement, section 256B.0947, subdivision 2, is amended to read:

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

(a) "Intensive nonresidential rehabilitative mental health services" means child rehabilitative mental health services as defined in section 256B.0943, except that these services are provided by a multidisciplinary staff using a total team approach consistent with assertive community treatment, as adapted for youth, and are directed to recipients who are eight years of age or older and under 26 years of age who require intensive services to prevent admission to an inpatient psychiatric hospital or placement in a residential treatment facility or who require intensive services to step down from inpatient or residential care to community-based care.

(b) "Co-occurring mental illness and substance use disorder" means a dual diagnosis of at least one form of mental illness and at least one substance use disorder. Substance use disorders include alcohol or drug abuse or dependence, excluding nicotine use.

(c) "Standard diagnostic assessment" means the assessment described in section 245I.10, subdivision 6.

(d) "Medication education services" means services provided individually or in groups, which focus on:

(1) educating the client and client's family or significant nonfamilial supporters about mental illness and symptoms;

(2) the role and effects of medications in treating symptoms of mental illness; and

(3) the side effects of medications.

Medication education is coordinated with medication management services and does not duplicate it. Medication education services are provided by physicians, pharmacists, or registered nurses with certification in psychiatric and mental health care.

(e) "Mental health professional" means a staff person who is qualified according to section 245I.04, subdivision 2.

(f) "Provider agency" means a for-profit or nonprofit organization established to administer an assertive community treatment for youth team.

(g) "Substance use disorders" means one or more of the disorders defined in the diagnostic and statistical manual of mental disorders, current edition.

(h) "Transition services" means:

(1) activities, materials, consultation, and coordination that ensures continuity of the client's care in advance of and in preparation for the client's move from one stage of care or life to another by maintaining contact with the client and assisting the client to establish provider relationships;

(2) providing the client with knowledge and skills needed posttransition;

(3) establishing communication between sending and receiving entities;

(4) supporting a client's request for service authorization and enrollment; and

(5) establishing and enforcing procedures and schedules.

~~A youth's transition from the children's mental health system and services to the adult mental health system and services and return to the client's home and entry or re-entry into community-based mental health services following discharge from an out-of-home placement or inpatient hospital stay.~~

(i) "Treatment team" means all staff who provide services to recipients under this section.

(j) "Family peer specialist" means a staff person who is qualified under section 256B.0616.

Sec. 30. Minnesota Statutes 2021 Supplement, section 256B.0947, subdivision 6, is amended to read:

Subd. 6. **Service standards.** The standards in this subdivision apply to intensive nonresidential rehabilitative mental health services.

(a) The treatment team must use team treatment, not an individual treatment model.

(b) Services must be available at times that meet client needs.

(c) Services must be age-appropriate and meet the specific needs of the client.

(d) The level of care assessment as defined in section 245I.02, subdivision 19, and functional assessment as defined in section 245I.02, subdivision 17, must be updated at least every ~~90 days~~ six months or prior to discharge from the service, whichever comes first.

(e) The treatment team must complete an individual treatment plan for each client, according to section 245I.10, subdivisions 7 and 8, and the individual treatment plan must:

(1) be completed in consultation with the client's current therapist and key providers and provide for ongoing consultation with the client's current therapist to ensure therapeutic continuity and to facilitate the client's return to the community. For clients under the age of 18, the treatment team must consult with parents and guardians in developing the treatment plan;

(2) if a need for substance use disorder treatment is indicated by validated assessment:

(i) identify goals, objectives, and strategies of substance use disorder treatment;

(ii) develop a schedule for accomplishing substance use disorder treatment goals and objectives; and

(iii) identify the individuals responsible for providing substance use disorder treatment services and supports; and

(3) provide for the client's transition out of intensive nonresidential rehabilitative mental health services by defining the team's actions to assist the client and subsequent providers in the transition to less intensive or "stepped down" services~~; and~~.

~~(4) notwithstanding section 245I.10, subdivision 8, be reviewed at least every 90 days and revised to document treatment progress or, if progress is not documented, to document changes in treatment.~~

(f) The treatment team shall actively and assertively engage the client's family members and significant others by establishing communication and collaboration with the family and significant others and educating the family and significant others about the client's mental illness, symptom management, and the family's role in treatment, unless the team knows or has reason to suspect that the client has suffered or faces a threat of suffering any physical or mental injury, abuse, or neglect from a family member or significant other.

(g) For a client age 18 or older, the treatment team may disclose to a family member, other relative, or a close personal friend of the client, or other person identified by the client, the protected health information directly relevant to such person's involvement with the client's care, as provided in Code of Federal Regulations, title 45, part 164.502(b). If the client is present, the treatment team shall obtain the client's agreement, provide the client with an opportunity to object, or reasonably infer from the circumstances, based on the exercise of professional judgment, that the client does not object. If the client is not present or is unable, by incapacity or emergency circumstances, to agree or object, the treatment team may, in the exercise of professional judgment, determine whether the disclosure is in the best interests of the client and, if so, disclose only the protected health information that is directly relevant to the family member's, relative's, friend's, or client-identified person's involvement with the client's health care. The client may orally agree or object to the disclosure and may prohibit or restrict disclosure to specific individuals.

(h) The treatment team shall provide interventions to promote positive interpersonal relationships.

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. 31. Minnesota Statutes 2021 Supplement, section 256B.0949, subdivision 2, is amended to read:

Subd. 2. **Definitions.** (a) The terms used in this section have the meanings given in this subdivision.

(b) "Agency" means the legal entity that is enrolled with Minnesota health care programs as a medical assistance provider according to Minnesota Rules, part 9505.0195, to provide EIDBI services and that has the legal responsibility to ensure that its employees or contractors carry out the responsibilities defined in this section. Agency includes a licensed individual professional who practices independently and acts as an agency.

(c) "Autism spectrum disorder or a related condition" or "ASD or a related condition" means either autism spectrum disorder (ASD) as defined in the current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM) or a condition that is found to be closely related to ASD, as identified under the current version of the DSM, and meets all of the following criteria:

(1) is severe and chronic;

(2) results in impairment of adaptive behavior and function similar to that of a person with ASD;

(3) requires treatment or services similar to those required for a person with ASD; and

(4) results in substantial functional limitations in three core developmental deficits of ASD: social or interpersonal interaction; functional communication, including nonverbal or social communication; and restrictive or repetitive behaviors or hyperreactivity or hyporeactivity to sensory input; and may include deficits or a high level of support in one or more of the following domains:

(i) behavioral challenges and self-regulation;

(ii) cognition;

(iii) learning and play;

(iv) self-care; or

(v) safety.

(d) "Person" means a person under 21 years of age.

(e) "Clinical supervision" means the overall responsibility for the control and direction of EIDBI service delivery, including individual treatment planning, staff supervision, individual treatment plan progress monitoring, and treatment review for each person. Clinical supervision is provided by a qualified supervising professional (QSP) who takes full professional responsibility for the service provided by each supervisee.

(f) "Commissioner" means the commissioner of human services, unless otherwise specified.

(g) "Comprehensive multidisciplinary evaluation" or "CMDE" means a comprehensive evaluation of a person to determine medical necessity for EIDBI services based on the requirements in subdivision 5.

(h) "Department" means the Department of Human Services, unless otherwise specified.

(i) "Early intensive developmental and behavioral intervention benefit" or "EIDBI benefit" means a variety of individualized, intensive treatment modalities approved and published by the commissioner that are based in behavioral and developmental science consistent with best practices on effectiveness.

(j) "Generalizable goals" means results or gains that are observed during a variety of activities over time with different people, such as providers, family members, other adults,

and people, and in different environments including~~,~~ but not limited to~~,~~ clinics, homes, schools, and the community.

(k) "Incident" means when any of the following occur:

(1) an illness, accident, or injury that requires first aid treatment;

(2) a bump or blow to the head; or

(3) an unusual or unexpected event that jeopardizes the safety of a person or staff, including a person leaving the agency unattended.

(l) "Individual treatment plan" or "ITP" means the person-centered, individualized written plan of care that integrates and coordinates person and family information from the CMDE for a person who meets medical necessity for the EIDBI benefit. An individual treatment plan must meet the standards in subdivision 6.

(m) "Legal representative" means the parent of a child who is under 18 years of age, a court-appointed guardian, or other representative with legal authority to make decisions about service for a person. For the purpose of this subdivision, "other representative with legal authority to make decisions" includes a health care agent or an attorney-in-fact authorized through a health care directive or power of attorney.

(n) "Mental health professional" means a staff person who is qualified according to section 245I.04, subdivision 2.

(o) "Person-centered" means a service that both responds to the identified needs, interests, values, preferences, and desired outcomes of the person or the person's legal representative and respects the person's history, dignity, and cultural background and allows inclusion and participation in the person's community.

(p) "Qualified EIDBI provider" means a person who is a QSP or a level I, level II, or level III treatment provider.

(q) "Advanced certification" means a person who has completed advanced certification in an approved modality under subdivision 13, paragraph (b).

Sec. 32. Minnesota Statutes 2021 Supplement, section 256B.0949, subdivision 13, is amended to read:

Subd. 13. **Covered services.** (a) The services described in paragraphs (b) to (l) are eligible for reimbursement by medical assistance under this section. Services must be provided by a qualified EIDBI provider and supervised by a QSP. An EIDBI service must address the person's medically necessary treatment goals and must be targeted to develop,

enhance, or maintain the individual developmental skills of a person with ASD or a related condition to improve functional communication, including nonverbal or social communication, social or interpersonal interaction, restrictive or repetitive behaviors, hyperreactivity or hyporeactivity to sensory input, behavioral challenges and self-regulation, cognition, learning and play, self-care, and safety.

(b) EIDBI treatment must be delivered consistent with the standards of an approved modality, as published by the commissioner. EIDBI modalities include:

(1) applied behavior analysis (ABA);

(2) developmental individual-difference relationship-based model (DIR/Floortime);

(3) early start Denver model (ESDM);

(4) PLAY project;

(5) relationship development intervention (RDI); or

(6) additional modalities not listed in clauses (1) to (5) upon approval by the commissioner.

(c) An EIDBI provider may use one or more of the EIDBI modalities in paragraph (b), clauses (1) to (5), as the primary modality for treatment as a covered service, or several EIDBI modalities in combination as the primary modality of treatment, as approved by the commissioner. An EIDBI provider that identifies and provides assurance of qualifications for a single specific treatment modality, including an EIDBI provider with advanced certification overseeing implementation, must document the required qualifications to meet fidelity to the specific model in a manner determined by the commissioner.

(d) Each qualified EIDBI provider must identify and provide assurance of qualifications for professional licensure certification, or training in evidence-based treatment methods, and must document the required qualifications outlined in subdivision 15 in a manner determined by the commissioner.

(e) CMDE is a comprehensive evaluation of the person's developmental status to determine medical necessity for EIDBI services and meets the requirements of subdivision 5. The services must be provided by a qualified CMDE provider.

(f) EIDBI intervention observation and direction is the clinical direction and oversight of EIDBI services by the QSP, level I treatment provider, or level II treatment provider, including developmental and behavioral techniques, progress measurement, data collection, function of behaviors, and generalization of acquired skills for the direct benefit of a person.

EIDBI intervention observation and direction informs any modification of the current treatment protocol to support the outcomes outlined in the ITP.

(g) Intervention is medically necessary direct treatment provided to a person with ASD or a related condition as outlined in their ITP. All intervention services must be provided under the direction of a QSP. Intervention may take place across multiple settings. The frequency and intensity of intervention services are provided based on the number of treatment goals, person and family or caregiver preferences, and other factors. Intervention services may be provided individually or in a group. Intervention with a higher provider ratio may occur when deemed medically necessary through the person's ITP.

(1) Individual intervention is treatment by protocol administered by a single qualified EIDBI provider delivered to one person.

(2) Group intervention is treatment by protocol provided by one or more qualified EIDBI providers, delivered to at least two people who receive EIDBI services.

(3) Higher provider ratio intervention is treatment with protocol modification provided by two or more qualified EIDBI providers delivered to one person in an environment that meets the person's needs and under the direction of the QSP or level I provider.

(h) ITP development and ITP progress monitoring is development of the initial, annual, and progress monitoring of an ITP. ITP development and ITP progress monitoring documents provide oversight and ongoing evaluation of a person's treatment and progress on targeted goals and objectives and integrate and coordinate the person's and the person's legal representative's information from the CMDE and ITP progress monitoring. This service must be reviewed and completed by the QSP, and may include input from a level I provider or a level II provider.

(i) Family caregiver training and counseling is specialized training and education for a family or primary caregiver to understand the person's developmental status and help with the person's needs and development. This service must be provided by the QSP, level I provider, or level II provider.

(j) A coordinated care conference is a voluntary meeting with the person and the person's family to review the CMDE or ITP progress monitoring and to integrate and coordinate services across providers and service-delivery systems to develop the ITP. This service ~~must be provided by the QSP and~~ may include the CMDE provider ~~or~~, QSP, a level I provider, or a level II provider.

(k) Travel time is allowable billing for traveling to and from the person's home, school, a community setting, or place of service outside of an EIDBI center, clinic, or office from a specified location to provide in-person EIDBI intervention, observation and direction, or family caregiver training and counseling. The person's ITP must specify the reasons the provider must travel to the person.

(l) Medical assistance covers medically necessary EIDBI services and consultations delivered ~~by a licensed health care provider~~ via telehealth, as defined under section 256B.0625, subdivision 3b, in the same manner as if the service or consultation was delivered in person.

Sec. 33. Minnesota Statutes 2020, section 256K.26, subdivision 2, is amended to read:

Subd. 2. **Implementation.** The commissioner, in consultation with the commissioners of the Department of Corrections and the Minnesota Housing Finance Agency, counties, Tribes, providers, and funders of supportive housing and services, shall develop application requirements and make funds available according to this section, with the goal of providing maximum flexibility in program design.

Sec. 34. Minnesota Statutes 2020, section 256K.26, subdivision 6, is amended to read:

Subd. 6. **Outcomes.** Projects will be selected to further the following outcomes:

(1) reduce the number of Minnesota individuals and families that experience long-term homelessness;

(2) increase the number of housing opportunities with supportive services;

(3) develop integrated, cost-effective service models that address the multiple barriers to obtaining housing stability faced by people experiencing long-term homelessness, including abuse, neglect, chemical dependency, disability, chronic health problems, or other factors including ethnicity and race that may result in poor outcomes or service disparities;

(4) encourage partnerships among counties, Tribes, community agencies, schools, and other providers so that the service delivery system is seamless for people experiencing long-term homelessness;

(5) increase employability, self-sufficiency, and other social outcomes for individuals and families experiencing long-term homelessness; and

(6) reduce inappropriate use of emergency health care, shelter, ~~chemical dependency~~ substance use disorder treatment, foster care, child protection, corrections, and similar services used by people experiencing long-term homelessness.

Sec. 35. Minnesota Statutes 2020, section 256K.26, subdivision 7, is amended to read:

Subd. 7. **Eligible services.** Services eligible for funding under this section are all services needed to maintain households in permanent supportive housing, as determined by the ~~county or~~ counties or Tribes administering the project or projects.

Sec. 36. Minnesota Statutes 2021 Supplement, section 256P.01, subdivision 6a, is amended to read:

Subd. 6a. **Qualified professional.** (a) For illness, injury, or incapacity, a "qualified professional" means a licensed physician, physician assistant, advanced practice registered nurse, physical therapist, occupational therapist, or licensed chiropractor, according to their scope of practice.

(b) For developmental disability, learning disability, and intelligence testing, a "qualified professional" means a licensed physician, physician assistant, advanced practice registered nurse, licensed independent clinical social worker, licensed psychologist, certified school psychologist, or certified psychometrist working under the supervision of a licensed psychologist.

(c) For mental health, a "qualified professional" means a licensed physician, advanced practice registered nurse, or qualified mental health professional under section 245I.04, subdivision 2.

(d) For substance use disorder, a "qualified professional" means a licensed physician, a qualified mental health professional under section ~~245.462, subdivision 18, clauses (1) to (6)~~ 245I.04, subdivision 2, or an individual as defined in section 245G.11, subdivision 3, 4, or 5.

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. 37. Minnesota Statutes 2020, section 256Q.06, is amended by adding a subdivision to read:

Subd. 6. **Account creation.** If an eligible individual is unable to establish the eligible individual's own ABLE account, an ABLE account may be established on behalf of the eligible individual by the eligible individual's agent under a power of attorney or, if none, by the eligible individual's conservator or legal guardian, spouse, parent, sibling, or grandparent or a representative payee appointed for the eligible individual by the Social Security Administration, in that order.

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

Sec. 38. 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;

(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. 39. **REVISOR INSTRUCTION.**

In Minnesota Statutes and Minnesota Rules, the revisor of statutes shall change the term "chemical dependency" or similar terms to "substance use disorder." The revisor may make grammatical changes related to the term change.

Sec. 40. **REPEALER.**

(a) Minnesota Statutes 2020, sections 254A.04; and 254B.14, subdivisions 1, 2, 3, 4, and 6, are repealed.

(b) Minnesota Statutes 2021 Supplement, section 254B.14, subdivision 5, is repealed.

ARTICLE 9
COMMUNITY SUPPORTS

Section 1. Minnesota Statutes 2020, section 245A.04, is amended by adding a subdivision to read:

Subd. 15b. **Additional community residential setting closure requirements.** (a) In addition to the requirements in subdivision 15a, in the event that a license holder elects to voluntarily close a community residential setting, the license holder must notify the commissioner, the Office of Ombudsman for Mental Health and Developmental Disabilities, and the Office of Ombudsman for Long-Term Care in writing by submitting notification at least 60 days prior to closure. The closure notification must include:

(1) assurance the license holder notified or will notify residents and their expanded support teams, if applicable, of the closure and comply with the conditions for service terminations under section 245D.10, subd. 3a;

(2) procedures and actions the license holder will implement to maintain compliance with this subdivision and subdivision 15a; and

(3) assurance the license holder will meet with the case manager and the person's expanded support team, as defined in section 245D.02, subdivision 8b, within ten working days of delivering any service terminations to develop a person-centered relocation plan with each individual impacted by the change in service. The license holder must complete a relocation plan for each impacted individual 45 days prior to the service termination or closure date, whichever is sooner.

(b) The commissioner may require the license holder to work with a transitional team comprised of department staff, staff of the Office of Ombudsman for Mental Health and Developmental Disabilities, staff of the Office of Ombudsman for Long-Term Care, and other professionals the commissioner deems necessary to assist in the proper relocation of residents.

(c) The commissioner may eliminate a closure rate adjustment under section 256B.493 for violations of this subdivision.

Sec. 2. Minnesota Statutes 2020, section 245D.10, subdivision 3a, is amended to read:

Subd. 3a. **Service termination.** (a) The license holder must establish policies and procedures for service termination that promote continuity of care and service coordination with the person and the case manager and with other licensed caregivers, if any, who also provide support to the person. The policy must include the requirements specified in paragraphs (b) to (f).

(b) The license holder must permit each person to remain in the program or to continue receiving services and must not terminate services unless:

(1) the termination is necessary for the person's welfare and the ~~facility~~ license holder cannot meet the person's needs;

(2) the safety of the person ~~or~~, others in the program, or staff is endangered and positive support strategies were attempted and have not achieved and effectively maintained safety for the person or others;

(3) the health of the person ~~or~~, others in the program, or staff would otherwise be endangered;

(4) the ~~program~~ license holder has not been paid for services;

(5) the program or license holder ceases to operate;

(6) the person has been terminated by the lead agency from waiver eligibility; or

(7) for state-operated community-based services, the person no longer demonstrates complex behavioral needs that cannot be met by private community-based providers identified in section 252.50, subdivision 5, paragraph (a), clause (1).

(c) Prior to giving notice of service termination, the license holder must document actions taken to minimize or eliminate the need for termination. Action taken by the license holder must include, at a minimum:

(1) consultation with the person's support team or expanded support team to identify and resolve issues leading to issuance of the termination notice;

(2) a request to the case manager for intervention services identified in section 245D.03, subdivision 1, paragraph (c), clause (1), or other professional consultation or intervention services to support the person in the program. This requirement does not apply to notices of service termination issued under paragraph (b), clauses (4) and (7); and

(3) for state-operated community-based services terminating services under paragraph (b), clause (7), the state-operated community-based services must engage in consultation with the person's support team or expanded support team to:

(i) identify that the person no longer demonstrates complex behavioral needs that cannot be met by private community-based providers identified in section 252.50, subdivision 5, paragraph (a), clause (1);

(ii) provide notice of intent to issue a termination of services to the lead agency when a finding has been made that a person no longer demonstrates complex behavioral needs that cannot be met by private community-based providers identified in section 252.50, subdivision 5, paragraph (a), clause (1);

(iii) assist the lead agency and case manager in developing a person-centered transition plan to a private community-based provider to ensure continuity of care; and

(iv) coordinate with the lead agency to ensure the private community-based service provider is able to meet the person's needs and criteria established in a person's person-centered transition plan.

If, based on the best interests of the person, the circumstances at the time of the notice were such that the license holder was unable to take the action specified in clauses (1) and (2), the license holder must document the specific circumstances and the reason for being unable to do so.

(d) The notice of service termination must meet the following requirements:

(1) the license holder must notify the person or the person's legal representative and the case manager in writing of the intended service termination. If the service termination is from residential supports and services as defined in section 245D.03, subdivision 1, paragraph (c), clause (3), the license holder must also notify the commissioner in writing; and

(2) the notice must include:

(i) the reason for the action;

(ii) except for a service termination under paragraph (b), clause (5), a summary of actions taken to minimize or eliminate the need for service termination or temporary service suspension as required under paragraph (c), and why these measures failed to prevent the termination or suspension;

(iii) the person's right to appeal the termination of services under section 256.045, subdivision 3, paragraph (a); and

(iv) the person's right to seek a temporary order staying the termination of services according to the procedures in section 256.045, subdivision 4a or 6, paragraph (c).

(e) Notice of the proposed termination of service, including those situations that began with a temporary service suspension, must be given at least 90 days prior to termination of services under paragraph (b), clause (7), 60 days prior to termination when a license holder is providing intensive supports and services identified in section 245D.03, subdivision 1, paragraph (c), and 30 days prior to termination for all other services licensed under this chapter. This notice may be given in conjunction with a notice of temporary service suspension under subdivision 3.

(f) During the service termination notice period, the license holder must:

(1) work with the support team or expanded support team to develop reasonable alternatives to protect the person and others and to support continuity of care;

(2) provide information requested by the person or case manager; and

(3) maintain information about the service termination, including the written notice of intended service termination, in the service recipient record.

(g) For notices issued under paragraph (b), clause (7), the lead agency shall provide notice to the commissioner and state-operated services at least 30 days before the conclusion of the 90-day termination period, if an appropriate alternative provider cannot be secured. Upon receipt of this notice, the commissioner and state-operated services shall reassess whether a private community-based service can meet the person's needs. If the commissioner determines that a private provider can meet the person's needs, state-operated services shall, if necessary, extend notice of service termination until placement can be made. If the commissioner determines that a private provider cannot meet the person's needs, state-operated services shall rescind the notice of service termination and re-engage with the lead agency in service planning for the person.

(h) For state-operated community-based services, the license holder shall prioritize the capacity created within the existing service site by the termination of services under paragraph (b), clause (7), to serve persons described in section 252.50, subdivision 5, paragraph (a), clause (1).

Sec. 3. Minnesota Statutes 2020, section 256.01, is amended by adding a subdivision to read:

Subd. 12b. **Department of Human Services systemic critical incident review team.** (a) The commissioner may establish a Department of Human Services systemic critical incident review team to review required critical incident reports under section 626.557 for which the Department of Human Services is responsible under section 626.5572, subdivision 13; chapter 245D; or Minnesota Rules, chapter 9544. When reviewing a critical incident, the systemic critical incident review team must identify systemic influences to the incident rather than determining the culpability of any actors involved in the incident. The systemic critical incident review may assess the entire critical incident process from the point of an entity reporting the critical incident through the ongoing case management process. Department staff must lead and conduct the reviews and may utilize county staff as reviewers. The systemic critical incident review process may include but is not limited to:

(1) data collection about the incident and actors involved. Data may include the critical incident report under review; previous incident reports pertaining to the person receiving services; the service provider's policies and procedures applicable to the incident; the coordinated service and support plan as defined in section 245D.02, subdivision 4b, for the person receiving services; or an interview of an actor involved in the critical incident or the review of the critical incident. Actors may include:

(i) staff of the provider agency;

(ii) lead agency staff administering home and community-based services delivered by the provider;

(iii) Department of Human Services staff with oversight of home and community-based services;

(iv) Department of Health staff with oversight of home and community-based services;

(v) members of the community including advocates, legal representatives, health care providers, pharmacy staff, or others with knowledge of the incident or the actors in the incident; and

(vi) staff from the Office of the Ombudsman for Mental Health and Developmental Disabilities;

(2) systemic mapping of the critical incident. The team conducting the systemic mapping of the incident may include any actors identified in clause (1), designated representatives of other provider agencies, regional teams, and representatives of the local regional quality council identified in section 256B.097; and

(3) analysis of the case for systemic influences.

(b) The critical incident review team must aggregate data collected and provide the aggregated data to regional teams, participating regional quality councils, and the commissioner. The regional teams and quality councils must analyze the data and make recommendations to the commissioner regarding systemic changes that would decrease the number and severity of critical incidents in the future or improve the quality of the home and community-based service system.

(c) A selection committee must select cases for the systemic critical incident review process from among the following critical incident categories:

(1) cases of caregiver neglect identified in section 626.5572, subdivision 17;

(2) cases involving financial exploitation identified in section 626.5572, subdivision 9;

(3) incidents identified in section 245D.02, subdivision 11;

(4) incidents identified in Minnesota Rules, part 9544.0110; and

(5) service terminations reported to the department in accordance with section 245D.10, subdivision 3a.

(d) The systemic critical incident review under this section must not replace the process for screening or investigating cases of alleged maltreatment of an adult under section 626.557.

The department, under the jurisdiction of the commissioner, may select for systemic critical incident review cases reported for suspected maltreatment and closed following initial or final disposition.

(e) The proceedings and records of the review team are confidential data on individuals or protected nonpublic data as defined in section 13.02, subdivisions 3 and 13. Data that document a person's opinions formed as a result of the review are not subject to discovery or introduction into evidence in a civil or criminal action against a professional, the state, or a county agency arising out of the matters that the team is reviewing. Information, documents, and records otherwise available from other sources are not immune from discovery or use in a civil or criminal action solely because the information, documents, and records were assessed or presented during review team proceedings. A person who presented information before the systemic critical incident review team or who is a member of the team must not be prevented from testifying about matters within the person's knowledge. In a civil or criminal proceeding, a person must not be questioned about opinions formed by the person as a result of the review.

(f) By October 1 of each year, the commissioner shall prepare an annual public report containing the following information:

(1) the number of cases reviewed under each critical incident category identified in paragraph (b) and a geographical description of where cases under each category originated;

(2) an aggregate summary of the systemic themes from the critical incidents examined by the critical incident review team during the previous year;

(3) a synopsis of the conclusions, incident analyses, or exploratory activities taken in regard to the critical incidents examined by the critical incident review team; and

(4) recommendations made to the commissioner regarding systemic changes that could decrease the number and severity of critical incidents in the future or improve the quality of the home and community-based service system.

Sec. 4. Minnesota Statutes 2020, section 256.045, subdivision 3, is amended to read:

Subd. 3. **State agency hearings.** (a) State agency hearings are available for the following:

(1) any person applying for, receiving or having received public assistance, medical care, or a program of social services granted by the state agency or a county agency or the federal Food and Nutrition Act whose application for assistance is denied, not acted upon with reasonable promptness, or whose assistance is suspended, reduced, terminated, or claimed to have been incorrectly paid;

(2) any patient or relative aggrieved by an order of the commissioner under section 252.27;

(3) a party aggrieved by a ruling of a prepaid health plan;

(4) except as provided under chapter 245C, any individual or facility determined by a lead investigative agency to have maltreated a vulnerable adult under section 626.557 after they have exercised their right to administrative reconsideration under section 626.557;

(5) any person whose claim for foster care payment according to a placement of the child resulting from a child protection assessment under chapter 260E is denied or not acted upon with reasonable promptness, regardless of funding source;

(6) any person to whom a right of appeal according to this section is given by other provision of law;

(7) an applicant aggrieved by an adverse decision to an application for a hardship waiver under section 256B.15;

(8) an applicant aggrieved by an adverse decision to an application or redetermination for a Medicare Part D prescription drug subsidy under section 256B.04, subdivision 4a;

(9) except as provided under chapter 245A, an individual or facility determined to have maltreated a minor under chapter 260E, after the individual or facility has exercised the right to administrative reconsideration under chapter 260E;

(10) except as provided under chapter 245C, an individual disqualified under sections 245C.14 and 245C.15, following a reconsideration decision issued under section 245C.23, on the basis of serious or recurring maltreatment; a preponderance of the evidence that the individual has committed an act or acts that meet the definition of any of the crimes listed in section 245C.15, subdivisions 1 to 4; or for failing to make reports required under section 260E.06, subdivision 1, or 626.557, subdivision 3. Hearings regarding a maltreatment determination under clause (4) or (9) and a disqualification under this clause in which the basis for a disqualification is serious or recurring maltreatment, shall be consolidated into a single fair hearing. In such cases, the scope of review by the human services judge shall include both the maltreatment determination and the disqualification. The failure to exercise the right to an administrative reconsideration shall not be a bar to a hearing under this section if federal law provides an individual the right to a hearing to dispute a finding of maltreatment;

(11) any person with an outstanding debt resulting from receipt of public assistance, medical care, or the federal Food and Nutrition Act who is contesting a setoff claim by the

Department of Human Services or a county agency. The scope of the appeal is the validity of the claimant agency's intention to request a setoff of a refund under chapter 270A against the debt;

(12) a person issued a notice of service termination under section 245D.10, subdivision 3a, ~~from~~ by a licensed provider of any residential supports ~~and~~ or services ~~as defined~~ listed in section 245D.03, subdivision 1, ~~paragraph~~ paragraphs (b) and (c), ~~clause (3),~~ that is not otherwise subject to appeal under subdivision 4a;

(13) an individual disability waiver recipient based on a denial of a request for a rate exception under section 256B.4914; or

(14) a person issued a notice of service termination under section 245A.11, subdivision 11, that is not otherwise subject to appeal under subdivision 4a.

(b) The hearing for an individual or facility under paragraph (a), clause (4), (9), or (10), is the only administrative appeal to the final agency determination specifically, including a challenge to the accuracy and completeness of data under section 13.04. Hearings requested under paragraph (a), clause (4), apply only to incidents of maltreatment that occur on or after October 1, 1995. Hearings requested by nursing assistants in nursing homes alleged to have maltreated a resident prior to October 1, 1995, shall be held as a contested case proceeding under the provisions of chapter 14. Hearings requested under paragraph (a), clause (9), apply only to incidents of maltreatment that occur on or after July 1, 1997. A hearing for an individual or facility under paragraph (a), clauses (4), (9), and (10), is only available when there is no district court action pending. If such action is filed in district court while an administrative review is pending that arises out of some or all of the events or circumstances on which the appeal is based, the administrative review must be suspended until the judicial actions are completed. If the district court proceedings are completed, dismissed, or overturned, the matter may be considered in an administrative hearing.

(c) For purposes of this section, bargaining unit grievance procedures are not an administrative appeal.

(d) The scope of hearings involving claims to foster care payments under paragraph (a), clause (5), shall be limited to the issue of whether the county is legally responsible for a child's placement under court order or voluntary placement agreement and, if so, the correct amount of foster care payment to be made on the child's behalf and shall not include review of the propriety of the county's child protection determination or child placement decision.

(e) The scope of hearings under paragraph (a), clauses (12) and (14), shall be limited to whether the proposed termination of services is authorized under section 245D.10,

subdivision 3a, paragraph (b), or 245A.11, subdivision 11, and whether the requirements of section 245D.10, subdivision 3a, paragraphs (c) to (e), or 245A.11, subdivision 2a, paragraphs (d) to (f), were met. If the appeal includes a request for a temporary stay of termination of services, the scope of the hearing shall also include whether the case management provider has finalized arrangements for a residential facility, a program, or services that will meet the assessed needs of the recipient by the effective date of the service termination.

(f) A vendor of medical care as defined in section 256B.02, subdivision 7, or a vendor under contract with a county agency to provide social services is not a party and may not request a hearing under this section, except if assisting a recipient as provided in subdivision 4.

(g) An applicant or recipient is not entitled to receive social services beyond the services prescribed under chapter 256M or other social services the person is eligible for under state law.

(h) The commissioner may summarily affirm the county or state agency's proposed action without a hearing when the sole issue is an automatic change due to a change in state or federal law.

(i) Unless federal or Minnesota law specifies a different time frame in which to file an appeal, an individual or organization specified in this section may contest the specified action, decision, or final disposition before the state agency by submitting a written request for a hearing to the state agency within 30 days after receiving written notice of the action, decision, or final disposition, or within 90 days of such written notice if the applicant, recipient, patient, or relative shows good cause, as defined in section 256.0451, subdivision 13, why the request was not submitted within the 30-day time limit. The individual filing the appeal has the burden of proving good cause by a preponderance of the evidence.

Sec. 5. Minnesota Statutes 2020, section 256B.0651, subdivision 1, is amended to read:

Subdivision 1. **Definitions.** (a) For the purposes of sections 256B.0651 to 256B.0654 and 256B.0659, the terms in paragraphs (b) to ~~(g)~~ (i) have the meanings given.

(b) "Activities of daily living" has the meaning given in section 256B.0659, subdivision 1, paragraph (b).

(c) "Assessment" means a review and evaluation of a recipient's need for home care services conducted in person.

(d) "Care coordination" means a service performed by a licensed professional to coordinate both skilled and unskilled home care services, except personal care assistance, for a recipient, and may include documentation and coordination activities not carried out in conjunction with a care evaluation visit.

(e) "Care evaluation" means a start-of-care visit, a resumption-of-care visit, or a recertification visit that is a face-to-face assessment of a person by a licensed professional to develop, update, or review the service plan for both skilled and unskilled home care services, except personal care assistance.

~~(d)~~ (f) "Home care services" means medical assistance covered services that are home health agency services, including skilled nurse visits; home health aide visits; physical therapy, occupational therapy, respiratory therapy, and language-speech pathology therapy; home care nursing; and personal care assistance.

~~(e)~~ (g) "Home residence," effective January 1, 2010, means a residence owned or rented by the recipient either alone, with roommates of the recipient's choosing, or with an unpaid responsible party or legal representative; or a family foster home where the license holder lives with the recipient and is not paid to provide home care services for the recipient except as allowed under sections 256B.0652, subdivision 10, and 256B.0654, subdivision 4.

~~(f)~~ (h) "Medically necessary" has the meaning given in Minnesota Rules, parts 9505.0170 to 9505.0475.

~~(g)~~ (i) "Ventilator-dependent" means an individual who receives mechanical ventilation for life support at least six hours per day and is expected to be or has been dependent on a ventilator for at least 30 consecutive days.

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. 6. Minnesota Statutes 2020, section 256B.0651, subdivision 2, is amended to read:

Subd. 2. **Services covered.** Home care services covered under this section and sections 256B.0652 to 256B.0654 and 256B.0659 include:

(1) care coordination services under subdivision 1, paragraph (d);

(2) care evaluation services under subdivision 1, paragraph (e);

~~(1)~~ (3) nursing services under sections 256B.0625, subdivision 6a, and 256B.0653;

~~(2)~~ (4) home care nursing services under sections 256B.0625, subdivision 7, and 256B.0654;

~~(3)~~ (5) home health services under sections 256B.0625, subdivision 6a, and 256B.0653;

~~(4)~~ (6) personal care assistance services under sections 256B.0625, subdivision 19a, and 256B.0659;

~~(5)~~ (7) supervision of personal care assistance services provided by a qualified professional under sections 256B.0625, subdivision 19a, and 256B.0659;

~~(6)~~ (8) face-to-face assessments by county public health nurses for services under sections 256B.0625, subdivision 19a, and 256B.0659; and

~~(7)~~ (9) service updates and review of temporary increases for personal care assistance services by the county public health nurse for services under sections 256B.0625, subdivision 19a, and 256B.0659.

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. 7. Minnesota Statutes 2020, section 256B.0652, subdivision 11, is amended to read:

Subd. 11. **Limits on services without authorization.** A recipient may receive the following home care services during a calendar year:

(1) up to two face-to-face assessments to determine a recipient's need for personal care assistance services;

(2) one service update done to determine a recipient's need for personal care assistance services; ~~and~~

(3) up to nine face-to-face visits that may include both skilled nurse visits~~.~~ and care evaluations; and

(4) up to four 15-minute units of care coordination per episode of care to coordinate home health services for a recipient.

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. 8. Minnesota Statutes 2020, section 256B.0653, subdivision 6, is amended to read:

Subd. 6. **Noncovered home health agency services.** The following are not eligible for payment under medical assistance as a home health agency service:

(1) telehomecare skilled nurses services that is communication between the home care nurse and recipient that consists solely of a telephone conversation, facsimile, electronic mail, or a consultation between two health care practitioners;

(2) the following skilled nurse visits:

(i) for the purpose of monitoring medication compliance with an established medication program for a recipient;

(ii) administering or assisting with medication administration, including injections, prefilling syringes for injections, or oral medication setup of an adult recipient, when, as determined and documented by the registered nurse, the need can be met by an available pharmacy or the recipient or a family member is physically and mentally able to self-administer or prefill a medication;

(iii) services done for the sole purpose of supervision of the home health aide or personal care assistant;

(iv) services done for the sole purpose to train other home health agency workers;

(v) services done for the sole purpose of blood samples or lab draw when the recipient is able to access these services outside the home; and

(vi) Medicare evaluation or administrative nursing visits required by Medicare, with the exception of care evaluation as defined in section 256B.0651, subdivision 1, paragraph (e);

(3) home health aide visits when the following activities are the sole purpose for the visit: companionship, socialization, household tasks, transportation, and education;

(4) home care therapies provided in other settings such as a clinic or as an inpatient or when the recipient can access therapy outside of the recipient's residence; and

(5) home health agency services without qualifying documentation of a face-to-face encounter as specified in subdivision 7.

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. 9. Minnesota Statutes 2020, section 256B.0659, subdivision 1, is amended to read:

Subdivision 1. **Definitions.** (a) For the purposes of this section, the terms defined in paragraphs (b) to (r) have the meanings given unless otherwise provided in text.

(b) "Activities of daily living" means grooming, dressing, bathing, transferring, mobility, positioning, eating, and toileting.

(c) "Behavior," effective January 1, 2010, means a category to determine the home care rating and is based on the criteria found in this section. "Level I behavior" means physical aggression ~~towards~~ toward self, others, or destruction of property that requires the immediate response of another person.

(d) "Complex health-related needs," effective January 1, 2010, means a category to determine the home care rating and is based on the criteria found in this section.

(e) "Critical activities of daily living," effective January 1, 2010, means transferring, mobility, eating, and toileting.

(f) "Dependency in activities of daily living" means a person requires assistance to begin and complete one or more of the activities of daily living.

(g) "Extended personal care assistance service" means personal care assistance services included in a service plan under one of the home and community-based services waivers authorized under chapter 256S and sections 256B.092, subdivision 5, and 256B.49, which exceed the amount, duration, and frequency of the state plan personal care assistance services for participants who:

(1) need assistance provided periodically during a week, but less than daily will not be able to remain in their homes without the assistance, and other replacement services are more expensive or are not available when personal care assistance services are to be reduced; or

(2) need additional personal care assistance services beyond the amount authorized by the state plan personal care assistance assessment in order to ensure that their safety, health, and welfare are provided for in their homes.

(h) "Health-related procedures and tasks" means procedures and tasks that can be delegated or assigned by a licensed health care professional under state law to be performed by a personal care assistant.

(i) "Instrumental activities of daily living" means activities to include meal planning and preparation; basic assistance with paying bills; shopping for food, clothing, and other

essential items; performing household tasks integral to the personal care assistance services; communication by telephone and other media; and traveling, including to medical appointments and to participate in the community. For purposes of this paragraph, traveling includes driving and accompanying the recipient in the recipient's chosen mode of transportation and according to the recipient's personal care assistance care plan.

(j) "Managing employee" has the same definition as Code of Federal Regulations, title 42, section 455.

(k) "Qualified professional" means a professional providing supervision of personal care assistance services and staff as defined in section 256B.0625, subdivision 19c.

(l) "Personal care assistance provider agency" means a medical assistance enrolled provider that provides or assists with providing personal care assistance services and includes a personal care assistance provider organization, personal care assistance choice agency, class A licensed nursing agency, and Medicare-certified home health agency.

(m) "Personal care assistant" or "PCA" means an individual employed by a personal care assistance agency who provides personal care assistance services.

(n) "Personal care assistance care plan" means a written description of personal care assistance services developed by the personal care assistance provider according to the service plan.

(o) "Responsible party" means an individual who is capable of providing the support necessary to assist the recipient to live in the community.

(p) "Self-administered medication" means medication taken orally, by injection, nebulizer, or insertion, or applied topically without the need for assistance.

(q) "Service plan" means a written summary of the assessment and description of the services needed by the recipient.

(r) "Wages and benefits" means wages and salaries, the employer's share of FICA taxes, Medicare taxes, state and federal unemployment taxes, workers' compensation, mileage reimbursement, health and dental insurance, life insurance, disability insurance, long-term care insurance, uniform allowance, and contributions to employee retirement accounts.

EFFECTIVE DATE. This section is effective within 90 days following federal approval. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 10. Minnesota Statutes 2020, section 256B.0659, subdivision 12, is amended to read:

Subd. 12. **Documentation of personal care assistance services provided.** (a) Personal care assistance services for a recipient must be documented daily by each personal care assistant, on a time sheet form approved by the commissioner. All documentation may be web-based, electronic, or paper documentation. The completed form must be submitted on a monthly basis to the provider and kept in the recipient's health record.

(b) The activity documentation must correspond to the personal care assistance care plan and be reviewed by the qualified professional.

(c) The personal care assistant time sheet must be on a form approved by the commissioner documenting time the personal care assistant provides services in the home. The following criteria must be included in the time sheet:

(1) full name of personal care assistant and individual provider number;

(2) provider name and telephone numbers;

(3) full name of recipient and either the recipient's medical assistance identification number or date of birth;

(4) consecutive dates, including month, day, and year, and arrival and departure times with a.m. or p.m. notations;

(5) signatures of recipient or the responsible party;

(6) personal signature of the personal care assistant;

(7) any shared care provided, if applicable;

(8) a statement that it is a federal crime to provide false information on personal care service billings for medical assistance payments; ~~and~~

(9) dates and location of recipient stays in a hospital, care facility, or incarceration; and

(10) any time spent traveling, as described in subdivision 1, paragraph (i), including start and stop times with a.m. and p.m. designations, the origination site, and the destination site.

EFFECTIVE DATE. This section is effective within 90 days following federal approval. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 11. Minnesota Statutes 2020, section 256B.0659, subdivision 19, is amended to read:

Subd. 19. **Personal care assistance choice option; qualifications; duties.** (a) Under personal care assistance choice, the recipient or responsible party shall:

(1) recruit, hire, schedule, and terminate personal care assistants according to the terms of the written agreement required under subdivision 20, paragraph (a);

(2) develop a personal care assistance care plan based on the assessed needs and addressing the health and safety of the recipient with the assistance of a qualified professional as needed;

(3) orient and train the personal care assistant with assistance as needed from the qualified professional;

(4) ~~effective January 1, 2010,~~ supervise and evaluate the personal care assistant with the qualified professional, who is required to visit the recipient at least every 180 days;

(5) monitor and verify in writing and report to the personal care assistance choice agency the number of hours worked by the personal care assistant and the qualified professional;

(6) engage in an annual face-to-face reassessment to determine continuing eligibility and service authorization; ~~and~~

(7) use the same personal care assistance choice provider agency if shared personal assistance care is being used; and

(8) ensure that a personal care assistant driving the recipient under subdivision 1, paragraph (i), has a valid driver's license and the vehicle used is registered and insured according to Minnesota law.

(b) The personal care assistance choice provider agency shall:

(1) meet all personal care assistance provider agency standards;

(2) enter into a written agreement with the recipient, responsible party, and personal care assistants;

(3) not be related as a parent, child, sibling, or spouse to the recipient or the personal care assistant; and

(4) ensure arm's-length transactions without undue influence or coercion with the recipient and personal care assistant.

(c) The duties of the personal care assistance choice provider agency are to:

(1) be the employer of the personal care assistant and the qualified professional for employment law and related regulations including, but not limited to, purchasing and maintaining workers' compensation, unemployment insurance, surety and fidelity bonds, and liability insurance, and submit any or all necessary documentation including, but not limited to, workers' compensation, unemployment insurance, and labor market data required under section 256B.4912, subdivision 1a;

(2) bill the medical assistance program for personal care assistance services and qualified professional services;

(3) request and complete background studies that comply with the requirements for personal care assistants and qualified professionals;

(4) pay the personal care assistant and qualified professional based on actual hours of services provided;

(5) withhold and pay all applicable federal and state taxes;

(6) verify and keep records of hours worked by the personal care assistant and qualified professional;

(7) make the arrangements and pay taxes and other benefits, if any, and comply with any legal requirements for a Minnesota employer;

(8) enroll in the medical assistance program as a personal care assistance choice agency; and

(9) enter into a written agreement as specified in subdivision 20 before services are provided.

EFFECTIVE DATE. This section is effective within 90 days following federal approval. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 12. Minnesota Statutes 2020, section 256B.0659, subdivision 24, is amended to read:

Subd. 24. **Personal care assistance provider agency; general duties.** A personal care assistance provider agency shall:

(1) enroll as a Medicaid provider meeting all provider standards, including completion of the required provider training;

(2) comply with general medical assistance coverage requirements;

(3) demonstrate compliance with law and policies of the personal care assistance program to be determined by the commissioner;

(4) comply with background study requirements;

(5) verify and keep records of hours worked by the personal care assistant and qualified professional;

(6) not engage in any agency-initiated direct contact or marketing in person, by phone, or other electronic means to potential recipients, guardians, or family members;

(7) pay the personal care assistant and qualified professional based on actual hours of services provided;

(8) withhold and pay all applicable federal and state taxes;

(9) document that the agency uses a minimum of 72.5 percent of the revenue generated by the medical assistance rate for personal care assistance services for employee personal care assistant wages and benefits. The revenue generated by the qualified professional and the reasonable costs associated with the qualified professional shall not be used in making this calculation;

(10) make the arrangements and pay unemployment insurance, taxes, workers' compensation, liability insurance, and other benefits, if any;

(11) enter into a written agreement under subdivision 20 before services are provided;

(12) report suspected neglect and abuse to the common entry point according to section 256B.0651;

(13) provide the recipient with a copy of the home care bill of rights at start of service;

(14) request reassessments at least 60 days prior to the end of the current authorization for personal care assistance services, on forms provided by the commissioner;

(15) comply with the labor market reporting requirements described in section 256B.4912, subdivision 1a; ~~and~~

(16) document that the agency uses the additional revenue due to the enhanced rate under subdivision 17a for the wages and benefits of the PCAs whose services meet the requirements under subdivision 11, paragraph (d)<u>; and</u>

<u>(17) ensure that a personal care assistant driving a recipient under subdivision 1, paragraph (i), has a valid driver's license and the vehicle used is registered and insured according to Minnesota law</u>.

EFFECTIVE DATE. This section is effective within 90 days following federal approval. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 13. Minnesota Statutes 2020, section 256B.092, is amended by adding a subdivision to read:

Subd. 15. **Community residential setting notice of closure; planning process.** (a) The lead agency shall, within five working days of receiving initial notice of a community residential setting's intent to terminate services of a person due to closure pursuant to section 245A.04, subdivision 15b, provide the license holder and the expanded support team with the contact information of those persons responsible for coordinating county and state social services agency efforts in the planning process.

(b) Within ten working days of receipt of the notice of closure and proposed closure plan, the county social services agency and license holder shall meet to develop a person-centered relocation plan with each individual impacted by the closure. The license holder shall inform the commissioner, the Office of Ombudsman for Mental Health and Developmental Disabilities, and the Office of Ombudsman for Long-Term Care of the date, time, and location of the meeting so that their representatives may attend.

Sec. 14. Minnesota Statutes 2020, section 256B.49, is amended by adding a subdivision to read:

Subd. 30. **Community residential setting; notice of closure; planning process.** (a) The lead agency shall, within five working days of receiving initial notice of a community residential setting's intent to terminate services of a person due to closure pursuant to section 245A.04, subdivision 15b, provide the license holder and the expanded support team with the contact information of those persons responsible for coordinating county and state social services agency efforts in the planning process.

(b) Within ten working days of receipt of the notice of closure and proposed closure plan, the county social services agency and license holder shall meet to develop a person-centered relocation plan with each individual impacted by the closure. The license holder shall inform the commissioner, the Office of Ombudsman for Mental Health and Developmental Disabilities, and the Office of Ombudsman for Long-Term Care of the date, time, and location of the meeting so that their representatives may attend.

Sec. 15. Minnesota Statutes 2020, section 256B.4911, is amended by adding a subdivision to read:

Subd. 6. **Services provided by parents and spouses.** (a) Upon federal approval, this subdivision limits medical assistance payments under the consumer-directed community supports option for personal assistance services provided by a parent to the parent's minor child or by a spouse. This subdivision applies to the consumer-directed community supports option available under all of the following:

(1) alternative care program;

(2) brain injury waiver;

(3) community alternative care waiver;

(4) community access for disability inclusion waiver;

(5) developmental disabilities waiver;

(6) elderly waiver; and

(7) Minnesota senior health option.

(b) For the purposes of this subdivision, "parent" means a parent, stepparent, or legal guardian of a minor.

(c) If multiple parents are providing personal assistance services to their minor child or children, each parent may provide up to 40 hours of personal assistance services in any seven-day period regardless of the number of children served. The total number of hours of personal assistance services provided by all of the parents must not exceed 80 hours in a seven-day period regardless of the number of children served.

(d) If only one parent is providing personal assistance services to a minor child or children, the parent may provide up to 60 hours of personal assistance services in a seven-day period regardless of the number of children served.

(e) If a spouse is providing personal assistance services, the spouse may provide up to 60 hours of personal assistance services in a seven-day period.

(f) This subdivision must not be construed to permit an increase in the total authorized consumer-directed community supports budget for an individual.

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. 16. Minnesota Statutes 2020, section 256B.4914, subdivision 8, as amended by Laws 2022, chapter 33, section 1, is amended to read:

Subd. 8. **Unit-based services with programming; component values and calculation of payment rates.** (a) For the purpose of this section, unit-based services with programming include employment exploration services, employment development services, employment support services, individualized home supports with family training, individualized home supports with training, and positive support services provided to an individual outside of any service plan for a day program or residential support service.

(b) Component values for unit-based services with programming are:

(1) competitive workforce factor: 4.7 percent;

(2) supervisory span of control ratio: 11 percent;

(3) employee vacation, sick, and training allowance ratio: 8.71 percent;

(4) employee-related cost ratio: 23.6 percent;

(5) program plan support ratio: 15.5 percent;

(6) client programming and support ratio: 4.7 percent, updated as specified in subdivision 5b;

(7) general administrative support ratio: 13.25 percent;

(8) program-related expense ratio: 6.1 percent; and

(9) absence and utilization factor ratio: 3.9 percent.

(c) A unit of service for unit-based services with programming is 15 minutes.

(d) Payments for unit-based services with programming must be calculated as follows, unless the services are reimbursed separately as part of a residential support services or day program payment rate:

(1) determine the number of units of service to meet a recipient's needs;

(2) determine the appropriate hourly staff wage rates derived by the commissioner as provided in subdivisions 5 and 5a;

(3) except for subdivision 5a, clauses (1) to (4), multiply the result of clause (2) by the product of one plus the competitive workforce factor;

(4) for a recipient requiring customization for deaf and hard-of-hearing language accessibility under subdivision 12, add the customization rate provided in subdivision 12 to the result of clause (3);

(5) multiply the number of direct staffing hours by the appropriate staff wage;

(6) multiply the number of direct staffing hours by the product of the supervisory span of control ratio and the appropriate supervisory staff wage in subdivision 5a, clause (1);

(7) combine the results of clauses (5) and (6), and multiply the result by one plus the employee vacation, sick, and training allowance ratio. This is defined as the direct staffing rate;

(8) for program plan support, multiply the result of clause (7) by one plus the program plan support ratio;

(9) for employee-related expenses, multiply the result of clause (8) by one plus the employee-related cost ratio;

(10) for client programming and supports, multiply the result of clause (9) by one plus the client programming and support ratio;

(11) this is the subtotal rate;

(12) sum the standard general administrative support ratio, the program-related expense ratio, and the absence and utilization factor ratio;

(13) divide the result of clause (11) by one minus the result of clause (12). This is the total payment amount;

(14) for services provided in a shared manner, divide the total payment in clause (13) as follows:

(i) for employment exploration services, divide by the number of service recipients, not to exceed five;

(ii) for employment support services, divide by the number of service recipients, not to exceed six; and

(iii) for individualized home supports with training and individualized home supports with family training, divide by the number of service recipients, not to exceed ~~two~~ three; and

(15) adjust the result of clause (14) by a factor to be determined by the commissioner to adjust for regional differences in the cost of providing services.

EFFECTIVE DATE. This section is effective January 1, 2023, or upon federal approval, whichever occurs later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 17. Minnesota Statutes 2020, section 256B.4914, subdivision 9, as amended by Laws 2022, chapter 33, section 1, is amended to read:

Subd. 9. **Unit-based services without programming; component values and calculation of payment rates.** (a) For the purposes of this section, unit-based services without programming include individualized home supports without training and night supervision provided to an individual outside of any service plan for a day program or residential support service. Unit-based services without programming do not include respite.

(b) Component values for unit-based services without programming are:

(1) competitive workforce factor: 4.7 percent;

(2) supervisory span of control ratio: 11 percent;

(3) employee vacation, sick, and training allowance ratio: 8.71 percent;

(4) employee-related cost ratio: 23.6 percent;

(5) program plan support ratio: 7.0 percent;

(6) client programming and support ratio: 2.3 percent, updated as specified in subdivision 5b;

(7) general administrative support ratio: 13.25 percent;

(8) program-related expense ratio: 2.9 percent; and

(9) absence and utilization factor ratio: 3.9 percent.

(c) A unit of service for unit-based services without programming is 15 minutes.

(d) Payments for unit-based services without programming must be calculated as follows unless the services are reimbursed separately as part of a residential support services or day program payment rate:

(1) determine the number of units of service to meet a recipient's needs;

(2) determine the appropriate hourly staff wage rates derived by the commissioner as provided in subdivisions 5 to 5a;

(3) except for subdivision 5a, clauses (1) to (4), multiply the result of clause (2) by the product of one plus the competitive workforce factor;

(4) for a recipient requiring customization for deaf and hard-of-hearing language accessibility under subdivision 12, add the customization rate provided in subdivision 12 to the result of clause (3);

(5) multiply the number of direct staffing hours by the appropriate staff wage;

(6) multiply the number of direct staffing hours by the product of the supervisory span of control ratio and the appropriate supervisory staff wage in subdivision 5a, clause (1);

(7) combine the results of clauses (5) and (6), and multiply the result by one plus the employee vacation, sick, and training allowance ratio. This is defined as the direct staffing rate;

(8) for program plan support, multiply the result of clause (7) by one plus the program plan support ratio;

(9) for employee-related expenses, multiply the result of clause (8) by one plus the employee-related cost ratio;

(10) for client programming and supports, multiply the result of clause (9) by one plus the client programming and support ratio;

(11) this is the subtotal rate;

(12) sum the standard general administrative support ratio, the program-related expense ratio, and the absence and utilization factor ratio;

(13) divide the result of clause (11) by one minus the result of clause (12). This is the total payment amount;

(14) for individualized home supports without training provided in a shared manner, divide the total payment amount in clause (13) by the number of service recipients, not to exceed ~~two~~ three; and

(15) adjust the result of clause (14) by a factor to be determined by the commissioner to adjust for regional differences in the cost of providing services.

EFFECTIVE DATE. This section is effective January 1, 2023, or upon federal approval, whichever occurs later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 18. Minnesota Statutes 2021 Supplement, section 256B.85, subdivision 7, is amended to read:

Subd. 7. **Community first services and supports; covered services.** Services and supports covered under CFSS include:

(1) assistance to accomplish activities of daily living (ADLs), instrumental activities of daily living (IADLs), and health-related procedures and tasks through hands-on assistance to accomplish the task or constant supervision and cueing to accomplish the task;

(2) assistance to acquire, maintain, or enhance the skills necessary for the participant to accomplish activities of daily living, instrumental activities of daily living, or health-related tasks;

(3) expenditures for items, services, supports, environmental modifications, or goods, including assistive technology. These expenditures must:

(i) relate to a need identified in a participant's CFSS service delivery plan; and

(ii) increase independence or substitute for human assistance, to the extent that expenditures would otherwise be made for human assistance for the participant's assessed needs;

(4) observation and redirection for behavior or symptoms where there is a need for assistance;

(5) back-up systems or mechanisms, such as the use of pagers or other electronic devices, to ensure continuity of the participant's services and supports;

(6) services provided by a consultation services provider as defined under subdivision 17, that is under contract with the department and enrolled as a Minnesota health care program provider;

(7) services provided by an FMS provider as defined under subdivision 13a, that is an enrolled provider with the department;

(8) CFSS services provided by a support worker who is a parent, stepparent, or legal guardian of a participant under age 18, or who is the participant's spouse. ~~These support workers shall not:~~ Covered services under this clause are subject to the limitations described in subdivision 7b; and

~~(i) provide any medical assistance home and community-based services in excess of 40 hours per seven-day period regardless of the number of parents providing services,~~

~~combination of parents and spouses providing services, or number of children who receive medical assistance services; and~~

~~(ii) have a wage that exceeds the current rate for a CFSS support worker including the wage, benefits, and payroll taxes; and~~

(9) worker training and development services as described in subdivision 18a.

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. 19. Minnesota Statutes 2020, section 256B.85, is amended by adding a subdivision to read:

Subd. 7b. **Services provided by parents and spouses.** (a) This subdivision applies to services and supports described in subdivision 7, clause (8).

(b) If multiple parents are support workers providing CFSS services to their minor child or children, each parent may provide up to 40 hours of medical assistance home and community-based services in any seven-day period regardless of the number of children served. The total number of hours of medical assistance home and community-based services provided by all of the parents must not exceed 80 hours in a seven-day period regardless of the number of children served.

(c) If only one parent is a support worker providing CFSS services to the parent's minor child or children, the parent may provide up to 60 hours of medical assistance home and community-based services in a seven-day period regardless of the number of children served.

(d) If a spouse is a support worker providing CFSS services, the spouse may provide up to 60 hours of medical assistance home and community-based services in a seven-day period.

(e) Paragraphs (b) to (d) must not be construed to permit an increase in either the total authorized service budget for an individual or the total number of authorized service units.

(f) A parent or spouse must not receive a wage that exceeds the current rate for a CFSS support worker, including the wage, benefits, and payroll taxes.

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. 20. Minnesota Statutes 2021 Supplement, section 256B.85, subdivision 8, is amended to read:

Subd. 8. **Determination of CFSS service authorization amount.** (a) All community first services and supports must be authorized by the commissioner or the commissioner's designee before services begin. The authorization for CFSS must be completed as soon as possible following an assessment but no later than 40 calendar days from the date of the assessment.

(b) The amount of CFSS authorized must be based on the participant's home care rating described in paragraphs (d) and (e) and any additional service units for which the participant qualifies as described in paragraph (f).

(c) The home care rating shall be determined by the commissioner or the commissioner's designee based on information submitted to the commissioner identifying the following for a participant:

(1) the total number of dependencies of activities of daily living;

(2) the presence of complex health-related needs; and

(3) the presence of Level I behavior.

(d) The methodology to determine the total service units for CFSS for each home care rating is based on the median paid units per day for each home care rating from fiscal year 2007 data for the PCA program.

(e) Each home care rating is designated by the letters P through Z and EN and has the following base number of service units assigned:

(1) P home care rating requires Level I behavior or one to three dependencies in ADLs and qualifies the person for five service units;

(2) Q home care rating requires Level I behavior and one to three dependencies in ADLs and qualifies the person for six service units;

(3) R home care rating requires a complex health-related need and one to three dependencies in ADLs and qualifies the person for seven service units;

(4) S home care rating requires four to six dependencies in ADLs and qualifies the person for ten service units;

(5) T home care rating requires four to six dependencies in ADLs and Level I behavior and qualifies the person for 11 service units;

(6) U home care rating requires four to six dependencies in ADLs and a complex health-related need and qualifies the person for 14 service units;

(7) V home care rating requires seven to eight dependencies in ADLs and qualifies the person for 17 service units;

(8) W home care rating requires seven to eight dependencies in ADLs and Level I behavior and qualifies the person for 20 service units;

(9) Z home care rating requires seven to eight dependencies in ADLs and a complex health-related need and qualifies the person for 30 service units; and

(10) EN home care rating includes ventilator dependency as defined in section 256B.0651, subdivision 1, paragraph ~~(g)~~ (i). A person who meets the definition of ventilator-dependent and the EN home care rating and utilize a combination of CFSS and home care nursing services is limited to a total of 96 service units per day for those services in combination. Additional units may be authorized when a person's assessment indicates a need for two staff to perform activities. Additional time is limited to 16 service units per day.

(f) Additional service units are provided through the assessment and identification of the following:

(1) 30 additional minutes per day for a dependency in each critical activity of daily living;

(2) 30 additional minutes per day for each complex health-related need; and

(3) 30 additional minutes per day for each behavior under this clause that requires assistance at least four times per week:

(i) level I behavior that requires the immediate response of another person;

(ii) increased vulnerability due to cognitive deficits or socially inappropriate behavior; or

(iii) increased need for assistance for participants who are verbally aggressive or resistive to care so that the time needed to perform activities of daily living is increased.

(g) The service budget for budget model participants shall be based on:

(1) assessed units as determined by the home care rating; and

(2) an adjustment needed for administrative expenses.

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. 21. Minnesota Statutes 2021 Supplement, section 256B.851, subdivision 5, is amended to read:

Subd. 5. **Payment rates; component values.** (a) The commissioner must use the following component values:

(1) employee vacation, sick, and training factor, 8.71 percent;

(2) employer taxes and workers' compensation factor, 11.56 percent;

(3) employee benefits factor, 12.04 percent;

(4) client programming and supports factor, 2.30 percent;

(5) program plan support factor, 7.00 percent;

(6) general business and administrative expenses factor, 13.25 percent;

(7) program administration expenses factor, 2.90 percent; and

(8) absence and utilization factor, 3.90 percent.

(b) For purposes of implementation, the commissioner shall use the following implementation components:

(1) personal care assistance services and CFSS: ~~75.45~~ 79.5 percent;

(2) enhanced rate personal care assistance services and enhanced rate CFSS: ~~75.45~~ 79.5 percent; and

(3) qualified professional services and CFSS worker training and development: ~~75.45~~ 79.5 percent.

EFFECTIVE DATE. This section is effective January 1, 2023, or 60 days following federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 22. Minnesota Statutes 2020, section 256I.04, subdivision 3, is amended to read:

Subd. 3. **Moratorium on development of housing support beds.** (a) Agencies shall not enter into agreements for new housing support beds with total rates in excess of the MSA equivalent rate except:

(1) for establishments licensed under chapter 245D provided the facility is needed to meet the census reduction targets for persons with developmental disabilities at regional treatment centers;

(2) up to 80 beds in a single, specialized facility located in Hennepin County that will provide housing for chronic inebriates who are repetitive users of detoxification centers and are refused placement in emergency shelters because of their state of intoxication, and planning for the specialized facility must have been initiated before July 1, 1991, in anticipation of receiving a grant from the Housing Finance Agency under section 462A.05, subdivision 20a, paragraph (b);

(3) notwithstanding the provisions of subdivision 2a, for up to ~~226~~ 500 supportive housing units in Anoka, Carver, Dakota, Hennepin, ~~or~~ Ramsey, Scott, or Washington County for homeless adults with a disability, including but not limited to mental illness, a history of substance abuse, or human immunodeficiency virus or acquired immunodeficiency syndrome. For purposes of this ~~section~~ clause, "homeless adult" means a person who is: (i) living on the street or in a shelter; or (ii) discharged from a regional treatment center, community hospital, or residential treatment program and has no appropriate housing available and lacks the resources and support necessary to access appropriate housing. ~~At least 70 percent of the supportive housing units must serve homeless adults with mental illness, substance abuse problems, or human immunodeficiency virus or acquired immunodeficiency syndrome who are about to be or, within the previous six months, have been discharged from a regional treatment center, or a state-contracted psychiatric bed in a community hospital, or a residential mental health or chemical dependency treatment program.~~ If a person meets the requirements of subdivision 1, paragraph (a) or (b), and receives a federal or state housing subsidy, the housing support rate for that person is limited to the supplementary rate under section 256I.05, subdivision 1a~~, and is determined by subtracting the amount of the person's countable income that exceeds the MSA equivalent rate from the housing support supplementary service rate~~. A resident in a demonstration project site who no longer participates in the demonstration program shall retain eligibility for a housing support payment in an amount determined under section 256I.06, subdivision 8, using the MSA equivalent rate~~. Service funding under section 256I.05, subdivision 1a, will end June 30, 1997, if federal matching funds are available and the services can be provided through a managed care entity. If federal matching funds are not available, then service funding will continue under section 256I.05, subdivision 1a~~;

(4) for an additional two beds, resulting in a total of 32 beds, for a facility located in Hennepin County providing services for recovering and chemically dependent men that has

had a housing support contract with the county and has been licensed as a board and lodge facility with special services since 1980;

(5) for a housing support provider located in the city of St. Cloud, or a county contiguous to the city of St. Cloud, that operates a 40-bed facility, that received financing through the Minnesota Housing Finance Agency Ending Long-Term Homelessness Initiative and serves chemically dependent clientele, providing 24-hour-a-day supervision;

(6) for a new 65-bed facility in Crow Wing County that will serve chemically dependent persons, operated by a housing support provider that currently operates a 304-bed facility in Minneapolis, and a 44-bed facility in Duluth;

(7) for a housing support provider that operates two ten-bed facilities, one located in Hennepin County and one located in Ramsey County, that provide community support and 24-hour-a-day supervision to serve the mental health needs of individuals who have chronically lived unsheltered; and

(8) for a facility authorized for recipients of housing support in Hennepin County with a capacity of up to 48 beds that has been licensed since 1978 as a board and lodging facility and that until August 1, 2007, operated as a licensed chemical dependency treatment program.

(b) An agency may enter into a housing support agreement for beds with rates in excess of the MSA equivalent rate in addition to those currently covered under a housing support agreement if the additional beds are only a replacement of beds with rates in excess of the MSA equivalent rate which have been made available due to closure of a setting, a change of licensure or certification which removes the beds from housing support payment, or as a result of the downsizing of a setting authorized for recipients of housing support. The transfer of available beds from one agency to another can only occur by the agreement of both agencies.

(c) The appropriation for this subdivision must include administrative funding equal to the cost of two full-time equivalent employees to process eligibility. The commissioner must disburse administrative funding to the fiscal agent for the counties under this subdivision.

Sec. 23. Minnesota Statutes 2020, section 256S.16, is amended to read:

256S.16 AUTHORIZATION OF ELDERLY WAIVER SERVICES AND SERVICE RATES.

Subdivision 1. **Service rates; generally.** A lead agency must use the service rates and service rate limits published by the commissioner to authorize services.

Subd. 2. **Shared services; rates.** The commissioner shall provide a rate system for shared homemaker services and shared chore services, based on homemaker rates for a single individual under section 256S.215, subdivisions 9 to 11, and the chore rate for a single individual under section 256S.215, subdivision 7. For two persons sharing services, the rate paid to a provider must not exceed 1-1/2 times the rate paid for serving a single individual, and for three persons sharing services, the rate paid to a provider must not exceed two times the rate paid for serving a single individual. These rates apply only when all of the criteria for the shared service have been met.

Sec. 24. Minnesota Statutes 2020, section 256S.18, subdivision 1, is amended to read:

Subdivision 1. **Case mix classifications.** (a) The elderly waiver case mix classifications A to K shall be the resident classes A to K established under Minnesota Rules, parts 9549.0058 and 9549.0059.

(b) A participant assigned to elderly waiver case mix classification A must be reassigned to elderly waiver case mix classification L if an assessment or reassessment performed under section 256B.0911 determines that the participant has:

(1) no dependencies in activities of daily living; or

(2) up to two dependencies in bathing, dressing, grooming, walking, or eating when the dependency score in eating is three or greater.

(c) A participant must be assigned to elderly waiver case mix classification V if the participant meets the definition of ventilator-dependent in section 256B.0651, subdivision 1, paragraph ~~(g)~~ (i).

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. Laws 2021, First Special Session chapter 7, article 17, section 14, subdivision 3, is amended to read:

Subd. 3. **Membership.** (a) The task force consists of ~~16~~ 20 members, appointed as follows:

(1) the commissioner of human services or a designee;

(2) the commissioner of labor and industry or a designee;

(3) the commissioner of education or a designee;

(4) the commissioner of employment and economic development or a designee;

(5) a representative of the Department of Employment and Economic Development's Vocational Rehabilitation Services Division appointed by the commissioner of employment and economic development;

(6) one member appointed by the Minnesota Disability Law Center;

(7) one member appointed by The Arc of Minnesota;

(8) ~~three~~ four members who are persons with disabilities appointed by the commissioner of human services, at least one of whom ~~must be~~ is neurodiverse, ~~and~~ at least one of whom ~~must have~~ has a significant physical disability, and at least one of whom at the time of the appointment is being paid a subminimum wage;

(9) two representatives of employers authorized to pay subminimum wage and one representative of an employer who successfully transitioned away from payment of subminimum wages to people with disabilities, appointed by the commissioner of human services;

(10) one member appointed by the Minnesota Organization for Habilitation and Rehabilitation;

(11) one member appointed by ARRM; ~~and~~

(12) one member appointed by the State Rehabilitation Council; and

(13) three members who are parents or guardians of persons with disabilities appointed by the commissioner of human services, at least one of whom is a parent or guardian of a person who is neurodiverse, at least one of whom is a parent or guardian of a person with a significant physical disability, and at least one of whom is a parent or guardian of a person being paid a subminimum wage as of the date of the appointment.

(b) To the extent possible, membership on the task force under paragraph (a) shall reflect geographic parity throughout the state and representation from Black, Indigenous, and communities of color.

EFFECTIVE DATE. This section is effective the day following final enactment. The commissioner of human services must make the additional appointments required under this section within 30 days following final enactment.

Sec. 26. Laws 2022, chapter 33, section 1, subdivision 5a, is amended to read:

Subd. 5a. **Base wage index; calculations.** The base wage index must be calculated as follows:

(1) for supervisory staff, 100 percent of the median wage for community and social services specialist (SOC code 21-1099), with the exception of the supervisor of positive supports professional, positive supports analyst, and positive supports specialist, which is 100 percent of the median wage for clinical counseling and school psychologist (SOC code 19-3031);

(2) for registered nurse staff, 100 percent of the median wage for registered nurses (SOC code 29-1141);

(3) for licensed practical nurse staff, 100 percent of the median wage for licensed practical nurses (SOC code 29-2061);

(4) for residential asleep-overnight staff, the minimum wage in Minnesota for large employers, with the exception of asleep-overnight staff for family residential services, which is 36 percent of the minimum wage in Minnesota for large employers;

(5) for residential direct care staff, the sum of:

(i) 15 percent of the subtotal of 50 percent of the median wage for home health and personal care aide (SOC code 31-1120); 30 percent of the median wage for nursing assistant (SOC code 31-1131); and 20 percent of the median wage for social and human services aide (SOC code 21-1093); and

(ii) 85 percent of the subtotal of 40 percent of the median wage for home health and personal care aide (SOC code 31-1120); 20 percent of the median wage for nursing assistant (SOC code 31-1014); 20 percent of the median wage for psychiatric technician (SOC code 29-2053); and 20 percent of the median wage for social and human services aide (SOC code 21-1093);

(6) for adult day services staff, 70 percent of the median wage for nursing assistant (SOC code 31-1131); and 30 percent of the median wage for home health and personal care aide (SOC code 31-1120);

(7) for day support services staff and prevocational services staff, 20 percent of the median wage for nursing assistant (SOC code 31-1131); 20 percent of the median wage for psychiatric technician (SOC code 29-2053); and 60 percent of the median wage for social and human services aide (SOC code 21-1093);

(8) for positive supports analyst staff, 100 percent of the median wage for substance abuse, behavioral disorder, and mental health counselor (SOC code 21-1018);

(9) for positive supports professional staff, 100 percent of the median wage for clinical counseling and school psychologist (SOC code 19-3031);

(10) for positive supports specialist staff, 100 percent of the median wage for psychiatric technicians (SOC code 29-2053);

(11) for individualized home supports with family training staff, 20 percent of the median wage for nursing aide (SOC code 31-1131); 30 percent of the median wage for community social service specialist (SOC code 21-1099); 40 percent of the median wage for social and human services aide (SOC code 21-1093); and ten percent of the median wage for psychiatric technician (SOC code 29-2053);

(12) for individualized home supports with training services staff, 40 percent of the median wage for community social service specialist (SOC code 21-1099); 50 percent of the median wage for social and human services aide (SOC code 21-1093); and ten percent of the median wage for psychiatric technician (SOC code 29-2053);

(13) for employment support services staff, 50 percent of the median wage for rehabilitation counselor (SOC code 21-1015); and 50 percent of the median wage for community and social services specialist (SOC code 21-1099);

(14) for employment exploration services staff, 50 percent of the median wage for ~~rehabilitation counselor (SOC code 21-1015)~~ education, guidance, school, and vocational counselors (SOC code 21-1012); and 50 percent of the median wage for community and social services specialist (SOC code 21-1099);

(15) for employment development services staff, 50 percent of the median wage for education, guidance, school, and vocational counselors (SOC code 21-1012); and 50 percent of the median wage for community and social services specialist (SOC code 21-1099);

(16) for individualized home support without training staff, 50 percent of the median wage for home health and personal care aide (SOC code 31-1120); and 50 percent of the median wage for nursing assistant (SOC code 31-1131);

(17) for night supervision staff, 40 percent of the median wage for home health and personal care aide (SOC code 31-1120); 20 percent of the median wage for nursing assistant (SOC code 31-1131); 20 percent of the median wage for psychiatric technician (SOC code 29-2053); and 20 percent of the median wage for social and human services aide (SOC code 21-1093); and

(18) for respite staff, 50 percent of the median wage for home health and personal care aide (SOC code 31-1131); and 50 percent of the median wage for nursing assistant (SOC code 31-1014).~~.~~

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. 27. Laws 2022, chapter 33, section 1, subdivision 9a, is amended to read:

Subd. 9a. **Respite services; component values and calculation of payment rates.** (a) For the purposes of this section, respite services include respite services provided to an individual outside of any service plan for a day program or residential support service.

(b) Component values for respite services are:

(1) competitive workforce factor: 4.7 percent;

(2) supervisory span of control ratio: 11 percent;

(3) employee vacation, sick, and training allowance ratio: 8.71 percent;

(4) employee-related cost ratio: 23.6 percent;

(5) general administrative support ratio: 13.25 percent;

(6) program-related expense ratio: 2.9 percent; and

(7) absence and utilization factor ratio: 3.9 percent.

(c) A unit of service for respite services is 15 minutes.

(d) Payments for respite services must be calculated as follows unless the service is reimbursed separately as part of a residential support services or day program payment rate:

(1) determine the number of units of service to meet an individual's needs;

(2) determine the appropriate hourly staff wage rates derived by the commissioner as provided in subdivisions 5 and 5a;

(3) except for subdivision 5a, clauses (1) to (4), multiply the result of clause (2) by the product of one plus the competitive workforce factor;

(4) for a recipient requiring deaf and hard-of-hearing customization under subdivision 12, add the customization rate provided in subdivision 12 to the result of clause (3);

(5) multiply the number of direct staffing hours by the appropriate staff wage;

(6) multiply the number of direct staffing hours by the product of the supervisory span of control ratio and the appropriate supervisory staff wage in subdivision 5a, clause (1);

(7) combine the results of clauses (5) and (6), and multiply the result by one plus the employee vacation, sick, and training allowance ratio. This is defined as the direct staffing rate;

(8) for employee-related expenses, multiply the result of clause (7) by one plus the employee-related cost ratio;

(9) this is the subtotal rate;

(10) sum the standard general administrative support ratio, the program-related expense ratio, and the absence and utilization factor ratio;

(11) divide the result of clause (9) by one minus the result of clause (10). This is the total payment amount;

(12) for respite services provided in a shared manner, divide the total payment amount in clause (11) by the number of service recipients, not to exceed three; ~~and~~

(13) for night supervision provided in a shared manner, divide the total payment amount in clause (11) by the number of service recipients, not to exceed two; and

~~(13)~~ (14) adjust the result of ~~clause~~ clauses (12) and (13) by a factor to be determined by the commissioner to adjust for regional differences in the cost of providing services.

EFFECTIVE DATE. This section is effective January 1, 2023, or upon federal approval, whichever occurs later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 28. Laws 2022, chapter 40, section 7, is amended to read:

Sec. 7. **APPROPRIATION; TEMPORARY STAFFING POOL.**

~~$1,029,000~~ $3,181,000 in fiscal year 2022 is appropriated from the general fund to the commissioner of human services for the temporary staffing pool described in this act. This is a onetime appropriation and is available until ~~June 30, 2022~~ September 30, 2023.

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

Sec. 29. **WORKFORCE INCENTIVE FUND GRANTS.**

Subdivision 1. **Grant program established.** The commissioner of human services shall establish grants for behavioral health, housing, disability, and home and community-based

older adult providers to assist with recruiting and retaining direct support and frontline workers.

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

(b) "Commissioner" means the commissioner of human services.

(c) "Eligible employer" means an organization enrolled in a Minnesota health care program or providing housing services that is:

(1) a provider of home and community-based services under Minnesota Statutes, chapter 245D;

(2) an agency provider or financial management service provider under Minnesota Statutes, section 256B.85;

(3) a home care provider licensed under Minnesota Statutes, sections 144A.43 to 144A.482;

(4) a facility certified as an intermediate care facility for persons with developmental disabilities;

(5) a provider of home care services as defined in Minnesota Statutes, section 256B.0651, subdivision 1, paragraph (d);

(6) an agency as defined in Minnesota Statutes, section 256B.0949, subdivision 2;

(7) a provider of mental health day treatment services for children or adults;

(8) a provider of emergency services as defined in Minnesota Statutes, section 256E.36;

(9) a provider of housing support as defined in Minnesota Statutes, chapter 256I;

(10) a provider of housing stabilization services as defined in Minnesota Statutes, section 256B.051;

(11) a provider of transitional housing programs as defined in Minnesota Statutes, section 256E.33;

(12) a provider of substance use disorder services as defined in Minnesota Statutes, chapter 245G;

(13) an eligible financial management service provider serving people through consumer-directed community supports under Minnesota Statutes, sections 256B.092 and 256B.49, and chapter 256S, and consumer support grants under Minnesota Statutes, section 256.476;

(14) a provider of customized living services as defined in Minnesota Statutes, section 256S.02, subdivision 12; or

(15) a provider who serves children with an emotional disorder or adults with mental illness under Minnesota Statutes, section 245I.011 or 256B.0671, providing services, including:

(i) assertive community treatment;

(ii) intensive residential treatment services;

(iii) adult rehabilitative mental health services;

(iv) mobile crisis services;

(v) children's therapeutic services and supports;

(vi) children's residential services;

(vii) psychiatric residential treatment services;

(viii) outpatient mental health treatment provided by mental health professionals, community mental health center services, or certified community behavioral health clinics; and

(ix) intensive mental health outpatient treatment services.

(d) "Eligible worker" means a worker who earns $30 per hour or less and has worked in an eligible profession for at least six months. Eligible workers may receive up to $5,000 annually in payments from the workforce incentive fund.

Subd. 3. **Allowable uses of grant money.** (a) Grantees must use money awarded to provide payments to eligible workers for the following purposes:

(1) retention and incentive payments;

(2) postsecondary loan and tuition payments;

(3) child care costs;

(4) transportation-related costs; and

(5) other costs associated with retaining and recruiting workers, as approved by the commissioner.

(b) The commissioner must develop a grant cycle distribution plan that allows for equitable distribution of funding among eligible employer types. The commissioner's determination of the grant awards and amounts is final and is not subject to appeal.

(c) The commissioner must make efforts to prioritize eligible employers owned by persons who are Black, Indigenous, and people of color and small- to mid-sized eligible employers.

Subd. 4. **Attestation.** As a condition of obtaining grant payments under this section, an eligible employer must attest and agree to the following:

(1) the employer is an eligible employer;

(2) the total number of eligible employees;

(3) the employer will distribute the entire value of the grant to eligible employees, as allowed under this section;

(4) the employer will create and maintain records under subdivision 6;

(5) the employer will not use the money appropriated under this section for any purpose other than the purposes permitted under this section; and

(6) the entire value of any grant amounts must be distributed to eligible employees identified by the provider.

Subd. 5. **Audits and recoupment.** (a) The commissioner may perform an audit under this section up to six years after the grant is awarded to ensure:

(1) the grantee used the money solely for the purposes stated in subdivision 3;

(2) the grantee was truthful when making attestations under subdivision 5; and

(3) the grantee complied with the conditions of receiving a grant under this section.

(b) If the commissioner determines that a grantee used awarded money for purposes not authorized under this section, the commissioner must treat any amount used for a purpose not authorized under this section as an overpayment. The commissioner must recover any overpayment.

Subd. 6. **Self-directed services workforce.** Grants paid to eligible employees providing services within the covered programs defined in Minnesota Statutes, section 256B.0711, do not constitute a change in a term or condition for individual providers in covered programs and are not subject to the state's obligation to meet and negotiate under Minnesota Statutes, chapter 179A.

Subd. 7. **Grants not to be considered income.** (a) For the purposes of this subdivision, "subtraction" has the meaning given in Minnesota Statutes, section 290.0132, subdivision

1, paragraph (a), and the rules in that subdivision apply for this subdivision. The definitions in Minnesota Statutes, section 290.01, apply to this subdivision.

(b) The amount of grant awards received under this section is a subtraction.

(c) Grant awards under this section are excluded from income, as defined in Minnesota Statutes, sections 290.0674, subdivision 2a, and 290A.03, subdivision 3.

(d) Notwithstanding any law to the contrary, grant awards under this section must not be considered income, assets, or personal property for purposes of determining eligibility or recertifying eligibility for:

(1) child care assistance programs under Minnesota Statutes, chapter 119B;

(2) general assistance, Minnesota supplemental aid, and food support under Minnesota Statutes, chapter 256D;

(3) housing support under Minnesota Statutes, chapter 256I;

(4) Minnesota family investment program and diversionary work program under Minnesota Statutes, chapter 256J; and

(5) economic assistance programs under Minnesota Statutes, chapter 256P.

(e) The commissioner of human services must not consider grant awards under this section as income or assets under Minnesota Statutes, section 256B.056, subdivision 1a, paragraph (a); 3; or 3c, or for persons with eligibility determined under Minnesota Statutes, section 256B.057, subdivision 3, 3a, or 3b.

EFFECTIVE DATE. This section is effective July 1, 2022.

Sec. 30. **DIRECT CARE SERVICE CORPS PILOT PROJECT.**

Subdivision 1. **Establishment.** HealthForce Minnesota at Winona State University must develop a pilot project establishing the Minnesota Direct Care Service Corps. The pilot program must utilize financial incentives to attract postsecondary students to work as personal care assistants or direct support professionals. HealthForce Minnesota must establish the financial incentives and minimum work requirements to be eligible for incentive payments. The financial incentive must increase with each semester that the student participates in the Minnesota Direct Care Service Corps.

Subd. 2. **Pilot sites.** (a) Pilot sites must include one postsecondary institution in the seven-county metropolitan area and at least one postsecondary institution outside of the seven-county metropolitan area. If more than one postsecondary institution outside the

metropolitan area is selected, one must be located in northern Minnesota and the other must be located in southern Minnesota.

(b) After satisfactorily completing the work requirements for a semester, the pilot site or its fiscal agent must pay students the financial incentive developed for the pilot project.

Subd. 3. **Evaluation and report.** (a) HealthForce Minnesota must contract with a third party to evaluate the pilot project's impact on health care costs, retention of personal care assistants, and patients' and providers' satisfaction of care. The evaluation must include the number of participants, the hours of care provided by participants, and the retention of participants from semester to semester.

(b) By January 4, 2024, HealthForce Minnesota must report the findings under paragraph (a) to the chairs and ranking members of the legislative committees with jurisdiction over human services policy and finance.

Sec. 31. **DIRECTION TO COMMISSIONER OF HUMAN SERVICES; LIFE-SHARING SERVICES.**

Subdivision 1. **Recommendations required.** The commissioner of human services shall develop recommendations for establishing life sharing as a covered medical assistance waiver service.

Subd. 2. **Definition.** For the purposes of this section, "life sharing" means a relationship-based living arrangement between an adult with a disability and an individual or family in which they share their lives and experiences while the adult with a disability receives support from the individual or family using person-centered practices.

Subd. 3. **Stakeholder engagement and consultation.** (a) The commissioner must proactively solicit participation in the development of the life-sharing medical assistance service through a robust stakeholder engagement process that results in the inclusion of a racially, culturally, and geographically diverse group of interested stakeholders from each of the following groups:

(1) providers currently providing or interested in providing life-sharing services;

(2) people with disabilities accessing or interested in accessing life-sharing services;

(3) disability advocacy organizations; and

(4) lead agencies.

(b) The commissioner must proactively seek input into and assistance with the development of recommendations for establishing the life-sharing service from interested stakeholders.

(c) The commissioner must provide a method for the commissioner and interested stakeholders to cofacilitate public meetings. The first meeting must occur before January 31, 2023. The commissioner must host the cofacilitated meetings at least monthly through October 31, 2023. All meetings must be accessible to all interested stakeholders, recorded, and posted online within one week of the meeting date.

Subd. 4. **Required topics to be discussed during development of the recommendations.** The commissioner and the interested stakeholders must discuss the following topics:

(1) the distinction between life sharing and adult family foster care;

(2) successful life-sharing models used in other states;

(3) services and supports that could be included in a life-sharing service;

(4) potential barriers to providing or accessing life-sharing services;

(5) solutions to remove identified barriers to providing or accessing life-sharing services;

(6) potential medical assistance payment methodologies for life-sharing services;

(7) expanding awareness of the life-sharing model; and

(8) draft language for legislation necessary to define and implement life-sharing services.

Subd. 5. **Report to the legislature.** By December 31, 2023, the commissioner must provide to the chairs and ranking minority members of the house of representatives and senate committees and divisions with jurisdiction over direct care services a report summarizing the discussions between the commissioner and the interested stakeholders and the commissioner's recommendations. The report must also include any draft legislation necessary to define and implement life-sharing services.

Sec. 32. **TASK FORCE ON DISABILITY SERVICES ACCESSIBILITY.**

Subdivision 1. **Establishment; purpose.** The Task Force on Disability Services Accessibility is established to evaluate the accessibility of current state and county disability services and to develop and evaluate plans to address barriers to accessibility.

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

(b) "Accessible" means that a service or program is easily navigated without accommodation or assistance, or, if reasonable accommodations are needed to navigate a service or program, accommodations are chosen by the participant and effectively implemented without excessive burden to the participant. Accessible communication means communication that a person understands, with appropriate accommodations as needed, including language or other interpretation.

(c) "Commissioner" means the commissioner of the Department of Human Services.

(d) "Disability services" means services provided through Medicaid, including personal care assistance, home care, other home and community-based services, waivers, and other home and community-based disability services provided through lead agencies.

(e) "Lead agency" means a county, Tribe, or health plan under contract with the commissioner to administer disability services.

(f) "Task force" means the Task Force on Disability Services Accessibility.

Subd. 3. **Membership.** (a) The task force consists of 24 members as follows:

(1) the commissioner of human services or a designee;

(2) one member appointed by the Minnesota Council on Disability;

(3) the ombudsman for mental health and developmental disabilities or a designee;

(4) two representatives of counties or Tribal agencies appointed by the commissioner of human services;

(5) one member appointed by the Minnesota Association of County Social Service Administrators;

(6) one member appointed by the Minnesota Disability Law Center;

(7) one member appointed by the Arc of Minnesota;

(8) one member appointed by the Autism Society of Minnesota;

(9) one member appointed by the Service Employees International Union;

(10) five members appointed by the commissioner of human services who are people with disabilities, including at least one individual who has been denied services from the state or county and two individuals who use different types of disability services;

(11) three members appointed by the commissioner of human services who are parents of children with disabilities who use different types of disability services;

(12) one member appointed by the Association of Residential Resources in Minnesota;

(13) one member appointed by the Minnesota First Provider Alliance;

(14) one member appointed by the Minnesota Commission of the Deaf, DeafBlind and Hard of Hearing;

(15) one member appointed by the Minnesota Organization for Habilitation and Rehabilitation; and

(16) two members appointed by the commissioner of human services who are direct service professionals.

(b) To the extent possible, membership on the task force under paragraph (a) shall reflect geographic parity throughout the state and representation from Black and Indigenous communities and communities of color.

(c) The membership terms, compensation, expense reimbursement, and removal and filling of vacancies of task force members are as provided in section 15.059.

Subd. 4. **Appointment deadline; first meeting; chair.** Appointing authorities must complete member selections by August 1, 2022. The commissioner shall convene the first meeting of the task force by September 15, 2022. The task force shall select a chair from among its members at its first meeting. The chair shall convene all subsequent meetings.

Subd. 5. **Goals.** The goals of the task force include:

(1) developing plans and executing methods to investigate accessibility of disability services, including consideration of the following inquiries:

(i) how accessible is the program or service without assistance or accommodation, including what accessibility options exist, how the accessibility options are communicated, what communication options are available, what trainings are provided to ensure accessibility options are implemented, and available processes for filing consumer accessibility complaints and correcting administrative errors;

(ii) the impact of accessibility barriers on individuals' access to services, including information about service denials or reductions due to accessibility issues, and aggregate information about reductions and denials related to disability or support need types and reasons for reductions and denials; and

(iii) what areas of discrepancy exist between declared state and county disability policy goals and enumerated state and federal laws and the experiences of people who have disabilities in accessing services;

(2) identifying areas of inaccessibility creating inefficiencies that financially impact the state and counties, including:

(i) the number and cost of appeals, including the number of appeals of service denials or reductions that are ultimately overturned;

(ii) the cost of crisis intervention because of service failure; and

(iii) the cost of redoing work that was not done correctly initially; and

(3) assessing the efficacy of possible solutions.

Subd. 6. **Duties; plan and recommendations.** (a) The task force shall work with the commissioner to identify investigative areas and to develop a plan to conduct an accessibility assessment of disability services provided by lead agencies and the Department of Human Services. The assessment shall:

(1) identify accessibility barriers and impediments created by current policies, procedures, and implementation;

(2) identify and analyze accessibility barrier and impediment impacts on different demographics;

(3) gather information from:

(i) the Department of Human Services;

(ii) relevant state agencies and staff;

(iii) counties and relevant staff;

(iv) people who use disability services;

(v) disability advocates; and

(vi) family members and other support people for individuals who use disability services;

(4) identify barriers to accessibility improvements in state and county services; and

(5) identify benefits to the state and counties in improving accessibility of disability services.

(b) For the purposes of the assessment, disability services include:

(1) access to services;

(2) explanation of services;

(3) maintenance of services;

(4) application of services;

(5) services participant understanding of rights and responsibilities;

(6) communication regarding services;

(7) requests for accommodations;

(8) processes for filing complaints or grievances; and

(9) processes for appealing decisions denying or reducing services or eligibility.

(c) The task force shall collaborate with stakeholders, counties, and state agencies to develop recommendations from the findings of the assessment and to create sustainable and accessible changes to county and state services to improve outcomes for people with disabilities. The recommendations shall include:

(1) recommendations to eliminate barriers identified in the assessment, including but not limited to recommendations for state legislative action, state policy action, and lead agency changes;

(2) benchmarks for measuring annual progress toward increasing accessibility in county and state disability services to be annually evaluated by the commissioner and the Minnesota Council on Disability;

(3) a proposed method for monitoring and tracking accessibility in disability services;

(4) proposed initiatives, training, and services designed to improve accessibility and effectiveness of county and state disability services, including recommendations for needed electronic or other communication changes in order to facilitate accessible communication for participants; and

(5) recommendations for sustainable financial support and resources for improving accessibility.

(d) The task force shall oversee preparation of a report outlining the findings from the accessibility assessment in paragraph (a) and the recommendations developed pursuant to paragraph (b) according to subdivision 7.

Subd. 7. **Report.** By September 30, 2023, the task force shall submit a report with recommendations to the chairs and ranking minority members of the committees and divisions in the senate and house of representatives with jurisdiction over health and human services. This report must comply with subdivision 6, paragraph (d), include any changes to statutes, laws, or rules required to implement the recommendations of the task force, and include a recommendation concerning continuing the task force beyond its scheduled expiration.

Subd. 8. **Administrative support.** The commissioner of human services shall provide meeting space and administrative services to the task force.

Subd. 9. **Expiration.** The task force expires on June 30, 2023.

Sec. 33. **DIRECTION TO COMMISSIONER; SHARED SERVICES.**

(a) By December 1, 2022, the commissioner of human services shall seek any necessary changes to home and community-based services waiver plans regarding sharing services in order to:

(1) permit shared services for more services, including chore, homemaker, and night supervision;

(2) permit shared services for some services for higher ratios, including individualized home supports without training, individualized home supports with training, and individualized home supports with family training for a ratio of one staff person to three recipients;

(3) ensure that individuals who are seeking to share services permitted under the waiver plans in an own-home setting are not required to live in a licensed setting in order to share services so long as all other requirements are met; and

(4) issue guidance for shared services, including:

(i) informed choice for all individuals sharing the services;

(ii) guidance for when multiple shared services by different providers occur in one home and how lead agencies and individuals shall determine that shared service is appropriate to meet the needs, health, and safety of each individual for whom the lead agency provides case management or care coordination; and

(iii) guidance clarifying that an individual's decision to share services does not reduce any determination of the individual's overall or assessed needs for services.

(b) The commissioner shall develop or provide guidance outlining:

(1) instructions for shared services support planning;

(2) person-centered approaches and informed choice in shared services support planning; and

(3) required contents of shared services agreements.

(c) The commissioner shall seek and utilize stakeholder input for any proposed changes to waiver plans and any shared services guidance.

Sec. 34. **DIRECTION TO COMMISSIONER; DISABILITY WAIVER SHARED SERVICES RATES.**

The commissioner of human services shall provide a rate system for shared homemaker services and shared chore services provided under Minnesota Statutes, sections 256B.092 and 256B.49. For two persons sharing services, the rate paid to a provider must not exceed 1-1/2 times the rate paid for serving a single individual, and for three persons sharing services, the rate paid to a provider must not exceed two times the rate paid for serving a single individual. These rates apply only when all of the criteria for the shared service have been met.

Sec. 35. **DIRECTION TO COMMISSIONER; CONSUMER-DIRECTED COMMUNITY SUPPORTS.**

The commissioner of human services shall increase individual budgets for people receiving consumer-directed community supports available under programs established pursuant to home and community-based service waivers authorized under section 1915(c) of the federal Social Security Act and Minnesota Statutes, sections 256B.092 and 256B.49, by 2.8 percent.

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. 36. **DIRECTION TO COMMISSIONER; INTERMEDIATE CARE FACILITIES FOR PERSONS WITH DISABILITIES RATE STUDY.**

The commissioner of human services shall study medical assistance payment rates for intermediate care facilities for persons with disabilities under Minnesota Statutes, sections 256B.5011 to 256B.5015; make recommendations on establishing a new payment rate methodology for these facilities; and submit a report to the chairs and ranking minority members of the legislative committees with jurisdiction over human services finance by February 15, 2023, that includes the recommendations and any draft legislation necessary to implement the recommendations.

ARTICLE 10
BEHAVIORAL HEALTH

Section 1. Minnesota Statutes 2020, section 62N.25, subdivision 5, is amended to read:

Subd. 5. **Benefits.** Community integrated service networks must offer the health maintenance organization benefit set, as defined in chapter 62D, and other laws applicable to entities regulated under chapter 62D. Community networks and chemical dependency facilities under contract with a community network shall use the assessment criteria in ~~Minnesota Rules, parts 9530.6600 to 9530.6655,~~ section 245G.05 when assessing enrollees for chemical dependency treatment.

EFFECTIVE DATE. This section is effective July 1, 2022.

Sec. 2. Minnesota Statutes 2020, section 62Q.1055, is amended to read:

62Q.1055 CHEMICAL DEPENDENCY.

All health plan companies shall use the assessment criteria in ~~Minnesota Rules, parts 9530.6600 to 9530.6655,~~ section 245G.05 when assessing and ~~placing~~ treating enrollees for chemical dependency treatment.

EFFECTIVE DATE. This section is effective July 1, 2022.

Sec. 3. Minnesota Statutes 2020, section 62Q.47, is amended to read:

62Q.47 ALCOHOLISM, MENTAL HEALTH, AND CHEMICAL DEPENDENCY SERVICES.

(a) All health plans, as defined in section 62Q.01, that provide coverage for alcoholism, mental health, or chemical dependency services, must comply with the requirements of this section.

(b) Cost-sharing requirements and benefit or service limitations for outpatient mental health and outpatient chemical dependency and alcoholism services, except for persons ~~placed in~~ seeking chemical dependency services under ~~Minnesota Rules, parts 9530.6600 to 9530.6655~~ section 245G.05, must not place a greater financial burden on the insured or enrollee, or be more restrictive than those requirements and limitations for outpatient medical services.

(c) Cost-sharing requirements and benefit or service limitations for inpatient hospital mental health and inpatient hospital and residential chemical dependency and alcoholism services, except for persons ~~placed in~~ seeking chemical dependency services under ~~Minnesota~~

~~Rules, parts 9530.6600 to 9530.6655~~ section 245G.05, must not place a greater financial burden on the insured or enrollee, or be more restrictive than those requirements and limitations for inpatient hospital medical services.

(d) A health plan company must not impose an NQTL with respect to mental health and substance use disorders in any classification of benefits unless, under the terms of the health plan as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the NQTL to mental health and substance use disorders in the classification are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the NQTL with respect to medical and surgical benefits in the same classification.

(e) All health plans must meet the requirements of the federal Mental Health Parity Act of 1996, Public Law 104-204; Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008; the Affordable Care Act; and any amendments to, and federal guidance or regulations issued under, those acts.

(f) The commissioner may require information from health plan companies to confirm that mental health parity is being implemented by the health plan company. Information required may include comparisons between mental health and substance use disorder treatment and other medical conditions, including a comparison of prior authorization requirements, drug formulary design, claim denials, rehabilitation services, and other information the commissioner deems appropriate.

(g) Regardless of the health care provider's professional license, if the service provided is consistent with the provider's scope of practice and the health plan company's credentialing and contracting provisions, mental health therapy visits and medication maintenance visits shall be considered primary care visits for the purpose of applying any enrollee cost-sharing requirements imposed under the enrollee's health plan.

(h) By June 1 of each year, beginning June 1, 2021, the commissioner of commerce, in consultation with the commissioner of health, shall submit a report on compliance and oversight to the chairs and ranking minority members of the legislative committees with jurisdiction over health and commerce. The report must:

(1) describe the commissioner's process for reviewing health plan company compliance with United States Code, title 42, section 18031(j), any federal regulations or guidance relating to compliance and oversight, and compliance with this section and section 62Q.53;

(2) identify any enforcement actions taken by either commissioner during the preceding 12-month period regarding compliance with parity for mental health and substance use

disorders benefits under state and federal law, summarizing the results of any market conduct examinations. The summary must include: (i) the number of formal enforcement actions taken; (ii) the benefit classifications examined in each enforcement action; and (iii) the subject matter of each enforcement action, including quantitative and nonquantitative treatment limitations;

(3) detail any corrective action taken by either commissioner to ensure health plan company compliance with this section, section 62Q.53, and United States Code, title 42, section 18031(j); and

(4) describe the information provided by either commissioner to the public about alcoholism, mental health, or chemical dependency parity protections under state and federal law.

The report must be written in nontechnical, readily understandable language and must be made available to the public by, among other means as the commissioners find appropriate, posting the report on department websites. Individually identifiable information must be excluded from the report, consistent with state and federal privacy protections.

EFFECTIVE DATE. This section is effective July 1, 2022.

Sec. 4. Minnesota Statutes 2020, section 169A.70, subdivision 3, is amended to read:

Subd. 3. **Assessment report.** (a) The assessment report must be on a form prescribed by the commissioner and shall contain an evaluation of the convicted defendant concerning the defendant's prior traffic and criminal record, characteristics and history of alcohol and chemical use problems, and amenability to rehabilitation through the alcohol safety program. The report is classified as private data on individuals as defined in section 13.02, subdivision 12.

(b) The assessment report must include:

(1) a diagnosis of the nature of the offender's chemical and alcohol involvement;

(2) an assessment of the severity level of the involvement;

(3) a recommended level of care for the offender in accordance with the criteria contained in ~~rules adopted by the commissioner of human services under section 254A.03, subdivision 3 (chemical dependency treatment rules)~~ section 245G.05;

(4) an assessment of the offender's placement needs;

(5) recommendations for other appropriate remedial action or care, including aftercare services in section 254B.01, subdivision 3, that may consist of educational programs,

one-on-one counseling, a program or type of treatment that addresses mental health concerns, or a combination of them; and

(6) a specific explanation why no level of care or action was recommended, if applicable.

EFFECTIVE DATE. This section is effective July 1, 2022.

Sec. 5. Minnesota Statutes 2020, section 169A.70, subdivision 4, is amended to read:

Subd. 4. **Assessor standards; rules; assessment time limits.** A chemical use assessment required by this section must be conducted by an assessor appointed by the court. The assessor must meet the training and qualification requirements of ~~rules adopted by the commissioner of human services under section 254A.03, subdivision 3 (chemical dependency treatment rules)~~ section 245G.11, subdivisions 1 and 5. Notwithstanding section 13.82 (law enforcement data), the assessor shall have access to any police reports, laboratory test results, and other law enforcement data relating to the current offense or previous offenses that are necessary to complete the evaluation. ~~An assessor providing an assessment under this section may not have any direct or shared financial interest or referral relationship resulting in shared financial gain with a treatment provider, except as authorized under section 254A.19, subdivision 3. If an independent assessor is not available, the court may use the services of an assessor authorized to perform assessments for the county social services agency under a variance granted under rules adopted by the commissioner of human services under section 254A.03, subdivision 3.~~ An appointment for the defendant to undergo the assessment must be made by the court, a court services probation officer, or the court administrator as soon as possible but in no case more than one week after the defendant's court appearance. The assessment must be completed no later than three weeks after the defendant's court appearance. If the assessment is not performed within this time limit, the county where the defendant is to be sentenced shall perform the assessment. The county of financial responsibility must be determined under chapter 256G.

EFFECTIVE DATE. This section is effective July 1, 2022.

Sec. 6. **[245.4866] CHILDREN'S MENTAL HEALTH COMMUNITY OF PRACTICE.**

Subdivision 1. **Establishment; purpose.** The commissioner of human services, in consultation with children's mental health subject matter experts, shall establish a children's mental health community of practice. The purposes of the community of practice are to improve treatment outcomes for children and adolescents with mental illness and reduce

disparities. The community of practice shall use evidence-based and best practices through peer-to-peer and person-to-provider sharing.

Subd. 2. **Participants; meetings.** (a) The community of practice must include the following participants:

(1) researchers or members of the academic community who are children's mental health subject matter experts who do not have financial relationships with treatment providers;

(2) children's mental health treatment providers;

(3) a representative from a mental health advocacy organization;

(4) a representative from the Department of Human Services;

(5) a representative from the Department of Health;

(6) a representative from the Department of Education;

(7) representatives from county social services agencies;

(8) representatives from Tribal nations or Tribal social services providers; and

(9) representatives from managed care organizations.

(b) The community of practice must include, to the extent possible, individuals and family members who have used mental health treatment services and must highlight the voices and experiences of individuals who are Black, Indigenous, people of color, and people from other communities that are disproportionately impacted by mental illness.

(c) The community of practice must meet regularly and must hold its first meeting before January 1, 2023.

(d) Compensation and reimbursement for expenses for participants in paragraph (b) are governed by section 15.059, subdivision 3.

Subd. 3. **Duties.** (a) The community of practice must:

(1) identify gaps in children's mental health treatment services;

(2) enhance collective knowledge of issues related to children's mental health;

(3) understand evidence-based practices, best practices, and promising approaches to address children's mental health;

(4) use knowledge gathered through the community of practice to develop strategic plans to improve outcomes for children who participate in mental health treatment and related services in Minnesota;

(5) increase knowledge about the challenges and opportunities learned by implementing strategies; and

(6) develop capacity for community advocacy.

(b) The commissioner, in collaboration with subject matter experts and other participants, may issue reports and recommendations to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services policy and finance and to local and regional governments.

Sec. 7. Minnesota Statutes 2020, section 245.4882, is amended by adding a subdivision to read:

Subd. 2a. **Assessment requirements.** (a) A residential treatment service provider must complete a diagnostic assessment of a child within ten calendar days of the child's admission. If a diagnostic assessment has been completed by a mental health professional within the past 180 days, a new diagnostic assessment need not be completed unless in the opinion of the current treating mental health professional the child's mental health status has changed markedly since the assessment was completed.

(b) The service provider must complete the screenings required by Minnesota Rules, part 2960.0070, subpart 5, within ten calendar days.

Sec. 8. Minnesota Statutes 2020, section 245.4882, is amended by adding a subdivision to read:

Subd. 6. **Crisis admissions and stabilization.** (a) A child may be referred for residential treatment services under this section for the purpose of crisis stabilization by:

(1) a mental health professional as defined in section 245I.04, subdivision 2;

(2) a physician licensed under chapter 147 who is assessing a child in an emergency department; or

(3) a member of a mobile crisis team who meets the qualifications under section 256B.0624, subdivision 5.

(b) A provider making a referral under paragraph (a) must conduct an assessment of the child's mental health needs and make a determination that the child is experiencing a mental health crisis and is in need of residential treatment services under this section.

(c) A child may receive services under this subdivision for up to 30 days and must be subject to the screening and admissions criteria and processes under section 245.4885 thereafter.

Sec. 9. Minnesota Statutes 2021 Supplement, section 245.4885, subdivision 1, is amended to read:

Subdivision 1. **Admission criteria.** (a) Prior to admission or placement, except in the case of an emergency, all children referred for treatment of severe emotional disturbance in a treatment foster care setting, residential treatment facility, or informally admitted to a regional treatment center shall undergo an assessment to determine the appropriate level of care if county funds are used to pay for the child's services. An emergency includes when a child is in need of and has been referred for crisis stabilization services under section 245.4882, subdivision 6. A child who has been referred to residential treatment for crisis stabilization services in a residential treatment center is not required to undergo an assessment under this section.

(b) The county board shall determine the appropriate level of care for a child when county-controlled funds are used to pay for the child's residential treatment under this chapter, including residential treatment provided in a qualified residential treatment program as defined in section 260C.007, subdivision 26d. When a county board does not have responsibility for a child's placement and the child is enrolled in a prepaid health program under section 256B.69, the enrolled child's contracted health plan must determine the appropriate level of care for the child. When Indian Health Services funds or funds of a tribally owned facility funded under the Indian Self-Determination and Education Assistance Act, Public Law 93-638, are used for the child, the Indian Health Services or 638 tribal health facility must determine the appropriate level of care for the child. When more than one entity bears responsibility for a child's coverage, the entities shall coordinate level of care determination activities for the child to the extent possible.

(c) The child's level of care determination shall determine whether the proposed treatment:

(1) is necessary;

(2) is appropriate to the child's individual treatment needs;

(3) cannot be effectively provided in the child's home; and

(4) provides a length of stay as short as possible consistent with the individual child's needs.

(d) When a level of care determination is conducted, the county board or other entity may not determine that a screening of a child, referral, or admission to a residential treatment facility is not appropriate solely because services were not first provided to the child in a less restrictive setting and the child failed to make progress toward or meet treatment goals in the less restrictive setting. The level of care determination must be based on a diagnostic assessment of a child that evaluates the child's family, school, and community living situations; and an assessment of the child's need for care out of the home using a validated tool which assesses a child's functional status and assigns an appropriate level of care to the child. The validated tool must be approved by the commissioner of human services and may be the validated tool approved for the child's assessment under section 260C.704 if the juvenile treatment screening team recommended placement of the child in a qualified residential treatment program. If a diagnostic assessment has been completed by a mental health professional within the past 180 days, a new diagnostic assessment need not be completed unless in the opinion of the current treating mental health professional the child's mental health status has changed markedly since the assessment was completed. The child's parent shall be notified if an assessment will not be completed and of the reasons. A copy of the notice shall be placed in the child's file. Recommendations developed as part of the level of care determination process shall include specific community services needed by the child and, if appropriate, the child's family, and shall indicate whether these services are available and accessible to the child and the child's family. The child and the child's family must be invited to any meeting where the level of care determination is discussed and decisions regarding residential treatment are made. The child and the child's family may invite other relatives, friends, or advocates to attend these meetings.

(e) During the level of care determination process, the child, child's family, or child's legal representative, as appropriate, must be informed of the child's eligibility for case management services and family community support services and that an individual family community support plan is being developed by the case manager, if assigned.

(f) The level of care determination, placement decision, and recommendations for mental health services must be documented in the child's record and made available to the child's family, as appropriate.

Sec. 10. Minnesota Statutes 2021 Supplement, section 245.4889, subdivision 1, is amended to read:

Subdivision 1. **Establishment and authority.** (a) The commissioner is authorized to make grants from available appropriations to assist:

(1) counties;

(2) Indian tribes;

(3) children's collaboratives under section 124D.23 or 245.493; ~~or~~

(4) mental health service providers~~.~~; or

(5) school districts and charter schools.

(b) The following services are eligible for grants under this section:

(1) services to children with emotional disturbances as defined in section 245.4871, subdivision 15, and their families;

(2) transition services under section 245.4875, subdivision 8, for young adults under age 21 and their families;

(3) respite care services for children with emotional disturbances or severe emotional disturbances who are at risk of out-of-home placement or already in out-of-home placement and at risk of change in placement or a higher level of care. Allowable activities and expenses for respite care services are defined under subdivision 4. A child is not required to have case management services to receive respite care services;

(4) children's mental health crisis services;

(5) mental health services for people from cultural and ethnic minorities, including supervision of clinical trainees who are Black, indigenous, or people of color;

(6) children's mental health screening and follow-up diagnostic assessment and treatment;

(7) services to promote and develop the capacity of providers to use evidence-based practices in providing children's mental health services;

(8) school-linked mental health services under section 245.4901;

(9) building evidence-based mental health intervention capacity for children birth to age five;

(10) suicide prevention and counseling services that use text messaging statewide;

(11) mental health first aid training;

(12) training for parents, collaborative partners, and mental health providers on the impact of adverse childhood experiences and trauma and development of an interactive website to share information and strategies to promote resilience and prevent trauma;

(13) transition age services to develop or expand mental health treatment and supports for adolescents and young adults 26 years of age or younger;

(14) early childhood mental health consultation;

(15) evidence-based interventions for youth at risk of developing or experiencing a first episode of psychosis, and a public awareness campaign on the signs and symptoms of psychosis;

(16) psychiatric consultation for primary care practitioners; ~~and~~

(17) providers to begin operations and meet program requirements when establishing a new children's mental health program. These may be start-up grants.~~;~~ and

(18) intensive developmentally appropriate and culturally informed interventions for youth who are at risk of developing a mood disorder or experiencing a first episode of a mood disorder and a public awareness campaign on the signs and symptoms of mood disorders in youth.

(c) Services under paragraph (b) must be designed to help each child to function and remain with the child's family in the community and delivered consistent with the child's treatment plan. Transition services to eligible young adults under this paragraph must be designed to foster independent living in the community.

(d) As a condition of receiving grant funds, a grantee shall obtain all available third-party reimbursement sources, if applicable.

Sec. 11. Minnesota Statutes 2020, section 245.4889, is amended by adding a subdivision to read:

Subd. 4. **Covered respite care services.** Respite care services under subdivision 1, paragraph (b), clause (3), include hourly or overnight stays at a licensed foster home or with a qualified and approved family member or friend and may occur at a child's or a provider's home. Respite care services may also include the following activities and expenses:

(1) recreational, sport, and nonsport extracurricular activities and programs for the child such as camps, clubs, activities, lessons, group outings, sports, or other activities and programs;

(2) family activities, camps, and retreats that the whole family does together that provide a break from the family's circumstances;

(3) cultural programs and activities for the child and family designed to address the unique needs of individuals who share a common language or racial, ethnic, or social background; and

(4) costs of transportation, food, supplies, and equipment directly associated with approved respite care services and expenses necessary for the child and family to access and participate in respite care services.

EFFECTIVE DATE. This section is effective July 1, 2022.

Sec. 12. **[245.4903] CULTURAL AND ETHNIC MINORITY INFRASTRUCTURE GRANT PROGRAM.**

Subdivision 1. **Establishment.** The commissioner of human services shall establish a cultural and ethnic minority infrastructure grant program to ensure that mental health and substance use disorder treatment supports and services are culturally specific and culturally responsive to meet the cultural needs of the communities served.

Subd. 2. **Eligible applicants.** An eligible applicant is a licensed entity or provider from a cultural or ethnic minority population who:

(1) provides mental health or substance use disorder treatment services and supports to individuals from cultural and ethnic minority populations, including individuals who are lesbian, gay, bisexual, transgender, or queer, from cultural and ethnic minority populations;

(2) provides or is qualified and has the capacity to provide clinical supervision and support to members of culturally diverse and ethnic minority communities to qualify as mental health and substance use disorder treatment providers; or

(3) has the capacity and experience to provide training for mental health and substance use disorder treatment providers on cultural competency and cultural humility.

Subd. 3. **Allowable grant activities.** (a) The cultural and ethnic minority infrastructure grant program grantees must engage in activities and provide supportive services to ensure and increase equitable access to culturally specific and responsive care and to build organizational and professional capacity for licensure and certification for the communities served. Allowable grant activities include but are not limited to:

(1) workforce development activities focused on recruiting, supporting, training, and supervision activities for mental health and substance use disorder practitioners and professionals from diverse racial, cultural, and ethnic communities;

(2) supporting members of culturally diverse and ethnic minority communities to qualify as mental health and substance use disorder professionals, practitioners, clinical supervisors, recovery peer specialists, mental health certified peer specialists, and mental health certified family peer specialists;

(3) culturally specific outreach, early intervention, trauma-informed services, and recovery support in mental health and substance use disorder services;

(4) provision of trauma-informed, culturally responsive mental health and substance use disorder supports and services for children and families, youth, or adults who are from cultural and ethnic minority backgrounds and are uninsured or underinsured;

(5) mental health and substance use disorder service expansion and infrastructure improvement activities, particularly in greater Minnesota;

(6) training for mental health and substance use disorder treatment providers on cultural competency and cultural humility; and

(7) activities to increase the availability of culturally responsive mental health and substance use disorder services for children and families, youth, or adults or to increase the availability of substance use disorder services for individuals from cultural and ethnic minorities in the state.

(b) The commissioner must assist grantees with meeting third-party credentialing requirements, and grantees must obtain all available third-party reimbursement sources as a condition of receiving grant funds. Grantees must serve individuals from cultural and ethnic minority communities regardless of health coverage status or ability to pay.

Subd. 4. **Data collection and outcomes.** Grantees must provide regular data summaries to the commissioner for purposes of evaluating the effectiveness of the cultural and ethnic minority infrastructure grant program. The commissioner must use identified culturally appropriate outcome measures instruments to evaluate outcomes and must evaluate program activities by analyzing whether the program:

(1) increased access to culturally specific services for individuals from cultural and ethnic minority communities across the state;

(2) increased number of individuals from cultural and ethnic minority communities served by grantees;

(3) increased cultural responsiveness and cultural competency of mental health and substance use disorder treatment providers;

(4) increased number of mental health and substance use disorder treatment providers and clinical supervisors from cultural and ethnic minority communities;

(5) increased number of mental health and substance use disorder treatment organizations owned, managed, or led by individuals who are Black, Indigenous, or people of color;

(6) reduced in health disparities through improved clinical and functional outcomes for those accessing services; and

(7) led to an overall increase in culturally specific mental health and substance use disorder service availability.

Sec. 13. **[245.4904] EMERGING MOOD DISORDER GRANT PROGRAM.**

Subdivision 1. **Creation.** (a) The emerging mood disorder grant program is established in the Department of Human Services to fund:

(1) evidence-informed interventions for youth and young adults who are at risk of developing a mood disorder or are experiencing an emerging mood disorder, including major depression and bipolar disorders; and

(2) a public awareness campaign on the signs and symptoms of mood disorders in youth and young adults.

(b) Emerging mood disorder services are eligible for children's mental health grants as specified in section 245.4889, subdivision 1, paragraph (b), clause (18).

Subd. 2. **Activities.** (a) All emerging mood disorder grant programs must:

(1) provide intensive treatment and support to adolescents and young adults experiencing or at risk of experiencing an emerging mood disorder. Intensive treatment and support includes medication management, psychoeducation for the individual and the individual's family, case management, employment support, education support, cognitive behavioral approaches, social skills training, peer support, crisis planning, and stress management;

(2) conduct outreach and provide training and guidance to mental health and health care professionals, including postsecondary health clinicians, on early symptoms of mood disorders, screening tools, and best practices;

(3) ensure access for individuals to emerging mood disorder services under this section, including ensuring access for individuals who live in rural areas; and

(4) use all available funding streams.

(b) Grant money may also be used to pay for housing or travel expenses for individuals receiving services or to address other barriers preventing individuals and their families from participating in emerging mood disorder services.

(c) Grant money may be used by the grantee to evaluate the efficacy of providing intensive services and supports to people with emerging mood disorders.

Subd. 3. **Eligibility.** Program activities must be provided to youth and young adults with early signs of an emerging mood disorder.

Subd. 4. **Outcomes.** Evaluation of program activities must utilize evidence-based practices and must include the following outcome evaluation criteria:

(1) whether individuals experience a reduction in mood disorder symptoms; and

(2) whether individuals experience a decrease in inpatient mental health hospitalizations.

Sec. 14. **[245.4905] FIRST EPISODE OF PSYCHOSIS GRANT PROGRAM.**

Subdivision 1. **Creation.** The first episode of psychosis grant program is established in the Department of Human Services to fund evidence-based interventions for youth at risk of developing or experiencing a first episode of psychosis and a public awareness campaign on the signs and symptoms of psychosis. First episode of psychosis services are eligible for children's mental health grants as specified in section 245.4889, subdivision 1, paragraph (b), clause (15).

Subd. 2. **Activities.** (a) All first episode of psychosis grant programs must:

(1) provide intensive treatment and support for adolescents and adults experiencing or at risk of experiencing a first psychotic episode. Intensive treatment and support includes medication management, psychoeducation for an individual and an individual's family, case management, employment support, education support, cognitive behavioral approaches, social skills training, peer support, crisis planning, and stress management;

(2) conduct outreach and provide training and guidance to mental health and health care professionals, including postsecondary health clinicians, on early psychosis symptoms, screening tools, and best practices;

(3) ensure access for individuals to first psychotic episode services under this section, including access for individuals who live in rural areas; and

(4) use all available funding streams.

(b) Grant money may also be used to pay for housing or travel expenses for individuals receiving services or to address other barriers preventing individuals and their families from participating in first psychotic episode services.

Subd. 3. **Eligibility.** Program activities must be provided to people 15 to 40 years old with early signs of psychosis.

Subd. 4. **Outcomes.** Evaluation of program activities must utilize evidence-based practices and must include the following outcome evaluation criteria:

(1) whether individuals experience a reduction in psychotic symptoms;

(2) whether individuals experience a decrease in inpatient mental health hospitalizations; and

(3) whether individuals experience an increase in educational attainment.

Subd. 5. **Federal aid or grants.** The commissioner of human services must comply with all conditions and requirements necessary to receive federal aid or grants.

Sec. 15. Minnesota Statutes 2020, section 245.713, subdivision 2, is amended to read:

Subd. 2. **Total funds available; allocation.** Funds granted to the state by the federal government under United States Code, title 42, sections 300X to 300X-9 each federal fiscal year for mental health services must be allocated as follows:

(a) Any amount set aside by the commissioner of human services for American Indian organizations within the state, which funds shall not duplicate any direct federal funding of American Indian organizations and which funds shall be at least 25 percent of the total federal allocation to the state for mental health services~~; provided that sufficient applications for funding are received by the commissioner which meet the specifications contained in requests for proposals~~. Money from this source may be used for special committees to advise the commissioner on mental health programs and services for American Indians and other minorities or underserved groups. For purposes of this subdivision, "American Indian organization" means an American Indian tribe or band or an organization providing mental health services that is legally incorporated as a nonprofit organization registered with the secretary of state and governed by a board of directors having at least a majority of American Indian directors.

(b) An amount not to exceed five percent of the federal block grant allocation for mental health services to be retained by the commissioner for administration.

(c) Any amount permitted under federal law which the commissioner approves for demonstration or research projects for severely disturbed children and adolescents, the underserved, special populations or multiply disabled mentally ill persons. The groups to be served, the extent and nature of services to be provided, the amount and duration of any grant awards are to be based on criteria set forth in the Alcohol, Drug Abuse and Mental Health Block Grant Law, United States Code, title 42, sections 300X to 300X-9, and on state policies and procedures determined necessary by the commissioner. Grant recipients must comply with applicable state and federal requirements and demonstrate fiscal and program management capabilities that will result in provision of quality, cost-effective services.

(d) The amount required under federal law, for federally mandated expenditures.

(e) An amount not to exceed 15 percent of the federal block grant allocation for mental health services to be retained by the commissioner for planning and evaluation.

EFFECTIVE DATE. This section is effective July 1, 2022.

Sec. 16. **[245.991] PROJECTS FOR ASSISTANCE IN TRANSITION FROM HOMELESSNESS PROGRAM.**

Subdivision 1. **Creation.** The projects for assistance in transition from homelessness program is established in the Department of Human Services to prevent or end homelessness for people with serious mental illness and substance use disorders and ensure the commissioner may achieve the goals of the housing mission statement in section 245.461, subdivision 4.

Subd. 2. **Activities.** All projects for assistance in transition from homelessness must provide homeless outreach and case management services. Projects may provide clinical assessment, habilitation and rehabilitation services, community mental health services, substance use disorder treatment, housing transition and sustaining services, direct assistance funding, and other activities as determined by the commissioner.

Subd. 3. **Eligibility.** Program activities must be provided to people with serious mental illness or a substance use disorder who meet homeless criteria determined by the commissioner. People receiving homeless outreach may be presumed eligible until a serious mental illness or a substance use disorder can be verified.

Subd. 4. **Outcomes.** Evaluation of each project must include the following outcome evaluation criteria:

(1) whether people are contacted through homeless outreach services;

(2) whether people are enrolled in case management services;

(3) whether people access behavioral health services; and

(4) whether people transition from homelessness to housing.

Subd. 5. **Federal aid or grants.** The commissioner of human services must comply with all conditions and requirements necessary to receive federal aid or grants with respect to homeless services or programs as specified in section 245.70.

Sec. 17. **[245.992] HOUSING WITH SUPPORT FOR BEHAVIORAL HEALTH.**

Subdivision 1. **Creation.** The housing with support for behavioral health program is established in the Department of Human Services to prevent or end homelessness for people with serious mental illness and substance use disorders, increase the availability of housing with support, and ensure the commissioner may achieve the goals of the housing mission statement in section 245.461, subdivision 4.

Subd. 2. **Activities.** The housing with support for behavioral health program may provide a range of activities and supportive services to ensure that people obtain and retain permanent supportive housing. Program activities may include case management, site-based housing services, housing transition and sustaining services, outreach services, community support services, direct assistance funding, and other activities as determined by the commissioner.

Subd. 3. **Eligibility.** Program activities must be provided to people with a serious mental illness or a substance use disorder who meet homeless criteria determined by the commissioner.

Subd. 4. **Outcomes.** Evaluation of program activities must utilize evidence-based practices and must include the following outcome evaluation criteria:

(1) whether housing and activities utilize evidence-based practices;

(2) whether people transition from homelessness to housing;

(3) whether people retain housing; and

(4) whether people are satisfied with their current housing.

Sec. 18. Minnesota Statutes 2021 Supplement, section 245A.043, subdivision 3, is amended to read:

Subd. 3. **Change of ownership process.** (a) When a change in ownership is proposed and the party intends to assume operation without an interruption in service longer than 60

days after acquiring the program or service, the license holder must provide the commissioner with written notice of the proposed change on a form provided by the commissioner at least 60 days before the anticipated date of the change in ownership. For purposes of this subdivision and subdivision 4, "party" means the party that intends to operate the service or program.

(b) The party must submit a license application under this chapter on the form and in the manner prescribed by the commissioner at least 30 days before the change in ownership is complete, and must include documentation to support the upcoming change. The party must comply with background study requirements under chapter 245C and shall pay the application fee required under section 245A.10. A party that intends to assume operation without an interruption in service longer than 60 days after acquiring the program or service is exempt from the requirements of sections 245G.03, subdivision 2, paragraph (b), and 254B.03, subdivision 2, paragraphs ~~(d)~~ (c) and ~~(e)~~ (d).

(c) The commissioner may streamline application procedures when the party is an existing license holder under this chapter and is acquiring a program licensed under this chapter or service in the same service class as one or more licensed programs or services the party operates and those licenses are in substantial compliance. For purposes of this subdivision, "substantial compliance" means within the previous 12 months the commissioner did not (1) issue a sanction under section 245A.07 against a license held by the party, or (2) make a license held by the party conditional according to section 245A.06.

(d) Except when a temporary change in ownership license is issued pursuant to subdivision 4, the existing license holder is solely responsible for operating the program according to applicable laws and rules until a license under this chapter is issued to the party.

(e) If a licensing inspection of the program or service was conducted within the previous 12 months and the existing license holder's license record demonstrates substantial compliance with the applicable licensing requirements, the commissioner may waive the party's inspection required by section 245A.04, subdivision 4. The party must submit to the commissioner (1) proof that the premises was inspected by a fire marshal or that the fire marshal deemed that an inspection was not warranted, and (2) proof that the premises was inspected for compliance with the building code or that no inspection was deemed warranted.

(f) If the party is seeking a license for a program or service that has an outstanding action under section 245A.06 or 245A.07, the party must submit a letter as part of the application

process identifying how the party has or will come into full compliance with the licensing requirements.

(g) The commissioner shall evaluate the party's application according to section 245A.04, subdivision 6. If the commissioner determines that the party has remedied or demonstrates the ability to remedy the outstanding actions under section 245A.06 or 245A.07 and has determined that the program otherwise complies with all applicable laws and rules, the commissioner shall issue a license or conditional license under this chapter. The conditional license remains in effect until the commissioner determines that the grounds for the action are corrected or no longer exist.

(h) The commissioner may deny an application as provided in section 245A.05. An applicant whose application was denied by the commissioner may appeal the denial according to section 245A.05.

(i) This subdivision does not apply to a licensed program or service located in a home where the license holder resides.

Sec. 19. **[245A.26] CHILDREN'S RESIDENTIAL FACILITY CRISIS STABILIZATION SERVICES.**

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

(b) "Clinical trainee" means a staff person who is qualified under section 245I.04, subdivision 6.

(c) "License holder" means an individual, organization, or government entity that was issued a license by the commissioner of human services under this chapter for residential mental health treatment for children with emotional disturbance according to Minnesota Rules, parts 2960.0010 to 2960.0220 and 2960.0580 to 2960.0700, or shelter care services according to Minnesota Rules, parts 2960.0010 to 2960.0120 and 2960.0510 to 2960.0530.

(d) "Mental health professional" means an individual who is qualified under section 245I.04, subdivision 2.

Subd. 2. **Scope and applicability.** (a) This section establishes additional licensing requirements for a children's residential facility to provide children's residential crisis stabilization services to a child who is experiencing a mental health crisis and is in need of residential treatment services.

(b) A children's residential facility may provide residential crisis stabilization services only if the facility is licensed to provide:

(1) residential mental health treatment for children with emotional disturbance according to Minnesota Rules, parts 2960.0010 to 2960.0220 and 2960.0580 to 2960.0700; or

(2) shelter care services according to Minnesota Rules, parts 2960.0010 to 2960.0120 and 2960.0510 to 2960.0530.

(c) If a child receives residential crisis stabilization services for 35 days or fewer in a facility licensed according to paragraph (b), clause (1), the facility is not required to complete a diagnostic assessment or treatment plan under Minnesota Rules, part 2960.0180, subpart 2, and part 2960.0600.

(d) If a child receives residential crisis stabilization services for 35 days or fewer in a facility licensed according to paragraph (b), clause (2), the facility is not required to develop a plan for meeting the child's immediate needs under Minnesota Rules, part 2960.0520, subpart 3.

Subd. 3. **Eligibility for services.** An individual is eligible for children's residential crisis stabilization services if the individual is under 19 years of age and meets the eligibility criteria for crisis services under section 256B.0624, subdivision 3.

Subd. 4. **Required services; providers.** (a) A license holder providing residential crisis stabilization services must continually follow a child's individual crisis treatment plan to improve the child's functioning.

(b) The license holder must offer and have the capacity to directly provide the following treatment services to a child:

(1) crisis stabilization services as described in section 256B.0624, subdivision 7;

(2) mental health services as specified in the child's individual crisis treatment plan, according to the child's treatment needs;

(3) health services and medication administration, if applicable; and

(4) referrals for the child to community-based treatment providers and support services for the child's transition from residential crisis stabilization to another treatment setting.

(c) Children's residential crisis stabilization services must be provided by a qualified staff person listed in section 256B.0624, subdivision 8, according to the scope of practice for the individual staff person's position.

Subd. 5. **Assessment and treatment planning.** (a) Within 24 hours of a child's admission for residential crisis stabilization, the license holder must assess the child and document the child's immediate needs, including the child's:

(1) health and safety, including the need for crisis assistance; and

(2) need for connection to family and other natural supports.

(b) Within 24 hours of a child's admission for residential crisis stabilization, the license holder must complete a crisis treatment plan for the child, according to the requirements for a crisis treatment plan under section 256B.0624, subdivision 11. The license holder must base the child's crisis treatment plan on the child's referral information and the assessment of the child's immediate needs under paragraph (a). A mental health professional or a clinical trainee under the supervision of a mental health professional must complete the crisis treatment plan. A crisis treatment plan completed by a clinical trainee must contain documentation of approval, as defined in section 245I.02, subdivision 2, by a mental health professional within five business days of initial completion by the clinical trainee.

(c) A mental health professional must review a child's crisis treatment plan each week and document the weekly reviews in the child's client file.

(d) For a client receiving children's residential crisis stabilization services who is 18 years of age or older, the license holder must complete an individual abuse prevention plan for the client, pursuant to section 245A.65, subdivision 2, as part of the client's crisis treatment plan.

Subd. 6. **Staffing requirements.** Staff members of facilities providing services under this section must have access to a mental health professional or clinical trainee within 30 minutes, either in person or by telephone. The license holder must maintain a current schedule of available mental health professionals or clinical trainees and include contact information for each mental health professional or clinical trainee. The schedule must be readily available to all staff members.

Sec. 20. Minnesota Statutes 2020, section 245F.03, is amended to read:

245F.03 APPLICATION.

(a) This chapter establishes minimum standards for withdrawal management programs licensed by the commissioner that serve one or more unrelated persons.

(b) This chapter does not apply to a withdrawal management program licensed as a hospital under sections 144.50 to 144.581. A withdrawal management program located in

a hospital licensed under sections 144.50 to 144.581 that chooses to be licensed under this chapter is deemed to be in compliance with section 245F.13.

~~(c) Minnesota Rules, parts 9530.6600 to 9530.6655, do not apply to withdrawal management programs licensed under this chapter.~~

EFFECTIVE DATE. This section is effective July 1, 2022.

Sec. 21. Minnesota Statutes 2020, section 245G.05, subdivision 2, is amended to read:

Subd. 2. **Assessment summary.** (a) An alcohol and drug counselor must complete an assessment summary within three calendar days from the day of service initiation for a residential program and within three calendar days on which a treatment session has been provided from the day of service initiation for a client in a nonresidential program. The comprehensive assessment summary is complete upon a qualified staff member's dated signature. If the comprehensive assessment is used to authorize the treatment service, the alcohol and drug counselor must prepare an assessment summary on the same date the comprehensive assessment is completed. If the comprehensive assessment and assessment summary are to authorize treatment services, the assessor must determine appropriate level of care and services for the client using the ~~dimensions in Minnesota Rules, part 9530.6622~~ criteria established in section 254B.04, subdivision 4, and document the recommendations.

(b) An assessment summary must include:

(1) a risk description according to section 245G.05 for each dimension listed in paragraph (c);

(2) a narrative summary supporting the risk descriptions; and

(3) a determination of whether the client has a substance use disorder.

(c) An assessment summary must contain information relevant to treatment service planning and recorded in the dimensions in clauses (1) to (6). The license holder must consider:

(1) Dimension 1, acute intoxication/withdrawal potential; the client's ability to cope with withdrawal symptoms and current state of intoxication;

(2) Dimension 2, biomedical conditions and complications; the degree to which any physical disorder of the client would interfere with treatment for substance use, and the client's ability to tolerate any related discomfort. The license holder must determine the impact of continued substance use on the unborn child, if the client is pregnant;

(3) Dimension 3, emotional, behavioral, and cognitive conditions and complications; the degree to which any condition or complication is likely to interfere with treatment for substance use or with functioning in significant life areas and the likelihood of harm to self or others;

(4) Dimension 4, readiness for change; the support necessary to keep the client involved in treatment service;

(5) Dimension 5, relapse, continued use, and continued problem potential; the degree to which the client recognizes relapse issues and has the skills to prevent relapse of either substance use or mental health problems; and

(6) Dimension 6, recovery environment; whether the areas of the client's life are supportive of or antagonistic to treatment participation and recovery.

EFFECTIVE DATE. This section is effective July 1, 2022.

Sec. 22. Minnesota Statutes 2020, section 245G.22, 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 them.

(b) "Diversion" means the use of a medication for the treatment of opioid addiction being diverted from intended use of the medication.

(c) "Guest dose" means administration of a medication used for the treatment of opioid addiction to a person who is not a client of the program that is administering or dispensing the medication.

(d) "Medical director" means a practitioner licensed to practice medicine in the jurisdiction that the opioid treatment program is located who assumes responsibility for administering all medical services performed by the program, either by performing the services directly or by delegating specific responsibility to a practitioner of the opioid treatment program.

(e) "Medication used for the treatment of opioid use disorder" means a medication approved by the Food and Drug Administration for the treatment of opioid use disorder.

(f) "Minnesota health care programs" has the meaning given in section 256B.0636.

(g) "Opioid treatment program" has the meaning given in Code of Federal Regulations, title 42, section 8.12, and includes programs licensed under this chapter.

~~(h) "Placing authority" has the meaning given in Minnesota Rules, part 9530.6605, subpart 21a.~~

~~(i)~~ (h) "Practitioner" means a staff member holding a current, unrestricted license to practice medicine issued by the Board of Medical Practice or nursing issued by the Board of Nursing and is currently registered with the Drug Enforcement Administration to order or dispense controlled substances in Schedules II to V under the Controlled Substances Act, United States Code, title 21, part B, section 821. Practitioner includes an advanced practice registered nurse and physician assistant if the staff member receives a variance by the state opioid treatment authority under section 254A.03 and the federal Substance Abuse and Mental Health Services Administration.

~~(j)~~ (i) "Unsupervised use" means the use of a medication for the treatment of opioid use disorder dispensed for use by a client outside of the program setting.

EFFECTIVE DATE. This section is effective July 1, 2022.

Sec. 23. Minnesota Statutes 2020, section 245G.22, subdivision 15, is amended to read:

Subd. 15. **Nonmedication treatment services; documentation.** ~~(a) The program must offer at least 50 consecutive minutes of individual or group therapy treatment services as defined in section 245G.07, subdivision 1, paragraph (a), clause (1), per week, for the first ten weeks following the day of service initiation, and at least 50 consecutive minutes per month thereafter. As clinically appropriate, the program may offer these services cumulatively and not consecutively in increments of no less than 15 minutes over the required time period, and for a total of 60 minutes of treatment services over the time period, and must document the reason for providing services cumulatively in the client's record. The program may offer additional levels of service when deemed clinically necessary.~~

(a) The program must meet the requirements in section 245G.07, subdivision 1, paragraph (a), and must document each occurrence when the program offered the client an individual or group counseling service. If the program offered an individual or group counseling service but did not provide the service to the client, the program must document the reason the service was not provided. If the service is provided, the program must ensure that the staff member who provides the treatment service documents in the client record the date, type, and amount of the treatment service and the client's response to the treatment service within seven days of providing the treatment service.

(b) Notwithstanding the requirements of comprehensive assessments in section 245G.05, the assessment must be completed within 21 days from the day of service initiation.

(c) Notwithstanding the requirements of individual treatment plans set forth in section 245G.06:

(1) treatment plan contents for a maintenance client are not required to include goals the client must reach to complete treatment and have services terminated;

(2) treatment plans for a client in a taper or detox status must include goals the client must reach to complete treatment and have services terminated; and

(3) for the ten weeks following the day of service initiation for all new admissions, readmissions, and transfers, a weekly treatment plan review must be documented once the treatment plan is completed. Subsequently, the counselor must document treatment plan reviews in the six dimensions at least once monthly or, when clinical need warrants, more frequently.

Sec. 24. Minnesota Statutes 2021 Supplement, section 245I.23, is amended by adding a subdivision to read:

Subd. 19a. **Additional requirements for locked program facility.** (a) A license holder that prohibits clients from leaving the facility by locking exit doors or other permissible methods must meet the additional requirements of this subdivision.

(b) The license holder must meet all applicable building and fire codes to operate a building with locked exit doors. The license holder must have the appropriate license from the Department of Health, as determined by the Department of Health, for operating a program with locked exit doors.

(c) The license holder's policies and procedures must clearly describe the types of court orders that authorize the license holder to prohibit clients from leaving the facility.

(d) For each client present in the facility under a court order, the license holder must maintain documentation of the court order authorizing the license holder to prohibit the client from leaving the facility.

(e) Upon a client's admission to a locked program facility, the license holder must document in the client file that the client was informed:

(1) that the client has the right to leave the facility according to the client's rights under section 144.651, subdivision 12, if the client is not subject to a court order authorizing the license holder to prohibit the client from leaving the facility; or

(2) that the client cannot leave the facility due to a court order authorizing the license holder to prohibit the client from leaving the facility.

(f) If the license holder prohibits a client from leaving the facility, the client's treatment plan must reflect this restriction.

Sec. 25. Minnesota Statutes 2021 Supplement, section 254A.03, subdivision 3, is amended to read:

Subd. 3. **Rules for substance use disorder care.** (a) ~~The commissioner of human services shall establish by rule criteria to be used in determining the appropriate level of chemical dependency care for each recipient of public assistance seeking treatment for substance misuse or substance use disorder. Upon federal approval of a comprehensive assessment as a Medicaid benefit, or on July 1, 2018, whichever is later, and notwithstanding the criteria in Minnesota Rules, parts 9530.6600 to 9530.6655,~~ An eligible vendor of comprehensive assessments under section 254B.05 may determine ~~and approve~~ the appropriate level of substance use disorder treatment for a recipient of public assistance. ~~The process for determining an individual's financial eligibility for the behavioral health fund or determining an individual's enrollment in or eligibility for a publicly subsidized health plan is not affected by the individual's choice to access a comprehensive assessment for placement.~~

(b) The commissioner shall develop and implement a utilization review process for publicly funded treatment placements to monitor and review the clinical appropriateness and timeliness of all publicly funded placements in treatment.

(c) If a screen result is positive for alcohol or substance misuse, a brief screening for alcohol or substance use disorder that is provided to a recipient of public assistance within a primary care clinic, hospital, or other medical setting or school setting establishes medical necessity and approval for an initial set of substance use disorder services identified in section 254B.05, subdivision 5. The initial set of services approved for a recipient whose screen result is positive may include any combination of up to four hours of individual or group substance use disorder treatment, two hours of substance use disorder treatment coordination, or two hours of substance use disorder peer support services provided by a qualified individual according to chapter 245G. A recipient must obtain an assessment pursuant to paragraph (a) to be approved for additional treatment services. ~~Minnesota Rules, parts 9530.6600 to 9530.6655, and~~ A comprehensive assessment pursuant to section 245G.05 ~~are not applicable~~ is not required to receive the initial set of services allowed under this subdivision. A positive screen result establishes eligibility for the initial set of services allowed under this subdivision.

(d) ~~Notwithstanding Minnesota Rules, parts 9530.6600 to 9530.6655,~~ An individual may choose to obtain a comprehensive assessment as provided in section 245G.05. Individuals obtaining a comprehensive assessment may access any enrolled provider that is licensed to provide the level of service authorized pursuant to section 254A.19, subdivision 3~~, paragraph (d)~~. If the individual is enrolled in a prepaid health plan, the individual must comply with any provider network requirements or limitations. ~~This paragraph expires July 1, 2022.~~

EFFECTIVE DATE. This section is effective July 1, 2022.

Sec. 26. Minnesota Statutes 2020, section 254A.19, subdivision 1, is amended to read:

Subdivision 1. **Persons arrested outside of ~~home county~~ county of residence.** When a chemical use assessment is required ~~under Minnesota Rules, parts 9530.6600 to 9530.6655,~~ for a person who is arrested and taken into custody by a peace officer outside of the person's county of residence, the ~~assessment must be completed by the person's county of residence no later than three weeks after the assessment is initially requested. If the assessment is not performed within this time limit, the county where the person is to be sentenced shall perform the assessment~~ county where the person is detained must facilitate access to an assessor qualified under subdivision 3. The county of financial responsibility is determined under chapter 256G.

EFFECTIVE DATE. This section is effective July 1, 2022.

Sec. 27. Minnesota Statutes 2020, section 254A.19, subdivision 3, is amended to read:

Subd. 3. **~~Financial conflicts of interest~~ Comprehensive assessments.** ~~(a) Except as provided in paragraph (b), (c), or (d), an assessor conducting a chemical use assessment under Minnesota Rules, parts 9530.6600 to 9530.6655, may not have any direct or shared financial interest or referral relationship resulting in shared financial gain with a treatment provider.~~

~~(b) A county may contract with an assessor having a conflict described in paragraph (a) if the county documents that:~~

~~(1) the assessor is employed by a culturally specific service provider or a service provider with a program designed to treat individuals of a specific age, sex, or sexual preference;~~

~~(2) the county does not employ a sufficient number of qualified assessors and the only qualified assessors available in the county have a direct or shared financial interest or a referral relationship resulting in shared financial gain with a treatment provider; or~~

~~(3) the county social service agency has an existing relationship with an assessor or service provider and elects to enter into a contract with that assessor to provide both assessment and treatment under circumstances specified in the county's contract, provided the county retains responsibility for making placement decisions.~~

~~(c) The county may contract with a hospital to conduct chemical assessments if the requirements in subdivision 1a are met.~~

~~An assessor under this paragraph may not place clients in treatment. The assessor shall gather required information and provide it to the county along with any required documentation. The county shall make all placement decisions for clients assessed by assessors under this paragraph.~~

~~(d)~~ An eligible vendor under section 254B.05 conducting a comprehensive assessment for an individual seeking treatment shall approve the nature, intensity level, and duration of treatment service if a need for services is indicated, but the individual assessed can access any enrolled provider that is licensed to provide the level of service authorized, including the provider or program that completed the assessment. If an individual is enrolled in a prepaid health plan, the individual must comply with any provider network requirements or limitations. An eligible vendor of a comprehensive assessment must provide information, in a format provided by the commissioner, on medical assistance and the behavioral health fund to individuals seeking an assessment.

EFFECTIVE DATE. This section is effective July 1, 2022.

Sec. 28. Minnesota Statutes 2021 Supplement, section 254A.19, subdivision 4, is amended to read:

Subd. 4. **Civil commitments.** ~~A Rule 25 assessment, under Minnesota Rules, part 9530.6615,~~ For the purposes of determining level of care, a comprehensive assessment does not need to be completed for an individual being committed as a chemically dependent person, as defined in section 253B.02, and for the duration of a civil commitment under section ~~253B.065,~~ 253B.09~~,~~ or 253B.095 in order for a county to access the behavioral health fund under section 254B.04. The county must determine if the individual meets the financial eligibility requirements for the behavioral health fund under section 254B.04. ~~Nothing in this subdivision prohibits placement in a treatment facility or treatment program governed under this chapter or Minnesota Rules, parts 9530.6600 to 9530.6655.~~

EFFECTIVE DATE. This section is effective July 1, 2022.

Sec. 29. Minnesota Statutes 2020, section 254A.19, is amended by adding a subdivision to read:

Subd. 6. **Assessments for detoxification programs.** For detoxification programs licensed under chapter 245A according to Minnesota Rules, parts 9530.6510 to 9530.6590, a "chemical use assessment" means a comprehensive assessment and assessment summary completed according to section 245G.05 and a "chemical dependency assessor" or "assessor" means an individual who meets the qualifications of section 245G.11, subdivisions 1 and 5.

EFFECTIVE DATE. This section is effective July 1, 2022.

Sec. 30. Minnesota Statutes 2020, section 254A.19, is amended by adding a subdivision to read:

Subd. 7. **Assessments for children's residential facilities.** For children's residential facilities licensed under chapter 245A according to Minnesota Rules, parts 2960.0010 to 2960.0220 and 2960.0430 to 2960.0490, a "chemical use assessment" means a comprehensive assessment and assessment summary completed according to section 245G.05 by an individual who meets the qualifications of section 245G.11, subdivisions 1 and 5.

EFFECTIVE DATE. This section is effective July 1, 2022.

Sec. 31. Minnesota Statutes 2020, section 254B.01, is amended by adding a subdivision to read:

Subd. 2a. **Behavioral health fund.** "Behavioral health fund" means money allocated for payment of treatment services under this chapter.

EFFECTIVE DATE. This section is effective July 1, 2022.

Sec. 32. Minnesota Statutes 2020, section 254B.01, is amended by adding a subdivision to read:

Subd. 2b. **Client.** "Client" means an individual who has requested substance use disorder services, or for whom substance use disorder services have been requested.

EFFECTIVE DATE. This section is effective July 1, 2022.

Sec. 33. Minnesota Statutes 2020, section 254B.01, is amended by adding a subdivision to read:

Subd. 2c. **Co-payment.** "Co-payment" means the amount an insured person is obligated to pay before the person's third-party payment source is obligated to make a payment, or the amount an insured person is obligated to pay in addition to the amount the person's third-party payment source is obligated to pay.

EFFECTIVE DATE. This section is effective July 1, 2022.

Sec. 34. Minnesota Statutes 2020, section 254B.01, is amended by adding a subdivision to read:

Subd. 4c. **Department.** "Department" means the Department of Human Services.

EFFECTIVE DATE. This section is effective July 1, 2022.

Sec. 35. Minnesota Statutes 2020, section 254B.01, is amended by adding a subdivision to read:

Subd. 4d. **Drug and alcohol abuse normative evaluation system or DAANES.** "Drug and alcohol abuse normative evaluation system" or "DAANES" means the reporting system used to collect substance use disorder treatment data across all levels of care and providers.

EFFECTIVE DATE. This section is effective July 1, 2022.

Sec. 36. Minnesota Statutes 2020, section 254B.01, subdivision 5, is amended to read:

Subd. 5. **Local agency.** "Local agency" means the agency designated by a board of county commissioners, a local social services agency, or a human services board ~~to make placements and submit state invoices according to Laws 1986, chapter 394, sections 8 to 20~~ authorized under section 254B.03, subdivision 1, to determine financial eligibility for the behavioral health fund.

Sec. 37. Minnesota Statutes 2020, section 254B.01, is amended by adding a subdivision to read:

Subd. 6a. **Minor child.** "Minor child" means an individual under the age of 18 years.

EFFECTIVE DATE. This section is effective July 1, 2022.

Sec. 38. Minnesota Statutes 2020, section 254B.01, is amended by adding a subdivision to read:

Subd. 6b. **Policy holder.** "Policy holder" means a person who has a third-party payment policy under which a third-party payment source has an obligation to pay all or part of a client's treatment costs.

EFFECTIVE DATE. This section is effective July 1, 2022.

Sec. 39. Minnesota Statutes 2020, section 254B.01, is amended by adding a subdivision to read:

Subd. 9. **Responsible relative.** "Responsible relative" means a person who is a member of the client's household and is a client's spouse or the parent of a minor child who is a client.

EFFECTIVE DATE. This section is effective July 1, 2022.

Sec. 40. Minnesota Statutes 2020, section 254B.01, is amended by adding a subdivision to read:

Subd. 10. **Third-party payment source.** "Third-party payment source" means a person, entity, or public or private agency other than medical assistance or general assistance medical care that has a probable obligation to pay all or part of the costs of a client's substance use disorder treatment.

EFFECTIVE DATE. This section is effective July 1, 2022.

Sec. 41. Minnesota Statutes 2020, section 254B.01, is amended by adding a subdivision to read:

Subd. 11. **Vendor.** "Vendor" means a provider of substance use disorder treatment services that meets the criteria established in section 254B.05 and that has applied to participate as a provider in the medical assistance program according to Minnesota Rules, part 9505.0195.

EFFECTIVE DATE. This section is effective July 1, 2022.

Sec. 42. Minnesota Statutes 2020, section 254B.01, is amended by adding a subdivision to read:

Subd. 12. **American Society of Addiction Medicine criteria or ASAM criteria.** "American Society of Addiction Medicine criteria" or "ASAM criteria" means the

clinical guidelines for purposes of the assessment, treatment, placement, and transfer or discharge of individuals with substance use disorders. The ASAM criteria are contained in the current edition of the ASAM Criteria: Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions.

EFFECTIVE DATE. This section is effective July 1, 2022.

Sec. 43. Minnesota Statutes 2020, section 254B.01, is amended by adding a subdivision to read:

Subd. 13. **Skilled treatment services.** "Skilled treatment services" means the "treatment services" described by section 245G.07, subdivisions 1, paragraph (a), clauses (1) to (4); and 2, clauses (1) to (6). Skilled treatment services must be provided by qualified professionals as identified in section 245G.07, subdivision 3.

EFFECTIVE DATE. This section is effective July 1, 2022.

Sec. 44. Minnesota Statutes 2020, section 254B.03, subdivision 1, is amended to read:

Subdivision 1. **Local agency duties.** (a) Every local agency ~~shall~~ must determine financial eligibility for substance use disorder services and provide ~~chemical dependency~~ substance use disorder services to persons residing within its jurisdiction who meet criteria established by the commissioner ~~for placement in a chemical dependency residential or nonresidential treatment service~~. Chemical dependency money must be administered by the local agencies according to law and rules adopted by the commissioner under sections 14.001 to 14.69.

(b) In order to contain costs, the commissioner of human services shall select eligible vendors of chemical dependency services who can provide economical and appropriate treatment. Unless the local agency is a social services department directly administered by a county or human services board, the local agency shall not be an eligible vendor under section 254B.05. The commissioner may approve proposals from county boards to provide services in an economical manner or to control utilization, with safeguards to ensure that necessary services are provided. If a county implements a demonstration or experimental medical services funding plan, the commissioner shall transfer the money as appropriate.

~~(c) A culturally specific vendor that provides assessments under a variance under Minnesota Rules, part 9530.6610, shall be allowed to provide assessment services to persons not covered by the variance.~~

~~(d) Notwithstanding Minnesota Rules, parts 9530.6600 to 9530.6655,~~ (c) An individual may choose to obtain a comprehensive assessment as provided in section 245G.05.

Individuals obtaining a comprehensive assessment may access any enrolled provider that is licensed to provide the level of service authorized pursuant to section 254A.19, subdivision 3~~, paragraph (d)~~. If the individual is enrolled in a prepaid health plan, the individual must comply with any provider network requirements or limitations.

~~(c)~~ (d) Beginning July 1, 2022, local agencies shall not make placement location determinations.

EFFECTIVE DATE. This section is effective July 1, 2022.

Sec. 45. Minnesota Statutes 2021 Supplement, section 254B.03, subdivision 2, is amended to read:

Subd. 2. **Behavioral health fund payment.** (a) Payment from the behavioral health fund is limited to payments for services identified in section 254B.05, other than detoxification licensed under Minnesota Rules, parts 9530.6510 to 9530.6590, and detoxification provided in another state that would be required to be licensed as a chemical dependency program if the program were in the state. Out of state vendors must also provide the commissioner with assurances that the program complies substantially with state licensing requirements and possesses all licenses and certifications required by the host state to provide chemical dependency treatment. Vendors receiving payments from the behavioral health fund must not require co-payment from a recipient of benefits for services provided under this subdivision. The vendor is prohibited from using the client's public benefits to offset the cost of services paid under this section. The vendor shall not require the client to use public benefits for room or board costs. This includes but is not limited to cash assistance benefits under chapters 119B, 256D, and 256J, or SNAP benefits. Retention of SNAP benefits is a right of a client receiving services through the behavioral health fund or through state contracted managed care entities. Payment from the behavioral health fund shall be made for necessary room and board costs provided by vendors meeting the criteria under section 254B.05, subdivision 1a, or in a community hospital licensed by the commissioner of health according to sections 144.50 to 144.56 to a client who is:

(1) determined to meet the criteria for placement in a residential chemical dependency treatment program according to rules adopted under section 254A.03, subdivision 3; and

(2) concurrently receiving a chemical dependency treatment service in a program licensed by the commissioner and reimbursed by the behavioral health fund.

~~(b) A county may, from its own resources, provide chemical dependency services for which state payments are not made. A county may elect to use the same invoice procedures~~

~~and obtain the same state payment services as are used for chemical dependency services for which state payments are made under this section if county payments are made to the state in advance of state payments to vendors. When a county uses the state system for payment, the commissioner shall make monthly billings to the county using the most recent available information to determine the anticipated services for which payments will be made in the coming month. Adjustment of any overestimate or underestimate based on actual expenditures shall be made by the state agency by adjusting the estimate for any succeeding month.~~

~~(c)~~ (b) The commissioner shall coordinate chemical dependency services and determine whether there is a need for any proposed expansion of chemical dependency treatment services. The commissioner shall deny vendor certification to any provider that has not received prior approval from the commissioner for the creation of new programs or the expansion of existing program capacity. The commissioner shall consider the provider's capacity to obtain clients from outside the state based on plans, agreements, and previous utilization history, when determining the need for new treatment services.

~~(d)~~ (c) At least 60 days prior to submitting an application for new licensure under chapter 245G, the applicant must notify the county human services director in writing of the applicant's intent to open a new treatment program. The written notification must include, at a minimum:

(1) a description of the proposed treatment program; and

(2) a description of the target population to be served by the treatment program.

~~(e)~~ (d) The county human services director may submit a written statement to the commissioner, within 60 days of receiving notice from the applicant, regarding the county's support of or opposition to the opening of the new treatment program. The written statement must include documentation of the rationale for the county's determination. The commissioner shall consider the county's written statement when determining whether there is a need for the treatment program as required by paragraph ~~(c)~~ (b).

EFFECTIVE DATE. This section is effective July 1, 2022.

Sec. 46. Minnesota Statutes 2020, section 254B.03, subdivision 4, is amended to read:

Subd. 4. **Division of costs.** (a) Except for services provided by a county under section 254B.09, subdivision 1, or services provided under section 256B.69, the county shall, out of local money, pay the state for 22.95 percent of the cost of chemical dependency services, except for those services provided to persons enrolled in medical assistance under chapter

256B and room and board services under section 254B.05, subdivision 5, paragraph (b), clause ~~(12)~~ (11). Counties may use the indigent hospitalization levy for treatment and hospital payments made under this section.

(b) 22.95 percent of any state collections from private or third-party pay, less 15 percent for the cost of payment and collections, must be distributed to the county that paid for a portion of the treatment under this section.

Sec. 47. Minnesota Statutes 2020, section 254B.03, subdivision 5, is amended to read:

Subd. 5. **Rules; appeal.** The commissioner shall adopt rules as necessary to implement this chapter. ~~The commissioner shall establish an appeals process for use by recipients when services certified by the county are disputed. The commissioner shall adopt rules and standards for the appeal process to assure adequate redress for persons referred to inappropriate services.~~

EFFECTIVE DATE. This section is effective July 1, 2022.

Sec. 48. Minnesota Statutes 2021 Supplement, section 254B.04, subdivision 1, is amended to read:

Subdivision 1. **Client eligibility.** (a) Persons eligible for benefits under Code of Federal Regulations, title 25, part 20, who meet the income standards of section 256B.056, subdivision 4, and are not enrolled in medical assistance, are entitled to behavioral health fund services. State money appropriated for this paragraph must be placed in a separate account established for this purpose.

(b) Persons with dependent children who are determined to be in need of chemical dependency treatment pursuant to an assessment under section 260E.20, subdivision 1, or a case plan under section 260C.201, subdivision 6, or 260C.212, shall be assisted by the local agency to access needed treatment services. Treatment services must be appropriate for the individual or family, which may include long-term care treatment or treatment in a facility that allows the dependent children to stay in the treatment facility. The county shall pay for out-of-home placement costs, if applicable.

(c) Notwithstanding paragraph (a), persons enrolled in medical assistance are eligible for room and board services under section 254B.05, subdivision 5, paragraph (b), clause ~~(12)~~ (11).

(d) A client is eligible to have substance use disorder treatment paid for with funds from the behavioral health fund if:

(1) the client is eligible for MFIP as determined under chapter 256J;

(2) the client is eligible for medical assistance as determined under Minnesota Rules, parts 9505.0010 to 9505.0150;

(3) the client is eligible for general assistance, general assistance medical care, or work readiness as determined under Minnesota Rules, parts 9500.1200 to 9500.1272; or

(4) the client's income is within current household size and income guidelines for entitled persons, as defined in this subdivision and subdivision 7.

(e) Clients who meet the financial eligibility requirement in paragraph (a) and who have a third-party payment source are eligible for the behavioral health fund if the third-party payment source pays less than 100 percent of the cost of treatment services for eligible clients.

(f) A client is ineligible to have substance use disorder treatment services paid for by the behavioral health fund if the client:

(1) has an income that exceeds current household size and income guidelines for entitled persons, as defined in this subdivision and subdivision 7; or

(2) has an available third-party payment source that will pay the total cost of the client's treatment.

(g) A client who is disenrolled from a state prepaid health plan during a treatment episode is eligible for continued treatment service paid for by the behavioral health fund until the treatment episode is completed or the client is re-enrolled in a state prepaid health plan if the client:

(1) continues to be enrolled in MinnesotaCare, medical assistance, or general assistance medical care; or

(2) is eligible according to paragraphs (a) and (b) and is determined eligible by a local agency under this section.

(h) If a county commits a client under chapter 253B to a regional treatment center for substance use disorder services and the client is ineligible for the behavioral health fund, the county is responsible for payment to the regional treatment center according to section 254B.05, subdivision 4.

EFFECTIVE DATE. This section is effective July 1, 2022.

Sec. 49. Minnesota Statutes 2020, section 254B.04, subdivision 2a, is amended to read:

Subd. 2a. **Eligibility for ~~treatment in residential settings~~ room and board services for persons in outpatient substance use disorder treatment.** ~~Notwithstanding provisions of Minnesota Rules, part 9530.6622, subparts 5 and 6, related to an assessor's discretion in making placements to residential treatment settings,~~ A person eligible for room and board services under ~~this~~ section 254B.05, subdivision 5, paragraph (b), clause (12), must score at level 4 on assessment dimensions related to readiness to change, relapse, continued use, or recovery environment ~~in order~~ to be assigned to services with a room and board component reimbursed under this section. Whether a treatment facility has been designated an institution for mental diseases under United States Code, title 42, section 1396d, shall not be a factor in making placements.

EFFECTIVE DATE. This section is effective July 1, 2022.

Sec. 50. Minnesota Statutes 2020, section 254B.04, is amended by adding a subdivision to read:

Subd. 4. **Assessment criteria and risk descriptions.** (a) The level of care determination must follow criteria approved by the commissioner.

(b) Dimension 1: the vendor must use the criteria in Dimension 1 to determine a client's acute intoxication and withdrawal potential.

(1) "0" The client displays full functioning with good ability to tolerate and cope with withdrawal discomfort. The client displays no signs or symptoms of intoxication or withdrawal or diminishing signs or symptoms.

(2) "1" The client can tolerate and cope with withdrawal discomfort. The client displays mild to moderate intoxication or signs and symptoms interfering with daily functioning but does not immediately endanger self or others. The client poses minimal risk of severe withdrawal.

(3) "2" The client has some difficulty tolerating and coping with withdrawal discomfort. The client's intoxication may be severe, but the client responds to support and treatment such that the client does not immediately endanger self or others. The client displays moderate signs and symptoms with moderate risk of severe withdrawal.

(4) "3" The client tolerates and copes with withdrawal discomfort poorly. The client has severe intoxication, such that the client endangers self or others, or has intoxication that has not abated with less intensive services. The client displays severe signs and symptoms, risk

of severe but manageable withdrawal, or worsening withdrawal despite detoxification at a less intensive level.

(5) "4" The client is incapacitated with severe signs and symptoms. The client displays severe withdrawal and is a danger to self or others.

(c) Dimension 2: the vendor must use the criteria in Dimension 2 to determine a client's biomedical conditions and complications.

(1) "0" The client displays full functioning with good ability to cope with physical discomfort.

(2) "1" The client tolerates and copes with physical discomfort and is able to get the services that the client needs.

(3) "2" The client has difficulty tolerating and coping with physical problems or has other biomedical problems that interfere with recovery and treatment. The client neglects or does not seek care for serious biomedical problems.

(4) "3" The client tolerates and copes poorly with physical problems or has poor general health. The client neglects the client's medical problems without active assistance.

(5) "4" The client is unable to participate in substance use disorder treatment and has severe medical problems, has a condition that requires immediate intervention, or is incapacitated.

(d) Dimension 3: the vendor must use the criteria in Dimension 3 to determine a client's emotional, behavioral, and cognitive conditions and complications.

(1) "0" The client has good impulse control and coping skills and presents no risk of harm to self or others. The client functions in all life areas and displays no emotional, behavioral, or cognitive problems or the problems are stable.

(2) "1" The client has impulse control and coping skills. The client presents a mild to moderate risk of harm to self or others or displays symptoms of emotional, behavioral, or cognitive problems. The client has a mental health diagnosis and is stable. The client functions adequately in significant life areas.

(3) "2" The client has difficulty with impulse control and lacks coping skills. The client has thoughts of suicide or harm to others without means; however, the thoughts may interfere with participation in some activities. The client has difficulty functioning in significant life areas. The client has moderate symptoms of emotional, behavioral, or cognitive problems. The client is able to participate in most treatment activities.

(4) "3" The client has a severe lack of impulse control and coping skills. The client also has frequent thoughts of suicide or harm to others, including a plan and the means to carry out the plan. In addition, the client is severely impaired in significant life areas and has severe symptoms of emotional, behavioral, or cognitive problems that interfere with the client's participation in treatment activities.

(5) "4" The client has severe emotional or behavioral symptoms that place the client or others at acute risk of harm. The client also has intrusive thoughts of harming self or others. The client is unable to participate in treatment activities.

(e) Dimension 4: the vendor must use the criteria in Dimension 4 to determine a client's readiness for change.

(1) "0" The client admits to problems and is cooperative, motivated, ready to change, committed to change, and engaged in treatment as a responsible participant.

(2) "1" The client is motivated with active reinforcement to explore treatment and strategies for change but ambivalent about the client's illness or need for change.

(3) "2" The client displays verbal compliance but lacks consistent behaviors, has low motivation for change, and is passively involved in treatment.

(4) "3" The client displays inconsistent compliance, has minimal awareness of either the client's addiction or mental disorder, and is minimally cooperative.

(5) "4" The client is:

(i) noncompliant with treatment and has no awareness of addiction or mental disorder and does not want or is unwilling to explore change or is in total denial of the client's illness and its implications; or

(ii) dangerously oppositional to the extent that the client is a threat of imminent harm to self and others.

(f) Dimension 5: the vendor must use the criteria in Dimension 5 to determine a client's relapse, continued substance use, and continued problem potential.

(1) "0" The client recognizes risk well and is able to manage potential problems.

(2) "1" The client recognizes relapse issues and prevention strategies, but displays some vulnerability for further substance use or mental health problems.

(3) "2" The client has minimal recognition and understanding of relapse and recidivism issues and displays moderate vulnerability for further substance use or mental health problems. The client has some coping skills inconsistently applied.

(4) "3" The client has poor recognition and understanding of relapse and recidivism issues and displays moderately high vulnerability for further substance use or mental health problems. The client has few coping skills and rarely applies coping skills.

(5) "4" The client has no coping skills to arrest mental health or addiction illnesses or to prevent relapse. The client has no recognition or understanding of relapse and recidivism issues and displays high vulnerability for further substance use or mental health problems.

(g) Dimension 6: the vendor must use the criteria in Dimension 6 to determine a client's recovery environment.

(1) "0" The client is engaged in structured, meaningful activity and has a supportive significant other, family, and living environment.

(2) "1" The client has passive social network support or the client's family and significant other are not interested in the client's recovery. The client is engaged in structured, meaningful activity.

(3) "2" The client is engaged in structured, meaningful activity, but the client's peers, family, significant other, and living environment are unsupportive, or there is criminal justice system involvement by the client or among the client's peers or significant other or in the client's living environment.

(4) "3" The client is not engaged in structured, meaningful activity and the client's peers, family, significant other, and living environment are unsupportive, or there is significant criminal justice system involvement.

(5) "4" The client has:

(i) a chronically antagonistic significant other, living environment, family, or peer group or long-term criminal justice system involvement that is harmful to the client's recovery or treatment progress; or

(ii) an actively antagonistic significant other, family, work, or living environment, with an immediate threat to the client's safety and well-being.

EFFECTIVE DATE. This section is effective July 1, 2022.

Sec. 51. Minnesota Statutes 2020, section 254B.04, is amended by adding a subdivision to read:

Subd. 5. **Scope and applicability.** This section governs administration of the behavioral health fund, establishes the criteria to be applied by local agencies to determine a client's

financial eligibility under the behavioral health fund, and determines a client's obligation to pay for substance use disorder treatment services.

EFFECTIVE DATE. This section is effective July 1, 2022.

Sec. 52. Minnesota Statutes 2020, section 254B.04, is amended by adding a subdivision to read:

Subd. 6. **Local agency responsibility to provide services.** The local agency may employ individuals to conduct administrative activities and facilitate access to substance use disorder treatment services.

EFFECTIVE DATE. This section is effective July 1, 2022.

Sec. 53. Minnesota Statutes 2020, section 254B.04, is amended by adding a subdivision to read:

Subd. 7. **Local agency to determine client financial eligibility.** (a) The local agency shall determine a client's financial eligibility for the behavioral health fund according to subdivision 1 with the income calculated prospectively for one year from the date of comprehensive assessment. The local agency shall pay for eligible clients according to chapter 256G. The local agency shall enter the financial eligibility span within ten calendar days of request. Client eligibility must be determined using forms prescribed by the commissioner. The local agency must determine a client's eligibility as follows:

(1) The local agency must determine the client's income. A client who is a minor child must not be deemed to have income available to pay for substance use disorder treatment, unless the minor child is responsible for payment under section 144.347 for substance use disorder treatment services sought under section 144.343, subdivision 1.

(2) The local agency must determine the client's household size according to the following:

(i) If the client is a minor child, the household size includes the following persons living in the same dwelling unit:

(A) the client;

(B) the client's birth or adoptive parents; and

(C) the client's siblings who are minors.

(ii) If the client is an adult, the household size includes the following persons living in the same dwelling unit:

(A) the client;

(B) the client's spouse;

(C) the client's minor children; and

(D) the client's spouse's minor children.

(iii) Household size includes a person listed in items (i) and (ii) who is in out-of-home placement if a person listed in item (i) or (ii) is contributing to the cost of care of the person in out-of-home placement.

(3) The local agency must determine the client's current prepaid health plan enrollment and the availability of a third-party payment source, including the availability of total or partial payment and the amount of co-payment.

(4) The local agency must provide the required eligibility information to the commissioner in the manner specified by the commissioner.

(5) The local agency must require the client and policyholder to conditionally assign to the department the client's and policyholder's rights and the rights of minor children to benefits or services provided to the client if the commissioner is required to collect from a third-party payment source.

(b) The local agency must redetermine a client's eligibility for the behavioral health fund every 12 months.

(c) A client, responsible relative, and policyholder must provide income or wage verification and household size verification under paragraph (a), clause (3), and must make an assignment of third-party payment rights under paragraph (a), clause (5). If a client, responsible relative, or policyholder does not comply with this subdivision, the client is ineligible for behavioral health fund payment for substance use disorder treatment, and the client and responsible relative are obligated to pay the full cost of substance use disorder treatment services provided to the client.

EFFECTIVE DATE. This section is effective July 1, 2022.

Sec. 54. Minnesota Statutes 2020, section 254B.04, is amended by adding a subdivision to read:

Subd. 8. **Client fees.** A client whose household income is within current household size and income guidelines for entitled persons as defined in subdivision 1 must pay no fee.

EFFECTIVE DATE. This section is effective July 1, 2022.

Sec. 55. Minnesota Statutes 2020, section 254B.04, is amended by adding a subdivision to read:

Subd. 9. **Vendor must participate in DAANES.** To be eligible for payment under the behavioral health fund, a vendor must participate in DAANES or submit to the commissioner the information required in DAANES in the format specified by the commissioner.

EFFECTIVE DATE. This section is effective July 1, 2022.

Sec. 56. Minnesota Statutes 2021 Supplement, section 254B.05, subdivision 1a, is amended to read:

Subd. 1a. **Room and board provider requirements.** (a) Effective January 1, 2000, vendors of room and board are eligible for behavioral health fund payment if the vendor:

(1) has rules prohibiting residents bringing chemicals into the facility or using chemicals while residing in the facility and provide consequences for infractions of those rules;

(2) is determined to meet applicable health and safety requirements;

(3) is not a jail or prison;

(4) is not concurrently receiving funds under chapter 256I for the recipient;

(5) admits individuals who are 18 years of age or older;

(6) is registered as a board and lodging or lodging establishment according to section 157.17;

(7) has awake staff on site 24 hours per day;

(8) has staff who are at least 18 years of age and meet the requirements of section 245G.11, subdivision 1, paragraph (b);

(9) has emergency behavioral procedures that meet the requirements of section 245G.16;

(10) meets the requirements of section 245G.08, subdivision 5, if administering medications to clients;

(11) meets the abuse prevention requirements of section 245A.65, including a policy on fraternization and the mandatory reporting requirements of section 626.557;

(12) documents coordination with the treatment provider to ensure compliance with section 254B.03, subdivision 2;

(13) protects client funds and ensures freedom from exploitation by meeting the provisions of section 245A.04, subdivision 13;

(14) has a grievance procedure that meets the requirements of section 245G.15, subdivision 2; and

(15) has sleeping and bathroom facilities for men and women separated by a door that is locked, has an alarm, or is supervised by awake staff.

(b) Programs licensed according to Minnesota Rules, chapter 2960, are exempt from paragraph (a), clauses (5) to (15).

(c) Programs providing children's mental health crisis admissions and stabilization under section 245.4882, subdivision 6, are eligible vendors of room and board.

~~(c)~~ (d) Licensed programs providing intensive residential treatment services or residential crisis stabilization services pursuant to section 256B.0622 or 256B.0624 are eligible vendors of room and board and are exempt from paragraph (a), clauses (6) to (15).

Sec. 57. Minnesota Statutes 2021 Supplement, section 254B.05, subdivision 4, is amended to read:

Subd. 4. **Regional treatment centers.** Regional treatment center chemical dependency treatment units are eligible vendors. The commissioner may expand the capacity of chemical dependency treatment units beyond the capacity funded by direct legislative appropriation to serve individuals who are referred for treatment by counties and whose treatment will be paid for by funding under this chapter or other funding sources. Notwithstanding the provisions of sections 254B.03 to ~~254B.041~~ 254B.04, payment for any person committed at county request to a regional treatment center under chapter 253B for chemical dependency treatment and determined to be ineligible under the behavioral health fund, shall become the responsibility of the county.

Sec. 58. Minnesota Statutes 2021 Supplement, section 254B.05, subdivision 5, is amended to read:

Subd. 5. **Rate requirements.** (a) The commissioner shall establish rates for substance use disorder services and service enhancements funded under this chapter.

(b) Eligible substance use disorder treatment services include:

~~(1) outpatient treatment services that are licensed according to sections 245G.01 to 245G.17, or applicable tribal license;~~

(1) outpatient treatment services licensed according to sections 245G.01 to 245G.17, or applicable Tribal license, including:

(i) ASAM 1.0 Outpatient: zero to eight hours per week of skilled treatment services for adults and zero to five hours per week for adolescents. Peer recovery and treatment coordination may be provided beyond the skilled treatment service hours allowable per week; and

(ii) ASAM 2.1 Intensive Outpatient: nine or more hours per week of skilled treatment services for adults and six or more hours per week for adolescents in accordance with the limitations in paragraph (h). Peer recovery and treatment coordination may be provided beyond the skilled treatment service hours allowable per week;

(2) comprehensive assessments provided according to sections 245.4863, paragraph (a), and 245G.05;

(3) care coordination services provided according to section 245G.07, subdivision 1, paragraph (a), clause (5);

(4) peer recovery support services provided according to section 245G.07, subdivision 2, clause (8);

(5) on July 1, 2019, or upon federal approval, whichever is later, withdrawal management services provided according to chapter 245F;

(6) ~~medication-assisted therapy services that are~~ substance use disorder treatment with medication for opioid use disorders provided in an opioid treatment program that is licensed according to sections 245G.01 to 245G.17 and 245G.22, or applicable tribal license;

~~(7) medication-assisted therapy plus enhanced treatment services that meet the requirements of clause (6) and provide nine hours of clinical services each week;~~

~~(8)~~ (7) high, medium, and low intensity residential treatment services that are licensed according to sections 245G.01 to 245G.17 and 245G.21 or applicable tribal license which provide, respectively, 30, 15, and five hours of clinical services each week;

~~(9)~~ (8) hospital-based treatment services that are licensed according to sections 245G.01 to 245G.17 or applicable tribal license and licensed as a hospital under sections 144.50 to 144.56;

~~(10)~~ (9) adolescent treatment programs that are licensed as outpatient treatment programs according to sections 245G.01 to 245G.18 or as residential treatment programs according to Minnesota Rules, parts 2960.0010 to 2960.0220, and 2960.0430 to 2960.0490, or applicable tribal license;

~~(11)~~ (10) high-intensity residential treatment services that are licensed according to sections 245G.01 to 245G.17 and 245G.21 or applicable tribal license, which provide 30 hours of clinical services each week provided by a state-operated vendor or to clients who have been civilly committed to the commissioner, present the most complex and difficult care needs, and are a potential threat to the community; and

~~(12)~~ (11) room and board facilities that meet the requirements of subdivision 1a.

(c) The commissioner shall establish higher rates for programs that meet the requirements of paragraph (b) and one of the following additional requirements:

(1) programs that serve parents with their children if the program:

(i) provides on-site child care during the hours of treatment activity that:

(A) is licensed under chapter 245A as a child care center under Minnesota Rules, chapter 9503; or

(B) meets the licensure exclusion criteria of section 245A.03, subdivision 2, paragraph (a), clause (6), and meets the requirements under section 245G.19, subdivision 4; or

(ii) arranges for off-site child care during hours of treatment activity at a facility that is licensed under chapter 245A as:

(A) a child care center under Minnesota Rules, chapter 9503; or

(B) a family child care home under Minnesota Rules, chapter 9502;

(2) culturally specific or culturally responsive programs as defined in section 254B.01, subdivision 4a;

(3) disability responsive programs as defined in section 254B.01, subdivision 4b;

(4) programs that offer medical services delivered by appropriately credentialed health care staff in an amount equal to two hours per client per week if the medical needs of the client and the nature and provision of any medical services provided are documented in the client file; or

(5) programs that offer services to individuals with co-occurring mental health and chemical dependency problems if:

(i) the program meets the co-occurring requirements in section 245G.20;

(ii) 25 percent of the counseling staff are licensed mental health professionals, as defined in section 245.462, subdivision 18, clauses (1) to (6), or are students or licensing candidates under the supervision of a licensed alcohol and drug counselor supervisor and licensed

mental health professional, except that no more than 50 percent of the mental health staff may be students or licensing candidates with time documented to be directly related to provisions of co-occurring services;

(iii) clients scoring positive on a standardized mental health screen receive a mental health diagnostic assessment within ten days of admission;

(iv) the program has standards for multidisciplinary case review that include a monthly review for each client that, at a minimum, includes a licensed mental health professional and licensed alcohol and drug counselor, and their involvement in the review is documented;

(v) family education is offered that addresses mental health and substance abuse disorders and the interaction between the two; and

(vi) co-occurring counseling staff shall receive eight hours of co-occurring disorder training annually.

(d) In order to be eligible for a higher rate under paragraph (c), clause (1), a program that provides arrangements for off-site child care must maintain current documentation at the chemical dependency facility of the child care provider's current licensure to provide child care services. Programs that provide child care according to paragraph (c), clause (1), must be deemed in compliance with the licensing requirements in section 245G.19.

(e) Adolescent residential programs that meet the requirements of Minnesota Rules, parts 2960.0430 to 2960.0490 and 2960.0580 to 2960.0690, are exempt from the requirements in paragraph (c), clause (4), items (i) to (iv).

(f) Subject to federal approval, substance use disorder services that are otherwise covered as direct face-to-face services may be provided via telehealth as defined in section 256B.0625, subdivision 3b. The use of telehealth to deliver services must be medically appropriate to the condition and needs of the person being served. Reimbursement shall be at the same rates and under the same conditions that would otherwise apply to direct face-to-face services.

(g) For the purpose of reimbursement under this section, substance use disorder treatment services provided in a group setting without a group participant maximum or maximum client to staff ratio under chapter 245G shall not exceed a client to staff ratio of 48 to one. At least one of the attending staff must meet the qualifications as established under this chapter for the type of treatment service provided. A recovery peer may not be included as part of the staff ratio.

(h) Payment for outpatient substance use disorder services that are licensed according to sections 245G.01 to 245G.17 is limited to six hours per day or 30 hours per week unless prior authorization of a greater number of hours is obtained from the commissioner.

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. 59. Minnesota Statutes 2020, section 256.042, subdivision 1, is amended to read:

Subdivision 1. **Establishment of the advisory council.** (a) The Opiate Epidemic Response Advisory Council is established to develop and implement a comprehensive and effective statewide effort to address the opioid addiction and overdose epidemic in Minnesota. The council shall focus on:

(1) prevention and education, including public education and awareness for adults and youth, prescriber education, the development and sustainability of opioid overdose prevention and education programs, the role of adult protective services in prevention and response, and providing financial support to local law enforcement agencies for opiate antagonist programs;

(2) training on the treatment of opioid addiction, including the use of all Food and Drug Administration approved opioid addiction medications, detoxification, relapse prevention, patient assessment, individual treatment planning, counseling, recovery supports, diversion control, and other best practices;

(3) the expansion and enhancement of a continuum of care for opioid-related substance use disorders, including primary prevention, early intervention, treatment, recovery, and aftercare services; and

(4) the development of measures to assess and protect the ability of cancer patients and survivors, persons battling life-threatening illnesses, persons suffering from severe chronic pain, and persons at the end stages of life, who legitimately need prescription pain medications, to maintain their quality of life by accessing these pain medications without facing unnecessary barriers. The measures must also address the needs of individuals described in this clause who are elderly or who reside in underserved or rural areas of the state.

(b) The council shall:

(1) review local, state, and federal initiatives and activities related to education, prevention, treatment, and services for individuals and families experiencing and affected by opioid use disorder;

(2) establish priorities to address the state's opioid epidemic, for the purpose of recommending initiatives to fund;

(3) recommend to the commissioner of human services specific projects and initiatives to be funded;

(4) ensure that available funding is allocated to align with other state and federal funding, to achieve the greatest impact and ensure a coordinated state effort;

(5) consult with the commissioners of human services, health, and management and budget to develop measurable outcomes to determine the effectiveness of funds allocated; ~~and~~

(6) develop recommendations for an administrative and organizational framework for the allocation, on a sustainable and ongoing basis, of any money deposited into the separate account under section 16A.151, subdivision 2, paragraph (f), in order to address the opioid abuse and overdose epidemic in Minnesota and the areas of focus specified in paragraph (a) ~~.~~ ;

(7) review reports, data, and performance measures submitted by municipalities, as defined in section 466.01, subdivision 1, in receipt of direct payments from settlement agreements, as described in section 256.043, subdivision 4; and

(8) consult with relevant stakeholders, including lead agencies and municipalities, to review and provide recommendations for necessary revisions to required reporting to ensure the reporting reflects measures of progress in addressing the harms of the opioid epidemic.

(c) The council, in consultation with the commissioner of management and budget, and within available appropriations, shall select from the awarded grants projects or may select municipality projects funded by settlement monies as described in section 256.043, subdivision 4, that include promising practices or theory-based activities for which the commissioner of management and budget shall conduct evaluations using experimental or quasi-experimental design. Grants awarded to proposals or municipality projects funded by settlement monies that include promising practices or theory-based activities and that are selected for an evaluation shall be administered to support the experimental or quasi-experimental evaluation and require grantees and municipality projects to collect and report information that is needed to complete the evaluation. The commissioner of

management and budget, under section 15.08, may obtain additional relevant data to support the experimental or quasi-experimental evaluation studies. For the purposes of this paragraph, "municipality" has the meaning given in section 466.01, subdivision 1.

(d) The council, in consultation with the commissioners of human services, health, public safety, and management and budget, shall establish goals related to addressing the opioid epidemic and determine a baseline against which progress shall be monitored and set measurable outcomes, including benchmarks. The goals established must include goals for prevention and public health, access to treatment, and multigenerational impacts. The council shall use existing measures and data collection systems to determine baseline data against which progress shall be measured. The council shall include the proposed goals, the measurable outcomes, and proposed benchmarks to meet these goals in its initial report to the legislature under subdivision 5, paragraph (a), due January 31, 2021.

Sec. 60. Minnesota Statutes 2020, section 256.042, subdivision 2, is amended to read:

Subd. 2. **Membership.** (a) The council shall consist of the following ~~19~~ 30 voting members, appointed by the commissioner of human services except as otherwise specified, and three nonvoting members:

(1) two members of the house of representatives, appointed in the following sequence: the first from the majority party appointed by the speaker of the house and the second from the minority party appointed by the minority leader. Of these two members, one member must represent a district outside of the seven-county metropolitan area, and one member must represent a district that includes the seven-county metropolitan area. The appointment by the minority leader must ensure that this requirement for geographic diversity in appointments is met;

(2) two members of the senate, appointed in the following sequence: the first from the majority party appointed by the senate majority leader and the second from the minority party appointed by the senate minority leader. Of these two members, one member must represent a district outside of the seven-county metropolitan area and one member must represent a district that includes the seven-county metropolitan area. The appointment by the minority leader must ensure that this requirement for geographic diversity in appointments is met;

(3) one member appointed by the Board of Pharmacy;

(4) one member who is a physician appointed by the Minnesota Medical Association;

(5) one member representing opioid treatment programs, sober living programs, or substance use disorder programs licensed under chapter 245G;

(6) one member appointed by the Minnesota Society of Addiction Medicine who is an addiction psychiatrist;

(7) one member representing professionals providing alternative pain management therapies, including, but not limited to, acupuncture, chiropractic, or massage therapy;

(8) one member representing nonprofit organizations conducting initiatives to address the opioid epidemic, with the commissioner's initial appointment being a member representing the Steve Rummler Hope Network, and subsequent appointments representing this or other organizations;

(9) one member appointed by the Minnesota Ambulance Association who is serving with an ambulance service as an emergency medical technician, advanced emergency medical technician, or paramedic;

(10) one member representing the Minnesota courts who is a judge or law enforcement officer;

(11) one public member who is a Minnesota resident and who is in opioid addiction recovery;

(12) ~~two~~ 11 members representing Indian tribes, one representing ~~the Ojibwe tribes and one representing the Dakota tribes~~ each of Minnesota's Tribal Nations;

(13) two members representing the urban American Indian population;

~~(13)~~ (14) one public member who is a Minnesota resident and who is suffering from chronic pain, intractable pain, or a rare disease or condition;

~~(14)~~ (15) one mental health advocate representing persons with mental illness;

~~(15)~~ (16) one member appointed by the Minnesota Hospital Association;

~~(16)~~ (17) one member representing a local health department; and

~~(17)~~ (18) the commissioners of human services, health, and corrections, or their designees, who shall be ex officio nonvoting members of the council.

(b) The commissioner of human services shall coordinate the commissioner's appointments to provide geographic, racial, and gender diversity, and shall ensure that at least one-half of council members appointed by the commissioner reside outside of the seven-county metropolitan area and that at least one-half of the members have lived

experience with opiate addiction. Of the members appointed by the commissioner, to the extent practicable, at least one member must represent a community of color disproportionately affected by the opioid epidemic.

(c) The council is governed by section 15.059, except that members of the council shall serve three-year terms and shall receive no compensation other than reimbursement for expenses. Notwithstanding section 15.059, subdivision 6, the council shall not expire.

(d) The chair shall convene the council at least quarterly, and may convene other meetings as necessary. The chair shall convene meetings at different locations in the state to provide geographic access, and shall ensure that at least one-half of the meetings are held at locations outside of the seven-county metropolitan area.

(e) The commissioner of human services shall provide staff and administrative services for the advisory council.

(f) The council is subject to chapter 13D.

Sec. 61. Minnesota Statutes 2021 Supplement, section 256.042, subdivision 4, is amended to read:

Subd. 4. **Grants.** (a) The commissioner of human services shall submit a report of the grants proposed by the advisory council to be awarded for the upcoming calendar year to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services policy and finance, by December 1 of each year, beginning March 1, 2020.

(b) The grants shall be awarded to proposals selected by the advisory council that address the priorities in subdivision 1, paragraph (a), clauses (1) to (4), unless otherwise appropriated by the legislature. The advisory council shall determine grant awards and funding amounts based on the funds appropriated to the commissioner under section 256.043, subdivision 3, paragraph (e). The commissioner shall award the grants from the opiate epidemic response fund and administer the grants in compliance with section 16B.97. No more than ten percent of the grant amount may be used by a grantee for administration. The commissioner must award at least 40 percent of grants to projects that include a focus on addressing the opiate crisis in Black and Indigenous communities and communities of color.

Sec. 62. Minnesota Statutes 2020, section 256.042, subdivision 5, is amended to read:

Subd. 5. **Reports.** (a) The advisory council shall report annually to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human

services policy and finance by January 31 of each year~~, beginning January 31, 2021~~. The report shall include information about the individual projects that receive grants, the municipality projects funded by settlement monies as described in section 256.043, subdivision 4, and the overall role of the ~~project~~ projects in addressing the opioid addiction and overdose epidemic in Minnesota. The report must describe the grantees and the activities implemented, along with measurable outcomes as determined by the council in consultation with the commissioner of human services and the commissioner of management and budget. At a minimum, the report must include information about the number of individuals who received information or treatment, the outcomes the individuals achieved, and demographic information about the individuals participating in the project; an assessment of the progress toward achieving statewide access to qualified providers and comprehensive treatment and recovery services; and an update on the evaluations implemented by the commissioner of management and budget for the promising practices and theory-based projects that receive funding.

(b) The commissioner of management and budget, in consultation with the Opiate Epidemic Response Advisory Council, shall report to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services policy and finance when an evaluation study described in subdivision 1, paragraph (c), is complete on the promising practices or theory-based projects that are selected for evaluation activities. The report shall include demographic information; outcome information for the individuals in the program; the results for the program in promoting recovery, employment, family reunification, and reducing involvement with the criminal justice system; and other relevant outcomes determined by the commissioner of management and budget that are specific to the projects that are evaluated. The report shall include information about the ability of grant programs to be scaled to achieve the statewide results that the grant project demonstrated.

(c) The advisory council, in its annual report to the legislature under paragraph (a) due by January 31, 2024, shall include recommendations on whether the appropriations to the specified entities under Laws 2019, chapter 63, should be continued, adjusted, or discontinued; whether funding should be appropriated for other purposes related to opioid abuse prevention, education, and treatment; and on the appropriate level of funding for existing and new uses.

(d) Municipalities receiving direct payments for settlement agreements as described in section 256.043, subdivision 4, must annually report to the commissioner on how the funds were used on opioid remediation. The report must be submitted in a format prescribed by

the commissioner. The report must include data and measurable outcomes on expenditures funded with opioid settlement funds, as identified by the commissioner, including details on services drawn from the categories of approved uses, as identified in agreements between the state of Minnesota, the Association of Minnesota Counties, and the League of Minnesota Cities. Minimum reporting requirements must include:

(1) contact information;

(2) information on funded services and programs; and

(3) target populations for each funded service and program.

(e) In reporting data and outcomes under paragraph (d), municipalities should include information on the use of evidence-based and culturally relevant services, to the extent feasible.

(f) Reporting requirements for municipal projects using $25,000 or more of settlement funds in a calendar year must also include:

(1) a brief qualitative description of successes or challenges; and

(2) results using process and quality measures.

(g) For the purposes of this subdivision, "municipality" or "municipalities" has the meaning given in section 466.01, subdivision 1.

Sec. 63. Minnesota Statutes 2021 Supplement, section 256B.0625, subdivision 5m, is amended to read:

Subd. 5m. **Certified community behavioral health clinic services.** (a) Medical assistance covers services provided by a not-for-profit certified community behavioral health clinic (CCBHC) ~~services~~ that ~~meet~~ meets the requirements of section 245.735, subdivision 3.

(b) The commissioner shall reimburse CCBHCs on a ~~per-visit~~ per-day basis ~~under the prospective payment~~ for each day that an eligible service is delivered using the CCBHC daily bundled rate system for medical assistance payments as described in paragraph (c). The commissioner shall include a quality incentive payment in the ~~prospective payment~~ CCBHC daily bundled rate system as described in paragraph (e). There is no county share for medical assistance services when reimbursed through the CCBHC ~~prospective payment~~ daily bundled rate system.

(c) The commissioner shall ensure that the ~~prospective payment~~ CCBHC daily bundled rate system for CCBHC payments under medical assistance meets the following requirements:

(1) the ~~prospective payment~~ CCBHC daily bundled rate shall be a provider-specific rate calculated for each CCBHC, based on the daily cost of providing CCBHC services and the total annual allowable CCBHC costs ~~for CCBHCs~~ divided by the total annual number of CCBHC visits. For calculating the payment rate, total annual visits include visits covered by medical assistance and visits not covered by medical assistance. Allowable costs include but are not limited to the salaries and benefits of medical assistance providers; the cost of CCBHC services provided under section 245.735, subdivision 3, paragraph (a), clauses (6) and (7); and other costs such as insurance or supplies needed to provide CCBHC services;

(2) payment shall be limited to one payment per day per medical assistance enrollee ~~for each~~ when an eligible CCBHC ~~visit eligible for reimbursement~~ service is provided. A CCBHC visit is eligible for reimbursement if at least one of the CCBHC services listed under section 245.735, subdivision 3, paragraph (a), clause (6), is furnished to a medical assistance enrollee by a health care practitioner or licensed agency employed by or under contract with a CCBHC;

(3) ~~new payment~~ initial CCBHC daily bundled rates ~~set by the commissioner~~ for newly certified CCBHCs under section 245.735, subdivision 3, shall be ~~based on rates for established CCBHCs with a similar scope of services. If no comparable CCBHC exists, the commissioner shall establish a clinic-specific rate using audited historical cost report data adjusted for the estimated cost of delivering CCBHC services, including the estimated cost of providing the full scope of services and the projected change in visits resulting from the change in scope~~ established by the commissioner using a provider-specific rate based on the newly certified CCBHC's audited historical cost report data adjusted for the expected cost of delivering CCBHC services. Estimates are subject to review by the commissioner and must include the expected cost of providing the full scope of CCBHC services and the expected number of visits for the rate period;

(4) the commissioner shall rebase CCBHC rates once every three years following the last rebasing and no less than 12 months following an initial rate or a rate change due to a change in the scope of services;

(5) the commissioner shall provide for a 60-day appeals process after notice of the results of the rebasing;

(6) the ~~prospective payment~~ CCBHC daily bundled rate under this section does not apply to services rendered by CCBHCs to individuals who are dually eligible for Medicare and medical assistance when Medicare is the primary payer for the service. An entity that receives

a ~~prospective payment~~ CCBHC daily bundled rate system ~~rate~~ that overlaps with the CCBHC rate is not eligible for the CCBHC rate;

(7) payments for CCBHC services to individuals enrolled in managed care shall be coordinated with the state's phase-out of CCBHC wrap payments. The commissioner shall complete the phase-out of CCBHC wrap payments within 60 days of the implementation of the ~~prospective payment~~ CCBHC daily bundled rate system in the Medicaid Management Information System (MMIS), for CCBHCs reimbursed under this chapter, with a final settlement of payments due made payable to CCBHCs no later than 18 months thereafter;

(8) the ~~prospective payment~~ CCBHC daily bundled rate for each CCBHC shall be updated by trending each provider-specific rate by the Medicare Economic Index for primary care services. This update shall occur each year in between rebasing periods determined by the commissioner in accordance with clause (4). CCBHCs must provide data on costs and visits to the state annually using the CCBHC cost report established by the commissioner; and

(9) a CCBHC may request a rate adjustment for changes in the CCBHC's scope of services when such changes are expected to result in an adjustment to the CCBHC payment rate by 2.5 percent or more. The CCBHC must provide the commissioner with information regarding the changes in the scope of services, including the estimated cost of providing the new or modified services and any projected increase or decrease in the number of visits resulting from the change. Estimated costs are subject to review by the commissioner. Rate adjustments for changes in scope shall occur no more than once per year in between rebasing periods per CCBHC and are effective on the date of the annual CCBHC rate update.

(d) Managed care plans and county-based purchasing plans shall reimburse CCBHC providers at the ~~prospective payment~~ CCBHC daily bundled rate. The commissioner shall monitor the effect of this requirement on the rate of access to the services delivered by CCBHC providers. If, for any contract year, federal approval is not received for this paragraph, the commissioner must adjust the capitation rates paid to managed care plans and county-based purchasing plans for that contract year to reflect the removal of this provision. Contracts between managed care plans and county-based purchasing plans and providers to whom this paragraph applies must allow recovery of payments from those providers if capitation rates are adjusted in accordance with this paragraph. Payment recoveries must not exceed the amount equal to any increase in rates that results from this provision. This paragraph expires if federal approval is not received for this paragraph at any time.

(e) The commissioner shall implement a quality incentive payment program for CCBHCs that meets the following requirements:

(1) a CCBHC shall receive a quality incentive payment upon meeting specific numeric thresholds for performance metrics established by the commissioner, in addition to payments for which the CCBHC is eligible under the ~~prospective payment~~ CCBHC daily bundled rate system described in paragraph (c);

(2) a CCBHC must be certified and enrolled as a CCBHC for the entire measurement year to be eligible for incentive payments;

(3) each CCBHC shall receive written notice of the criteria that must be met in order to receive quality incentive payments at least 90 days prior to the measurement year; and

(4) a CCBHC must provide the commissioner with data needed to determine incentive payment eligibility within six months following the measurement year. The commissioner shall notify CCBHC providers of their performance on the required measures and the incentive payment amount within 12 months following the measurement year.

(f) All claims to managed care plans for CCBHC services as provided under this section shall be submitted directly to, and paid by, the commissioner on the dates specified no later than January 1 of the following calendar year, if:

(1) one or more managed care plans does not comply with the federal requirement for payment of clean claims to CCBHCs, as defined in Code of Federal Regulations, title 42, section 447.45(b), and the managed care plan does not resolve the payment issue within 30 days of noncompliance; and

(2) the total amount of clean claims not paid in accordance with federal requirements by one or more managed care plans is 50 percent of, or greater than, the total CCBHC claims eligible for payment by managed care plans.

If the conditions in this paragraph are met between January 1 and June 30 of a calendar year, claims shall be submitted to and paid by the commissioner beginning on January 1 of the following year. If the conditions in this paragraph are met between July 1 and December 31 of a calendar year, claims shall be submitted to and paid by the commissioner beginning on July 1 of the following year.

Sec. 64. Minnesota Statutes 2020, section 256B.0757, subdivision 5, is amended to read:

Subd. 5. **Payments.** The commissioner shall ~~make payments to each designated provider for the provision of~~ establish a single statewide reimbursement rate for health home services

~~described in subdivision 3 to each eligible individual under subdivision 2 that selects the health home as a provider~~ under this section. In setting this rate, the commissioner must include input from stakeholders, including providers of the services. The statewide reimbursement rate shall be adjusted annually to match the growth in the Medicare Economic Index.

EFFECTIVE DATE. This section is effective July 1, 2022.

Sec. 65. Minnesota Statutes 2021 Supplement, section 256B.0759, subdivision 4, is amended to read:

Subd. 4. **Provider payment rates.** (a) Payment rates for participating providers must be increased for services provided to medical assistance enrollees. To receive a rate increase, participating providers must meet demonstration project requirements and provide evidence of formal referral arrangements with providers delivering step-up or step-down levels of care. Providers that have enrolled in the demonstration project but have not met the provider standards under subdivision 3 as of July 1, 2022, are not eligible for a rate increase under this subdivision until the date that the provider meets the provider standards in subdivision 3. Services provided from July 1, 2022, to the date that the provider meets the provider standards under subdivision 3 shall be reimbursed at rates according to section 254B.05, subdivision 5, paragraph (b). Rate increases paid under this subdivision to a provider for services provided between July 1, 2021, and July 1, 2022, are not subject to recoupment when the provider is taking meaningful steps to meet demonstration project requirements that are not otherwise required by law, and the provider provides documentation to the commissioner, upon request, of the steps being taken.

(b) The commissioner may temporarily suspend payments to the provider according to section 256B.04, subdivision 21, paragraph (d), if the provider does not meet the requirements in paragraph (a). Payments withheld from the provider must be made once the commissioner determines that the requirements in paragraph (a) are met.

(c) For substance use disorder services under section 254B.05, subdivision 5, paragraph (b), clause ~~(8)~~ (7), provided on or after July 1, 2020, payment rates must be increased by 25 percent over the rates in effect on December 31, 2019.

(d) For substance use disorder services under section 254B.05, subdivision 5, paragraph (b), clauses (1)~~,~~ and (6), ~~and (7),~~ and adolescent treatment programs that are licensed as outpatient treatment programs according to sections 245G.01 to 245G.18, provided on or after January 1, 2021, payment rates must be increased by 20 percent over the rates in effect on December 31, 2020.

(e) Effective January 1, 2021, and contingent on annual federal approval, managed care plans and county-based purchasing plans must reimburse providers of the substance use disorder services meeting the criteria described in paragraph (a) who are employed by or under contract with the plan an amount that is at least equal to the fee-for-service base rate payment for the substance use disorder services described in paragraphs (c) and (d). The commissioner must monitor the effect of this requirement on the rate of access to substance use disorder services and residential substance use disorder rates. Capitation rates paid to managed care organizations and county-based purchasing plans must reflect the impact of this requirement. This paragraph expires if federal approval is not received at any time as required under this paragraph.

(f) Effective July 1, 2021, contracts between managed care plans and county-based purchasing plans and providers to whom paragraph (e) applies must allow recovery of payments from those providers if, for any contract year, federal approval for the provisions of paragraph (e) is not received, and capitation rates are adjusted as a result. Payment recoveries must not exceed the amount equal to any decrease in rates that results from this provision.

Sec. 66. Minnesota Statutes 2020, section 256B.0941, is amended by adding a subdivision to read:

Subd. 2a. **Sleeping hours.** During normal sleeping hours, a psychiatric residential treatment facility provider must provide at least one staff person for every six residents present within a living unit. A provider must adjust sleeping-hour staffing levels based on the clinical needs of the residents in the facility.

Sec. 67. Minnesota Statutes 2020, section 256B.0941, subdivision 3, is amended to read:

Subd. 3. **Per diem rate.** (a) The commissioner must establish one per diem rate per provider for psychiatric residential treatment facility services for individuals 21 years of age or younger. The rate for a provider must not exceed the rate charged by that provider for the same service to other payers. Payment must not be made to more than one entity for each individual for services provided under this section on a given day. The commissioner must set rates prospectively for the annual rate period. The commissioner must require providers to submit annual cost reports on a uniform cost reporting form and must use submitted cost reports to inform the rate-setting process. The cost reporting must be done according to federal requirements for Medicare cost reports.

(b) The following are included in the rate:

(1) costs necessary for licensure and accreditation, meeting all staffing standards for participation, meeting all service standards for participation, meeting all requirements for active treatment, maintaining medical records, conducting utilization review, meeting inspection of care, and discharge planning. The direct services costs must be determined using the actual cost of salaries, benefits, payroll taxes, and training of direct services staff and service-related transportation; and

(2) payment for room and board provided by facilities meeting all accreditation and licensing requirements for participation.

(c) A facility may submit a claim for payment outside of the per diem for professional services arranged by and provided at the facility by an appropriately licensed professional who is enrolled as a provider with Minnesota health care programs. Arranged services may be billed by either the facility or the licensed professional. These services must be included in the individual plan of care and are subject to prior authorization.

(d) Medicaid must reimburse for concurrent services as approved by the commissioner to support continuity of care and successful discharge from the facility. "Concurrent services" means services provided by another entity or provider while the individual is admitted to a psychiatric residential treatment facility. Payment for concurrent services may be limited and these services are subject to prior authorization by the state's medical review agent. Concurrent services may include targeted case management, assertive community treatment, clinical care consultation, team consultation, and treatment planning.

(e) Payment rates under this subdivision must not include the costs of providing the following services:

(1) educational services;

(2) acute medical care or specialty services for other medical conditions;

(3) dental services; and

(4) pharmacy drug costs.

(f) For purposes of this section, "actual cost" means costs that are allowable, allocable, reasonable, and consistent with federal reimbursement requirements in Code of Federal Regulations, title 48, chapter 1, part 31, relating to for-profit entities, and the Office of Management and Budget Circular Number A-122, relating to nonprofit entities.

(g) The commissioner shall consult with providers and stakeholders to develop an assessment tool that identifies when a child with a medical necessity for psychiatric residential treatment facility level of care will require specialized care planning, including

but not limited to a one-on-one staffing ratio in a living environment. The commissioner must develop the tool based on clinical and safety review and recommend best uses of the protocols to align with reimbursement structures.

Sec. 68. Minnesota Statutes 2020, section 256B.0941, is amended by adding a subdivision to read:

Subd. 5. **Start-up grants.** Start-up grants to prospective psychiatric residential treatment facility sites may be used for:

(1) administrative expenses;

(2) consulting services;

(3) Health Insurance Portability and Accountability Act of 1996 compliance;

(4) therapeutic resources including evidence-based, culturally appropriate curriculums, and training programs for staff and clients;

(5) allowable physical renovations to the property; and

(6) emergency workforce shortage uses, as determined by the commissioner.

Sec. 69. Minnesota Statutes 2021 Supplement, section 256B.0946, subdivision 1, is amended to read:

Subdivision 1. **Required covered service components.** (a) Subject to federal approval, medical assistance covers medically necessary intensive behavioral health treatment services when the services are provided by a provider entity certified under and meeting the standards in this section. The provider entity must make reasonable and good faith efforts to report individual client outcomes to the commissioner, using instruments and protocols approved by the commissioner.

(b) Intensive behavioral health treatment services to children with mental illness residing in foster family settings or with legal guardians that comprise specific required service components provided in clauses (1) to (6) are reimbursed by medical assistance when they meet the following standards:

(1) psychotherapy provided by a mental health professional or a clinical trainee;

(2) crisis planning;

(3) individual, family, and group psychoeducation services provided by a mental health professional or a clinical trainee;

(4) clinical care consultation provided by a mental health professional or a clinical trainee;

(5) individual treatment plan development as defined in Minnesota Rules, part 9505.0371, subpart 7; and

(6) service delivery payment requirements as provided under subdivision 4.

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. 70. Minnesota Statutes 2021 Supplement, section 256B.0946, subdivision 1a, is amended to read:

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

(a) "At risk of out-of-home placement" means the child has participated in community-based therapeutic or behavioral services including psychotherapy within the past 30 days and has experienced severe difficulty in managing mental health and behavior in multiple settings and has one of the following:

(1) has previously been in out-of-home placement for mental health issues within the past six months;

(2) has a history of threatening harm to self or others and has actively engaged in self-harming or threatening behavior in the past 30 days;

(3) demonstrates extremely inappropriate or dangerous social behavior in home, community, and school settings;

(4) has a history of repeated intervention from mental health programs, social services, mobile crisis programs, or law enforcement to maintain safety in the home, community, or school within the past 60 days; or

(5) whose parent is unable to safely manage the child's mental health, behavioral, or emotional problems in the home and has been actively seeking placement for at least two weeks.

~~(a)~~ (b) "Clinical care consultation" means communication from a treating clinician to other providers working with the same client to inform, inquire, and instruct regarding the client's symptoms, strategies for effective engagement, care and intervention needs, and treatment expectations across service settings, including but not limited to the client's school,

social services, day care, probation, home, primary care, medication prescribers, disabilities services, and other mental health providers and to direct and coordinate clinical service components provided to the client and family.

~~(b)~~ (c) "Clinical trainee" means a staff person who is qualified according to section 245I.04, subdivision 6.

~~(c)~~ (d) "Crisis planning" has the meaning given in section 245.4871, subdivision 9a.

~~(d)~~ (e) "Culturally appropriate" means providing mental health services in a manner that incorporates the child's cultural influences into interventions as a way to maximize resiliency factors and utilize cultural strengths and resources to promote overall wellness.

~~(e)~~ (f) "Culture" means the distinct ways of living and understanding the world that are used by a group of people and are transmitted from one generation to another or adopted by an individual.

~~(f)~~ (g) "Standard diagnostic assessment" means the assessment described in section 245I.10, subdivision 6.

~~(g)~~ (h) "Family" means a person who is identified by the client or the client's parent or guardian as being important to the client's mental health treatment. Family may include, but is not limited to, parents, foster parents, children, spouse, committed partners, former spouses, persons related by blood or adoption, persons who are a part of the client's permanency plan, or persons who are presently residing together as a family unit.

~~(h)~~ (i) "Foster care" has the meaning given in section 260C.007, subdivision 18.

~~(i)~~ (j) "Foster family setting" means the foster home in which the license holder resides.

~~(j)~~ (k) "Individual treatment plan" means the plan described in section 245I.10, subdivisions 7 and 8.

~~(k)~~ (l) "Mental health certified family peer specialist" means a staff person who is qualified according to section 245I.04, subdivision 12.

~~(l)~~ (m) "Mental health professional" means a staff person who is qualified according to section 245I.04, subdivision 2.

~~(m)~~ (n) "Mental illness" has the meaning given in section 245I.02, subdivision 29.

~~(n)~~ (o) "Parent" has the meaning given in section 260C.007, subdivision 25.

~~(o)~~ (p) "Psychoeducation services" means information or demonstration provided to an individual, family, or group to explain, educate, and support the individual, family, or group

in understanding a child's symptoms of mental illness, the impact on the child's development, and needed components of treatment and skill development so that the individual, family, or group can help the child to prevent relapse, prevent the acquisition of comorbid disorders, and achieve optimal mental health and long-term resilience.

~~(p)~~ (q) "Psychotherapy" means the treatment described in section 256B.0671, subdivision 11.

~~(q)~~ (r) "Team consultation and treatment planning" means the coordination of treatment plans and consultation among providers in a group concerning the treatment needs of the child, including disseminating the child's treatment service schedule to all members of the service team. Team members must include all mental health professionals working with the child, a parent, the child unless the team lead or parent deem it clinically inappropriate, and at least two of the following: an individualized education program case manager; probation agent; children's mental health case manager; child welfare worker, including adoption or guardianship worker; primary care provider; foster parent; and any other member of the child's service team.

~~(r)~~ (s) "Trauma" has the meaning given in section 245I.02, subdivision 38.

~~(s)~~ (t) "Treatment supervision" means the supervision described under section 245I.06.

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. 71. Minnesota Statutes 2021 Supplement, section 256B.0946, subdivision 2, is amended to read:

Subd. 2. **Determination of client eligibility.** An eligible recipient is an individual, from birth through age 20, who is currently placed in a foster home licensed under Minnesota Rules, parts 2960.3000 to 2960.3340, or placed in a foster home licensed under the regulations established by a federally recognized Minnesota Tribe, or who is residing in the legal guardian's home and is at risk of out-of-home placement, and has received: (1) a standard diagnostic assessment within 180 days before the start of service that documents that intensive behavioral health treatment services are medically necessary ~~within a foster family setting~~ to ameliorate identified symptoms and functional impairments; and (2) a level of care assessment as defined in section 245I.02, subdivision 19, that demonstrates that the individual requires intensive intervention without 24-hour medical monitoring, and a functional assessment as defined in section 245I.02, subdivision 17. The level of care

assessment and the functional assessment must include information gathered from the placing county, Tribe, or case manager.

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. 72. Minnesota Statutes 2021 Supplement, section 256B.0946, subdivision 3, is amended to read:

Subd. 3. **Eligible mental health services providers.** (a) Eligible providers for children's intensive ~~children's mental health~~ behavioral health services ~~in a foster family setting~~ must be certified by the state ~~and have a service provision contract with a county board or a reservation tribal council~~ and must be able to demonstrate the ability to provide all of the services required in this section and meet the standards in chapter 245I, as required in section 245I.011, subdivision 5.

(b) For purposes of this section, a provider agency must be:

(1) a county-operated entity certified by the state;

(2) an Indian Health Services facility operated by a Tribe or Tribal organization under funding authorized by United States Code, title 25, sections 450f to 450n, or title 3 of the Indian Self-Determination Act, Public Law 93-638, section 638 (facilities or providers); or

(3) a noncounty entity.

(c) Certified providers that do not meet the service delivery standards required in this section shall be subject to a decertification process.

(d) For the purposes of this section, all services delivered to a client must be provided by a mental health professional or a clinical trainee.

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. 73. Minnesota Statutes 2021 Supplement, section 256B.0946, subdivision 4, is amended to read:

Subd. 4. **Service delivery payment requirements.** (a) To be eligible for payment under this section, a provider must develop and practice written policies and procedures for children's intensive ~~treatment in foster care~~ behavioral health services, consistent with

subdivision 1, paragraph (b), and comply with the following requirements in paragraphs (b) to (n).

(b) Each previous and current mental health, school, and physical health treatment provider must be contacted to request documentation of treatment and assessments that the eligible client has received. This information must be reviewed and incorporated into the standard diagnostic assessment and team consultation and treatment planning review process.

(c) Each client receiving treatment must be assessed for a trauma history, and the client's treatment plan must document how the results of the assessment will be incorporated into treatment.

(d) The level of care assessment as defined in section 245I.02, subdivision 19, and functional assessment as defined in section 245I.02, subdivision 17, must be updated at least every 90 days or prior to discharge from the service, whichever comes first.

(e) Each client receiving treatment services must have an individual treatment plan that is reviewed, evaluated, and approved every 90 days using the team consultation and treatment planning process.

(f) Clinical care consultation must be provided in accordance with the client's individual treatment plan.

(g) Each client must have a crisis plan within ten days of initiating services and must have access to clinical phone support 24 hours per day, seven days per week, during the course of treatment. The crisis plan must demonstrate coordination with the local or regional mobile crisis intervention team.

(h) Services must be delivered and documented at least three days per week, equaling at least six hours of treatment per week. If the mental health professional, client, and family agree, service units may be temporarily reduced for a period of no more than 60 days in order to meet the needs of the client and family, or as part of transition or on a discharge plan to another service or level of care. The reasons for service reduction must be identified, documented, and included in the treatment plan. Billing and payment are prohibited for days on which no services are delivered and documented.

(i) Location of service delivery must be in the client's home, day care setting, school, or other community-based setting that is specified on the client's individualized treatment plan.

(j) Treatment must be developmentally and culturally appropriate for the client.

(k) Services must be delivered in continual collaboration and consultation with the client's medical providers and, in particular, with prescribers of psychotropic medications,

including those prescribed on an off-label basis. Members of the service team must be aware of the medication regimen and potential side effects.

(l) Parents, siblings, foster parents, legal guardians, and members of the child's permanency plan must be involved in treatment and service delivery unless otherwise noted in the treatment plan.

(m) Transition planning for ~~the~~ a child in foster care must be conducted starting with the first treatment plan and must be addressed throughout treatment to support the child's permanency plan and postdischarge mental health service needs.

(n) In order for a provider to receive the daily per-client encounter rate, at least one of the services listed in subdivision 1, paragraph (b), clauses (1) to (3), must be provided. The services listed in subdivision 1, paragraph (b), clauses (4) and (5), may be included as part of the daily per-client encounter rate.

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. 74. Minnesota Statutes 2021 Supplement, section 256B.0946, subdivision 6, is amended to read:

Subd. 6. **Excluded services.** (a) Services in clauses (1) to (7) are not covered under this section and are not eligible for medical assistance payment as components of children's intensive ~~treatment in foster care~~ behavioral health services, but may be billed separately:

(1) inpatient psychiatric hospital treatment;

(2) mental health targeted case management;

(3) partial hospitalization;

(4) medication management;

(5) children's mental health day treatment services;

(6) crisis response services under section 256B.0624;

(7) transportation; and

(8) mental health certified family peer specialist services under section 256B.0616.

(b) Children receiving intensive ~~treatment in foster care~~ behavioral health services are not eligible for medical assistance reimbursement for the following services while receiving children's intensive ~~treatment in foster care~~ behavioral health services:

(1) psychotherapy and skills training components of children's therapeutic services and supports under section 256B.0943;

(2) mental health behavioral aide services as defined in section 256B.0943, subdivision 1, paragraph (l);

(3) home and community-based waiver services;

(4) mental health residential treatment; and

(5) room and board costs as defined in section 256I.03, subdivision 6.

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. 75. Minnesota Statutes 2020, section 256B.0946, subdivision 7, is amended to read:

Subd. 7. **Medical assistance payment and rate setting.** The commissioner shall establish a single daily per-client encounter rate for children's intensive ~~treatment in foster care~~ behavioral health services. The rate must be constructed to cover only eligible services delivered to an eligible recipient by an eligible provider, as prescribed in subdivision 1, paragraph (b).

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. 76. Minnesota Statutes 2021 Supplement, section 256B.0947, subdivision 2, is amended to read:

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

(a) "Intensive nonresidential rehabilitative mental health services" means child rehabilitative mental health services as defined in section 256B.0943, except that these services are provided by a multidisciplinary staff using a total team approach consistent with assertive community treatment, as adapted for youth, and are directed to recipients who are eight years of age or older and under ~~26~~ 21 years of age who require intensive services to prevent admission to an inpatient psychiatric hospital or placement in a residential treatment facility or who require intensive services to step down from inpatient or residential care to community-based care.

(b) "Co-occurring mental illness and substance use disorder" means a dual diagnosis of at least one form of mental illness and at least one substance use disorder. Substance use disorders include alcohol or drug abuse or dependence, excluding nicotine use.

(c) "Standard diagnostic assessment" means the assessment described in section 245I.10, subdivision 6.

(d) "Medication education services" means services provided individually or in groups, which focus on:

(1) educating the client and client's family or significant nonfamilial supporters about mental illness and symptoms;

(2) the role and effects of medications in treating symptoms of mental illness; and

(3) the side effects of medications.

Medication education is coordinated with medication management services and does not duplicate it. Medication education services are provided by physicians, pharmacists, or registered nurses with certification in psychiatric and mental health care.

(e) "Mental health professional" means a staff person who is qualified according to section 245I.04, subdivision 2.

(f) "Provider agency" means a for-profit or nonprofit organization established to administer an assertive community treatment for youth team.

(g) "Substance use disorders" means one or more of the disorders defined in the diagnostic and statistical manual of mental disorders, current edition.

(h) "Transition services" means:

(1) activities, materials, consultation, and coordination that ensures continuity of the client's care in advance of and in preparation for the client's move from one stage of care or life to another by maintaining contact with the client and assisting the client to establish provider relationships;

(2) providing the client with knowledge and skills needed posttransition;

(3) establishing communication between sending and receiving entities;

(4) supporting a client's request for service authorization and enrollment; and

(5) establishing and enforcing procedures and schedules.

A youth's transition from the children's mental health system and services to the adult mental health system and services and return to the client's home and entry or re-entry into

community-based mental health services following discharge from an out-of-home placement or inpatient hospital stay.

(i) "Treatment team" means all staff who provide services to recipients under this section.

(j) "Family peer specialist" means a staff person who is qualified under section 256B.0616.

Sec. 77. Minnesota Statutes 2021 Supplement, section 256B.0947, subdivision 3, is amended to read:

Subd. 3. **Client eligibility.** An eligible recipient is an individual who:

(1) is eight years of age or older and under ~~26~~ 21 years of age;

(2) is diagnosed with a serious mental illness or co-occurring mental illness and substance use disorder, for which intensive nonresidential rehabilitative mental health services are needed;

(3) has received a level of care assessment as defined in section 245I.02, subdivision 19, that indicates a need for intensive integrated intervention without 24-hour medical monitoring and a need for extensive collaboration among multiple providers;

(4) has received a functional assessment as defined in section 245I.02, subdivision 17, that indicates functional impairment and a history of difficulty in functioning safely and successfully in the community, school, home, or job; or who is likely to need services from the adult mental health system during adulthood; and

(5) has had a recent standard diagnostic assessment that documents that intensive nonresidential rehabilitative mental health services are medically necessary to ameliorate identified symptoms and functional impairments and to achieve individual transition goals.

Sec. 78. Minnesota Statutes 2021 Supplement, section 256B.0947, subdivision 5, is amended to read:

Subd. 5. **Standards for intensive nonresidential rehabilitative providers.** (a) Services must meet the standards in this section and chapter 245I as required in section 245I.011, subdivision 5.

(b) The treatment team must have specialized training in providing services to the specific age group of youth that the team serves. An individual treatment team must serve youth who are: (1) at least eight years of age or older and under 16 years of age, or (2) at least 14 years of age or older and under ~~26~~ 21 years of age.

(c) The treatment team for intensive nonresidential rehabilitative mental health services comprises both permanently employed core team members and client-specific team members as follows:

(1) Based on professional qualifications and client needs, clinically qualified core team members are assigned on a rotating basis as the client's lead worker to coordinate a client's care. The core team must comprise at least four full-time equivalent direct care staff and must minimally include:

(i) a mental health professional who serves as team leader to provide administrative direction and treatment supervision to the team;

(ii) an advanced-practice registered nurse with certification in psychiatric or mental health care or a board-certified child and adolescent psychiatrist, either of which must be credentialed to prescribe medications;

(iii) a licensed alcohol and drug counselor who is also trained in mental health interventions; and

(iv) a mental health certified peer specialist who is qualified according to section 245I.04, subdivision 10, and is also a former children's mental health consumer.

(2) The core team may also include any of the following:

(i) additional mental health professionals;

(ii) a vocational specialist;

(iii) an educational specialist with knowledge and experience working with youth regarding special education requirements and goals, special education plans, and coordination of educational activities with health care activities;

(iv) a child and adolescent psychiatrist who may be retained on a consultant basis;

(v) a clinical trainee qualified according to section 245I.04, subdivision 6;

(vi) a mental health practitioner qualified according to section 245I.04, subdivision 4;

(vii) a case management service provider, as defined in section 245.4871, subdivision 4;

(viii) a housing access specialist; and

(ix) a family peer specialist as defined in subdivision 2, paragraph (j).

(3) A treatment team may include, in addition to those in clause (1) or (2), ad hoc members not employed by the team who consult on a specific client and who must accept

overall clinical direction from the treatment team for the duration of the client's placement with the treatment team and must be paid by the provider agency at the rate for a typical session by that provider with that client or at a rate negotiated with the client-specific member. Client-specific treatment team members may include:

(i) the mental health professional treating the client prior to placement with the treatment team;

(ii) the client's current substance use counselor, if applicable;

(iii) a lead member of the client's individualized education program team or school-based mental health provider, if applicable;

(iv) a representative from the client's health care home or primary care clinic, as needed to ensure integration of medical and behavioral health care;

(v) the client's probation officer or other juvenile justice representative, if applicable; and

(vi) the client's current vocational or employment counselor, if applicable.

(d) The treatment supervisor shall be an active member of the treatment team and shall function as a practicing clinician at least on a part-time basis. The treatment team shall meet with the treatment supervisor at least weekly to discuss recipients' progress and make rapid adjustments to meet recipients' needs. The team meeting must include client-specific case reviews and general treatment discussions among team members. Client-specific case reviews and planning must be documented in the individual client's treatment record.

(e) The staffing ratio must not exceed ten clients to one full-time equivalent treatment team position.

(f) The treatment team shall serve no more than 80 clients at any one time. Should local demand exceed the team's capacity, an additional team must be established rather than exceed this limit.

(g) Nonclinical staff shall have prompt access in person or by telephone to a mental health practitioner, clinical trainee, or mental health professional. The provider shall have the capacity to promptly and appropriately respond to emergent needs and make any necessary staffing adjustments to ensure the health and safety of clients.

(h) The intensive nonresidential rehabilitative mental health services provider shall participate in evaluation of the assertive community treatment for youth (Youth ACT) model

as conducted by the commissioner, including the collection and reporting of data and the reporting of performance measures as specified by contract with the commissioner.

(i) A regional treatment team may serve multiple counties.

Sec. 79. Minnesota Statutes 2020, section 256B.0949, subdivision 15, is amended to read:

Subd. 15. **EIDBI provider qualifications.** (a) A QSP must be employed by an agency and be:

(1) a licensed mental health professional who has at least 2,000 hours of supervised clinical experience or training in examining or treating people with ASD or a related condition or equivalent documented coursework at the graduate level by an accredited university in ASD diagnostics, ASD developmental and behavioral treatment strategies, and typical child development; or

(2) a developmental or behavioral pediatrician who has at least 2,000 hours of supervised clinical experience or training in examining or treating people with ASD or a related condition or equivalent documented coursework at the graduate level by an accredited university in the areas of ASD diagnostics, ASD developmental and behavioral treatment strategies, and typical child development.

(b) A level I treatment provider must be employed by an agency and:

(1) have at least 2,000 hours of supervised clinical experience or training in examining or treating people with ASD or a related condition or equivalent documented coursework at the graduate level by an accredited university in ASD diagnostics, ASD developmental and behavioral treatment strategies, and typical child development or an equivalent combination of documented coursework or hours of experience; and

(2) have or be at least one of the following:

(i) a master's degree in behavioral health or child development or related fields including, but not limited to, mental health, special education, social work, psychology, speech pathology, or occupational therapy from an accredited college or university;

(ii) a bachelor's degree in a behavioral health, child development, or related field including, but not limited to, mental health, special education, social work, psychology, speech pathology, or occupational therapy, from an accredited college or university, and advanced certification in a treatment modality recognized by the department;

(iii) a board-certified behavior analyst; or

(iv) a board-certified assistant behavior analyst with 4,000 hours of supervised clinical experience that meets all registration, supervision, and continuing education requirements of the certification.

(c) A level II treatment provider must be employed by an agency and must be:

(1) a person who has a bachelor's degree from an accredited college or university in a behavioral or child development science or related field including, but not limited to, mental health, special education, social work, psychology, speech pathology, or occupational therapy; and meets at least one of the following:

(i) has at least 1,000 hours of supervised clinical experience or training in examining or treating people with ASD or a related condition or equivalent documented coursework at the graduate level by an accredited university in ASD diagnostics, ASD developmental and behavioral treatment strategies, and typical child development or a combination of coursework or hours of experience;

(ii) has certification as a board-certified assistant behavior analyst from the Behavior Analyst Certification Board;

(iii) is a registered behavior technician as defined by the Behavior Analyst Certification Board; or

(iv) is certified in one of the other treatment modalities recognized by the department; or

(2) a person who has:

(i) an associate's degree in a behavioral or child development science or related field including, but not limited to, mental health, special education, social work, psychology, speech pathology, or occupational therapy from an accredited college or university; and

(ii) at least 2,000 hours of supervised clinical experience in delivering treatment to people with ASD or a related condition. Hours worked as a mental health behavioral aide or level III treatment provider may be included in the required hours of experience; or

(3) a person who has at least 4,000 hours of supervised clinical experience in delivering treatment to people with ASD or a related condition. Hours worked as a mental health behavioral aide or level III treatment provider may be included in the required hours of experience; or

(4) a person who is a graduate student in a behavioral science, child development science, or related field and is receiving clinical supervision by a QSP affiliated with an agency to

meet the clinical training requirements for experience and training with people with ASD or a related condition; or

(5) a person who is at least 18 years of age and who:

(i) is fluent in a non-English language or an individual certified by a Tribal Nation;

(ii) completed the level III EIDBI training requirements; and

(iii) receives observation and direction from a QSP or level I treatment provider at least once a week until the person meets 1,000 hours of supervised clinical experience.

(d) A level III treatment provider must be employed by an agency, have completed the level III training requirement, be at least 18 years of age, and have at least one of the following:

(1) a high school diploma or commissioner of education-selected high school equivalency certification;

(2) fluency in a non-English language or certification by a Tribal Nation;

(3) one year of experience as a primary personal care assistant, community health worker, waiver service provider, or special education assistant to a person with ASD or a related condition within the previous five years; or

(4) completion of all required EIDBI training within six months of employment.

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. 80. Minnesota Statutes 2020, section 256D.09, subdivision 2a, is amended to read:

Subd. 2a. **Vendor payments for drug dependent persons.** If, at the time of application or at any other time, there is a reasonable basis for questioning whether a person applying for or receiving financial assistance is drug dependent, as defined in section 254A.02, subdivision 5, the person shall be referred for a chemical health assessment, and only emergency assistance payments or general assistance vendor payments may be provided until the assessment is complete and the results of the assessment made available to the county agency. A reasonable basis for referring an individual for an assessment exists when:

(1) the person has required detoxification two or more times in the past 12 months;

(2) the person appears intoxicated at the county agency as indicated by two or more of the following:

(i) the odor of alcohol;

(ii) slurred speech;

(iii) disconjugate gaze;

(iv) impaired balance;

(v) difficulty remaining awake;

(vi) consumption of alcohol;

(vii) responding to sights or sounds that are not actually present;

(viii) extreme restlessness, fast speech, or unusual belligerence;

(3) the person has been involuntarily committed for drug dependency at least once in the past 12 months; or

(4) the person has received treatment, including domiciliary care, for drug abuse or dependency at least twice in the past 12 months.

The assessment and determination of drug dependency, if any, must be made by an assessor qualified under ~~Minnesota Rules, part 9530.6615, subpart 2~~ section 245G.11, subdivisions 1 and 5, to perform an assessment of chemical use. The county shall only provide emergency general assistance or vendor payments to an otherwise eligible applicant or recipient who is determined to be drug dependent, except up to 15 percent of the grant amount the person would otherwise receive may be paid in cash. Notwithstanding subdivision 1, the commissioner of human services shall also require county agencies to provide assistance only in the form of vendor payments to all eligible recipients who assert chemical dependency as a basis for eligibility under section 256D.05, subdivision 1, paragraph (a), clauses (1) and (5).

The determination of drug dependency shall be reviewed at least every 12 months. If the county determines a recipient is no longer drug dependent, the county may cease vendor payments and provide the recipient payments in cash.

Sec. 81. Minnesota Statutes 2021 Supplement, section 256L.03, subdivision 2, is amended to read:

Subd. 2. **Alcohol and drug dependency.** Beginning July 1, 1993, covered health services shall include individual outpatient treatment of alcohol or drug dependency by a qualified health professional or outpatient program.

Persons who may need chemical dependency services under the provisions of this chapter ~~shall be assessed by a local agency~~ must be offered access by a local agency to a comprehensive assessment as defined under section ~~254B.01~~ 245G.05, and under the assessment provisions of section 254A.03, subdivision 3. A local agency or managed care plan under contract with the Department of Human Services must ~~place~~ offer services to a person in need of chemical dependency services ~~as provided in Minnesota Rules, parts 9530.6600 to 9530.6655~~ based on the recommendations of section 245G.05. Persons who are recipients of medical benefits under the provisions of this chapter and who are financially eligible for behavioral health fund services provided under the provisions of chapter 254B shall receive chemical dependency treatment services under the provisions of chapter 254B only if:

(1) they have exhausted the chemical dependency benefits offered under this chapter; or

(2) an assessment indicates that they need a level of care not provided under the provisions of this chapter.

Recipients of covered health services under the children's health plan, as provided in Minnesota Statutes 1990, section 256.936, and as amended by Laws 1991, chapter 292, article 4, section 17, and recipients of covered health services enrolled in the children's health plan or the MinnesotaCare program after October 1, 1992, pursuant to Laws 1992, chapter 549, article 4, sections 5 and 17, are eligible to receive alcohol and drug dependency benefits under this subdivision.

Sec. 82. Minnesota Statutes 2020, section 256L.12, subdivision 8, is amended to read:

Subd. 8. **Chemical dependency assessments.** The managed care plan shall be responsible for assessing the need and ~~placement for~~ provision of chemical dependency services according to criteria set forth in ~~Minnesota Rules, parts 9530.6600 to 9530.6655~~ section 245G.05.

Sec. 83. Minnesota Statutes 2020, section 260B.157, subdivision 1, is amended to read:

Subdivision 1. **Investigation.** Upon request of the court the local social services agency or probation officer shall investigate the personal and family history and environment of any minor coming within the jurisdiction of the court under section 260B.101 and shall report its findings to the court. The court may order any minor coming within its jurisdiction to be examined by a duly qualified physician, psychiatrist, or psychologist appointed by the court.

The court shall order a chemical use assessment conducted when a child is (1) found to be delinquent for violating a provision of chapter 152, or for committing a felony-level violation of a provision of chapter 609 if the probation officer determines that alcohol or drug use was a contributing factor in the commission of the offense, or (2) alleged to be delinquent for violating a provision of chapter 152, if the child is being held in custody under a detention order. The assessor's qualifications must comply with section 245G.11, subdivisions 1 and 5, and the assessment criteria ~~shall~~ must comply with ~~Minnesota Rules, parts 9530.6600 to 9530.6655~~ section 245G.05. If funds under chapter 254B are to be used to pay for the recommended treatment, the assessment ~~and placement~~ must comply with all provisions of ~~Minnesota Rules, parts 9530.6600 to 9530.6655 and 9530.7000 to 9530.7030~~ sections 245G.05 and 254B.04. The commissioner of human services shall reimburse the court for the cost of the chemical use assessment, up to a maximum of $100.

The court shall order a children's mental health screening conducted when a child is found to be delinquent. The screening shall be conducted with a screening instrument approved by the commissioner of human services and shall be conducted by a mental health practitioner as defined in section 245.4871, subdivision 26, or a probation officer who is trained in the use of the screening instrument. If the screening indicates a need for assessment, the local social services agency, in consultation with the child's family, shall have a diagnostic assessment conducted, including a functional assessment, as defined in section 245.4871.

With the consent of the commissioner of corrections and agreement of the county to pay the costs thereof, the court may, by order, place a minor coming within its jurisdiction in an institution maintained by the commissioner for the detention, diagnosis, custody and treatment of persons adjudicated to be delinquent, in order that the condition of the minor be given due consideration in the disposition of the case. Any funds received under the provisions of this subdivision shall not cancel until the end of the fiscal year immediately following the fiscal year in which the funds were received. The funds are available for use by the commissioner of corrections during that period and are hereby appropriated annually to the commissioner of corrections as reimbursement of the costs of providing these services to the juvenile courts.

Sec. 84. Minnesota Statutes 2020, section 260B.157, subdivision 3, is amended to read:

Subd. 3. **Juvenile treatment screening team.** (a) The local social services agency shall establish a juvenile treatment screening team to conduct screenings and prepare case plans under this subdivision. The team, which may be the team constituted under section 245.4885 or 256B.092 or ~~Minnesota Rules, parts 9530.6600 to 9530.6655~~ chapter 254B, shall consist

of social workers, juvenile justice professionals, and persons with expertise in the treatment of juveniles who are emotionally disabled, chemically dependent, or have a developmental disability. The team shall involve parents or guardians in the screening process as appropriate. The team may be the same team as defined in section 260C.157, subdivision 3.

(b) If the court, prior to, or as part of, a final disposition, proposes to place a child:

(1) for the primary purpose of treatment for an emotional disturbance, and residential placement is consistent with section 260.012, a developmental disability, or chemical dependency in a residential treatment facility out of state or in one which is within the state and licensed by the commissioner of human services under chapter 245A; or

(2) in any out-of-home setting potentially exceeding 30 days in duration, including a post-dispositional placement in a facility licensed by the commissioner of corrections or human services, the court shall notify the county welfare agency. The county's juvenile treatment screening team must either:

(i) screen and evaluate the child and file its recommendations with the court within 14 days of receipt of the notice; or

(ii) elect not to screen a given case, and notify the court of that decision within three working days.

(c) If the screening team has elected to screen and evaluate the child, the child may not be placed for the primary purpose of treatment for an emotional disturbance, a developmental disability, or chemical dependency, in a residential treatment facility out of state nor in a residential treatment facility within the state that is licensed under chapter 245A, unless one of the following conditions applies:

(1) a treatment professional certifies that an emergency requires the placement of the child in a facility within the state;

(2) the screening team has evaluated the child and recommended that a residential placement is necessary to meet the child's treatment needs and the safety needs of the community, that it is a cost-effective means of meeting the treatment needs, and that it will be of therapeutic value to the child; or

(3) the court, having reviewed a screening team recommendation against placement, determines to the contrary that a residential placement is necessary. The court shall state the reasons for its determination in writing, on the record, and shall respond specifically to the findings and recommendation of the screening team in explaining why the

recommendation was rejected. The attorney representing the child and the prosecuting attorney shall be afforded an opportunity to be heard on the matter.

Sec. 85. Minnesota Statutes 2021 Supplement, section 260C.157, subdivision 3, is amended to read:

Subd. 3. **Juvenile treatment screening team.** (a) The responsible social services agency shall establish a juvenile treatment screening team to conduct screenings under this chapter and chapter 260D, for a child to receive treatment for an emotional disturbance, a developmental disability, or related condition in a residential treatment facility licensed by the commissioner of human services under chapter 245A, or licensed or approved by a Tribe. A screening team is not required for a child to be in: (1) a residential facility specializing in prenatal, postpartum, or parenting support; (2) a facility specializing in high-quality residential care and supportive services to children and youth who have been or are at risk of becoming victims of sex trafficking or commercial sexual exploitation; (3) supervised settings for youth who are 18 years of age or older and living independently; or (4) a licensed residential family-based treatment facility for substance abuse consistent with section 260C.190. Screenings are also not required when a child must be placed in a facility due to an emotional crisis or other mental health emergency.

(b) The responsible social services agency shall conduct screenings within 15 days of a request for a screening, unless the screening is for the purpose of residential treatment and the child is enrolled in a prepaid health program under section 256B.69, in which case the agency shall conduct the screening within ten working days of a request. The responsible social services agency shall convene the juvenile treatment screening team, which may be constituted under section 245.4885 ~~or~~, 254B.05, or 256B.092 ~~or Minnesota Rules, parts 9530.6600 to 9530.6655~~. The team shall consist of social workers; persons with expertise in the treatment of juveniles who are emotionally disturbed, chemically dependent, or have a developmental disability; and the child's parent, guardian, or permanent legal custodian. The team may include the child's relatives as defined in section 260C.007, subdivisions 26b and 27, the child's foster care provider, and professionals who are a resource to the child's family such as teachers, medical or mental health providers, and clergy, as appropriate, consistent with the family and permanency team as defined in section 260C.007, subdivision 16a. Prior to forming the team, the responsible social services agency must consult with the child's parents, the child if the child is age 14 or older, and, if applicable, the child's Tribe to obtain recommendations regarding which individuals to include on the team and to ensure that the team is family-centered and will act in the child's best interests. If the child, child's

parents, or legal guardians raise concerns about specific relatives or professionals, the team should not include those individuals. This provision does not apply to paragraph (c).

(c) If the agency provides notice to Tribes under section 260.761, and the child screened is an Indian child, the responsible social services agency must make a rigorous and concerted effort to include a designated representative of the Indian child's Tribe on the juvenile treatment screening team, unless the child's Tribal authority declines to appoint a representative. The Indian child's Tribe may delegate its authority to represent the child to any other federally recognized Indian Tribe, as defined in section 260.755, subdivision 12. The provisions of the Indian Child Welfare Act of 1978, United States Code, title 25, sections 1901 to 1963, and the Minnesota Indian Family Preservation Act, sections 260.751 to 260.835, apply to this section.

(d) If the court, prior to, or as part of, a final disposition or other court order, proposes to place a child with an emotional disturbance or developmental disability or related condition in residential treatment, the responsible social services agency must conduct a screening. If the team recommends treating the child in a qualified residential treatment program, the agency must follow the requirements of sections 260C.70 to 260C.714.

The court shall ascertain whether the child is an Indian child and shall notify the responsible social services agency and, if the child is an Indian child, shall notify the Indian child's Tribe as paragraph (c) requires.

(e) When the responsible social services agency is responsible for placing and caring for the child and the screening team recommends placing a child in a qualified residential treatment program as defined in section 260C.007, subdivision 26d, the agency must: (1) begin the assessment and processes required in section 260C.704 without delay; and (2) conduct a relative search according to section 260C.221 to assemble the child's family and permanency team under section 260C.706. Prior to notifying relatives regarding the family and permanency team, the responsible social services agency must consult with the child's parent or legal guardian, the child if the child is age 14 or older, and, if applicable, the child's Tribe to ensure that the agency is providing notice to individuals who will act in the child's best interests. The child and the child's parents may identify a culturally competent qualified individual to complete the child's assessment. The agency shall make efforts to refer the assessment to the identified qualified individual. The assessment may not be delayed for the purpose of having the assessment completed by a specific qualified individual.

(f) When a screening team determines that a child does not need treatment in a qualified residential treatment program, the screening team must:

(1) document the services and supports that will prevent the child's foster care placement and will support the child remaining at home;

(2) document the services and supports that the agency will arrange to place the child in a family foster home; or

(3) document the services and supports that the agency has provided in any other setting.

(g) When the Indian child's Tribe or Tribal health care services provider or Indian Health Services provider proposes to place a child for the primary purpose of treatment for an emotional disturbance, a developmental disability, or co-occurring emotional disturbance and chemical dependency, the Indian child's Tribe or the Tribe delegated by the child's Tribe shall submit necessary documentation to the county juvenile treatment screening team, which must invite the Indian child's Tribe to designate a representative to the screening team.

(h) The responsible social services agency must conduct and document the screening in a format approved by the commissioner of human services.

Sec. 86. Minnesota Statutes 2020, section 260E.20, subdivision 1, is amended to read:

Subdivision 1. **General duties.** (a) The local welfare agency shall offer services to prevent future maltreatment, safeguarding and enhancing the welfare of the maltreated child, and supporting and preserving family life whenever possible.

(b) If the report alleges a violation of a criminal statute involving maltreatment or child endangerment under section 609.378, the local law enforcement agency and local welfare agency shall coordinate the planning and execution of their respective investigation and assessment efforts to avoid a duplication of fact-finding efforts and multiple interviews. Each agency shall prepare a separate report of the results of the agency's investigation or assessment.

(c) In cases of alleged child maltreatment resulting in death, the local agency may rely on the fact-finding efforts of a law enforcement investigation to make a determination of whether or not maltreatment occurred.

(d) When necessary, the local welfare agency shall seek authority to remove the child from the custody of a parent, guardian, or adult with whom the child is living.

(e) In performing any of these duties, the local welfare agency shall maintain an appropriate record.

(f) In conducting a family assessment or investigation, the local welfare agency shall gather information on the existence of substance abuse and domestic violence.

(g) If the family assessment or investigation indicates there is a potential for abuse of alcohol or other drugs by the parent, guardian, or person responsible for the child's care, the local welfare agency ~~shall conduct a chemical use~~ must coordinate a comprehensive assessment pursuant to ~~Minnesota Rules, part 9530.6615~~ section 245G.05.

(h) The agency may use either a family assessment or investigation to determine whether the child is safe when responding to a report resulting from birth match data under section 260E.03, subdivision 23, paragraph (c). If the child subject of birth match data is determined to be safe, the agency shall consult with the county attorney to determine the appropriateness of filing a petition alleging the child is in need of protection or services under section 260C.007, subdivision 6, clause (16), in order to deliver needed services. If the child is determined not to be safe, the agency and the county attorney shall take appropriate action as required under section 260C.503, subdivision 2.

Sec. 87. Minnesota Statutes 2020, section 299A.299, subdivision 1, is amended to read:

Subdivision 1. **Establishment of team.** A county, a multicounty organization of counties formed by an agreement under section 471.59, or a city with a population of no more than 50,000, may establish a multidisciplinary chemical abuse prevention team. The chemical abuse prevention team may include, but not be limited to, representatives of health, mental health, public health, law enforcement, educational, social service, court service, community education, religious, and other appropriate agencies, and parent and youth groups. For purposes of this section, "chemical abuse" has the meaning given in ~~Minnesota Rules, part 9530.6605, subpart 6~~ section 254A.02, subdivision 6a. When possible the team must coordinate its activities with existing local groups, organizations, and teams dealing with the same issues the team is addressing.

Sec. 88. Laws 2021, First Special Session chapter 7, article 17, section 1, subdivision 2, is amended to read:

Subd. 2. **Eligibility.** An individual is eligible for the transition to community initiative if the individual does not meet eligibility criteria for the medical assistance program under section 256B.056 or 256B.057, but who meets at least one of the following criteria:

(1) the person otherwise meets the criteria under section 256B.092, subdivision 13, or 256B.49, subdivision 24;

(2) the person has met treatment objectives and no longer requires a hospital-level care or a secure treatment setting, but the person's discharge from the Anoka Metro Regional Treatment Center, the Minnesota Security Hospital, or a community behavioral health hospital would be substantially delayed without additional resources available through the transitions to community initiative;

(3) the person is in a community hospital ~~and on the waiting list for the Anoka Metro Regional Treatment Center~~, but alternative community living options would be appropriate for the person~~, and the person has received approval from the commissioner~~; or

(4)(i) the person is receiving customized living services reimbursed under section 256B.4914, 24-hour customized living services reimbursed under section 256B.4914, or community residential services reimbursed under section 256B.4914; (ii) the person expresses a desire to move; and (iii) the person has received approval from the commissioner.

Sec. 89. 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) and children's mobile crisis services under Minnesota Statutes, section 256B.0944. The general fund base in this act for this purpose is ~~$4,000,000~~ $8,000,000 in fiscal year 2024 and ~~$0~~ $8,000,000 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. 90. 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~~ ADULT AND CHILDREN'S MOBILE TRANSITION ~~UNIT~~ UNITS.**

(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 adult and children's mental health transition and support teams to facilitate transition back to the community ~~of children~~ or to the least restrictive level of care from inpatient psychiatric settings, emergency departments, residential treatment facilities, and child and adolescent behavioral health hospitals. 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. 91. **RATE INCREASE FOR MENTAL HEALTH ADULT DAY TREATMENT.**

The commissioner of human services must increase the reimbursement rate for adult day treatment by 50 percent over the reimbursement rate in effect as of June 30, 2022.

EFFECTIVE DATE. This section is effective January 1, 2023, or 60 days following federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 92. **DIRECTION TO COMMISSIONER.**

The commissioner must update the behavioral health fund room and board rate schedule to include programs providing children's mental health crisis admissions and stabilization under Minnesota Statutes, section 245.4882, subdivision 6. The commissioner must establish room and board rates commensurate with current room and board rates for adolescent programs licensed under Minnesota Statutes, section 245G.18.

Sec. 93. **DIRECTION TO COMMISSIONER; BEHAVIORAL HEALTH FUND ALLOCATION.**

The commissioner of human services, in consultation with counties and Tribal Nations, must make recommendations on an updated allocation to local agencies from funds allocated under Minnesota Statutes, section 254B.02, subdivision 5. The commissioner must submit the recommendations to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services finance and policy by January 1, 2024.

Sec. 94. **DIRECTION TO COMMISSIONER; MEDICATION-ASSISTED THERAPY SERVICES PAYMENT METHODOLOGY.**

The commissioner of human services shall revise the payment methodology for medication-assisted therapy services under Minnesota Statutes, section 254B.05, subdivision 5, paragraph (b), clause (6). The revised payment methodology must only allow payment if the provider renders the service or services billed on the specified date of service or, in the case of drugs and drug-related services, within a week of the specified date of service, as defined by the commissioner. The revised payment methodology must include a weekly bundled rate, based on the Medicare rate, that includes the costs of drugs; drug administration and observation; drug packaging and preparation; and nursing time. The commissioner shall seek all necessary waivers, state plan amendments, and federal authorizations required to implement the revised payment methodology.

Sec. 95. **REVISOR INSTRUCTION.**

(a) The revisor of statutes shall change the terms "medication-assisted treatment" and "medication-assisted therapy" or similar terms to "substance use disorder treatment with medications for opioid use disorder" whenever the terms appear in Minnesota Statutes and Minnesota Rules. The revisor may make technical and other necessary grammatical changes related to the term change.

(b) The revisor of statutes shall change the term "intensive treatment in foster care" or similar terms to "children's intensive behavioral health services" wherever they appear in Minnesota Statutes and Minnesota Rules when referring to those providers and services regulated under Minnesota Statutes, section 256B.0946. The revisor shall make technical and grammatical changes related to the changes in terms.

Sec. 96. **REPEALER.**

(a) Minnesota Statutes 2020, sections 169A.70, subdivision 6; 245G.22, subdivision 19; 254A.02, subdivision 8a; 254A.16, subdivision 6; 254A.19, subdivisions 1a and 2; 254B.04, subdivisions 2b and 2c; and 254B.041, subdivision 2, are repealed.

(b) Minnesota Statutes 2021 Supplement, section 254A.19, subdivision 5, is repealed.

(c) Minnesota Rules, parts 9530.7000, subparts 1, 2, 5, 6, 7, 8, 9, 10, 11, 13, 14, 15, 17a, 19, 20, and 21; 9530.7005; 9530.7010; 9530.7012; 9530.7015, subparts 1, 2a, 4, 5, and 6; 9530.7020, subparts 1, 1a, and 2; 9530.7021; 9530.7022, subpart 1; 9530.7025; and 9530.7030, subpart 1, are repealed.

ARTICLE 11
CONTINUING CARE FOR OLDER ADULTS POLICY

Section 1. Minnesota Statutes 2020, section 245A.14, subdivision 14, is amended to read:

Subd. 14. **Attendance records for publicly funded services.** (a) A child care center licensed under this chapter and according to Minnesota Rules, chapter 9503, must maintain documentation of actual attendance for each child receiving care for which the license holder is reimbursed by a governmental program. The records must be accessible to the commissioner during the program's hours of operation, they must be completed on the actual day of attendance, and they must include:

(1) the first and last name of the child;

(2) the time of day that the child was dropped off; and

(3) the time of day that the child was picked up.

(b) A family child care provider licensed under this chapter and according to Minnesota Rules, chapter 9502, must maintain documentation of actual attendance for each child receiving care for which the license holder is reimbursed for the care of that child by a governmental program. The records must be accessible to the commissioner during the program's hours of operation, they must be completed on the actual day of attendance, and they must include:

(1) the first and last name of the child;

(2) the time of day that the child was dropped off; and

(3) the time of day that the child was picked up.

(c) An adult day services program licensed under this chapter and according to Minnesota Rules, parts 9555.5105 to 9555.6265, must maintain documentation of actual attendance for each adult day service recipient for which the license holder is reimbursed by a governmental program. The records must be accessible to the commissioner during the program's hours of operation, they must be completed on the actual day of attendance, and they must include:

(1) the first, middle, and last name of the recipient;

(2) the time of day that the recipient was dropped off; and

(3) the time of day that the recipient was picked up.

(d) ~~The commissioner shall not issue a correction for attendance record errors that occur before August 1, 2013.~~ Adult day services programs licensed under this chapter that are designated for remote adult day services must maintain documentation of actual participation for each adult day service recipient for whom the license holder is reimbursed by a governmental program. The records must be accessible to the commissioner during the program's hours of operation, must be completed on the actual day service is provided, and must include the:

(1) first, middle, and last name of the recipient;

(2) time of day the remote services started;

(3) time of day that the remote services ended; and

(4) means by which the remote services were provided, through audio remote services or through audio and video remote services.

EFFECTIVE DATE. This section is effective January 1, 2023.

Sec. 2. **[245A.70] REMOTE ADULT DAY SERVICES.**

(a) For the purposes of sections 245A.70 to 245A.75, the following terms have the meanings given.

(b) "Adult day care" and "adult day services" have the meanings given in section 245A.02, subdivision 2a.

(c) "Remote adult day services" means an individualized and coordinated set of services provided via live two-way communication by an adult day care or adult day services center.

(d) "Live two-way communication" means real-time audio or audio and video transmission of information between a participant and an actively involved staff member.

Sec. 3. **[245A.71] APPLICABILITY AND SCOPE.**

Subdivision 1. **Licensing requirements.** Adult day care centers or adult day services centers that provide remote adult day services must be licensed under this chapter and comply with the requirements set forth in this section.

Subd. 2. **Standards for licensure.** License holders seeking to provide remote adult day services must submit a request in the manner prescribed by the commissioner. Remote adult day services must not be delivered until approved by the commissioner. The designation to provide remote services is voluntary for license holders. Upon approval, the designation of approval for remote adult day services must be printed on the center's license, and identified on the commissioner's public website.

Subd. 3. **Federal requirements.** Adult day care centers or adult day services centers that provide remote adult day services to participants receiving alternative care under section 256B.0913, essential community supports under section 256B.0922, or home and community-based services waivers under chapter 256S or section 256B.092 or 256B.49 must comply with federally approved waiver plans.

Subd. 4. **Service limitations.** Remote adult day services must be provided during the days and hours of in-person services specified on the license of the adult day care center or adult day services center.

Sec. 4. **[245A.72] RECORD REQUIREMENTS.**

Adult day care centers and adult day services centers providing remote adult day services must comply with participant record requirements set forth in Minnesota Rules, part 9555.9660. The center must document how remote services will help a participant reach the short- and long-term objectives in the participant's plan of care.

Sec. 5. **[245A.73] REMOTE ADULT DAY SERVICES STAFF.**

Subdivision 1. **Staff ratios.** (a) A staff person who provides remote adult day services without two-way interactive video must only provide services to one participant at a time.

(b) A staff person who provides remote adult day services through two-way interactive video must not provide services to more than eight participants at one time.

Subd. 2. **Staff training.** A center licensed under section 245A.71 must document training provided to each staff person regarding the provision of remote services in the staff person's record. The training must be provided prior to a staff person delivering remote adult day services without supervision. The training must include:

(1) how to use the equipment, technology, and devices required to provide remote adult day services via live two-way communication;

(2) orientation and training on each participant's plan of care as directly related to remote adult day services; and

(3) direct observation by a manager or supervisor of the staff person while providing supervised remote service delivery sufficient to assess staff competency.

Sec. 6. **[245A.74] INDIVIDUAL SERVICE PLANNING.**

Subdivision 1. **Eligibility.** (a) A person must be eligible for and receiving in-person adult day services to receive remote adult day services from the same provider. The same provider must deliver both in-person adult day services and remote adult day services to a participant.

(b) The license holder must update the participant's plan of care according to Minnesota Rules, part 9555.9700.

(c) For a participant who chooses to receive remote adult day services, the license holder must document in the participant's plan of care the participant's proposed schedule and frequency for receiving both in-person and remote services. The license holder must also document in the participant's plan of care that remote services:

(1) are chosen as a service delivery method by the participant or the participant's legal representative;

(2) will meet the participant's assessed needs;

(3) are provided within the scope of adult day services; and

(4) will help the participant achieve identified short and long-term objectives specific to the provision of remote adult day services.

Subd. 2. **Participant daily service limitations.** In a 24-hour period, a participant may receive:

(1) a combination of in-person adult day services and remote adult day services on the same day but not at the same time;

(2) a combination of in-person and remote adult day services that does not exceed 12 hours in total; and

(3) up to six hours of remote adult day services.

Subd. 3. **Minimum in-person requirement.** A participant who receives remote services must receive services in-person as assigned in the participant's plan of care at least quarterly.

Sec. 7. **[245A.75] SERVICE AND PROGRAM REQUIREMENTS.**

Remote adult day services must be in the scope of adult day services provided in Minnesota Rules, part 9555.9710, subparts 3 to 7.

EFFECTIVE DATE. This section is effective January 1, 2023.

Sec. 8. Minnesota Statutes 2020, section 256R.02, subdivision 4, is amended to read:

Subd. 4. **Administrative costs.** "Administrative costs" means the identifiable costs for administering the overall activities of the nursing home. These costs include salaries and wages of the administrator, assistant administrator, business office employees, security guards, purchasing and inventory employees, and associated fringe benefits and payroll taxes, fees, contracts, or purchases related to business office functions, licenses, permits except as provided in the external fixed costs category, employee recognition, travel including meals and lodging, all training except as specified in subdivision 17, voice and data communication or transmission, office supplies, property and liability insurance and other forms of insurance except insurance that is a fringe benefit under subdivision 22, personnel recruitment, legal services, accounting services, management or business consultants, data processing, information technology, website, central or home office costs, business meetings and seminars, postage, fees for professional organizations, subscriptions, security services, nonpromotional advertising, board of directors fees, working capital interest expense, bad debts, bad debt collection fees, and costs incurred for travel and ~~housing~~ lodging for persons employed by a Minnesota-registered supplemental nursing services agency as defined in section 144A.70, subdivision 6.

Sec. 9. Minnesota Statutes 2020, section 256R.02, subdivision 17, is amended to read:

Subd. 17. **Direct care costs.** "Direct care costs" means costs for the wages of nursing administration, direct care registered nurses, licensed practical nurses, certified nursing assistants, trained medication aides, employees conducting training in resident care topics and associated fringe benefits and payroll taxes; services from a Minnesota-registered supplemental nursing services agency up to the maximum allowable charges under section 144A.74, excluding associated lodging and travel costs; supplies that are stocked at nursing stations or on the floor and distributed or used individually, including, but not limited to: rubbing alcohol or alcohol swabs, applicators, cotton balls, incontinence pads, disposable

ice bags, dressings, bandages, water pitchers, tongue depressors, disposable gloves, enemas, enema equipment, personal hygiene soap, medication cups, diapers, ~~plastic waste bags,~~ sanitary products, disposable thermometers, hypodermic needles and syringes, ~~clinical reagents or similar diagnostic agents,~~ drugs ~~that are not paid~~ not payable on a separate fee schedule by the medical assistance program or any other payer, and ~~technology related~~ clinical software costs specific to the provision of nursing care to residents, such as electronic charting systems; costs of materials used for resident care training, and training courses outside of the facility attended by direct care staff on resident care topics; and costs for nurse consultants, pharmacy consultants, and medical directors. Salaries and payroll taxes for nurse consultants who work out of a central office must be allocated proportionately by total resident days or by direct identification to the nursing facilities served by those consultants.

Sec. 10. Minnesota Statutes 2020, section 256R.02, subdivision 18, is amended to read:

Subd. 18. **Employer health insurance costs.** "Employer health insurance costs" means premium expenses for group coverage~~;~~ and actual expenses incurred for self-insured plans, including ~~reinsurance;~~ actual claims paid, stop-loss premiums, plan fees, and employer contributions to employee health reimbursement and health savings accounts. Actual costs of self-insurance plans must not include any allowance for future funding unless the plan meets the Medicare requirements for reporting on a premium basis when the Medicare regulations define the actual costs. Premium and expense costs and contributions are allowable for (1) all employees and (2) the spouse and dependents of those employees who are employed on average at least 30 hours per week.

Sec. 11. Minnesota Statutes 2020, section 256R.02, subdivision 19, is amended to read:

Subd. 19. **External fixed costs.** "External fixed costs" means costs related to the nursing home surcharge under section 256.9657, subdivision 1; licensure fees under section 144.122; family advisory council fee under section 144A.33; scholarships under section 256R.37; planned closure rate adjustments under section 256R.40; consolidation rate adjustments under section 144A.071, subdivisions 4c, paragraph (a), clauses (5) and (6), and 4d; single-bed room incentives under section 256R.41; property taxes, special assessments, and payments in lieu of taxes; employer health insurance costs; quality improvement incentive payment rate adjustments under section 256R.39; performance-based incentive payments under section 256R.38; special dietary needs under section 256R.51; ~~rate adjustments for compensation-related costs for minimum wage changes under section 256R.49 provided~~

~~on or after January 1, 2018;~~ Public Employees Retirement Association employer costs; and border city rate adjustments under section 256R.481.

Sec. 12. Minnesota Statutes 2020, section 256R.02, subdivision 22, is amended to read:

Subd. 22. **Fringe benefit costs.** "Fringe benefit costs" means the costs for group life, dental, workers' compensation, short- and long-term disability, long-term care insurance, accident insurance, supplemental insurance, legal assistance insurance, profit sharing, child care costs, health insurance costs not covered under subdivision 18, including costs associated with part-time employee family members or retirees, and pension and retirement plan contributions, except for the Public Employees Retirement Association costs.

Sec. 13. Minnesota Statutes 2020, section 256R.02, subdivision 29, is amended to read:

Subd. 29. **Maintenance and plant operations costs.** "Maintenance and plant operations costs" means the costs for the salaries and wages of the maintenance supervisor, engineers, heating-plant employees, and other maintenance employees and associated fringe benefits and payroll taxes. It also includes identifiable costs for maintenance and operation of the building and grounds, including, but not limited to, fuel, electricity, plastic waste bags, medical waste and garbage removal, water, sewer, supplies, tools, ~~and~~ repairs, and minor equipment not requiring capitalization under Medicare guidelines.

Sec. 14. Minnesota Statutes 2020, section 256R.02, is amended by adding a subdivision to read:

Subd. 32a. **Minor equipment.** "Minor equipment" means equipment that does not qualify as either fixed equipment or depreciable movable equipment as defined in section 256R.261.

Sec. 15. Minnesota Statutes 2020, section 256R.02, subdivision 42a, is amended to read:

Subd. 42a. **Real estate taxes.** "Real estate taxes" means the real estate tax liability shown on the annual property tax ~~statement~~ statements of the nursing facility for the reporting period. The term does not include personnel costs or fees for late payment.

Sec. 16. Minnesota Statutes 2020, section 256R.02, subdivision 48a, is amended to read:

Subd. 48a. **Special assessments.** "Special assessments" means the actual special assessments and related interest paid during the reporting period that are not voluntary costs. The term does not include personnel costs ~~or~~, fees for late payment, or special assessments for projects that are reimbursed in the property rate.

Sec. 17. Minnesota Statutes 2020, section 256R.02, is amended by adding a subdivision to read:

Subd. 53. **Vested.** "Vested" means the existence of a legally fixed unconditional right to a present or future benefit.

Sec. 18. Minnesota Statutes 2020, section 256R.07, subdivision 1, is amended to read:

Subdivision 1. **Criteria.** A nursing facility ~~shall~~ must keep adequate documentation. In order to be adequate, documentation must:

(1) be maintained in orderly, well-organized files;

(2) not include documentation of more than one nursing facility in one set of files unless transactions may be traced by the commissioner to the nursing facility's annual cost report;

(3) include a paid invoice or copy of a paid invoice with date of purchase, vendor name and address, purchaser name and delivery destination address, listing of items or services purchased, cost of items purchased, account number to which the cost is posted, and a breakdown of any allocation of costs between accounts or nursing facilities. If any of the information is not available, the nursing facility ~~shall~~ must document its good faith attempt to obtain the information;

(4) include contracts, agreements, amortization schedules, mortgages, other debt instruments, and all other documents necessary to explain the nursing facility's costs or revenues; ~~and~~

(5) include signed and dated position descriptions; and

(6) be retained by the nursing facility to support the five most recent annual cost reports. The commissioner may extend the period of retention if the field audit was postponed because of inadequate record keeping or accounting practices as in section 256R.13, subdivisions 2 and 4, the records are necessary to resolve a pending appeal, or the records are required for the enforcement of sections 256R.04; 256R.05, subdivision 2; 256R.06, subdivisions 2, 6, and 7; 256R.08, subdivisions 1 ~~to~~ and 3; and 256R.09, subdivisions 3 and 4.

Sec. 19. Minnesota Statutes 2020, section 256R.07, subdivision 2, is amended to read:

Subd. 2. **Documentation of compensation.** Compensation for personal services, regardless of whether treated as identifiable costs or costs that are not identifiable, must be documented on payroll records. Payrolls must be supported by time and attendance or

equivalent records for individual employees. Salaries and wages of employees which are allocated to more than one cost category must be supported by time distribution records. ~~The method used must produce a proportional distribution of actual time spent, or an accurate estimate of time spent performing assigned duties. The nursing facility that chooses to estimate time spent must use a statistically valid method. The compensation must reflect an amount proportionate to a full-time basis if the services are rendered on less than a full-time basis.~~ Salary allocations are allowable using the Medicare-approved allocation basis and methodology only if the salary costs cannot be directly determined, including when employees provide shared services to noncovered operations.

Sec. 20. Minnesota Statutes 2020, section 256R.07, subdivision 3, is amended to read:

Subd. 3. **Adequate documentation supporting nursing facility payrolls.** Payroll records supporting compensation costs claimed by nursing facilities must be supported by affirmative time and attendance records prepared by each individual at intervals of not more than one month. The requirements of this subdivision are met when documentation is provided under either clause (1) or (2) ~~as follows~~:

(1) the affirmative time and attendance record must identify the individual's name; the days worked during each pay period; the number of hours worked each day; and the number of hours taken each day by the individual for vacation, sick, and other leave. The affirmative time and attendance record must include a signed verification by the individual and the individual's supervisor, if any, that the entries reported on the record are correct; or

(2) if the affirmative time and attendance records identifying the individual's name, the days worked each pay period, the number of hours worked each day, and the number of hours taken each day by the individual for vacation, sick, and other leave are ~~placed on microfilm~~ stored electronically, equipment must be made available for viewing and printing ~~them, or if the records are stored as automated data, summary data must be available for viewing and printing~~ the records.

Sec. 21. Minnesota Statutes 2020, section 256R.08, subdivision 1, is amended to read:

Subdivision 1. **Reporting of financial statements.** (a) No later than February 1 of each year, a nursing facility ~~shall~~ must:

(1) provide the state agency with a copy of its audited financial statements or its working trial balance;

(2) provide the state agency with a statement of ownership for the facility;

(3) provide the state agency with separate, audited financial statements or working trial balances for every other facility owned in whole or in part by an individual or entity that has an ownership interest in the facility;

(4) upon request, provide the state agency with separate, audited financial statements or working trial balances for every organization with which the facility conducts business and which is owned in whole or in part by an individual or entity which has an ownership interest in the facility;

(5) provide the state agency with copies of leases, purchase agreements, and other documents related to the lease or purchase of the nursing facility; and

(6) upon request, provide the state agency with copies of leases, purchase agreements, and other documents related to the acquisition of equipment, goods, and services which are claimed as allowable costs.

(b) Audited financial statements submitted under paragraph (a) must include a balance sheet, income statement, statement of the rate or rates charged to private paying residents, statement of retained earnings, statement of cash flows, notes to the financial statements, audited applicable supplemental information, and the public accountant's report. Public accountants must conduct audits in accordance with chapter 326A. The cost of an audit ~~shall~~ must not be an allowable cost unless the nursing facility submits its audited financial statements in the manner otherwise specified in this subdivision. A nursing facility must permit access by the state agency to the public accountant's audit work papers that support the audited financial statements submitted under paragraph (a).

(c) Documents or information provided to the state agency pursuant to this subdivision ~~shall~~ must be public unless prohibited by the Health Insurance Portability and Accountability Act or any other federal or state regulation. Data, notes, and preliminary drafts of reports created, collected, and maintained by the audit offices of government entities, or persons performing audits for government entities, and relating to an audit or investigation are confidential data on individuals or protected nonpublic data until the final report has been published or the audit or investigation is no longer being pursued actively, except that the data must be disclosed as required to comply with section 6.67 or 609.456.

(d) If the requirements of paragraphs (a) and (b) are not met, the reimbursement rate may be reduced to 80 percent of the rate in effect on the first day of the fourth calendar month after the close of the reporting period and the reduction ~~shall~~ must continue until the requirements are met.

Sec. 22. Minnesota Statutes 2020, section 256R.09, subdivision 2, is amended to read:

Subd. 2. **Reporting of statistical and cost information.** All nursing facilities ~~shall~~ must provide information annually to the commissioner on a form and in a manner determined by the commissioner. The commissioner may separately require facilities to submit in a manner specified by the commissioner documentation of statistical and cost information included in the report to ensure accuracy in establishing payment rates and to perform audit and appeal review functions under this chapter. The commissioner may also require nursing facilities to provide statistical and cost information for a subset of the items in the annual report on a semiannual basis. Nursing facilities ~~shall~~ must report only costs directly related to the operation of the nursing facility. The facility ~~shall~~ must not include costs which are separately reimbursed or reimbursable by residents, medical assistance, or other payors. Allocations of costs from central, affiliated, or corporate office and related organization transactions shall be reported according to sections 256R.07, subdivision 3, and 256R.12, subdivisions 1 to 7. The commissioner shall not grant facilities extensions to the filing deadline.

Sec. 23. Minnesota Statutes 2020, section 256R.09, subdivision 5, is amended to read:

Subd. 5. **Method of accounting.** The accrual method of accounting in accordance with generally accepted accounting principles is the only method acceptable for purposes of satisfying the reporting requirements of this chapter. If a governmentally owned nursing facility demonstrates that the accrual method of accounting is not applicable to its accounts and that a cash or modified accrual method of accounting more accurately reports the nursing facility's financial operations, the commissioner shall permit the governmentally owned nursing facility to use a cash or modified accrual method of accounting. For reimbursement purposes, the accrued expense must be paid by the providers within 180 days following the end of the reporting period. An expense disallowed by the commissioner under this section in any cost report period must not be claimed by a provider on a subsequent cost report. Specific exemptions to the 180-day rule may be granted by the commissioner for documented contractual arrangements such as receivership, property tax installment payments, and pension contributions.

Sec. 24. Minnesota Statutes 2020, section 256R.13, subdivision 4, is amended to read:

Subd. 4. **Extended record retention requirements.** The commissioner shall extend the period for retention of records under section 256R.09, subdivision 3, for purposes of performing field audits as necessary to enforce sections 256R.04; 256R.05, subdivision 2;

256R.06, subdivisions 2, 6, and 7; 256R.08, subdivisions 1 ~~to~~ and 3; and 256R.09, subdivisions 3 and 4, with written notice to the facility postmarked no later than 90 days prior to the expiration of the record retention requirement.

Sec. 25. Minnesota Statutes 2020, section 256R.16, subdivision 1, is amended to read:

Subdivision 1. **Calculation of a quality score.** (a) The commissioner shall determine a quality score for each nursing facility using quality measures established in section 256B.439, according to methods determined by the commissioner in consultation with stakeholders and experts, and using the most recently available data as provided in the Minnesota Nursing Home Report Card. These methods ~~shall~~ must be exempt from the rulemaking requirements under chapter 14.

(b) For each quality measure, a score ~~shall~~ must be determined with the number of points assigned as determined by the commissioner using the methodology established according to this subdivision. The determination of the quality measures to be used and the methods of calculating scores may be revised annually by the commissioner.

(c) The quality score ~~shall~~ must include up to 50 points related to the Minnesota quality indicators score derived from the minimum data set, up to 40 points related to the resident quality of life score derived from the consumer survey conducted under section 256B.439, subdivision 3, and up to ten points related to the state inspection results score.

(d) The commissioner, in cooperation with the commissioner of health, may adjust the formula in paragraph (c), or the methodology for computing the total quality score, ~~effective July 1 of any year,~~ with five months advance public notice. In changing the formula, the commissioner shall consider quality measure priorities registered by report card users, advice of stakeholders, and available research.

Sec. 26. Minnesota Statutes 2020, section 256R.17, subdivision 3, is amended to read:

Subd. 3. **Resident assessment schedule.** (a) Nursing facilities ~~shall~~ must conduct and submit case mix classification assessments according to the schedule established by the commissioner of health under section 144.0724, subdivisions 4 and 5.

(b) The case mix classifications established under section 144.0724, subdivision 3a, ~~shall be~~ are effective the day of admission for new admission assessments. The effective date for significant change assessments ~~shall be~~ is the assessment reference date. The effective date for annual and quarterly assessments ~~shall be~~ and significant corrections assessments is the first day of the month following assessment reference date.

Sec. 27. Minnesota Statutes 2020, section 256R.26, subdivision 1, is amended to read:

Subdivision 1. **Determination of limited undepreciated replacement cost.** A facility's limited URC is the lesser of:

(1) the facility's recognized URC from the appraisal; or

(2) the product of (i) the number of the facility's licensed beds three months prior to the beginning of the rate year, (ii) the construction cost per square foot value, and (iii) 1,000 square feet.

Sec. 28. Minnesota Statutes 2020, section 256R.261, subdivision 13, is amended to read:

Subd. 13. **Equipment allowance per bed value.** The equipment allowance per bed value is $10,000 adjusted annually for rate years beginning on or after January 1, 2021, by the percentage change indicated by the urban consumer price index for Minneapolis-St. Paul, as published by the Bureau of Labor Statistics (series ~~1967=100~~ 1982-84=100) for the two previous Julys. The computation for this annual adjustment is based on the data that is publicly available on November 1 immediately preceding the start of the rate year.

Sec. 29. Minnesota Statutes 2020, section 256R.37, is amended to read:

256R.37 SCHOLARSHIPS.

~~(a) For the 27-month period beginning October 1, 2015, through December 31, 2017, the commissioner shall allow a scholarship per diem of up to 25 cents for each nursing facility with no scholarship per diem that is requesting a scholarship per diem to be added to the external fixed payment rate to be used:~~

~~(1) for employee scholarships that satisfy the following requirements:~~

~~(i) scholarships are available to all employees who work an average of at least ten hours per week at the facility except the administrator, and to reimburse student loan expenses for newly hired registered nurses and licensed practical nurses, and training expenses for nursing assistants as specified in section 144A.611, subdivisions 2 and 4, who are newly hired; and~~

~~(ii) the course of study is expected to lead to career advancement with the facility or in long-term care, including medical care interpreter services and social work; and~~

~~(2) to provide job-related training in English as a second language.~~

~~(b) All facilities may annually request a rate adjustment under this section by submitting information to the commissioner on a schedule and in a form supplied by the commissioner.~~

~~The commissioner shall allow a scholarship payment rate equal to the reported and allowable costs divided by resident days.~~

~~(c) In calculating the per diem under paragraph (b), the commissioner shall allow costs related to tuition, direct educational expenses, and reasonable costs as defined by the commissioner for child care costs and transportation expenses related to direct educational expenses.~~

~~(d) The rate increase under this section is an optional rate add-on that the facility must request from the commissioner in a manner prescribed by the commissioner. The rate increase must be used for scholarships as specified in this section.~~

~~(e) For instances in which a rate adjustment will be 15 cents or greater, nursing facilities that close beds during a rate year may request to have their scholarship adjustment under paragraph (b) recalculated by the commissioner for the remainder of the rate year to reflect the reduction in resident days compared to the cost report year.~~

(a) The commissioner shall provide a scholarship per diem rate calculated using the criteria in paragraphs (b) to (d). The per diem rate must be based on the allowable costs the facility paid for employee scholarships for any eligible employee, except the facility administrator, who works an average of at least ten hours per week in the licensed nursing facility building when the facility has paid expenses related to:

(1) an employee's course of study that is expected to lead to career advancement with the facility or in the field of long-term care;

(2) an employee's job-related training in English as a second language;

(3) the reimbursement of student loan expenses for newly hired registered nurses and licensed practical nurses; and

(4) the reimbursement of training, testing, and associated expenses for newly hired nursing assistants as specified in section 144A.611, subdivisions 2 and 4. The reimbursement of nursing assistant expenses under this clause is not subject to the ten-hour minimum work requirement under this paragraph.

(b) Allowable scholarship costs include: tuition, student loan reimbursement, other direct educational expenses, and reasonable costs for child care and transportation expenses directly related to education, as defined by the commissioner.

(c) The commissioner shall provide a scholarship per diem rate equal to the allowable scholarship costs divided by resident days. The commissioner shall compute the scholarship

per diem rate annually and include the scholarship per diem rate in the external fixed costs payment rate.

(d) When the resulting scholarship per diem rate is 15 cents or more, nursing facilities that close beds during a rate year may request to have the scholarship rate recalculated. This recalculation is effective from the date of the bed closure through the remainder of the rate year and reflects the estimated reduction in resident days compared to the previous cost report year.

(e) Facilities seeking to have the facility's scholarship expenses recognized for the payment rate computation in section 256R.25 may apply annually by submitting information to the commissioner on a schedule and in a form supplied by the commissioner.

Sec. 30. Minnesota Statutes 2020, section 256R.39, is amended to read:

256R.39 QUALITY IMPROVEMENT INCENTIVE PROGRAM.

The commissioner shall develop a quality improvement incentive program in consultation with stakeholders. The annual funding pool available for quality improvement incentive payments ~~shall~~ must be equal to 0.8 percent of all operating payments, not including any rate components resulting from equitable cost-sharing for publicly owned nursing facility program participation under section 256R.48, critical access nursing facility program participation under section 256R.47, or performance-based incentive payment program participation under section 256R.38. ~~For the period from October 1, 2015, to December 31, 2016, rate adjustments provided under this section shall be effective for 15 months. Beginning January 1, 2017,~~ An annual rate ~~adjustments~~ adjustment provided under this section ~~shall~~ must be effective for one rate year.

Sec. 31. **REPEALER.**

Minnesota Statutes 2020, sections 245A.03, subdivision 5; 256R.08, subdivision 2; and 256R.49, and Minnesota Rules, part 9555.6255, are repealed.

ARTICLE 12
CONTINUING CARE FOR OLDER ADULTS

Section 1. Minnesota Statutes 2020, section 177.27, subdivision 4, is amended to read:

Subd. 4. **Compliance orders.** The commissioner may issue an order requiring an employer to comply with sections 177.21 to 177.435, 181.02, 181.03, 181.031, 181.032, 181.101, 181.11, 181.13, 181.14, 181.145, 181.15, 181.172, paragraph (a) or (d), 181.214

to 181.217, 181.275, subdivision 2a, 181.722, 181.79, and 181.939 to 181.943, or with any rule promulgated under section 177.28 or 181.213. The commissioner shall issue an order requiring an employer to comply with sections 177.41 to 177.435 if the violation is repeated. For purposes of this subdivision only, a violation is repeated if at any time during the two years that preceded the date of violation, the commissioner issued an order to the employer for violation of sections 177.41 to 177.435 and the order is final or the commissioner and the employer have entered into a settlement agreement that required the employer to pay back wages that were required by sections 177.41 to 177.435. The department shall serve the order upon the employer or the employer's authorized representative in person or by certified mail at the employer's place of business. An employer who wishes to contest the order must file written notice of objection to the order with the commissioner within 15 calendar days after being served with the order. A contested case proceeding must then be held in accordance with sections 14.57 to 14.69. If, within 15 calendar days after being served with the order, the employer fails to file a written notice of objection with the commissioner, the order becomes a final order of the commissioner.

Sec. 2. Minnesota Statutes 2020, section 177.27, subdivision 7, is amended to read:

Subd. 7. **Employer liability.** If an employer is found by the commissioner to have violated a section identified in subdivision 4, or any rule adopted under section 177.28 or 181.213, and the commissioner issues an order to comply, the commissioner shall order the employer to cease and desist from engaging in the violative practice and to take such affirmative steps that in the judgment of the commissioner will effectuate the purposes of the section or rule violated. The commissioner shall order the employer to pay to the aggrieved parties back pay, gratuities, and compensatory damages, less any amount actually paid to the employee by the employer, and for an additional equal amount as liquidated damages. Any employer who is found by the commissioner to have repeatedly or willfully violated a section or sections identified in subdivision 4 shall be subject to a civil penalty of up to $1,000 for each violation for each employee. In determining the amount of a civil penalty under this subdivision, the appropriateness of such penalty to the size of the employer's business and the gravity of the violation shall be considered. In addition, the commissioner may order the employer to reimburse the department and the attorney general for all appropriate litigation and hearing costs expended in preparation for and in conducting the contested case proceeding, unless payment of costs would impose extreme financial hardship on the employer. If the employer is able to establish extreme financial hardship, then the commissioner may order the employer to pay a percentage of the total costs that will not cause extreme financial hardship. Costs include but are not limited to the costs of

services rendered by the attorney general, private attorneys if engaged by the department, administrative law judges, court reporters, and expert witnesses as well as the cost of transcripts. Interest shall accrue on, and be added to, the unpaid balance of a commissioner's order from the date the order is signed by the commissioner until it is paid, at an annual rate provided in section 549.09, subdivision 1, paragraph (c). The commissioner may establish escrow accounts for purposes of distributing damages.

Sec. 3. **[181.211] DEFINITIONS.**

Subdivision 1. **Application.** The terms defined in this section apply to sections 181.211 to 181.217.

Subd. 2. **Board.** "Board" means the Minnesota Nursing Home Workforce Standards Board established under section 181.212.

Subd. 3. **Certified worker organization.** "Certified worker organization" means a worker organization that is certified by the board to conduct nursing home worker trainings under section 181.214.

Subd. 4. **Commissioner.** "Commissioner" means the commissioner of labor and industry.

Subd. 5. **Employer organization.** "Employer organization" means:

(1) an organization that is exempt from federal income taxation under section 501(c)(6) of the Internal Revenue Code and that represents nursing home employers; or

(2) an entity that employers, who together employ a majority of nursing home workers in Minnesota, have selected as a representative.

Subd. 6. **Nursing home.** "Nursing home" means a nursing home licensed under chapter 144A, or a boarding care home licensed under sections 144.50 to 144.56.

Subd. 7. **Nursing home employer.** "Nursing home employer" means an employer of nursing home workers.

Subd. 8. **Nursing home worker.** "Nursing home worker" means any worker who provides services in a nursing home in Minnesota, including direct care staff, administrative staff, and contractors.

Subd. 9. **Retaliatory personnel action.** "Retaliatory personnel action" means any form of intimidation, threat, reprisal, harassment, discrimination, or adverse employment action, including discipline, discharge, suspension, transfer, or reassignment to a lesser position in terms of job classification, job security, or other condition of employment; reduction in pay or hours or denial of additional hours; informing another employer that a nursing home

worker has engaged in activities protected under sections 181.211 to 181.217; or reporting or threatening to report the actual or suspected citizenship or immigration status of a nursing home worker, former nursing home worker, or family member of a nursing home worker to a federal, state, or local agency.

Subd. 10. **Worker organization.** "Worker organization" means an organization that is exempt from federal income taxation under section 501(c)(3), 501(c)(4), or 501(c)(5) of the Internal Revenue Code, that is not dominated or controlled by any nursing home employer within the meaning of United States Code, title 29, section 158a(2), and that has at least five years of demonstrated experience engaging with and advocating for nursing home workers.

Sec. 4. **[181.212] MINNESOTA NURSING HOME WORKFORCE STANDARDS BOARD; ESTABLISHMENT.**

Subdivision 1. **Board established; membership.** The Minnesota Nursing Home Workforce Standards Board is created with the powers and duties established by law. The board is composed of the following members:

(1) the commissioner of human services or a designee;

(2) the commissioner of health or a designee;

(3) the commissioner of labor and industry or a designee;

(4) three members who represent nursing home employers or employer organizations, appointed by the governor; and

(5) three members who represent nursing home workers or worker organizations, appointed by the governor.

Subd. 2. **Terms; vacancies.** (a) Board members appointed under subdivision 1, clause (4) or (5), shall serve four-year terms following the initial staggered-lot determination. The initial terms of members appointed under subdivision 1, clauses (4) and (5), shall be determined by lot by the secretary of state and shall be as follows:

(1) one member appointed under each of subdivision 1, clauses (4) and (5), shall serve a two-year term;

(2) one member appointed under each of subdivision 1, clauses (4) and (5), shall serve a three-year term; and

(3) one member appointed under each of subdivision 1, clauses (4) and (5), shall serve a four-year term.

(b) For members appointed under subdivision 1, clause (4) or (5), the governor shall fill vacancies occurring prior to the expiration of a member's term by appointment for the unexpired term. A member appointed under subdivision 1, clause (4) or (5), must not be appointed to more than two consecutive four-year terms.

Subd. 3. **Chairperson.** The board shall elect a member by majority vote to serve as its chairperson and shall determine the term to be served by the chairperson.

Subd. 4. **Staffing.** The board may employ an executive director and other personnel to carry out duties of the board under sections 181.211 to 181.217.

Subd. 5. **Compensation.** Compensation of board members is governed by section 15.0575.

Subd. 6. **Application of other laws.** Meetings of the board are subject to chapter 13D. The board is subject to chapter 13.

Subd. 7. **Voting.** The affirmative vote of five board members is required for the board to take any action, including action to establish minimum nursing home employment standards under section 181.213.

Subd. 8. **Hearings and investigations.** To carry out its duties, the board shall hold public hearings on, and conduct investigations into, working conditions in the nursing home industry.

Sec. 5. **[181.213] DUTIES OF THE BOARD; MINIMUM NURSING HOME EMPLOYMENT STANDARDS.**

Subdivision 1. **Authority to establish minimum nursing home employment standards.** (a) The board must adopt rules establishing minimum nursing home employment standards that are reasonably necessary and appropriate to protect the health and welfare of nursing home workers, to ensure that nursing home workers are properly trained and fully informed of their rights under sections 181.211 to 181.217, and to otherwise satisfy the purposes of sections 181.211 to 181.217. Standards established by the board must include, as appropriate, standards on compensation, working hours, and other working conditions for nursing home workers. Any standards established by the board under this section must be at least as protective of or beneficial to nursing home workers as any other applicable statute or rule or any standard previously established by the board. In establishing standards under this section, the board may establish statewide standards, standards that apply to specific nursing home occupations, standards that apply to specific geographic areas within the state, or any combination thereof.

(b) The board must adopt rules establishing initial standards for wages and working hours for nursing home workers no later than August 1, 2023. The board may use the authority in section 14.389 to adopt rules under this paragraph.

(c) To the extent that any minimum standards that the board finds are reasonably necessary and appropriate to protect the health and welfare of nursing home workers fall within the jurisdiction of chapter 182, the board shall not adopt rules establishing the standards but shall instead recommend the standards to the commissioner of labor and industry. The commissioner of labor and industry shall adopt nursing home health and safety standards under section 182.655 as recommended by the board, unless the commissioner determines that the recommended standard is outside the statutory authority of the commissioner or is otherwise unlawful and issues a written explanation of this determination.

Subd. 2. **Investigation of market conditions.** The board must investigate market conditions and the existing wages, benefits, and working conditions of nursing home workers for specific geographic areas of the state and specific nursing home occupations. Based on this information, the board must seek to adopt minimum nursing home employment standards that meet or exceed existing industry conditions for a majority of nursing home workers in the relevant geographic area and nursing home occupation. The board must consider the following types of information in making wage rate determinations that are reasonably necessary to protect the health and welfare of nursing home workers:

(1) wage rate and benefit data collected by or submitted to the board for nursing home workers in the relevant geographic area and nursing home occupations;

(2) statements showing wage rates and benefits paid to nursing home workers in the relevant geographic area and nursing home occupations;

(3) signed collective bargaining agreements applicable to nursing home workers in the relevant geographic area and nursing home occupations;

(4) testimony and information from current and former nursing home workers, worker organizations, nursing home employers, and employer organizations;

(5) local minimum nursing home employment standards;

(6) information submitted by or obtained from state and local government entities; and

(7) any other information pertinent to establishing minimum nursing home employment standards.

Subd. 3. **Review of standards.** At least once every two years, the board shall:

(1) conduct a full review of the adequacy of the minimum nursing home employment standards previously established by the board; and

(2) following that review, adopt new rules, amend or repeal existing rules, or make recommendations to adopt new rules or amend or repeal existing rules, as appropriate to meet the purposes of sections 181.211 to 181.217.

Subd. 4. **Conflict.** In the event of a conflict between a standard established by the board in rule and a rule adopted by another state agency, the rule adopted by the board shall apply to nursing home workers and nursing home employers, except where the conflicting rule is issued after the board's standard, and the rule issued by the other state agency is more protective or more beneficial, then the subsequent more protective or more beneficial rule must apply to nursing home workers and nursing home employers.

Subd. 5. **Effect on other agreements.** Nothing in sections 181.211 to 181.217 shall be construed to:

(1) limit the rights of parties to a collective bargaining agreement to bargain and agree with respect to nursing home employment standards; or

(2) diminish the obligation of a nursing home employer to comply with any contract, collective bargaining agreement, or employment benefit program or plan that meets or exceeds, and does not conflict with, the minimum standards and requirements in sections 181.211 to 181.217 or established by the board.

Sec. 6. **[181.214] DUTIES OF THE BOARD; TRAINING FOR NURSING HOME WORKERS.**

Subdivision 1. **Certification of worker organizations.** The board shall certify worker organizations that it finds are qualified to provide training to nursing home workers according to this section. The board shall by rule establish certification criteria that a worker organization must meet in order to be certified. In adopting rules to establish initial certification criteria under this subdivision, the board may use the authority in section 14.389. The criteria must ensure that a worker organization, if certified, is able to provide:

(1) effective, interactive training on the information required by this section; and

(2) follow-up written materials and responses to inquiries from nursing home workers in the languages in which nursing home workers are proficient.

Subd. 2. **Curriculum.** (a) The board shall establish requirements for the curriculum for the nursing home worker training required by this section. A curriculum must at least provide the following information to nursing home workers:

(1) the applicable compensation, working hours, and working conditions in the minimum standards or local minimum standards established by the board;

(2) the antiretaliation protections established in section 181.216;

(3) information on how to enforce sections 181.211 to 181.217 and on how to report violations of sections 181.211 to 181.217 or of standards established by the board, including contact information for the Department of Labor and Industry, the board, and any local enforcement agencies, and information on the remedies available for violations;

(4) the purposes and functions of the board and information on upcoming hearings, investigations, or other opportunities for nursing home workers to become involved in board proceedings;

(5) other rights, duties, and obligations under sections 181.211 to 181.217;

(6) any updates or changes to the information provided according to clauses (1) to (5) since the most recent training session;

(7) any other information the board deems appropriate to facilitate compliance with sections 181.211 to 181.217; and

(8) information on other applicable local, state, and federal laws, rules, and ordinances regarding nursing home working conditions or nursing home worker health and safety.

(b) Before establishing initial curriculum requirements, the board must hold at least one public hearing to solicit input on the requirements.

Subd. 3. **Topics covered in training session.** A certified worker organization is not required to cover all of the topics listed in subdivision 2 in a single training session. A curriculum used by a certified worker organization may provide instruction on each topic listed in subdivision 2 over the course of up to three training sessions.

Subd. 4. **Annual review of curriculum requirements.** The board must review the adequacy of its curriculum requirements at least annually and must revise the requirements as appropriate to meet the purposes of sections 181.211 to 181.217. As part of each annual review of the curriculum requirements, the board must hold at least one public hearing to solicit input on the requirements.

Subd. 5. **Duties of certified worker organizations.** A certified worker organization:

(1) must use a curriculum for its training sessions that meets requirements established by the board;

(2) must provide trainings that are interactive and conducted in the languages in which the attending nursing home workers are proficient;

(3) must, at the end of each training session, provide attending nursing home workers with follow-up written or electronic materials on the topics covered in the training session, in order to fully inform nursing home workers of their rights and opportunities under sections 181.211 to 181.217 and other applicable laws, rules, and ordinances governing nursing home working conditions or worker health and safety;

(4) must make itself reasonably available to respond to inquiries from nursing home workers during and after training sessions; and

(5) may conduct surveys of nursing home workers who attend a training session to assess the effectiveness of the training session and industry compliance with sections 181.211 to 181.217 and other applicable laws, rules, and ordinances governing nursing home working conditions or worker health and safety.

Subd. 6. **Nursing home employer duties regarding training.** (a) A nursing home employer must ensure, and must provide proof to the commissioner of labor and industry, that every six months each of its nursing home workers completes one hour of training that meets the requirements of this section and is provided by a certified worker organization. A nursing home employer may, but is not required to, host training sessions on the premises of the nursing home.

(b) If requested by a certified worker organization, a nursing home employer must, after a training session provided by the certified worker organization, provide the certified worker organization with the names and contact information of the nursing home workers who attended the training session, unless a nursing home worker opts out according to paragraph (c).

(c) A nursing home worker may opt out of having the worker's nursing home employer provide the worker's name and contact information to a certified worker organization that provided a training session attended by the worker by submitting a written statement to that effect to the nursing home employer.

Subd. 7. **Compensation.** A nursing home employer must compensate its nursing home workers at their regular hourly rate of wages and benefits for each hour of training completed as required by this section.

Sec. 7. **[181.215] REQUIRED NOTICES.**

Subdivision 1. **Provision of notice.** (a) Nursing home employers must provide notices informing nursing home workers of the rights and obligations provided under sections 181.211 to 181.217 of applicable minimum nursing home employment standards or local minimum standards and that for assistance and information, nursing home workers should contact the Department of Labor and Industry. A nursing home employer must provide notice using the same means that the nursing home employer uses to provide other work-related notices to nursing home workers. Provision of notice must be at least as conspicuous as:

(1) posting a copy of the notice at each work site where nursing home workers work and where the notice may be readily observed and reviewed by all nursing home workers working at the site; or

(2) providing a paper or electronic copy of the notice to all nursing home workers and applicants for employment as a nursing home worker.

(b) The notice required by this subdivision must include text provided by the board that informs nursing home workers that they may request the notice to be provided in a particular language. The nursing home employer must provide the notice in the language requested by the nursing home worker. The board must assist nursing home employers in translating the notice in the languages requested by their nursing home workers.

Subd. 2. **Minimum content and posting requirements.** The board must adopt rules specifying the minimum content and posting requirements for the notices required in subdivision 1. The board must make available to nursing home employers a template or sample notice that satisfies the requirements of this section and rules adopted under this section.

Sec. 8. **[181.216] RETALIATION ON CERTAIN GROUNDS PROHIBITED.**

A nursing home employer must not retaliate against a nursing home worker, including taking retaliatory personnel action, for:

(1) exercising any right afforded to the nursing home worker under sections 181.211 to 181.217;

(2) participating in any process or proceeding under sections 181.211 to 181.217, including but not limited to board hearings, investigations, or other proceedings; or

(3) attending or participating in the training required by section 181.214.

Sec. 9. **[181.217] ENFORCEMENT.**

Subdivision 1. **Minimum nursing home employment standards.** The minimum wages, maximum hours of work, and other working conditions established by the board in rule as minimum nursing home employment standards shall be the minimum wages, maximum hours of work, and standard conditions of labor for nursing home workers or a subgroup of nursing home workers as a matter of state law. It shall be unlawful for a nursing home employer to employ a nursing home worker for lower wages or for longer hours than those established as the minimum nursing home employment standards or under any other working conditions that violate the minimum nursing home employment standards.

Subd. 2. **Investigations.** The commissioner may investigate possible violations of sections 181.214 to 181.217 or of the minimum nursing home employment standards established by the board whenever it has cause to believe that a violation has occurred, either on the basis of a report of a suspected violation or on the basis of any other credible information, including violations found during the course of an investigation.

Subd. 3. **Enforcement authority.** The Department of Labor and Industry shall enforce sections 181.214 to 181.217 and compliance with the minimum nursing home employment standards established by the board according to the authority in section 177.27, subdivisions 4 and 7.

Subd. 4. **Civil action by nursing home worker.** (a) One or more nursing home workers may bring a civil action in district court seeking redress for violations of sections 181.211 to 181.217 or of any applicable minimum nursing home employment standards or local minimum nursing home employment standards. Such an action may be filed in the district court of the county where a violation or violations are alleged to have been committed or where the nursing home employer resides, or in any other court of competent jurisdiction, and may represent a class of similarly situated nursing home workers.

(b) Upon a finding of one or more violations, a nursing home employer shall be liable to each nursing home worker for the full amount of the wages, benefits, and overtime compensation, less any amount the nursing home employer is able to establish was actually paid to each nursing home worker and for an additional equal amount as liquidated damages. In an action under this subdivision, nursing home workers may seek damages and other appropriate relief provided by section 177.27, subdivision 7, or otherwise provided by law, including reasonable costs, disbursements, witness fees, and attorney fees. A court may also issue an order requiring compliance with sections 181.211 to 181.217 or with the applicable minimum nursing home employment standards or local minimum nursing home employment

standards. A nursing home worker found to have experienced a retaliatory personnel action in violation of section 181.216 shall be entitled to reinstatement to the worker's previous position, wages, benefits, hours, and other conditions of employment.

(c) An agreement between a nursing home employer and nursing home worker or labor union that fails to meet the minimum standards and requirements in sections 181.211 to 181.217 or established by the board is not a defense to an action brought under this subdivision.

Sec. 10. Minnesota Statutes 2020, section 256B.0913, subdivision 4, is amended to read:

Subd. 4. **Eligibility for funding for services for nonmedical assistance recipients.** (a) Funding for services under the alternative care program is available to persons who meet the following criteria:

(1) the person is a citizen of the United States or a United States national;

(2) the person has been determined by a community assessment under section 256B.0911 to be a person who would require the level of care provided in a nursing facility, as determined under section 256B.0911, subdivision 4e, but for the provision of services under the alternative care program;

(3) the person is age 65 or older;

(4) the person would be eligible for medical assistance within 135 days of admission to a nursing facility;

(5) the person is not ineligible for the payment of long-term care services by the medical assistance program due to an asset transfer penalty under section 256B.0595 or equity interest in the home exceeding $500,000 as stated in section 256B.056;

(6) the person needs long-term care services that are not funded through other state or federal funding, or other health insurance or other third-party insurance such as long-term care insurance;

(7) except for individuals described in clause (8), the monthly cost of the alternative care services funded by the program for this person does not exceed 75 percent of the monthly limit described under section 256S.18. This monthly limit does not prohibit the alternative care client from payment for additional services, but in no case may the cost of additional services purchased under this section exceed the difference between the client's monthly service limit defined under section 256S.04, and the alternative care program monthly service limit defined in this paragraph. If care-related supplies and equipment or

environmental modifications and adaptations are or will be purchased for an alternative care services recipient, the costs may be prorated on a monthly basis for up to 12 consecutive months beginning with the month of purchase. If the monthly cost of a recipient's other alternative care services exceeds the monthly limit established in this paragraph, the annual cost of the alternative care services ~~shall~~ must be determined. In this event, the annual cost of alternative care services ~~shall~~ must not exceed 12 times the monthly limit described in this paragraph;

(8) for individuals assigned a case mix classification A as described under section 256S.18, with (i) no dependencies in activities of daily living, or (ii) up to two dependencies in bathing, dressing, grooming, walking, and eating when the dependency score in eating is three or greater as determined by an assessment performed under section 256B.0911, the monthly cost of alternative care services funded by the program cannot exceed $593 per month for all new participants enrolled in the program on or after July 1, 2011. This monthly limit shall be applied to all other participants who meet this criteria at reassessment. This monthly limit ~~shall~~ must be increased annually as described in section 256S.18. This monthly limit does not prohibit the alternative care client from payment for additional services, but in no case may the cost of additional services purchased exceed the difference between the client's monthly service limit defined in this clause and the limit described in clause (7) for case mix classification A; ~~and~~

(9) the person is making timely payments of the assessed monthly fee~~.~~; and

(10) for a person participating in consumer-directed community supports, the person's monthly service limit must be equal to the monthly service limits in clause (7), except that a person assigned a case mix classification L must receive the monthly service limit for case mix classification A.

A person is ineligible if payment of the fee is over 60 days past due, unless the person agrees to:

(i) the appointment of a representative payee;

(ii) automatic payment from a financial account;

(iii) the establishment of greater family involvement in the financial management of payments; or

(iv) another method acceptable to the lead agency to ensure prompt fee payments.

The lead agency may extend the client's eligibility as necessary while making arrangements to facilitate payment of past-due amounts and future premium payments.

Following disenrollment due to nonpayment of a monthly fee, eligibility ~~shall~~ must not be reinstated for a period of 30 days.

(b) Alternative care funding under this subdivision is not available for a person who is a medical assistance recipient or who would be eligible for medical assistance without a spenddown or waiver obligation. A person whose initial application for medical assistance and the elderly waiver program is being processed may be served under the alternative care program for a period up to 60 days. If the individual is found to be eligible for medical assistance, medical assistance must be billed for services payable under the federally approved elderly waiver plan and delivered from the date the individual was found eligible for the federally approved elderly waiver plan. Notwithstanding this provision, alternative care funds may not be used to pay for any service the cost of which: (i) is payable by medical assistance; (ii) is used by a recipient to meet a waiver obligation; or (iii) is used to pay a medical assistance income spenddown for a person who is eligible to participate in the federally approved elderly waiver program under the special income standard provision.

(c) Alternative care funding is not available for a person who resides in a licensed nursing home, certified boarding care home, hospital, or intermediate care facility, except for case management services which are provided in support of the discharge planning process for a nursing home resident or certified boarding care home resident to assist with a relocation process to a community-based setting.

(d) Alternative care funding is not available for a person whose income is greater than the maintenance needs allowance under section 256S.05, but equal to or less than 120 percent of the federal poverty guideline effective July 1 in the fiscal year for which alternative care eligibility is determined, who would be eligible for the elderly waiver with a waiver obligation.

EFFECTIVE DATE. This section is effective January 1, 2023.

Sec. 11. Minnesota Statutes 2020, section 256B.0913, subdivision 5, is amended to read:

Subd. 5. **Services covered under alternative care.** Alternative care funding may be used for payment of costs of:

(1) adult day services and adult day services bath;

(2) home care;

(3) homemaker services;

(4) personal care;

(5) case management and conversion case management;

(6) respite care;

(7) specialized supplies and equipment;

(8) home-delivered meals;

(9) nonmedical transportation;

(10) nursing services;

(11) chore services;

(12) companion services;

(13) nutrition services;

(14) family caregiver training and education;

(15) coaching and counseling;

(16) telehome care to provide services in their own homes in conjunction with in-home visits;

(17) consumer-directed community supports ~~under the alternative care programs which are available statewide and limited to the average monthly expenditures representative of all alternative care program participants for the same case mix resident class assigned in the most recent fiscal year for which complete expenditure data is available~~;

(18) environmental accessibility and adaptations; and

(19) discretionary services, for which lead agencies may make payment from their alternative care program allocation for services not otherwise defined in this section or section 256B.0625, following approval by the commissioner.

Total annual payments for discretionary services for all clients served by a lead agency must not exceed 25 percent of that lead agency's annual alternative care program base allocation, except that when alternative care services receive federal financial participation under the 1115 waiver demonstration, funding shall be allocated in accordance with subdivision 17.

EFFECTIVE DATE. This section is effective January 1, 2023.

Sec. 12. Minnesota Statutes 2020, section 256S.15, subdivision 2, is amended to read:

Subd. 2. **Foster care limit.** The elderly waiver payment for the foster care service in combination with the payment for all other elderly waiver services, including case

management, must not exceed the monthly case mix budget cap for the participant as specified in sections 256S.18, subdivision 3, and 256S.19, ~~subdivisions~~ subdivision 3 ~~and~~ ~~4~~.

EFFECTIVE DATE. This section is effective January 1, 2023.

Sec. 13. Minnesota Statutes 2020, section 256S.18, is amended by adding a subdivision to read:

Subd. 3a. **Monthly case mix budget caps for consumer-directed community supports.** The monthly case mix budget caps for each case mix classification for consumer-directed community supports must be equal to the monthly case mix budget caps in subdivision 3.

EFFECTIVE DATE. This section is effective January 1, 2023.

Sec. 14. Minnesota Statutes 2020, section 256S.19, subdivision 3, is amended to read:

Subd. 3. **Calculation of monthly conversion budget ~~cap without consumer-directed community supports~~ caps.** (a) The elderly waiver monthly conversion budget cap for the cost of elderly waiver services ~~without consumer-directed community supports~~ must be based on the nursing facility case mix adjusted total payment rate of the nursing facility where the elderly waiver applicant currently resides for the applicant's case mix classification as determined according to section 256R.17.

(b) The elderly waiver monthly conversion budget cap for the cost of elderly waiver services ~~without consumer-directed community supports shall~~ must be calculated by multiplying the applicable nursing facility case mix adjusted total payment rate by 365, dividing by 12, and subtracting the participant's maintenance needs allowance.

(c) A participant's initially approved monthly conversion budget cap for elderly waiver services ~~without consumer-directed community supports shall~~ must be adjusted at least annually as described in section 256S.18, subdivision 5.

(d) Conversion budget caps for individuals participating in consumer-directed community supports are also set as described in paragraphs (a) to (c).

EFFECTIVE DATE. This section is effective January 1, 2023.

Sec. 15. Minnesota Statutes 2021 Supplement, section 256S.21, is amended to read:

256S.21 RATE SETTING; APPLICATION.

The payment methodologies in sections 256S.2101 to 256S.215 apply to:

(1) elderly waiver, elderly waiver customized living, and elderly waiver foster care under this chapter;

(2) alternative care under section 256B.0913;

(3) essential community supports under section 256B.0922; ~~and~~

(4) homemaker services under the developmental disability waiver under section 256B.092 and community alternative care, community access for disability inclusion, and brain injury waiver under section 256B.49; and

(5) community access for disability inclusion customized living and brain injury customized living under section 256B.49.

EFFECTIVE DATE. This section is effective January 1, 2023.

Sec. 16. Minnesota Statutes 2021 Supplement, section 256S.2101, subdivision 2, is amended to read:

Subd. 2. **Phase-in for elderly waiver rates.** Except for home-delivered meals ~~as described in section 256S.215, subdivision 15~~, all rates and rate components for elderly waiver, elderly waiver customized living, and elderly waiver foster care under this chapter; alternative care under section 256B.0913; and essential community supports under section 256B.0922 ~~shall~~ must be the sum of ~~18.8~~ 21.6 percent of the rates calculated under sections 256S.211 to 256S.215, and ~~81.2~~ 78.4 percent of the rates calculated using the rate methodology in effect as of June 30, 2017. ~~The rate for home-delivered meals shall be the sum of the service rate in effect as of January 1, 2019, and the increases described in section 256S.215, subdivision 15.~~

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

Sec. 17. Minnesota Statutes 2021 Supplement, section 256S.2101, is amended by adding a subdivision to read:

Subd. 3. **Phase-in for home-delivered meals rate.** The home-delivered meals rate for elderly waiver under this chapter; alternative care under section 256B.0913; and essential community supports under section 256B.0922 must be the sum of 65 percent of the rate in

section 256S.215, subdivision 15, and 35 percent of the rate calculated using the rate methodology in effect as of June 30, 2017.

EFFECTIVE DATE. This section is effective January 1, 2023.

Sec. 18. Minnesota Statutes 2020, section 256S.211, is amended by adding a subdivision to read:

Subd. 3. **Updating homemaker services rates.** On January 1, 2023, and every two years thereafter, the commissioner shall recalculate rates for homemaker services as directed by section 256S.215, subdivisions 9 to 11. Prior to recalculating the rates, the commissioner shall:

(1) update the base wage index for homemaker services in section 256S.212, subdivisions 8 to 10, based on the most recently available Bureau of Labor Statistics Minneapolis-St. Paul-Bloomington, MN-WI MetroSA data;

(2) update the payroll taxes and benefits factor in section 256S.213, subdivision 1, and the general and administrative factor in section 256S.213, subdivision 2, based on the most recently available nursing facility cost report data;

(3) update the registered nurse management and supervision wage component in section 256S.213, subdivision 4, based on the most recently available Bureau of Labor Statistics Minneapolis-St. Paul-Bloomington, MN-WI MetroSA data; and

(4) update the adjusted base wage for homemaker services as directed in section 256S.214.

EFFECTIVE DATE. This section is effective January 1, 2023.

Sec. 19. Minnesota Statutes 2020, section 256S.211, is amended by adding a subdivision to read:

Subd. 4. **Updating the home-delivered meals rate.** On July 1 of each year, the commissioner shall update the home-delivered meals rate in section 256S.215, subdivision 15, by the percent increase in the nursing facility dietary per diem using the two most recent and available nursing facility cost reports.

EFFECTIVE DATE. This section is effective July 1, 2022.

Sec. 20. Minnesota Statutes 2020, section 256S.212, is amended to read:

256S.212 RATE SETTING; BASE WAGE INDEX.

Subdivision 1. **Updating SOC codes.** If any of the SOC codes and positions used in this section are no longer available, the commissioner shall, in consultation with stakeholders, select a new SOC code and position that is the closest match to the previously used SOC position.

Subd. 2. **Home management and support services base wage.** For customized living~~,~~ and foster care~~, and residential care~~ component services, the home management and support services base wage equals 33.33 percent of the Minneapolis-St. Paul-Bloomington, MN-WI MetroSA average wage for home health and personal ~~and home~~ care ~~aide~~ aides (SOC code ~~39-9021~~ 31-1120); 33.33 percent of the Minneapolis-St. Paul-Bloomington, MN-WI MetroSA average wage for food preparation workers (SOC code 35-2021); and 33.34 percent of the Minneapolis-St. Paul-Bloomington, MN-WI MetroSA average wage for maids and housekeeping cleaners (SOC code 37-2012).

Subd. 3. **Home care aide base wage.** For customized living~~,~~ and foster care~~, and residential care~~ component services, the home care aide base wage equals ~~50~~ 75 percent of the Minneapolis-St. Paul-Bloomington, MN-WI MetroSA average wage for home health and personal care aides (SOC code ~~31-1011~~ 31-1120); and ~~50~~ 25 percent of the Minneapolis-St. Paul-Bloomington, MN-WI MetroSA average wage for nursing assistants (SOC code ~~31-1014~~ 31-1131).

Subd. 4. **Home health aide base wage.** For customized living~~,~~ and foster care~~, and residential care~~ component services, the home health aide base wage equals ~~20~~ 33.33 percent of the Minneapolis-St. Paul-Bloomington, MN-WI MetroSA average wage for licensed practical and licensed vocational nurses (SOC code 29-2061); ~~and 80~~ 33.33 percent of the Minneapolis-St. Paul-Bloomington, MN-WI MetroSA average wage for nursing assistants (SOC code ~~31-1014~~ 31-1131); and 33.34 percent of the Minneapolis-St. Paul-Bloomington, MN-WI MetroSA average wage for home health and personal care aides (SOC code 31-1120).

Subd. 5. **Medication setups by licensed nurse base wage.** For customized living~~,~~ and foster care~~, and residential care~~ component services, the medication setups by licensed nurse base wage equals ~~ten~~ 25 percent of the Minneapolis-St. Paul-Bloomington, MN-WI MetroSA average wage for licensed practical and licensed vocational nurses (SOC code 29-2061); and ~~90~~ 75 percent of the Minneapolis-St. Paul-Bloomington, MN-WI MetroSA average wage for registered nurses (SOC code 29-1141).

Subd. 6. **Chore services base wage.** The chore services base wage equals ~~100~~ 50 percent of the Minneapolis-St. Paul-Bloomington, MN-WI MetroSA average wage for landscaping and groundskeeping workers (SOC code 37-3011); and 50 percent of the Minneapolis-St. Paul-Bloomington, MN-WI MetroSA average wage for maids and housekeeping cleaners (SOC code 37-2012).

Subd. 7. **Companion services base wage.** The companion services base wage equals ~~50~~ 80 percent of the Minneapolis-St. Paul-Bloomington, MN-WI MetroSA average wage for home health and personal ~~and home~~ care aides (SOC code ~~39-9021~~ 31-1120); and ~~50~~ 20 percent of the Minneapolis-St. Paul-Bloomington, MN-WI MetroSA average wage for maids and housekeeping cleaners (SOC code 37-2012).

Subd. 8. **Homemaker services and assistance with personal care base wage.** The homemaker services and assistance with personal care base wage equals ~~60~~ 50 percent of the Minneapolis-St. Paul-Bloomington, MN-WI MetroSA average wage for home health and personal ~~and home~~ care ~~aide~~ aides (SOC code ~~39-9021~~ 31-1120); ~~20~~ and 50 percent of the Minneapolis-St. Paul-Bloomington, MN-WI MetroSA average wage for nursing assistants (SOC code ~~31-1014~~ 31-1131)~~; and 20 percent of the Minneapolis-St. Paul-Bloomington, MN-WI MetroSA average wage for maids and housekeeping cleaners (SOC code 37-2012)~~.

Subd. 9. **Homemaker services and cleaning base wage.** The homemaker services and cleaning base wage equals ~~60 percent of the Minneapolis-St. Paul-Bloomington, MN-WI MetroSA average wage for personal and home care aide (SOC code 39-9021); 20 percent of the Minneapolis-St. Paul-Bloomington, MN-WI MetroSA average wage for nursing assistants (SOC code 31-1014); and 20~~ 100 percent of the Minneapolis-St. Paul-Bloomington, MN-WI MetroSA average wage for maids and housekeeping cleaners (SOC code 37-2012).

Subd. 10. **Homemaker services and home management base wage.** The homemaker services and home management base wage equals ~~60~~ 50 percent of the Minneapolis-St. Paul-Bloomington, MN-WI MetroSA average wage for home health and personal ~~and home~~ care ~~aide~~ aides (SOC code ~~39-9021~~ 31-1120); ~~20~~ and 50 percent of the Minneapolis-St. Paul-Bloomington, MN-WI MetroSA average wage for nursing assistants (SOC code ~~31-1014~~ 31-1131)~~; and 20 percent of the Minneapolis-St. Paul-Bloomington, MN-WI MetroSA average wage for maids and housekeeping cleaners (SOC code 37-2012)~~.

Subd. 11. **In-home respite care services base wage.** The in-home respite care services base wage equals ~~five~~ 15 percent of the Minneapolis-St. Paul-Bloomington, MN-WI MetroSA average wage for registered nurses (SOC code 29-1141); 75 percent of the Minneapolis-St. Paul-Bloomington, MN-WI MetroSA average wage for ~~nursing assistants~~ home health and

personal care aides (SOC code ~~31-1014~~ 31-1120); and ~~20~~ ten percent of the Minneapolis-St. Paul-Bloomington, MN-WI MetroSA average wage for licensed practical and licensed vocational nurses (SOC code 29-2061).

Subd. 12. **Out-of-home respite care services base wage.** The out-of-home respite care services base wage equals ~~five~~ 15 percent of the Minneapolis-St. Paul-Bloomington, MN-WI MetroSA average wage for registered nurses (SOC code 29-1141); 75 percent of the Minneapolis-St. Paul-Bloomington, MN-WI MetroSA average wage for ~~nursing assistants~~ home health and personal care aides (SOC code ~~31-1014~~ 31-1120); and ~~20~~ ten percent of the Minneapolis-St. Paul-Bloomington, MN-WI MetroSA average wage for licensed practical and licensed vocational nurses (SOC code 29-2061).

Subd. 13. **Individual community living support base wage.** The individual community living support base wage equals ~~20~~ 60 percent of the Minneapolis-St. Paul-Bloomington, MN-WI MetroSA average wage for ~~licensed practical and licensed vocational nurses~~ social and human services aides (SOC code ~~29-2061~~ 21-1093); and ~~80~~ 40 percent of the Minneapolis-St. Paul-Bloomington, MN-WI MetroSA average wage for nursing assistants (SOC code ~~31-1014~~ 31-1131).

Subd. 14. **Registered nurse base wage.** The registered nurse base wage equals 100 percent of the Minneapolis-St. Paul-Bloomington, MN-WI MetroSA average wage for registered nurses (SOC code 29-1141).

Subd. 15. ~~**Social worker**~~ **Unlicensed supervisor base wage.** The ~~social worker~~ unlicensed supervisor base wage equals 100 percent of the Minneapolis-St. Paul-Bloomington, MN-WI MetroSA average wage for ~~medical and public health social~~ first-line supervisors of personal service workers (SOC code ~~21-1022~~ 39-1098).

Subd. 16. **Adult day services base wage.** The adult day services base wage equals 75 percent of the Minneapolis-St. Paul-Bloomington, MN-WI MetroSA average wage for home health and personal care aides (SOC code 31-1120); and 25 percent of the Minneapolis-St. Paul-Bloomington, MN-WI MetroSA average wage for nursing assistants (SOC code 31-1131).

EFFECTIVE DATE. This section is effective January 1, 2023.

Sec. 21. Minnesota Statutes 2020, section 256S.213, is amended to read:

256S.213 RATE SETTING; FACTORS AND SUPERVISION WAGE COMPONENTS.

Subdivision 1. **Payroll taxes and benefits factor.** The payroll taxes and benefits factor is the sum of net payroll taxes and benefits, divided by the sum of all salaries for all nursing facilities on the most recent and available cost report.

Subd. 2. **General and administrative factor.** The general and administrative factor is ~~the difference of net general and administrative expenses and administrative salaries, divided by total operating expenses for all nursing facilities on the most recent and available cost report~~ 14.4 percent.

Subd. 3. **Program plan support factor.** (a) The program plan support factor is ~~12.8~~ ten percent for the following services to cover the cost of direct service staff needed to provide support for ~~home and community-based~~ the service when not engaged in direct contact with participants~~.~~:

(1) adult day services;

(2) customized living; and

(3) foster care.

(b) The program plan support factor is 15.5 percent for the following services to cover the cost of direct service staff needed to provide support for the service when not engaged in direct contact with participants:

(1) chore services;

(2) companion services;

(3) homemaker services and assistance with personal care;

(4) homemaker services and cleaning;

(5) homemaker services and home management;

(6) in-home respite care;

(7) individual community living support; and

(8) out-of-home respite care.

Subd. 4. **Registered nurse management and supervision ~~factor~~ wage component.** The registered nurse management and supervision ~~factor~~ wage component equals 15 percent of the registered nurse adjusted base wage as defined in section 256S.214.

Subd. 5. **~~Social worker~~ Unlicensed supervisor supervision ~~factor~~ wage component.** The ~~social worker~~ unlicensed supervisor supervision ~~factor~~ wage component equals 15 percent of the ~~social worker~~ unlicensed supervisor adjusted base wage as defined in section 256S.214.

Subd. 6. **Facility and equipment factor.** The facility and equipment factor for adult day services is 16.2 percent.

Subd. 7. **Food, supplies, and transportation factor.** The food, supplies, and transportation factor for adult day services is 24 percent.

Subd. 8. **Supplies and transportation factor.** The supplies and transportation factor for the following services is 1.56 percent:

(1) chore services;

(2) companion services;

(3) homemaker services and assistance with personal care;

(4) homemaker services and cleaning;

(5) homemaker services and home management;

(6) in-home respite care;

(7) individual community living support; and

(8) out-of-home respite care.

Subd. 9. **Absence factor.** The absence factor for the following services is 4.5 percent:

(1) adult day services;

(2) chore services;

(3) companion services;

(4) homemaker services and assistance with personal care;

(5) homemaker services and cleaning;

(6) homemaker services and home management;

(7) in-home respite care;

(8) individual community living support; and

(9) out-of-home respite care.

EFFECTIVE DATE. This section is effective January 1, 2023.

Sec. 22. Minnesota Statutes 2020, section 256S.214, is amended to read:

256S.214 RATE SETTING; ADJUSTED BASE WAGE.

For the purposes of section 256S.215, the adjusted base wage for each position equals the position's base wage under section 256S.212 plus:

(1) the position's base wage multiplied by the payroll taxes and benefits factor under section 256S.213, subdivision 1;

~~(2) the position's base wage multiplied by the general and administrative factor under section 256S.213, subdivision 2; and~~

~~(3)~~ (2) the position's base wage multiplied by the applicable program plan support factor under section 256S.213, subdivision 3~~.~~; and

(3) the position's base wage multiplied by the absence factor under section 256S.213, subdivision 9, if applicable.

EFFECTIVE DATE. This section is effective January 1, 2023.

Sec. 23. Minnesota Statutes 2020, section 256S.215, is amended to read:

256S.215 RATE SETTING; COMPONENT RATES.

Subdivision 1. **Medication setups by licensed nurse component rate.** The component rate for medication setups by a licensed nurse equals the medication setups by licensed nurse adjusted base wage.

Subd. 2. **Home management and support services component rate.** The component rate for home management and support services is calculated as follows:

(1) sum the home management and support services adjusted base wage ~~plus~~ and the registered nurse management and supervision ~~factor.~~ wage component;

(2) multiply the result of clause (1) by the general and administrative factor; and

(3) sum the results of clauses (1) and (2).

Subd. 3. **Home care aide services component rate.** The component rate for home care aide services is calculated as follows:

(1) sum the home health aide services adjusted base wage ~~plus~~ and the registered nurse management and supervision ~~factor.~~ wage component;

(2) multiply clause (1) by the general and administrative factor; and

(3) sum the results of clauses (1) and (2).

Subd. 4. **Home health aide services component rate.** The component rate for home health aide services is calculated as follows:

(1) sum the home health aide services adjusted base wage ~~plus~~ and the registered nurse management and supervision ~~factor.~~ wage component;

(2) multiply the result of clause (1) by the general and administrative factor; and

(3) sum the results of clauses (1) and (2).

Subd. 5. **Socialization component rate.** The component rate under elderly waiver customized living for one-to-one socialization equals the home management and support services component rate.

Subd. 6. **Transportation component rate.** The component rate under elderly waiver customized living for one-to-one transportation equals the home management and support services component rate.

Subd. 7. **Chore services rate.** The 15-minute unit rate for chore services is calculated as follows:

(1) sum the chore services adjusted base wage and the ~~social worker~~ unlicensed supervisor supervision ~~factor~~ wage component; ~~and~~

(2) multiply the result of clause (1) by the general and administrative factor;

(3) multiply the result of clause (1) by the supplies and transportation factor; and

(4) sum the results of clauses (1) to (3) and divide the result ~~of clause (1)~~ by four.

Subd. 8. **Companion services rate.** The 15-minute unit rate for companion services is calculated as follows:

(1) sum the companion services adjusted base wage and the ~~social worker~~ unlicensed supervisor supervision ~~factor~~ wage component; ~~and~~

(2) multiply the result of clause (1) by the general and administrative factor;

(3) multiply the result of clause (1) by the supplies and transportation factor; and

(4) sum the results of clauses (1) to (3) and divide the result ~~of clause (1)~~ by four.

Subd. 9. **Homemaker services and assistance with personal care rate.** The 15-minute unit rate for homemaker services and assistance with personal care is calculated as follows:

(1) sum the homemaker services and assistance with personal care adjusted base wage and the ~~registered nurse management and~~ unlicensed supervisor supervision ~~factor~~ wage component; ~~and~~

(2) multiply the result of clause (1) by the general and administrative factor;

(3) multiply the result of clause (1) by the supplies and transportation factor; and

(4) sum the results of clauses (1) to (3) and divide the result ~~of clause (1)~~ by four.

Subd. 10. **Homemaker services and cleaning rate.** The 15-minute unit rate for homemaker services and cleaning is calculated as follows:

(1) sum the homemaker services and cleaning adjusted base wage and the ~~registered nurse management and~~ unlicensed supervisor supervision ~~factor~~ base wage; ~~and~~

(2) multiply the result of clause (1) by the general and administrative factor;

(3) multiply the result of clause (1) by the supplies and transportation factor; and

(4) sum the results of clauses (1) to (3) and divide the result ~~of clause (1)~~ by four.

Subd. 11. **Homemaker services and home management rate.** The 15-minute unit rate for homemaker services and home management is calculated as follows:

(1) sum the homemaker services and home management adjusted base wage and the ~~registered nurse management and~~ unlicensed supervisor supervision ~~factor~~ wage component; ~~and~~

(2) multiply the result of clause (1) by the general and administrative factor;

(3) multiply the result of clause (1) by the supplies and transportation factor; and

(4) sum the results of clauses (1) to (3) and divide the result ~~of clause (1)~~ by four.

Subd. 12. **In-home respite care services rates.** (a) The 15-minute unit rate for in-home respite care services is calculated as follows:

(1) sum the in-home respite care services adjusted base wage and the registered nurse management and supervision ~~factor~~ wage component; ~~and~~

(2) multiply the result of clause (1) by the general and administrative factor;

(3) multiply the result of clause (1) by the supplies and transportation factor; and

(4) sum the results of clauses (1) to (3) and divide the result ~~of clause (1)~~ by four.

(b) The in-home respite care services daily rate equals the in-home respite care services 15-minute unit rate multiplied by 18.

Subd. 13. **Out-of-home respite care services rates.** (a) The 15-minute unit rate for out-of-home respite care is calculated as follows:

(1) sum the out-of-home respite care services adjusted base wage and the registered nurse management and supervision ~~factor~~ wage component; ~~and~~

(2) multiply the result of clause (1) by the general and administrative factor;

(3) multiply the result of clause (1) by the supplies and transportation factor; and

(4) sum the results of clauses (1) to (3) and divide the result ~~of clause (1)~~ by four.

(b) The out-of-home respite care services daily rate equals the 15-minute unit rate for out-of-home respite care services multiplied by 18.

Subd. 14. **Individual community living support rate.** The individual community living support rate is calculated as follows:

(1) sum the ~~home care aide~~ individual community living support adjusted base wage and the ~~social worker~~ registered nurse management and supervision ~~factor~~ wage component; ~~and~~

(2) multiply the result of clause (1) by the general and administrative factor;

(3) multiply the result of clause (1) by the supplies and transportation factor; and

(4) sum the results of clauses (1) to (3) and divide the result ~~of clause (1)~~ by four.

Subd. 15. **Home-delivered meals rate.** The home-delivered meals rate equals ~~$9.30~~ $8.17. ~~The commissioner shall increase the home delivered meals rate every July 1 by the percent increase in the nursing facility dietary per diem using the two most recent and available nursing facility cost reports.~~

Subd. 16. **Adult day services rate.** The 15-minute unit rate for adult day services~~, with an assumed staffing ratio of one staff person to four participants, is the sum of~~ is calculated as follows:

(1) ~~one-sixteenth of the home care aide~~ divide the adult day services adjusted base wage~~, except that the general and administrative factor used to determine the home care aide services adjusted base wage is 20 percent~~ by five to reflect an assumed staffing ratio of one to five;

(2) ~~one-fourth of the registered nurse management and supervision factor~~ sum the result of clause (1) and the registered nurse management and supervision wage component; ~~and~~

(3) ~~$0.63 to cover the cost of meals.~~ multiply the result of clause (2) by the general and administrative factor;

(4) multiply the result of clause (2) by the facility and equipment factor;

(5) multiply the result of clause (2) by the food, supplies, and transportation factor; and

(6) sum the results of clauses (2) to (5) and divide the result by four.

Subd. 17. **Adult day services bath rate.** The 15-minute unit rate for adult day services bath is ~~the sum of~~ calculated as follows:

(1) ~~one-fourth of the home care aide~~ sum the adult day services adjusted base wage~~,~~ ~~except that the general and administrative factor used to determine the home care aide services adjusted base wage is 20 percent~~ and the nurse management and supervision wage component;

(2) ~~one-fourth of the registered nurse management and supervision factor~~ multiply the result of clause (1) by the general and administrative factor; ~~and~~

(3) ~~$0.63 to cover the cost of meals.~~ multiply the result of clause (1) by the facility and equipment factor;

(4) multiply the result of clause (1) by the food, supplies, and transportation factor; and

(5) sum the results of clauses (1) to (4) and divide the result by four.

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

Sec. 24. **DIRECTION TO COMMISSIONER; INITIAL PACE IMPLEMENTATION FUNDING.**

The commissioner of human services must work with stakeholders to develop recommendations for financing mechanisms to complete the actuarial work and cover the administrative costs of a program of all-inclusive care for the elderly (PACE). The commissioner must recommend a financing mechanism that could begin July 1, 2024. By December 15, 2023, the commissioner shall inform the chairs and ranking minority members of the legislative committees with jurisdiction over health care funding on the commissioner's progress toward developing a recommended financing mechanism.

Sec. 25. **TITLE.**

Sections 181.212 to 181.217 shall be known as the "Minnesota Nursing Home Workforce Standards Board Act."

Sec. 26. **INITIAL APPOINTMENTS.**

The governor shall make initial appointments to the Minnesota Nursing Home Workforce Standards Board under Minnesota Statutes, section 181.212, no later than August 1, 2022.

Sec. 27. **REVISOR INSTRUCTION.**

(a) In Minnesota Statutes, chapter 256S, the revisor of statutes shall change the following terms:

(1) "homemaker services and assistance with personal care" to "homemaker assistance with personal care services";

(2) "homemaker services and cleaning" to "homemaker cleaning services"; and

(3) "homemaker services and home management" to "homemaker home management services" wherever the terms appear.

(b) The revisor shall also make necessary grammatical changes related to the changes in terms.

Sec. 28. **REPEALER.**

Minnesota Statutes 2020, section 256S.19, subdivision 4, is repealed.

EFFECTIVE DATE. This section is effective January 1, 2023.

ARTICLE 13
CHILD AND VULNERABLE ADULT PROTECTION POLICY

Section 1. Minnesota Statutes 2020, section 260.012, is amended to read:

260.012 DUTY TO ENSURE PLACEMENT PREVENTION AND FAMILY REUNIFICATION; REASONABLE EFFORTS.

(a) Once a child alleged to be in need of protection or services is under the court's jurisdiction, the court shall ensure that reasonable efforts, including culturally appropriate services and practices, by the social services agency are made to prevent placement or to eliminate the need for removal and to reunite the child with the child's family at the earliest possible time, and the court must ensure that the responsible social services agency makes

reasonable efforts to finalize an alternative permanent plan for the child as provided in paragraph (e). In determining reasonable efforts to be made with respect to a child and in making those reasonable efforts, the child's best interests, health, and safety must be of paramount concern. Reasonable efforts to prevent placement and for rehabilitation and reunification are always required except upon a determination by the court that a petition has been filed stating a prima facie case that:

(1) the parent has subjected a child to egregious harm as defined in section 260C.007, subdivision 14;

(2) the parental rights of the parent to another child have been terminated involuntarily;

(3) the child is an abandoned infant under section 260C.301, subdivision 2, paragraph (a), clause (2);

(4) the parent's custodial rights to another child have been involuntarily transferred to a relative under Minnesota Statutes 2010, section 260C.201, subdivision 11, paragraph (d), clause (1), section 260C.515, subdivision 4, or a similar law of another jurisdiction;

(5) the parent has committed sexual abuse as defined in section 260E.03, against the child or another child of the parent;

(6) the parent has committed an offense that requires registration as a predatory offender under section 243.166, subdivision 1b, paragraph (a) or (b); or

(7) the provision of services or further services for the purpose of reunification is futile and therefore unreasonable under the circumstances.

(b) When the court makes one of the prima facie determinations under paragraph (a), either permanency pleadings under section 260C.505, or a termination of parental rights petition under sections 260C.141 and 260C.301 must be filed. A permanency hearing under sections 260C.503 to 260C.521 must be held within 30 days of this determination.

(c) In the case of an Indian child, in proceedings under sections 260B.178, 260C.178, 260C.201, 260C.202, 260C.204, 260C.301, or 260C.503 to 260C.521, the juvenile court must make findings and conclusions consistent with the Indian Child Welfare Act of 1978, United States Code, title 25, section 1901 et seq., as to the provision of active efforts. In cases governed by the Indian Child Welfare Act of 1978, United States Code, title 25, section 1901, the responsible social services agency must provide active efforts as required under United States Code, title 25, section 1911(d).

(d) "Reasonable efforts to prevent placement" means:

(1) the agency has made reasonable efforts to prevent the placement of the child in foster care by working with the family to develop and implement a safety plan that is individualized to the needs of the child and the child's family and may include support persons from the child's extended family, kin network, and community; or

(2) the agency has demonstrated to the court that, given the particular circumstances of the child and family at the time of the child's removal, there are no services or efforts available ~~which~~ that could allow the child to safely remain in the home.

(e) "Reasonable efforts to finalize a permanent plan for the child" means due diligence by the responsible social services agency to:

(1) reunify the child with the parent or guardian from whom the child was removed;

(2) assess a noncustodial parent's ability to provide day-to-day care for the child and, where appropriate, provide services necessary to enable the noncustodial parent to safely provide the care, as required by section 260C.219;

(3) conduct a relative search to identify and provide notice to adult relatives, and engage relatives in case planning and permanency planning, as required under section 260C.221;

(4) consider placing the child with relatives in the order specified in section 260C.212, subdivision 2, paragraph (a);

~~(4)~~ (5) place siblings removed from their home in the same home for foster care or adoption, or transfer permanent legal and physical custody to a relative. Visitation between siblings who are not in the same foster care, adoption, or custodial placement or facility shall be consistent with section 260C.212, subdivision 2; and

~~(5)~~ (6) when the child cannot return to the parent or guardian from whom the child was removed, to plan for and finalize a safe and legally permanent alternative home for the child, and considers permanent alternative homes for the child inside or outside of the state, preferably with a relative in the order specified in section 260C.212, subdivision 2, paragraph (a), through adoption or transfer of permanent legal and physical custody of the child.

(f) Reasonable efforts are made upon the exercise of due diligence by the responsible social services agency to use culturally appropriate and available services to meet the individualized needs of the child and the child's family. Services may include those provided by the responsible social services agency and other culturally appropriate services available in the community. The responsible social services agency must select services for a child and the child's family by collaborating with the child's family and, if appropriate, the child. At each stage of the proceedings ~~where~~ when the court is required to review the

appropriateness of the responsible social services agency's reasonable efforts as described in paragraphs (a), (d), and (e), the social services agency has the burden of demonstrating that:

(1) ~~it~~ the agency has made reasonable efforts to prevent placement of the child in foster care, including that the agency considered or established a safety plan according to paragraph (d), clause (1);

(2) ~~it~~ the agency has made reasonable efforts to eliminate the need for removal of the child from the child's home and to reunify the child with the child's family at the earliest possible time;

(3) the agency has made reasonable efforts to finalize a permanent plan for the child pursuant to paragraph (e);

~~(3) it~~ (4) the agency has made reasonable efforts to finalize an alternative permanent home for the child, and ~~considers~~ considered permanent alternative homes for the child ~~inside or outside~~ in or out of the state, preferably with a relative in the order specified in section 260C.212, subdivision 2, paragraph (a); or

~~(4)~~ (5) reasonable efforts to prevent placement and to reunify the child with the parent or guardian are not required. The agency may meet this burden by stating facts in a sworn petition filed under section 260C.141, by filing an affidavit summarizing the agency's reasonable efforts or facts that the agency believes demonstrate that there is no need for reasonable efforts to reunify the parent and child, or through testimony or a certified report required under juvenile court rules.

(g) Once the court determines that reasonable efforts for reunification are not required because the court has made one of the prima facie determinations under paragraph (a), the court may only require the agency to make reasonable efforts for reunification after a hearing according to section 260C.163, ~~where~~ if the court finds that there is not clear and convincing evidence of the facts upon which the court based ~~its~~ the court's prima facie determination. ~~In this case when~~ If there is clear and convincing evidence that the child is in need of protection or services, the court may find the child in need of protection or services and order any of the dispositions available under section 260C.201, subdivision 1. Reunification of a child with a parent is not required if the parent has been convicted of:

(1) a violation of, or an attempt or conspiracy to commit a violation of, sections 609.185 to 609.20; 609.222, subdivision 2; or 609.223 in regard to another child of the parent;

(2) a violation of section 609.222, subdivision 2; or 609.223, in regard to the child;

(3) a violation of, or an attempt or conspiracy to commit a violation of, United States Code, title 18, section 1111(a) or 1112(a), in regard to another child of the parent;

(4) committing sexual abuse as defined in section 260E.03, against the child or another child of the parent; or

(5) an offense that requires registration as a predatory offender under section 243.166, subdivision 1b, paragraph (a) or (b).

(h) The juvenile court, in proceedings under sections 260B.178, 260C.178, 260C.201, 260C.202, 260C.204, 260C.301, or 260C.503 to 260C.521, shall make findings and conclusions as to the provision of reasonable efforts. When determining whether reasonable efforts have been made by the agency, the court shall consider whether services to the child and family were:

(1) selected in collaboration with the child's family and, if appropriate, the child;

(2) tailored to the individualized needs of the child and child's family;

~~(1)~~ (3) relevant to the safety ~~and~~, protection, and well-being of the child;

~~(2)~~ (4) adequate to meet the individualized needs of the child and family;

~~(3)~~ (5) culturally appropriate;

~~(4)~~ (6) available and accessible;

~~(5)~~ (7) consistent and timely; and

~~(6)~~ (8) realistic under the circumstances.

In the alternative, the court may determine that the provision of services or further services for the purpose of rehabilitation is futile and therefore unreasonable under the circumstances or that reasonable efforts are not required as provided in paragraph (a).

(i) This section does not prevent out-of-home placement for the treatment of a child with a mental disability when it is determined to be medically necessary as a result of the child's diagnostic assessment or the child's individual treatment plan indicates that appropriate and necessary treatment cannot be effectively provided outside of a residential or inpatient treatment program and the level or intensity of supervision and treatment cannot be effectively and safely provided in the child's home or community and it is determined that a residential treatment setting is the least restrictive setting that is appropriate to the needs of the child.

(j) If continuation of reasonable efforts to prevent placement or reunify the child with the parent or guardian from whom the child was removed is determined by the court to be inconsistent with the permanent plan for the child or upon the court making one of the prima facie determinations under paragraph (a), reasonable efforts must be made to place the child in a timely manner in a safe and permanent home and to complete whatever steps are necessary to legally finalize the permanent placement of the child.

(k) Reasonable efforts to place a child for adoption or in another permanent placement may be made concurrently with reasonable efforts to prevent placement or to reunify the child with the parent or guardian from whom the child was removed. When the responsible social services agency decides to concurrently make reasonable efforts for both reunification and permanent placement away from the parent under paragraph (a), the agency shall disclose ~~its~~ the agency's decision and both plans for concurrent reasonable efforts to all parties and the court. When the agency discloses ~~its~~ the agency's decision to proceed ~~on~~ with both plans for reunification and permanent placement away from the parent, the court's review of the agency's reasonable efforts shall include the agency's efforts under both plans.

Sec. 2. Minnesota Statutes 2020, section 260C.001, subdivision 3, is amended to read:

Subd. 3. **Permanency, termination of parental rights, and adoption.** The purpose of the laws relating to permanency, termination of parental rights, and children who come under the guardianship of the commissioner of human services is to ensure that:

(1) when required and appropriate, reasonable efforts have been made by the social services agency to reunite the child with the child's parents in a home that is safe and permanent;

(2) if placement with the parents is not reasonably foreseeable, to secure for the child a safe and permanent placement according to the requirements of section 260C.212, subdivision 2, preferably ~~with adoptive parents~~ with a relative through an adoption or a transfer of permanent legal and physical custody or, if that is not possible or in the best interests of the child, ~~a fit and willing relative through transfer of permanent legal and physical custody to that relative~~ with a nonrelative caregiver through adoption; and

(3) when a child is under the guardianship of the commissioner of human services, reasonable efforts are made to finalize an adoptive home for the child in a timely manner.

Nothing in this section requires reasonable efforts to prevent placement or to reunify the child with the parent or guardian to be made in circumstances where the court has determined that the child has been subjected to egregious harm, when the child is an

abandoned infant, the parent has involuntarily lost custody of another child through a proceeding under section 260C.515, subdivision 4, or similar law of another state, the parental rights of the parent to a sibling have been involuntarily terminated, or the court has determined that reasonable efforts or further reasonable efforts to reunify the child with the parent or guardian would be futile.

The paramount consideration in all proceedings for permanent placement of the child under sections 260C.503 to 260C.521, or the termination of parental rights is the best interests of the child. In proceedings involving an American Indian child, as defined in section 260.755, subdivision 8, the best interests of the child must be determined consistent with the Indian Child Welfare Act of 1978, United States Code, title 25, section 1901, et seq.

Sec. 3. Minnesota Statutes 2020, section 260C.007, subdivision 27, is amended to read:

Subd. 27. **Relative.** "Relative" means a person related to the child by blood, marriage, or adoption; the legal parent, guardian, or custodian of the child's siblings; or an individual who is an important friend of the child or of the child's parent or custodian, including an individual with whom the child has resided or had significant contact or who has a significant relationship to the child or the child's parent or custodian.

Sec. 4. Minnesota Statutes 2020, section 260C.151, subdivision 6, is amended to read:

Subd. 6. **Immediate custody.** If the court makes individualized, explicit findings, based on the notarized petition or sworn affidavit, that there are reasonable grounds to believe that the child is in surroundings or conditions ~~which~~ that endanger the child's health, safety, or welfare that require that responsibility for the child's care and custody be immediately assumed by the responsible social services agency and that continuation of the child in the custody of the parent or guardian is contrary to the child's welfare, the court may order that the officer serving the summons take the child into immediate custody for placement of the child in foster care, preferably with a relative. In ordering that responsibility for the care, custody, and control of the child be assumed by the responsible social services agency, the court is ordering emergency protective care as that term is defined in the juvenile court rules.

Sec. 5. Minnesota Statutes 2020, section 260C.152, subdivision 5, is amended to read:

Subd. 5. **Notice to foster parents and preadoptive parents and relatives.** The foster parents, if any, of a child and any preadoptive parent or relative providing care for the child must be provided notice of and a right to be heard in any review or hearing to be held with

respect to the child. Any other relative may also request, and must be granted, a notice and the ~~opportunity~~ right to be heard under this section. This subdivision does not require that a foster parent, preadoptive parent, or any relative providing care for the child be made a party to a review or hearing solely on the basis of the notice and right to be heard.

Sec. 6. Minnesota Statutes 2020, section 260C.175, subdivision 2, is amended to read:

Subd. 2. **Notice to parent or custodian and child; emergency placement with relative.** ~~Whenever~~ (a) At the time that a peace officer takes a child into custody for relative placement or shelter care ~~or relative placement~~ pursuant to subdivision 1, section 260C.151, subdivision 5, or section 260C.154, the officer shall notify the child's parent or custodian and the child, if the child is ten years of age or older, that under section 260C.181, subdivision 2, the parent or custodian or the child may request ~~that~~ to place the child ~~be placed~~ with a relative ~~or a designated caregiver under~~ as defined in section 260C.007, subdivision 27, ~~chapter 257A~~ instead of in a shelter care facility. When a child who is not alleged to be delinquent is taken into custody pursuant to subdivision 1, clause (1) or (2), item (ii), and placement with an identified relative is requested, the peace officer shall coordinate with the responsible social services agency to ensure the child's safety and well-being, and comply with section 260C.181, subdivision 2.

(c) The officer also shall give the parent or custodian of the child a list of names, addresses, and telephone numbers of social services agencies that offer child welfare services. If the parent or custodian was not present when the child was removed from the residence, the list shall be left with an adult on the premises or left in a conspicuous place on the premises if no adult is present. If the officer has reason to believe the parent or custodian is not able to read and understand English, the officer must provide a list that is written in the language of the parent or custodian. The list shall be prepared by the commissioner of human services. The commissioner shall prepare lists for each county and provide each county with copies of the list without charge. The list shall be reviewed annually by the commissioner and updated if it is no longer accurate. Neither the commissioner nor any peace officer or the officer's employer shall be liable to any person for mistakes or omissions in the list. The list does not constitute a promise that any agency listed will ~~in fact~~ assist the parent or custodian.

Sec. 7. Minnesota Statutes 2020, section 260C.176, subdivision 2, is amended to read:

Subd. 2. **Reasons for detention.** (a) If the child is not released as provided in subdivision 1, the person taking the child into custody shall notify the court as soon as possible of the detention of the child and the reasons for detention.

(b) No child taken into custody and placed in a relative's home or shelter care facility ~~or relative's home~~ by a peace officer pursuant to section 260C.175, subdivision 1, clause (1) or (2), item (ii), may be held in custody longer than 72 hours, excluding Saturdays, Sundays and holidays, unless a petition has been filed and the judge or referee determines pursuant to section 260C.178 that the child shall remain in custody or unless the court has made a finding of domestic abuse perpetrated by a minor after a hearing under Laws 1997, chapter 239, article 10, sections 2 to 26, in which case the court may extend the period of detention for an additional seven days, within which time the social services agency shall conduct an assessment and shall provide recommendations to the court regarding voluntary services or file a child in need of protection or services petition.

Sec. 8. Minnesota Statutes 2020, section 260C.178, subdivision 1, is amended to read:

Subdivision 1. **Hearing and release requirements.** (a) If a child was taken into custody under section 260C.175, subdivision 1, clause (1) or (2), item (ii), the court shall hold a hearing within 72 hours of the time that the child was taken into custody, excluding Saturdays, Sundays, and holidays, to determine whether the child should continue to be in custody.

(b) Unless there is reason to believe that the child would endanger self or others or not return for a court hearing, or that the child's health or welfare would be immediately endangered, the child shall be released to the custody of a parent, guardian, custodian, or other suitable person, subject to reasonable conditions of release including, but not limited to, a requirement that the child undergo a chemical use assessment as provided in section 260C.157, subdivision 1.

(c) If the court determines that there is reason to believe that the child would endanger self or others or not return for a court hearing, or that the child's health or welfare would be immediately endangered if returned to the care of the parent or guardian who has custody and from whom the child was removed, the court shall order the child:

(1) into the care of the child's noncustodial parent and order the noncustodial parent to comply with any conditions that the court determines appropriate to ensure the safety and care of the child, including requiring the noncustodial parent to cooperate with paternity

establishment proceedings if the noncustodial parent has not been adjudicated the child's father; or

(2) into foster care as defined in section 260C.007, subdivision 18, under the legal responsibility of the responsible social services agency or responsible probation or corrections agency for the purposes of protective care as that term is used in the juvenile court rules ~~or into the home of a noncustodial parent and order the noncustodial parent to comply with any conditions the court determines to be appropriate to the safety and care of the child, including cooperating with paternity establishment proceedings in the case of a man who has not been adjudicated the child's father~~. The court shall not give the responsible social services legal custody and order a trial home visit at any time prior to adjudication and disposition under section 260C.201, subdivision 1, paragraph (a), clause (3), but may order the child returned to the care of the parent or guardian who has custody and from whom the child was removed and order the parent or guardian to comply with any conditions the court determines to be appropriate to meet the safety, health, and welfare of the child.

(d) In determining whether the child's health or welfare would be immediately endangered, the court shall consider whether the child would reside with a perpetrator of domestic child abuse.

(e) The court, before determining whether a child should be placed in or continue in foster care under the protective care of the responsible agency, shall also make a determination, consistent with section 260.012 as to whether reasonable efforts were made to prevent placement or whether reasonable efforts to prevent placement are not required. In the case of an Indian child, the court shall determine whether active efforts, according to section 260.762 and the Indian Child Welfare Act of 1978, United States Code, title 25, section 1912(d), were made to prevent placement. The court shall enter a finding that the responsible social services agency has made reasonable efforts to prevent placement when the agency establishes either:

(1) that ~~it~~ the agency has actually provided services or made efforts in an attempt to prevent the child's removal but that such services or efforts have not proven sufficient to permit the child to safely remain in the home; or

(2) that there are no services or other efforts that could be made at the time of the hearing that could safely permit the child to remain home or to return home. The court shall not make a reasonable efforts determination under this clause unless the court is satisfied that the agency has sufficiently demonstrated to the court that there were no services or other efforts that the agency was able to provide at the time of the hearing enabling the child to

safely remain home or to safely return home. When reasonable efforts to prevent placement are required and there are services or other efforts that could be ordered ~~which~~ that would permit the child to safely return home, the court shall order the child returned to the care of the parent or guardian and the services or efforts put in place to ensure the child's safety. When the court makes a prima facie determination that one of the circumstances under paragraph (g) exists, the court shall determine that reasonable efforts to prevent placement and to return the child to the care of the parent or guardian are not required.

(f) If the court finds the social services agency's preventive or reunification efforts have not been reasonable but further preventive or reunification efforts could not permit the child to safely remain at home, the court may nevertheless authorize or continue the removal of the child.

~~(f)~~ (g) The court may not order or continue the foster care placement of the child unless the court makes explicit, individualized findings that continued custody of the child by the parent or guardian would be contrary to the welfare of the child and that placement is in the best interest of the child.

~~(g)~~ (h) At the emergency removal hearing, or at any time during the course of the proceeding, and upon notice and request of the county attorney, the court shall determine whether a petition has been filed stating a prima facie case that:

(1) the parent has subjected a child to egregious harm as defined in section 260C.007, subdivision 14;

(2) the parental rights of the parent to another child have been involuntarily terminated;

(3) the child is an abandoned infant under section 260C.301, subdivision 2, paragraph (a), clause (2);

(4) the parents' custodial rights to another child have been involuntarily transferred to a relative under Minnesota Statutes 2010, section 260C.201, subdivision 11, paragraph (e), clause (1); section 260C.515, subdivision 4; or a similar law of another jurisdiction;

(5) the parent has committed sexual abuse as defined in section 260E.03, against the child or another child of the parent;

(6) the parent has committed an offense that requires registration as a predatory offender under section 243.166, subdivision 1b, paragraph (a) or (b); or

(7) the provision of services or further services for the purpose of reunification is futile and therefore unreasonable.

~~(h)~~ (i) When a petition to terminate parental rights is required under section 260C.301, subdivision 4, or 260C.503, subdivision 2, but the county attorney has determined not to proceed with a termination of parental rights petition, and has instead filed a petition to transfer permanent legal and physical custody to a relative under section 260C.507, the court shall schedule a permanency hearing within 30 days of the filing of the petition.

~~(i)~~ (j) If the county attorney has filed a petition under section 260C.307, the court shall schedule a trial under section 260C.163 within 90 days of the filing of the petition except when the county attorney determines that the criminal case shall proceed to trial first under section 260C.503, subdivision 2, paragraph (c).

~~(j)~~ (k) If the court determines the child should be ordered into foster care and the child's parent refuses to give information to the responsible social services agency regarding the child's father or relatives of the child, the court may order the parent to disclose the names, addresses, telephone numbers, and other identifying information to the responsible social services agency for the purpose of complying with sections 260C.150, 260C.151, 260C.212, 260C.215, 260C.219, and 260C.221.

~~(k)~~ (l) If a child ordered into foster care has siblings, whether full, half, or step, who are also ordered into foster care, the court shall inquire of the responsible social services agency of the efforts to place the children together as required by section 260C.212, subdivision 2, paragraph (d), if placement together is in each child's best interests, unless a child is in placement for treatment or a child is placed with a previously noncustodial parent who is not a parent to all siblings. If the children are not placed together at the time of the hearing, the court shall inquire at each subsequent hearing of the agency's reasonable efforts to place the siblings together, as required under section 260.012. If any sibling is not placed with another sibling or siblings, the agency must develop a plan to facilitate visitation or ongoing contact among the siblings as required under section 260C.212, subdivision 1, unless it is contrary to the safety or well-being of any of the siblings to do so.

~~(l)~~ (m) When the court has ordered the child into the care of a noncustodial parent or in foster care ~~or into the home of a noncustodial parent~~, the court may order a chemical dependency evaluation, mental health evaluation, medical examination, and parenting assessment for the parent as necessary to support the development of a plan for reunification required under subdivision 7 and section 260C.212, subdivision 1, or the child protective services plan under section 260E.26, and Minnesota Rules, part 9560.0228.

Sec. 9. Minnesota Statutes 2020, section 260C.181, subdivision 2, is amended to read:

Subd. 2. **Least restrictive setting.** Notwithstanding the provisions of subdivision 1, if the child had been taken into custody pursuant to section 260C.175, subdivision 1, clause (1) or (2), item (ii), and is not alleged to be delinquent, the child shall be detained in the least restrictive setting consistent with the child's health and welfare and in closest proximity to the child's family as possible. Placement may be with a child's relative~~, a designated caregiver under chapter 257A,~~ or, if no placement is available with a relative, in a shelter care facility. The placing officer shall comply with this section and shall document why a less restrictive setting will or will not be in the best interests of the child for placement purposes.

Sec. 10. Minnesota Statutes 2020, section 260C.193, subdivision 3, is amended to read:

Subd. 3. **Best interests of the child.** (a) The policy of the state is to ensure that the best interests of children in foster care, who experience a transfer of permanent legal and physical custody to a relative under section 260C.515, subdivision 4, or adoption under this chapter, are met by:

(1) considering placement of a child with relatives in the order specified in section 260C.212, subdivision 2, paragraph (a); and

(2) requiring individualized determinations under section 260C.212, subdivision 2, paragraph (b), of the needs of the child and of how the selected home will serve the needs of the child.

(b) No later than three months after a child is ordered to be removed from the care of a parent in the hearing required under section 260C.202, the court shall review and enter findings regarding whether the responsible social services agency ~~made~~:

(1) ~~diligent efforts~~ exercised due diligence to identify ~~and~~, search for, notify, and engage relatives as required under section 260C.221; and

(2) made a placement consistent with section 260C.212, subdivision 2, that is based on an individualized determination ~~as required under section 260C.212, subdivision 2,~~ of the child's needs to select a home that meets the needs of the child.

(c) If the court finds that the agency has not ~~made efforts~~ exercised due diligence as required under section 260C.221, ~~and~~ the court shall order the agency to make reasonable efforts. If there is a relative who qualifies to be licensed to provide family foster care under chapter 245A, the court may order the child to be placed with the relative consistent with the child's best interests.

(d) If the agency's efforts under section 260C.221 are found by the court to be sufficient, the court shall order the agency to continue to appropriately engage relatives who responded to the notice under section 260C.221 in placement and case planning decisions and to appropriately engage relatives who subsequently come to the agency's attention. A court's finding that the agency has made reasonable efforts under this paragraph does not relieve the agency of the duty to continue notifying relatives who come to the agency's attention and engaging and considering relatives who respond to the notice under section 260C.221 in child placement and case planning decisions.

(e) If the child's birth parent ~~or parents~~ explicitly ~~request~~ requests that a specific relative ~~or important friend~~ not be considered for placement of the child, the court shall honor that request if it is consistent with the best interests of the child and consistent with the requirements of section 260C.221. The court shall not waive relative search, notice, and consideration requirements, unless section 260C.139 applies. If the child's birth parent ~~or parents express~~ expresses a preference for placing the child in a foster or adoptive home of the same or a similar religious background ~~to~~ as that of the birth parent or parents, the court shall order placement of the child with an individual who meets the birth parent's religious preference.

(f) Placement of a child ~~cannot~~ must not be delayed or denied based on race, color, or national origin of the foster parent or the child.

(g) Whenever possible, siblings requiring foster care placement ~~should~~ shall be placed together unless it is determined not to be in the best interests of one or more of the siblings after weighing the benefits of separate placement against the benefits of sibling connections for each sibling. The agency shall consider section 260C.008 when making this determination. If siblings were not placed together according to section 260C.212, subdivision 2, paragraph (d), the responsible social services agency shall report to the court the efforts made to place the siblings together and why the efforts were not successful. If the court is not satisfied that the agency has made reasonable efforts to place siblings together, the court must order the agency to make further reasonable efforts. If siblings are not placed together, the court shall order the responsible social services agency to implement the plan for visitation among siblings required as part of the out-of-home placement plan under section 260C.212.

(h) This subdivision does not affect the Indian Child Welfare Act, United States Code, title 25, sections 1901 to 1923, and the Minnesota Indian Family Preservation Act, sections 260.751 to 260.835.

Sec. 11. Minnesota Statutes 2020, section 260C.201, subdivision 1, is amended to read:

Subdivision 1. **Dispositions.** (a) If the court finds that the child is in need of protection or services or neglected and in foster care, ~~it~~ the court shall enter an order making any of the following dispositions of the case:

(1) place the child under the protective supervision of the responsible social services agency or child-placing agency in the home of a parent of the child under conditions prescribed by the court directed to the correction of the child's need for protection or services:

(i) the court may order the child into the home of a parent who does not otherwise have legal custody of the child, however, an order under this section does not confer legal custody on that parent;

(ii) if the court orders the child into the home of a father who is not adjudicated, the father must cooperate with paternity establishment proceedings regarding the child in the appropriate jurisdiction as one of the conditions prescribed by the court for the child to continue in the father's home; and

(iii) the court may order the child into the home of a noncustodial parent with conditions and may also order both the noncustodial and the custodial parent to comply with the requirements of a case plan under subdivision 2; or

(2) transfer legal custody to one of the following:

(i) a child-placing agency; or

(ii) the responsible social services agency. In making a foster care placement ~~for~~ of a child whose custody has been transferred under this subdivision, the agency shall make an individualized determination of how the placement is in the child's best interests using the placement consideration order for relatives~~,~~ and the best interest factors in section 260C.212, subdivision 2~~, paragraph (b)~~, and may include a child colocated with a parent in a licensed residential family-based substance use disorder treatment program under section 260C.190; or

(3) order a trial home visit without modifying the transfer of legal custody to the responsible social services agency under clause (2). Trial home visit means the child is returned to the care of the parent or guardian from whom the child was removed for a period not to exceed six months. During the period of the trial home visit, the responsible social services agency:

(i) shall continue to have legal custody of the child, which means that the agency may see the child in the parent's home, at school, in a child care facility, or other setting as the agency deems necessary and appropriate;

(ii) shall continue to have the ability to access information under section 260C.208;

(iii) shall continue to provide appropriate services to both the parent and the child during the period of the trial home visit;

(iv) without previous court order or authorization, may terminate the trial home visit in order to protect the child's health, safety, or welfare and may remove the child to foster care;

(v) shall advise the court and parties within three days of the termination of the trial home visit when a visit is terminated by the responsible social services agency without a court order; and

(vi) shall prepare a report for the court when the trial home visit is terminated whether by the agency or court order ~~which~~ that describes the child's circumstances during the trial home visit and recommends appropriate orders, if any, for the court to enter to provide for the child's safety and stability. In the event a trial home visit is terminated by the agency by removing the child to foster care without prior court order or authorization, the court shall conduct a hearing within ten days of receiving notice of the termination of the trial home visit by the agency and shall order disposition under this subdivision or commence permanency proceedings under sections 260C.503 to 260C.515. The time period for the hearing may be extended by the court for good cause shown and if it is in the best interests of the child as long as the total time the child spends in foster care without a permanency hearing does not exceed 12 months;

(4) if the child has been adjudicated as a child in need of protection or services because the child is in need of special services or care to treat or ameliorate a physical or mental disability or emotional disturbance as defined in section 245.4871, subdivision 15, the court may order the child's parent, guardian, or custodian to provide it. The court may order the child's health plan company to provide mental health services to the child. Section 62Q.535 applies to an order for mental health services directed to the child's health plan company. If the health plan, parent, guardian, or custodian fails or is unable to provide this treatment or care, the court may order it provided. Absent specific written findings by the court that the child's disability is the result of abuse or neglect by the child's parent or guardian, the court shall not transfer legal custody of the child for the purpose of obtaining special treatment or care solely because the parent is unable to provide the treatment or care. If the court's order for mental health treatment is based on a diagnosis made by a treatment

professional, the court may order that the diagnosing professional not provide the treatment to the child if it finds that such an order is in the child's best interests; or

(5) if the court believes that the child has sufficient maturity and judgment and that it is in the best interests of the child, the court may order a child 16 years old or older to be allowed to live independently, either alone or with others as approved by the court under supervision the court considers appropriate, if the county board, after consultation with the court, has specifically authorized this dispositional alternative for a child.

(b) If the child was adjudicated in need of protection or services because the child is a runaway or habitual truant, the court may order any of the following dispositions in addition to or as alternatives to the dispositions authorized under paragraph (a):

(1) counsel the child or the child's parents, guardian, or custodian;

(2) place the child under the supervision of a probation officer or other suitable person in the child's own home under conditions prescribed by the court, including reasonable rules for the child's conduct and the conduct of the parents, guardian, or custodian, designed for the physical, mental, and moral well-being and behavior of the child;

(3) subject to the court's supervision, transfer legal custody of the child to one of the following:

(i) a reputable person of good moral character. No person may receive custody of two or more unrelated children unless licensed to operate a residential program under sections 245A.01 to 245A.16; or

(ii) a county probation officer for placement in a group foster home established under the direction of the juvenile court and licensed pursuant to section 241.021;

(4) require the child to pay a fine of up to $100. The court shall order payment of the fine in a manner that will not impose undue financial hardship upon the child;

(5) require the child to participate in a community service project;

(6) order the child to undergo a chemical dependency evaluation and, if warranted by the evaluation, order participation by the child in a drug awareness program or an inpatient or outpatient chemical dependency treatment program;

(7) if the court believes that it is in the best interests of the child or of public safety that the child's driver's license or instruction permit be canceled, the court may order the commissioner of public safety to cancel the child's license or permit for any period up to the child's 18th birthday. If the child does not have a driver's license or permit, the court

may order a denial of driving privileges for any period up to the child's 18th birthday. The court shall forward an order issued under this clause to the commissioner, who shall cancel the license or permit or deny driving privileges without a hearing for the period specified by the court. At any time before the expiration of the period of cancellation or denial, the court may, for good cause, order the commissioner of public safety to allow the child to apply for a license or permit, and the commissioner shall so authorize;

(8) order that the child's parent or legal guardian deliver the child to school at the beginning of each school day for a period of time specified by the court; or

(9) require the child to perform any other activities or participate in any other treatment programs deemed appropriate by the court.

To the extent practicable, the court shall enter a disposition order the same day it makes a finding that a child is in need of protection or services or neglected and in foster care, but in no event more than 15 days after the finding unless the court finds that the best interests of the child will be served by granting a delay. If the child was under eight years of age at the time the petition was filed, the disposition order must be entered within ten days of the finding and the court may not grant a delay unless good cause is shown and the court finds the best interests of the child will be served by the delay.

(c) If a child who is 14 years of age or older is adjudicated in need of protection or services because the child is a habitual truant and truancy procedures involving the child were previously dealt with by a school attendance review board or county attorney mediation program under section 260A.06 or 260A.07, the court shall order a cancellation or denial of driving privileges under paragraph (b), clause (7), for any period up to the child's 18th birthday.

(d) In the case of a child adjudicated in need of protection or services because the child has committed domestic abuse and been ordered excluded from the child's parent's home, the court shall dismiss jurisdiction if the court, at any time, finds the parent is able or willing to provide an alternative safe living arrangement for the child, as defined in Laws 1997, chapter 239, article 10, section 2.

(e) When a parent has complied with a case plan ordered under subdivision 6 and the child is in the care of the parent, the court may order the responsible social services agency to monitor the parent's continued ability to maintain the child safely in the home under such terms and conditions as the court determines appropriate under the circumstances.

Sec. 12. Minnesota Statutes 2020, section 260C.201, subdivision 2, is amended to read:

Subd. 2. **Written findings.** (a) Any order for a disposition authorized under this section shall contain written findings of fact to support the disposition and case plan ordered and shall also set forth in writing the following information:

(1) why the best interests and safety of the child are served by the disposition and case plan ordered;

(2) what alternative dispositions or services under the case plan were considered by the court and why such dispositions or services were not appropriate in the instant case;

(3) when legal custody of the child is transferred, the appropriateness of the particular placement made or to be made by the placing agency using the relative and sibling placement considerations and best interest factors in section 260C.212, subdivision 2~~, paragraph (b)~~, or the appropriateness of a child colocated with a parent in a licensed residential family-based substance use disorder treatment program under section 260C.190;

(4) whether reasonable efforts to finalize the permanent plan for the child consistent with section 260.012 were made including reasonable efforts:

(i) to prevent the child's placement and to reunify the child with the parent or guardian from whom the child was removed at the earliest time consistent with the child's safety. The court's findings must include a brief description of what preventive and reunification efforts were made and why further efforts could not have prevented or eliminated the necessity of removal or that reasonable efforts were not required under section 260.012 or 260C.178, subdivision 1;

(ii) to identify and locate any noncustodial or nonresident parent of the child and to assess such parent's ability to provide day-to-day care of the child, and, where appropriate, provide services necessary to enable the noncustodial or nonresident parent to safely provide day-to-day care of the child as required under section 260C.219, unless such services are not required under section 260.012 or 260C.178, subdivision 1~~;~~. The court's findings must include a description of the agency's efforts to:

(A) identify and locate the child's noncustodial or nonresident parent;

(B) assess the noncustodial or nonresident parent's ability to provide day-to-day care of the child; and

(C) if appropriate, provide services necessary to enable the noncustodial or nonresident parent to safely provide the child's day-to-day care, including efforts to engage the noncustodial or nonresident parent in assuming care and responsibility of the child;

(iii) to make the diligent search for relatives and provide the notices required under section 260C.221; a finding made pursuant to a hearing under section 260C.202 that the agency has made diligent efforts to conduct a relative search and has appropriately engaged relatives who responded to the notice under section 260C.221 and other relatives, who came to the attention of the agency after notice under section 260C.221 was sent, in placement and case planning decisions fulfills the requirement of this item;

(iv) to identify and make a foster care placement of the child, considering the order in section 260C.212, subdivision 2, paragraph (a), in the home of an unlicensed relative, according to the requirements of section 245A.035, a licensed relative, or other licensed foster care provider, who will commit to being the permanent legal parent or custodian for the child in the event reunification cannot occur, but who will actively support the reunification plan for the child. If the court finds that the agency has not appropriately considered relatives for placement of the child, the court shall order the agency to comply with section 260C.212, subdivision 2, paragraph (a). The court may order the agency to continue considering relatives for placement of the child regardless of the child's current placement setting; and

(v) to place siblings together in the same home or to ensure visitation is occurring when siblings are separated in foster care placement and visitation is in the siblings' best interests under section 260C.212, subdivision 2, paragraph (d); and

(5) if the child has been adjudicated as a child in need of protection or services because the child is in need of special services or care to treat or ameliorate a mental disability or emotional disturbance as defined in section 245.4871, subdivision 15, the written findings shall also set forth:

(i) whether the child has mental health needs that must be addressed by the case plan;

(ii) what consideration was given to the diagnostic and functional assessments performed by the child's mental health professional and to health and mental health care professionals' treatment recommendations;

(iii) what consideration was given to the requests or preferences of the child's parent or guardian with regard to the child's interventions, services, or treatment; and

(iv) what consideration was given to the cultural appropriateness of the child's treatment or services.

(b) If the court finds that the social services agency's preventive or reunification efforts have not been reasonable but that further preventive or reunification efforts could not permit

the child to safely remain at home, the court may nevertheless authorize or continue the removal of the child.

(c) If the child has been identified by the responsible social services agency as the subject of concurrent permanency planning, the court shall review the reasonable efforts of the agency to develop a permanency plan for the child that includes a primary plan ~~which~~ that is for reunification with the child's parent or guardian and a secondary plan ~~which~~ that is for an alternative, legally permanent home for the child in the event reunification cannot be achieved in a timely manner.

Sec. 13. Minnesota Statutes 2020, section 260C.202, is amended to read:

260C.202 COURT REVIEW OF FOSTER CARE.

(a) If the court orders a child placed in foster care, the court shall review the out-of-home placement plan and the child's placement at least every 90 days as required in juvenile court rules to determine whether continued out-of-home placement is necessary and appropriate or whether the child should be returned home. This review is not required if the court has returned the child home, ordered the child permanently placed away from the parent under sections 260C.503 to 260C.521, or terminated rights under section 260C.301. Court review for a child permanently placed away from a parent, including where the child is under guardianship of the commissioner, shall be governed by section 260C.607. When a child is placed in a qualified residential treatment program setting as defined in section 260C.007, subdivision 26d, the responsible social services agency must submit evidence to the court as specified in section 260C.712.

(b) No later than three months after the child's placement in foster care, the court shall review agency efforts to search for and notify relatives pursuant to section 260C.221, and order that the agency's efforts begin immediately, or continue, if the agency has failed to perform, or has not adequately performed, the duties under that section. The court must order the agency to continue to appropriately engage relatives who responded to the notice under section 260C.221 in placement and case planning decisions and to consider relatives for foster care placement consistent with section 260C.221. Notwithstanding a court's finding that the agency has made reasonable efforts to search for and notify relatives under section 260C.221, the court may order the agency to continue making reasonable efforts to search for, notify, engage ~~other~~, and consider relatives who came to the agency's attention after sending the initial notice under section 260C.221 ~~was sent~~.

(c) The court shall review the out-of-home placement plan and may modify the plan as provided under section 260C.201, subdivisions 6 and 7.

(d) When the court ~~orders transfer of~~ transfers the custody of a child to a responsible social services agency resulting in foster care or protective supervision with a noncustodial parent under subdivision 1, the court shall notify the parents of the provisions of sections 260C.204 and 260C.503 to 260C.521, as required under juvenile court rules.

(e) When a child remains in or returns to foster care pursuant to section 260C.451 and the court has jurisdiction pursuant to section 260C.193, subdivision 6, paragraph (c), the court shall at least annually conduct the review required under section 260C.203.

Sec. 14. Minnesota Statutes 2020, section 260C.203, is amended to read:

260C.203 ADMINISTRATIVE OR COURT REVIEW OF PLACEMENTS.

(a) Unless the court is conducting the reviews required under section 260C.202, there shall be an administrative review of the out-of-home placement plan of each child placed in foster care no later than 180 days after the initial placement of the child in foster care and at least every six months thereafter if the child is not returned to the home of the parent or parents within that time. The out-of-home placement plan must be monitored and updated by the responsible social services agency at each administrative review. The administrative review shall be conducted by the responsible social services agency using a panel of appropriate persons at least one of whom is not responsible for the case management of, or the delivery of services to, either the child or the parents who are the subject of the review. The administrative review shall be open to participation by the parent or guardian of the child and the child, as appropriate.

(b) As an alternative to the administrative review required in paragraph (a), the court may, as part of any hearing required under the Minnesota Rules of Juvenile Protection Procedure, conduct a hearing to monitor and update the out-of-home placement plan pursuant to the procedure and standard in section 260C.201, subdivision 6, paragraph (d). The party requesting review of the out-of-home placement plan shall give parties to the proceeding notice of the request to review and update the out-of-home placement plan. A court review conducted pursuant to section 260C.141, subdivision 2; 260C.193; 260C.201, subdivision 1; 260C.202; 260C.204; 260C.317; or 260D.06 shall satisfy the requirement for the review so long as the other requirements of this section are met.

(c) As appropriate to the stage of the proceedings and relevant court orders, the responsible social services agency or the court shall review:

(1) the safety, permanency needs, and well-being of the child;

(2) the continuing necessity for and appropriateness of the placement, including whether the placement is consistent with the child's best interests and other placement considerations, including relative and sibling placement considerations under section 260C.212, subdivision 2;

(3) the extent of compliance with the out-of-home placement plan required under section 260C.212, subdivisions 1 and 1a, including services and resources that the agency has provided to the child and child's parents, services and resources that other agencies and individuals have provided to the child and child's parents, and whether the out-of-home placement plan is individualized to the needs of the child and child's parents;

(4) the extent of progress that has been made toward alleviating or mitigating the causes necessitating placement in foster care;

(5) the projected date by which the child may be returned to and safely maintained in the home or placed permanently away from the care of the parent or parents or guardian; and

(6) the appropriateness of the services provided to the child.

(d) When a child is age 14 or older:

(1) in addition to any administrative review conducted by the responsible social services agency, at the in-court review required under section 260C.317, subdivision 3, clause (3), or 260C.515, subdivision 5 or 6, the court shall review the independent living plan required under section 260C.212, subdivision 1, paragraph (c), clause (12), and the provision of services to the child related to the well-being of the child as the child prepares to leave foster care. The review shall include the actual plans related to each item in the plan necessary to the child's future safety and well-being when the child is no longer in foster care; and

(2) consistent with the requirements of the independent living plan, the court shall review progress toward or accomplishment of the following goals:

(i) the child has obtained a high school diploma or its equivalent;

(ii) the child has completed a driver's education course or has demonstrated the ability to use public transportation in the child's community;

(iii) the child is employed or enrolled in postsecondary education;

(iv) the child has applied for and obtained postsecondary education financial aid for which the child is eligible;

(v) the child has health care coverage and health care providers to meet the child's physical and mental health needs;

(vi) the child has applied for and obtained disability income assistance for which the child is eligible;

(vii) the child has obtained affordable housing with necessary supports, which does not include a homeless shelter;

(viii) the child has saved sufficient funds to pay for the first month's rent and a damage deposit;

(ix) the child has an alternative affordable housing plan, which does not include a homeless shelter, if the original housing plan is unworkable;

(x) the child, if male, has registered for the Selective Service; and

(xi) the child has a permanent connection to a caring adult.

Sec. 15. Minnesota Statutes 2020, section 260C.204, is amended to read:

260C.204 PERMANENCY PROGRESS REVIEW FOR CHILDREN IN FOSTER CARE FOR SIX MONTHS.

(a) When a child continues in placement out of the home of the parent or guardian from whom the child was removed, no later than six months after the child's placement the court shall conduct a permanency progress hearing to review:

(1) the progress of the case, the parent's progress on the case plan or out-of-home placement plan, whichever is applicable;

(2) the agency's reasonable, or in the case of an Indian child, active efforts for reunification and its provision of services;

(3) the agency's reasonable efforts to finalize the permanent plan for the child under section 260.012, paragraph (e), and to make a placement as required under section 260C.212, subdivision 2, in a home that will commit to being the legally permanent family for the child in the event the child cannot return home according to the timelines in this section; and

(4) in the case of an Indian child, active efforts to prevent the breakup of the Indian family and to make a placement according to the placement preferences under United States Code, title 25, chapter 21, section 1915.

(b) When a child is placed in a qualified residential treatment program setting as defined in section 260C.007, subdivision 26d, the responsible social services agency must submit evidence to the court as specified in section 260C.712.

(c) The court shall ensure that notice of the hearing is sent to any relative who:

(1) responded to the agency's notice provided under section 260C.221, indicating an interest in participating in planning for the child or being a permanency resource for the child and who has kept the court apprised of the relative's address; or

(2) asked to be notified of court proceedings regarding the child as is permitted in section 260C.152, subdivision 5.

(d)(1) If the parent or guardian has maintained contact with the child and is complying with the court-ordered out-of-home placement plan, and if the child would benefit from reunification with the parent, the court may either:

(i) return the child home, if the conditions ~~which~~ that led to the out-of-home placement have been sufficiently mitigated that it is safe and in the child's best interests to return home; or

(ii) continue the matter up to a total of six additional months. If the child has not returned home by the end of the additional six months, the court must conduct a hearing according to sections 260C.503 to 260C.521.

(2) If the court determines that the parent or guardian is not complying, is not making progress with or engaging with services in the out-of-home placement plan, or is not maintaining regular contact with the child as outlined in the visitation plan required as part of the out-of-home placement plan under section 260C.212, the court may order the responsible social services agency:

(i) to develop a plan for legally permanent placement of the child away from the parent;

(ii) to consider, identify, recruit, and support one or more permanency resources from the child's relatives and foster parent, consistent with section 260C.212, subdivision 2, paragraph (a), to be the legally permanent home in the event the child cannot be returned to the parent. Any relative or the child's foster parent may ask the court to order the agency to consider them for permanent placement of the child in the event the child cannot be returned to the parent. A relative or foster parent who wants to be considered under this item shall cooperate with the background study required under section 245C.08, if the individual has not already done so, and with the home study process required under chapter 245A for providing child foster care and for adoption under section 259.41. The home study

referred to in this item shall be a single-home study in the form required by the commissioner of human services or similar study required by the individual's state of residence when the subject of the study is not a resident of Minnesota. The court may order the responsible social services agency to make a referral under the Interstate Compact on the Placement of Children when necessary to obtain a home study for an individual who wants to be considered for transfer of permanent legal and physical custody or adoption of the child; and

(iii) to file a petition to support an order for the legally permanent placement plan.

(e) Following the review under this section:

(1) if the court has either returned the child home or continued the matter up to a total of six additional months, the agency shall continue to provide services to support the child's return home or to make reasonable efforts to achieve reunification of the child and the parent as ordered by the court under an approved case plan;

(2) if the court orders the agency to develop a plan for the transfer of permanent legal and physical custody of the child to a relative, a petition supporting the plan shall be filed in juvenile court within 30 days of the hearing required under this section and a trial on the petition held within 60 days of the filing of the pleadings; or

(3) if the court orders the agency to file a termination of parental rights, unless the county attorney can show cause why a termination of parental rights petition should not be filed, a petition for termination of parental rights shall be filed in juvenile court within 30 days of the hearing required under this section and a trial on the petition held within 60 days of the filing of the petition.

Sec. 16. Minnesota Statutes 2021 Supplement, section 260C.212, subdivision 1, is amended to read:

Subdivision 1. **Out-of-home placement; plan.** (a) An out-of-home placement plan shall be prepared within 30 days after any child is placed in foster care by court order or a voluntary placement agreement between the responsible social services agency and the child's parent pursuant to section 260C.227 or chapter 260D.

(b) An out-of-home placement plan means a written document ~~which~~ individualized to the needs of the child and the child's parents or guardians that is prepared by the responsible social services agency jointly with ~~the parent or parents or guardian of the child~~ the child's parents or guardians and in consultation with the child's guardian ad litem~~,~~; the child's tribe, if the child is an Indian child~~,~~; the child's foster parent or representative of the foster care facility~~,~~; and, ~~where~~ when appropriate, the child. When a child is age 14 or older, the child

may include two other individuals on the team preparing the child's out-of-home placement plan. The child may select one member of the case planning team to be designated as the child's advisor and to advocate with respect to the application of the reasonable and prudent parenting standards. The responsible social services agency may reject an individual selected by the child if the agency has good cause to believe that the individual would not act in the best interest of the child. For a child in voluntary foster care for treatment under chapter 260D, preparation of the out-of-home placement plan shall additionally include the child's mental health treatment provider. For a child 18 years of age or older, the responsible social services agency shall involve the child and the child's parents as appropriate. As appropriate, the plan shall be:

(1) submitted to the court for approval under section 260C.178, subdivision 7;

(2) ordered by the court, either as presented or modified after hearing, under section 260C.178, subdivision 7, or 260C.201, subdivision 6; and

(3) signed by the parent or parents or guardian of the child, the child's guardian ad litem, a representative of the child's tribe, the responsible social services agency, and, if possible, the child.

(c) The out-of-home placement plan shall be explained by the responsible social services agency to all persons involved in ~~its~~ the plan's implementation, including the child who has signed the plan, and shall set forth:

(1) a description of the foster care home or facility selected, including how the out-of-home placement plan is designed to achieve a safe placement for the child in the least restrictive, most family-like~~,~~ setting available ~~which~~ that is in close proximity to the home of the ~~parent or~~ child's parents or ~~guardian of the child~~ guardians when the case plan goal is reunification~~,~~; and how the placement is consistent with the best interests and special needs of the child according to the factors under subdivision 2, paragraph (b);

(2) the specific reasons for the placement of the child in foster care, and when reunification is the plan, a description of the problems or conditions in the home of the parent or parents ~~which~~ that necessitated removal of the child from home and the changes the parent or parents must make for the child to safely return home;

(3) a description of the services offered and provided to prevent removal of the child from the home and to reunify the family including:

(i) the specific actions to be taken by the parent or parents of the child to eliminate or correct the problems or conditions identified in clause (2), and the time period during which the actions are to be taken; and

(ii) the reasonable efforts, or in the case of an Indian child, active efforts to be made to achieve a safe and stable home for the child including social and other supportive services to be provided or offered to the parent or parents or guardian of the child, the child, and the residential facility during the period the child is in the residential facility;

(4) a description of any services or resources that were requested by the child or the child's parent, guardian, foster parent, or custodian since the date of the child's placement in the residential facility, and whether those services or resources were provided and if not, the basis for the denial of the services or resources;

(5) the visitation plan for the parent or parents or guardian, other relatives as defined in section 260C.007, subdivision 26b or 27, and siblings of the child if the siblings are not placed together in foster care, and whether visitation is consistent with the best interest of the child, during the period the child is in foster care;

(6) when a child cannot return to or be in the care of either parent, documentation of steps to finalize adoption as the permanency plan for the child through reasonable efforts to place the child for adoption pursuant to section 260C.605. At a minimum, the documentation must include consideration of whether adoption is in the best interests of the child, and child-specific recruitment efforts such as a relative search, consideration of relatives for adoptive placement, and the use of state, regional, and national adoption exchanges to facilitate orderly and timely placements in and outside of the state. A copy of this documentation shall be provided to the court in the review required under section 260C.317, subdivision 3, paragraph (b);

(7) when a child cannot return to or be in the care of either parent, documentation of steps to finalize the transfer of permanent legal and physical custody to a relative as the permanency plan for the child. This documentation must support the requirements of the kinship placement agreement under section 256N.22 and must include the reasonable efforts used to determine that it is not appropriate for the child to return home or be adopted, and reasons why permanent placement with a relative through a Northstar kinship assistance arrangement is in the child's best interest; how the child meets the eligibility requirements for Northstar kinship assistance payments; agency efforts to discuss adoption with the child's relative foster parent and reasons why the relative foster parent chose not to pursue adoption, if applicable; and agency efforts to discuss with the child's parent or parents the permanent

transfer of permanent legal and physical custody or the reasons why these efforts were not made;

(8) efforts to ensure the child's educational stability while in foster care for a child who attained the minimum age for compulsory school attendance under state law and is enrolled full time in elementary or secondary school, or instructed in elementary or secondary education at home, or instructed in an independent study elementary or secondary program, or incapable of attending school on a full-time basis due to a medical condition that is documented and supported by regularly updated information in the child's case plan. Educational stability efforts include:

(i) efforts to ensure that the child remains in the same school in which the child was enrolled prior to placement or upon the child's move from one placement to another, including efforts to work with the local education authorities to ensure the child's educational stability and attendance; or

(ii) if it is not in the child's best interest to remain in the same school that the child was enrolled in prior to placement or move from one placement to another, efforts to ensure immediate and appropriate enrollment for the child in a new school;

(9) the educational records of the child including the most recent information available regarding:

(i) the names and addresses of the child's educational providers;

(ii) the child's grade level performance;

(iii) the child's school record;

(iv) a statement about how the child's placement in foster care takes into account proximity to the school in which the child is enrolled at the time of placement; and

(v) any other relevant educational information;

(10) the efforts by the responsible social services agency to ensure the oversight and continuity of health care services for the foster child, including:

(i) the plan to schedule the child's initial health screens;

(ii) how the child's known medical problems and identified needs from the screens, including any known communicable diseases, as defined in section 144.4172, subdivision 2, shall be monitored and treated while the child is in foster care;

(iii) how the child's medical information shall be updated and shared, including the child's immunizations;

(iv) who is responsible to coordinate and respond to the child's health care needs, including the role of the parent, the agency, and the foster parent;

(v) who is responsible for oversight of the child's prescription medications;

(vi) how physicians or other appropriate medical and nonmedical professionals shall be consulted and involved in assessing the health and well-being of the child and determine the appropriate medical treatment for the child; and

(vii) the responsibility to ensure that the child has access to medical care through either medical insurance or medical assistance;

(11) the health records of the child including information available regarding:

(i) the names and addresses of the child's health care and dental care providers;

(ii) a record of the child's immunizations;

(iii) the child's known medical problems, including any known communicable diseases as defined in section 144.4172, subdivision 2;

(iv) the child's medications; and

(v) any other relevant health care information such as the child's eligibility for medical insurance or medical assistance;

(12) an independent living plan for a child 14 years of age or older, developed in consultation with the child. The child may select one member of the case planning team to be designated as the child's advisor and to advocate with respect to the application of the reasonable and prudent parenting standards in subdivision 14. The plan should include, but not be limited to, the following objectives:

(i) educational, vocational, or employment planning;

(ii) health care planning and medical coverage;

(iii) transportation including, where appropriate, assisting the child in obtaining a driver's license;

(iv) money management, including the responsibility of the responsible social services agency to ensure that the child annually receives, at no cost to the child, a consumer report as defined under section 13C.001 and assistance in interpreting and resolving any inaccuracies in the report;

(v) planning for housing;

(vi) social and recreational skills;

(vii) establishing and maintaining connections with the child's family and community; and

(viii) regular opportunities to engage in age-appropriate or developmentally appropriate activities typical for the child's age group, taking into consideration the capacities of the individual child;

(13) for a child in voluntary foster care for treatment under chapter 260D, diagnostic and assessment information, specific services relating to meeting the mental health care needs of the child, and treatment outcomes;

(14) for a child 14 years of age or older, a signed acknowledgment that describes the child's rights regarding education, health care, visitation, safety and protection from exploitation, and court participation; receipt of the documents identified in section 260C.452; and receipt of an annual credit report. The acknowledgment shall state that the rights were explained in an age-appropriate manner to the child; and

(15) for a child placed in a qualified residential treatment program, the plan must include the requirements in section 260C.708.

(d) The parent or parents or guardian and the child each shall have the right to legal counsel in the preparation of the case plan and shall be informed of the right at the time of placement of the child. The child shall also have the right to a guardian ad litem. If unable to employ counsel from their own resources, the court shall appoint counsel upon the request of the parent or parents or the child or the child's legal guardian. The parent or parents may also receive assistance from any person or social services agency in preparation of the case plan.

(e) After the plan has been agreed upon by the parties involved or approved or ordered by the court, the foster parents shall be fully informed of the provisions of the case plan and shall be provided a copy of the plan.

(f) Upon the child's discharge from foster care, the responsible social services agency must provide the child's parent, adoptive parent, or permanent legal and physical custodian, and the child, if the child is 14 years of age or older, with a current copy of the child's health and education record. If a child meets the conditions in subdivision 15, paragraph (b), the agency must also provide the child with the child's social and medical history. The responsible social services agency may give a copy of the child's health and education record and social and medical history to a child who is younger than 14 years of age, if it is appropriate and if subdivision 15, paragraph (b), applies.

Sec. 17. Minnesota Statutes 2021 Supplement, section 260C.212, subdivision 2, is amended to read:

Subd. 2. **Placement decisions based on best interests of the child.** (a) The policy of the state of Minnesota is to ensure that the child's best interests are met by requiring an individualized determination of the needs of the child in consideration of paragraphs (a) to (f), and of how the selected placement will serve the current and future needs of the child being placed. The authorized child-placing agency shall place a child, released by court order or by voluntary release by the parent or parents, in a family foster home selected by considering placement with relatives ~~and important friends~~ in the following order:

(1) with an individual who is related to the child by blood, marriage, or adoption, including the legal parent, guardian, or custodian of the child's ~~siblings~~ sibling; or

(2) with an individual who is an important friend of the child or of the child's parent or custodian, including an individual with whom the child has resided or had significant contact or who has a significant relationship to the child or the child's parent or custodian.

~~(2) with an individual who is an important friend with whom the child has resided or had significant contact.~~

For an Indian child, the agency shall follow the order of placement preferences in the Indian Child Welfare Act of 1978, United States Code, title 25, section 1915.

(b) Among the factors the agency shall consider in determining the current and future needs of the child are the following:

(1) the child's current functioning and behaviors;

(2) the medical needs of the child;

(3) the educational needs of the child;

(4) the developmental needs of the child;

(5) the child's history and past experience;

(6) the child's religious and cultural needs;

(7) the child's connection with a community, school, and faith community;

(8) the child's interests and talents;

(9) the child's ~~relationship to current caretakers,~~ current and long-term needs regarding relationships with parents, siblings, ~~and~~ relatives, and other caretakers;

(10) the reasonable preference of the child, if the court, or the child-placing agency in the case of a voluntary placement, deems the child to be of sufficient age to express preferences; and

(11) for an Indian child, the best interests of an Indian child as defined in section 260.755, subdivision 2a.

When placing a child in foster care or in a permanent placement based on an individualized determination of the child's needs, the agency must not use one factor in this paragraph to the exclusion of all others, and the agency shall consider that the factors in paragraph (b) may be interrelated.

(c) Placement of a child cannot be delayed or denied based on race, color, or national origin of the foster parent or the child.

(d) Siblings should be placed together for foster care and adoption at the earliest possible time unless it is documented that a joint placement would be contrary to the safety or well-being of any of the siblings or unless it is not possible after reasonable efforts by the responsible social services agency. In cases where siblings cannot be placed together, the agency is required to provide frequent visitation or other ongoing interaction between siblings unless the agency documents that the interaction would be contrary to the safety or well-being of any of the siblings.

(e) Except for emergency placement as provided for in section 245A.035, the following requirements must be satisfied before the approval of a foster or adoptive placement in a related or unrelated home: (1) a completed background study under section 245C.08; and (2) a completed review of the written home study required under section 260C.215, subdivision 4, clause (5), or 260C.611, to assess the capacity of the prospective foster or adoptive parent to ensure the placement will meet the needs of the individual child.

(f) The agency must determine whether colocation with a parent who is receiving services in a licensed residential family-based substance use disorder treatment program is in the child's best interests according to paragraph (b) and include that determination in the child's case plan under subdivision 1. The agency may consider additional factors not identified in paragraph (b). The agency's determination must be documented in the child's case plan before the child is colocated with a parent.

(g) The agency must establish a juvenile treatment screening team under section 260C.157 to determine whether it is necessary and appropriate to recommend placing a child in a qualified residential treatment program, as defined in section 260C.007, subdivision 26d.

Sec. 18. Minnesota Statutes 2020, section 260C.221, is amended to read:

260C.221 RELATIVE SEARCH AND ENGAGEMENT; PLACEMENT CONSIDERATION.

Subdivision 1. **Relative search requirements.** (a) The responsible social services agency shall exercise due diligence to identify and notify adult relatives and current caregivers of a child's sibling, prior to placement or within 30 days after the child's removal from the parent, regardless of whether a child is placed in a relative's home, as required under subdivision 2. ~~The county agency shall consider placement with a relative under this section without delay and whenever the child must move from or be returned to foster care.~~ The relative search required by this section shall be comprehensive in scope. ~~After a finding that the agency has made reasonable efforts to conduct the relative search under this paragraph, the agency has the continuing responsibility to appropriately involve relatives, who have responded to the notice required under this paragraph, in planning for the child and to continue to consider relatives according to the requirements of section 260C.212, subdivision 2. At any time during the course of juvenile protection proceedings, the court may order the agency to reopen its search for relatives when it is in the child's best interest to do so.~~

(b) The relative search required by this section shall include both maternal and paternal adult relatives of the child; all adult grandparents; all legal parents, guardians, or custodians of the child's siblings; and any other adult relatives suggested by the child's parents, subject to the exceptions due to family violence in subdivision 5, paragraph ~~(c)~~ (b). The search shall also include getting information from the child in an age-appropriate manner about who the child considers to be family members and important friends with whom the child has resided or had significant contact. The relative search required under this section must fulfill the agency's duties under the Indian Child Welfare Act regarding active efforts to prevent the breakup of the Indian family under United States Code, title 25, section 1912(d), and to meet placement preferences under United States Code, title 25, section 1915.

(c) The responsible social services agency has a continuing responsibility to search for and identify relatives of a child and send the notice to relatives that is required under subdivision 2, unless the court has relieved the agency of this duty under subdivision 5, paragraph (e).

Subd. 2. **Relative notice requirements.** (a) The agency may provide oral or written notice to a child's relatives. In the child's case record, the agency must document providing

the required notice to each of the child's relatives. The responsible social services agency must notify relatives ~~must be notified~~:

(1) of the need for a foster home for the child, the option to become a placement resource for the child, the order of placement that the agency will consider under section 260C.212, subdivision 2, paragraph (a), and the possibility of the need for a permanent placement for the child;

(2) of their responsibility to keep the responsible social services agency and the court informed of their current address in order to receive notice in the event that a permanent placement is sought for the child and to receive notice of the permanency progress review hearing under section 260C.204. A relative who fails to provide a current address to the responsible social services agency and the court forfeits the right to receive notice of the possibility of permanent placement and of the permanency progress review hearing under section 260C.204, until the relative provides a current address to the responsible social services agency and the court. A decision by a relative not to be identified as a potential permanent placement resource or participate in planning for the child ~~at the beginning of the case~~ shall not affect whether the relative is considered for placement of, or as a permanency resource for, the child with that relative ~~later~~ at any time in the case, and shall not be the sole basis for the court to rule out the relative as the child's placement or permanency resource;

(3) that the relative may participate in the care and planning for the child, as specified in subdivision 3, including that the opportunity for such participation may be lost by failing to respond to the notice sent under this subdivision~~. "Participate in the care and planning" includes, but is not limited to, participation in case planning for the parent and child, identifying the strengths and needs of the parent and child, supervising visits, providing respite and vacation visits for the child, providing transportation to appointments, suggesting other relatives who might be able to help support the case plan, and to the extent possible, helping to maintain the child's familiar and regular activities and contact with friends and relatives~~;

(4) of the family foster care licensing and adoption home study requirements, including how to complete an application and how to request a variance from licensing standards that do not present a safety or health risk to the child in the home under section 245A.04 and supports that are available for relatives and children who reside in a family foster home; ~~and~~

(5) of the relatives' right to ask to be notified of any court proceedings regarding the child, to attend the hearings, and of a relative's right ~~or opportunity~~ to be heard by the court as required under section 260C.152, subdivision 5~~.~~;

(6) that regardless of the relative's response to the notice sent under this subdivision, the agency is required to establish permanency for a child, including planning for alternative permanency options if the agency's reunification efforts fail or are not required; and

(7) that by responding to the notice, a relative may receive information about participating in a child's family and permanency team if the child is placed in a qualified residential treatment program as defined in section 260C.007, subdivision 26d.

(b) The responsible social services agency shall send the notice required under paragraph (a) to relatives who become known to the responsible social services agency, except for relatives that the agency does not contact due to safety reasons under subdivision 5, paragraph (b). The responsible social services agency shall continue to send notice to relatives notwithstanding a court's finding that the agency has made reasonable efforts to conduct a relative search.

(c) The responsible social services agency is not required to send the notice under paragraph (a) to a relative who becomes known to the agency after an adoption placement agreement has been fully executed under section 260C.613, subdivision 1. If the relative wishes to be considered for adoptive placement of the child, the agency shall inform the relative of the relative's ability to file a motion for an order for adoptive placement under section 260C.607, subdivision 6.

Subd. 3. **Relative engagement requirements.** (a) A relative who responds to the notice under subdivision 2 has the opportunity to participate in care and planning for a child, which must not be limited based solely on the relative's prior inconsistent participation or nonparticipation in care and planning for the child. Care and planning for a child may include but is not limited to:

(1) participating in case planning for the child and child's parent, including identifying services and resources that meet the individualized needs of the child and child's parent. A relative's participation in case planning may be in person, via phone call, or by electronic means;

(2) identifying the strengths and needs of the child and child's parent;

(3) asking the responsible social services agency to consider the relative for placement of the child according to subdivision 4;

(4) acting as a support person for the child, the child's parents, and the child's current caregiver;

(5) supervising visits;

(6) providing respite care for the child and having vacation visits with the child;

(7) providing transportation;

(8) suggesting other relatives who may be able to participate in the case plan or that the agency may consider for placement of the child. The agency shall send a notice to each relative identified by other relatives according to subdivision 2, paragraph (b), unless a relative received this notice earlier in the case;

(9) helping to maintain the child's familiar and regular activities and contact with the child's friends and relatives, including providing supervision of the child at family gatherings and events; and

(10) participating in the child's family and permanency team if the child is placed in a qualified residential treatment program as defined in section 260C.007, subdivision 26d.

(b) The responsible social services agency shall make reasonable efforts to contact and engage relatives who respond to the notice required under this section. Upon a request by a relative or party to the proceeding, the court may conduct a review of the agency's reasonable efforts to contact and engage relatives who respond to the notice. If the court finds that the agency did not make reasonable efforts to contact and engage relatives who respond to the notice, the court may order the agency to make reasonable efforts to contact and engage relatives who respond to the notice in care and planning for the child.

Subd. 4. **Placement considerations.** (a) The responsible social services agency shall consider placing a child with a relative under this section without delay and when the child:

(1) enters foster care;

(2) must be moved from the child's current foster setting;

(3) must be permanently placed away from the child's parent; or

(4) returns to foster care after permanency has been achieved for the child.

(b) The agency shall consider placing a child with relatives:

(1) in the order specified in section 260C.212, subdivision 2, paragraph (a); and

(2) based on the child's best interests using the factors in section 260C.212, subdivision 2.

(c) The agency shall document how the agency considered relatives in the child's case record.

(d) Any relative who requests to be a placement option for a child in foster care has the right to be considered for placement of the child according to section 260C.212, subdivision 2, paragraph (a), unless the court finds that placing the child with a specific relative would endanger the child, sibling, parent, guardian, or any other family member under subdivision 5, paragraph (b).

(e) When adoption is the responsible social services agency's permanency goal for the child, the agency shall consider adoptive placement of the child with a relative in the order specified under section 260C.212, subdivision 2, paragraph (a).

Subd. 5. **Data disclosure; court review.** ~~(c)~~ (a) A responsible social services agency may disclose private data, as defined in section 13.02 and chapter 260E, to relatives of the child for the purpose of locating and assessing a suitable placement and may use any reasonable means of identifying and locating relatives including the Internet or other electronic means of conducting a search. The agency shall disclose data that is necessary to facilitate possible placement with relatives and to ensure that the relative is informed of the needs of the child so the relative can participate in planning for the child and be supportive of services to the child and family.

(b) If the child's parent refuses to give the responsible social services agency information sufficient to identify the maternal and paternal relatives of the child, the agency shall ask the juvenile court to order the parent to provide the necessary information and shall use other resources to identify the child's maternal and paternal relatives. If a parent makes an explicit request that a specific relative not be contacted or considered for placement due to safety reasons, including past family or domestic violence, the agency shall bring the parent's request to the attention of the court to determine whether the parent's request is consistent with the best interests of the child ~~and~~. The agency shall not contact the specific relative when the juvenile court finds that contacting or placing the child with the specific relative would endanger the parent, guardian, child, sibling, or any family member. Unless section 260C.139 applies to the child's case, a court shall not waive or relieve the responsible social services agency of reasonable efforts to:

(1) conduct a relative search;

(2) notify relatives;

(3) contact and engage relatives in case planning; and

(4) consider relatives for placement of the child.

(c) Notwithstanding chapter 13, the agency shall disclose data to the court about particular relatives that the agency has identified, contacted, or considered for the child's placement for the court to review the agency's due diligence.

(d) At a regularly scheduled hearing not later than three months after the child's placement in foster care and as required in ~~section~~ sections 260C.193 and 260C.202, the agency shall report to the court:

(1) ~~its~~ the agency's efforts to identify maternal and paternal relatives of the child and to engage the relatives in providing support for the child and family, and document that the relatives have been provided the notice required under ~~paragraph (a)~~ subdivision 2; and

(2) ~~its~~ the agency's decision regarding placing the child with a relative as required under section 260C.212, subdivision 2~~, and to ask~~. If the responsible social services agency decides that relative placement is not in the child's best interests at the time of the hearing, the agency shall inform the court of the agency's decision, including:

(i) why the agency decided against relative placement of the child; and

(ii) the agency's efforts to engage relatives ~~to visit or maintain contact with the child in order~~ as required under subdivision 3 to support family connections for the child~~, when placement with a relative is not possible or appropriate~~.

~~(e) Notwithstanding chapter 13, the agency shall disclose data about particular relatives identified, searched for, and contacted for the purposes of the court's review of the agency's due diligence.~~

~~(f)~~ (e) When the court is satisfied that the agency has exercised due diligence to identify relatives and provide the notice required in ~~paragraph (a)~~ subdivision 2, the court may find that the agency made reasonable efforts ~~have been made~~ to conduct a relative search to identify and provide notice to adult relatives as required under section 260.012, paragraph (e), clause (3). A finding under this paragraph does not relieve the responsible social services agency of the ongoing duty to contact, engage, and consider relatives under this section nor is it a basis for the court to rule out any relative from being a foster care or permanent placement option for the child. The agency has the continuing responsibility to:

(1) involve relatives who respond to the notice in planning for the child; and

(2) continue considering relatives for the child's placement while taking the child's short- and long-term permanency goals into consideration, according to the requirements of section 260C.212, subdivision 2.

(f) At any time during the course of juvenile protection proceedings, the court may order the agency to reopen the search for relatives when it is in the child's best interests.

(g) If the court is not satisfied that the agency has exercised due diligence to identify relatives and provide the notice required in ~~paragraph (a)~~ subdivision 2, the court may order the agency to continue its search and notice efforts and to report back to the court.

~~(g) When the placing agency determines that permanent placement proceedings are necessary because there is a likelihood that the child will not return to a parent's care, the agency must send the notice provided in paragraph (h), may ask the court to modify the duty of the agency to send the notice required in paragraph (h), or may ask the court to completely relieve the agency of the requirements of paragraph (h). The relative notification requirements of paragraph (h) do not apply when the child is placed with an appropriate relative or a foster home that has committed to adopting the child or taking permanent legal and physical custody of the child and the agency approves of that foster home for permanent placement of the child. The actions ordered by the court under this section must be consistent with the best interests, safety, permanency, and welfare of the child.~~

(h) ~~Unless required under the Indian Child Welfare Act or relieved of this duty by the court under paragraph (f),~~ When the agency determines that it is necessary to prepare for permanent placement determination proceedings, or in anticipation of filing a termination of parental rights petition, the agency shall send notice to ~~the~~ relatives who responded to a notice under this section sent at any time during the case, any adult with whom the child is currently residing, any adult with whom the child has resided for one year or longer in the past, and any adults who have maintained a relationship or exercised visitation with the child as identified in the agency case plan. The notice must state that a permanent home is sought for the child and that the individuals receiving the notice may indicate to the agency their interest in providing a permanent home. The notice must state that within 30 days of receipt of the notice an individual receiving the notice must indicate to the agency the individual's interest in providing a permanent home for the child or that the individual may lose the opportunity to be considered for a permanent placement. A relative's failure to respond or timely respond to the notice is not a basis for ruling out the relative from being a permanent placement option for the child, should the relative request to be considered for permanent placement at a later date.

Sec. 19. Minnesota Statutes 2020, section 260C.513, is amended to read:

260C.513 PERMANENCY DISPOSITIONS WHEN CHILD CANNOT RETURN HOME.

(a) ~~Termination of parental rights and adoption, or guardianship to the commissioner of human services through a consent to adopt, are preferred permanency options for a child who cannot return home. If the court finds that termination of parental rights and guardianship to the commissioner is not in the child's best interests, the court may transfer permanent legal and physical custody of the child to a relative when that order is in the child's best interests.~~ For a child who cannot return home, a permanency placement with a relative is preferred. A permanency placement with a relative includes termination of parental rights and adoption by a relative, guardianship to the commissioner of human services through a consent to adopt with a relative, or a transfer of permanent legal and physical custody to a relative. The court must consider the best interests of the child and section 260C.212, subdivision 2, paragraph (a), when making a permanency determination.

(b) When the court has determined that permanent placement of the child away from the parent is necessary, the court shall consider permanent alternative homes that are available both inside and outside the state.

Sec. 20. Minnesota Statutes 2021 Supplement, section 260C.605, subdivision 1, is amended to read:

Subdivision 1. **Requirements.** (a) Reasonable efforts to finalize the adoption of a child under the guardianship of the commissioner shall be made by the responsible social services agency responsible for permanency planning for the child.

(b) Reasonable efforts to make a placement in a home according to the placement considerations under section 260C.212, subdivision 2, with a relative or foster parent who will commit to being the permanent resource for the child in the event the child cannot be reunified with a parent are required under section 260.012 and may be made concurrently with reasonable, or if the child is an Indian child, active efforts to reunify the child with the parent.

(c) Reasonable efforts under paragraph (b) must begin as soon as possible when the child is in foster care under this chapter, but not later than the hearing required under section 260C.204.

(d) Reasonable efforts to finalize the adoption of the child include:

(1) considering the child's preference for an adoptive family;

~~(1)~~ (2) using age-appropriate engagement strategies to plan for adoption with the child;

~~(2)~~ (3) identifying an appropriate prospective adoptive parent for the child by updating the child's identified needs using the factors in section 260C.212, subdivision 2;

~~(3)~~ (4) making an adoptive placement that meets the child's needs by:

(i) completing or updating the relative search required under section 260C.221 and giving notice of the need for an adoptive home for the child to:

(A) relatives who have kept the agency or the court apprised of their whereabouts ~~and who have indicated an interest in adopting the child~~; or

(B) relatives of the child who are located in an updated search;

(ii) an updated search is required whenever:

(A) there is no identified prospective adoptive placement for the child notwithstanding a finding by the court that the agency made diligent efforts under section 260C.221, in a hearing required under section 260C.202;

(B) the child is removed from the home of an adopting parent; or

(C) the court determines that a relative search by the agency is in the best interests of the child;

(iii) engaging the child's relatives or current or former foster ~~parent and the child's relatives identified as an adoptive resource during the search conducted under section 260C.221,~~ parents to commit to being the prospective adoptive parent of the child, and considering the child's relatives for adoptive placement of the child in the order specified under section 260C.212, subdivision 2, paragraph (a); or

(iv) when there is no identified prospective adoptive parent:

(A) registering the child on the state adoption exchange as required in section 259.75 unless the agency documents to the court an exception to placing the child on the state adoption exchange reported to the commissioner;

(B) reviewing all families with approved adoption home studies associated with the responsible social services agency;

(C) presenting the child to adoption agencies and adoption personnel who may assist with finding an adoptive home for the child;

(D) using newspapers and other media to promote the particular child;

(E) using a private agency under grant contract with the commissioner to provide adoption services for intensive child-specific recruitment efforts; and

(F) making any other efforts or using any other resources reasonably calculated to identify a prospective adoption parent for the child;

~~(4)~~ (5) updating and completing the social and medical history required under sections 260C.212, subdivision 15, and 260C.609;

~~(5)~~ (6) making, and keeping updated, appropriate referrals required by section 260.851, the Interstate Compact on the Placement of Children;

~~(6)~~ (7) giving notice regarding the responsibilities of an adoptive parent to any prospective adoptive parent as required under section 259.35;

~~(7)~~ (8) offering the adopting parent the opportunity to apply for or decline adoption assistance under chapter 256N;

~~(8)~~ (9) certifying the child for adoption assistance, assessing the amount of adoption assistance, and ascertaining the status of the commissioner's decision on the level of payment if the adopting parent has applied for adoption assistance;

~~(9)~~ (10) placing the child with siblings. If the child is not placed with siblings, the agency must document reasonable efforts to place the siblings together, as well as the reason for separation. The agency may not cease reasonable efforts to place siblings together for final adoption until the court finds further reasonable efforts would be futile or that placement together for purposes of adoption is not in the best interests of one of the siblings; and

~~(10)~~ (11) working with the adopting parent to file a petition to adopt the child and with the court administrator to obtain a timely hearing to finalize the adoption.

Sec. 21. Minnesota Statutes 2020, section 260C.607, subdivision 2, is amended to read:

Subd. 2. **Notice.** Notice of review hearings shall be given by the court to:

(1) the responsible social services agency;

(2) the child, if the child is age ten and older;

(3) the child's guardian ad litem;

(4) counsel appointed for the child pursuant to section 260C.163, subdivision 3;

(5) relatives of the child who have kept the court informed of their whereabouts as required in section 260C.221 and who have responded to the agency's notice under section 260C.221, ~~indicating a willingness to provide an adoptive home for the child~~ unless the

relative has been previously ruled out by the court as a suitable ~~foster parent or~~ permanency resource for the child;

(6) the current foster or adopting parent of the child;

(7) any foster or adopting parents of siblings of the child; and

(8) the Indian child's tribe.

Sec. 22. Minnesota Statutes 2020, section 260C.607, subdivision 5, is amended to read:

Subd. 5. **Required placement by responsible social services agency.** (a) No petition for adoption shall be filed for a child under the guardianship of the commissioner unless the child sought to be adopted has been placed for adoption with the adopting parent by the responsible social services agency as required under section 260C.613, subdivision 1. The court may order the agency to make an adoptive placement using standards and procedures under subdivision 6.

(b) Any relative or the child's foster parent who believes the responsible agency has not reasonably considered the relative's or foster parent's request to be considered for adoptive placement as required under section 260C.212, subdivision 2, and who wants to be considered for adoptive placement of the child shall bring a request for consideration to the attention of the court during a review required under this section. The child's guardian ad litem and the child may also bring a request for a relative or the child's foster parent to be considered for adoptive placement. After hearing from the agency, the court may order the agency to take appropriate action regarding the relative's or foster parent's request for consideration under section 260C.212, subdivision 2, paragraph (b).

Sec. 23. Minnesota Statutes 2021 Supplement, section 260C.607, subdivision 6, is amended to read:

Subd. 6. **Motion and hearing to order adoptive placement.** (a) At any time after the district court orders the child under the guardianship of the commissioner of human services, but not later than 30 days after receiving notice required under section 260C.613, subdivision 1, paragraph (c), that the agency has made an adoptive placement, a relative or the child's foster parent may file a motion for an order for adoptive placement of a child who is under the guardianship of the commissioner if the relative or the child's foster parent:

(1) has an adoption home study under section 259.41 approving the relative or foster parent for adoption ~~and has~~. If the relative or foster parent does not have an adoption home study, an affidavit attesting to efforts to complete an adoption home study may be filed with

the motion instead. The affidavit must be signed by the relative or foster parent and the responsible social services agency or licensed child-placing agency completing the adoption home study. The relative or foster parent must also have been a resident of Minnesota for at least six months before filing the motion; the court may waive the residency requirement for the moving party if there is a reasonable basis to do so; or

(2) is not a resident of Minnesota, but has an approved adoption home study by an agency licensed or approved to complete an adoption home study in the state of the individual's residence and the study is filed with the motion for adoptive placement. If the relative or foster parent does not have an adoption home study in the relative's or foster parent's state of residence, an affidavit attesting to efforts to complete an adoption home study may be filed with the motion instead. The affidavit must be signed by the relative or foster parent and the agency completing the adoption home study.

(b) The motion shall be filed with the court conducting reviews of the child's progress toward adoption under this section. The motion and supporting documents must make a prima facie showing that the agency has been unreasonable in failing to make the requested adoptive placement. The motion must be served according to the requirements for motions under the Minnesota Rules of Juvenile Protection Procedure and shall be made on all individuals and entities listed in subdivision 2.

(c) If the motion and supporting documents do not make a prima facie showing for the court to determine whether the agency has been unreasonable in failing to make the requested adoptive placement, the court shall dismiss the motion. If the court determines a prima facie basis is made, the court shall set the matter for evidentiary hearing.

(d) At the evidentiary hearing, the responsible social services agency shall proceed first with evidence about the reason for not making the adoptive placement proposed by the moving party. When the agency presents evidence regarding the child's current relationship with the identified adoptive placement resource, the court must consider the agency's efforts to support the child's relationship with the moving party consistent with section 260C.221. The moving party then has the burden of proving by a preponderance of the evidence that the agency has been unreasonable in failing to make the adoptive placement.

(e) The court shall review and enter findings regarding whether, in making an adoptive placement decision for the child, the agency:

(1) considered relatives for adoptive placement in the order specified under section 260C.212, subdivision 2, paragraph (a); and

(2) assessed how the identified adoptive placement resource and the moving party are each able to meet the child's current and future needs based on an individualized determination of the child's needs, as required under sections 260C.612, subdivision 2, and 260C.613, subdivision 1, paragraph (b).

~~(e)~~ (f) At the conclusion of the evidentiary hearing, if the court finds that the agency has been unreasonable in failing to make the adoptive placement and that the ~~relative or the child's foster parent~~ moving party is the most suitable adoptive home to meet the child's needs using the factors in section 260C.212, subdivision 2, paragraph (b), the court may:

(1) order the responsible social services agency to make an adoptive placement in the home of the ~~relative or the child's foster parent.~~ moving party if the moving party has an approved adoption home study; or

(2) order the responsible social services agency to place the child in the home of the moving party upon approval of an adoption home study. The agency must promote and support the child's ongoing visitation and contact with the moving party until the child is placed in the moving party's home. The agency must provide an update to the court after 90 days, including progress and any barriers encountered. If the moving party does not have an approved adoption home study within 180 days, the moving party and the agency must inform the court of any barriers to obtaining the approved adoption home study during a review hearing under this section. If the court finds that the moving party is unable to obtain an approved adoption home study, the court must dismiss the order for adoptive placement under this subdivision and order the agency to continue making reasonable efforts to finalize the adoption of the child as required under section 260C.605.

~~(f)~~ (g) If, in order to ensure that a timely adoption may occur, the court orders the responsible social services agency to make an adoptive placement under this subdivision, the agency shall:

(1) make reasonable efforts to obtain a fully executed adoption placement agreement, including assisting the moving party with the adoption home study process;

(2) work with the moving party regarding eligibility for adoption assistance as required under chapter 256N; and

(3) if the moving party is not a resident of Minnesota, timely refer the matter for approval of the adoptive placement through the Interstate Compact on the Placement of Children.

~~(g)~~ (h) Denial or granting of a motion for an order for adoptive placement after an evidentiary hearing is an order which may be appealed by the responsible social services

agency, the moving party, the child, when age ten or over, the child's guardian ad litem, and any individual who had a fully executed adoption placement agreement regarding the child at the time the motion was filed if the court's order has the effect of terminating the adoption placement agreement. An appeal shall be conducted according to the requirements of the Rules of Juvenile Protection Procedure.

Sec. 24. Minnesota Statutes 2020, section 260C.613, subdivision 1, is amended to read:

Subdivision 1. **Adoptive placement decisions.** (a) The responsible social services agency has exclusive authority to make an adoptive placement of a child under the guardianship of the commissioner. The child shall be considered placed for adoption when the adopting parent, the agency, and the commissioner have fully executed an adoption placement agreement on the form prescribed by the commissioner.

(b) The responsible social services agency shall use an individualized determination of the child's current and future needs, pursuant to section 260C.212, subdivision 2, paragraph (b), to determine the most suitable adopting parent for the child in the child's best interests. The responsible social services agency must consider adoptive placement of the child with relatives in the order specified in section 260C.212, subdivision 2, paragraph (a).

(c) The responsible social services agency shall notify the court and parties entitled to notice under section 260C.607, subdivision 2, when there is a fully executed adoption placement agreement for the child.

(d) In the event an adoption placement agreement terminates, the responsible social services agency shall notify the court, the parties entitled to notice under section 260C.607, subdivision 2, and the commissioner that the agreement and the adoptive placement have terminated.

Sec. 25. Minnesota Statutes 2020, section 260C.613, subdivision 5, is amended to read:

Subd. 5. **Required record keeping.** The responsible social services agency shall document, in the records required to be kept under section 259.79, the reasons for the adoptive placement decision regarding the child, including the individualized determination of the child's needs based on the factors in section 260C.212, subdivision 2, paragraph (b)~~,~~; the agency's consideration of relatives in the order specified in section 260C.212, subdivision 2, paragraph (a); and the assessment of how the selected adoptive placement meets the identified needs of the child. The responsible social services agency shall retain in the records required to be kept under section 259.79, copies of all out-of-home placement plans

made since the child was ordered under guardianship of the commissioner and all court orders from reviews conducted pursuant to section 260C.607.

Sec. 26. Minnesota Statutes 2021 Supplement, section 260E.20, subdivision 2, is amended to read:

Subd. 2. **Face-to-face contact.** (a) Upon receipt of a screened in report, the local welfare agency shall conduct a face-to-face contact with the child reported to be maltreated and with the child's primary caregiver sufficient to complete a safety assessment and ensure the immediate safety of the child. If the report alleges substantial child endangerment or sexual abuse, the local welfare agency or agency responsible for assessing or investigating the report is not required to provide notice before conducting the initial face-to-face contact with the child and the child's primary caregiver.

(b) The face-to-face contact with the child and primary caregiver shall occur immediately if sexual abuse or substantial child endangerment is alleged and within five calendar days for all other reports. If the alleged offender was not already interviewed as the primary caregiver, the local welfare agency shall also conduct a face-to-face interview with the alleged offender in the early stages of the assessment or investigation. Face-to-face contact with the child and primary caregiver in response to a report alleging sexual abuse or substantial child endangerment may be postponed for no more than five calendar days if the child is residing in a location that is confirmed to restrict contact with the alleged offender as established in guidelines issued by the commissioner, or if the local welfare agency is pursuing a court order for the child's caregiver to produce the child for questioning under section 260E.22, subdivision 5.

(c) At the initial contact with the alleged offender, the local welfare agency or the agency responsible for assessing or investigating the report must inform the alleged offender of the complaints or allegations made against the individual in a manner consistent with laws protecting the rights of the person who made the report. The interview with the alleged offender may be postponed if it would jeopardize an active law enforcement investigation.

(d) The local welfare agency or the agency responsible for assessing or investigating the report must provide the alleged offender with an opportunity to make a statement. The alleged offender may submit supporting documentation relevant to the assessment or investigation.

Sec. 27. Minnesota Statutes 2020, section 260E.22, subdivision 2, is amended to read:

Subd. 2. **Child interview procedure.** (a) The interview may take place at school or at any facility or other place where the alleged victim or other children might be found or the child may be transported to, and the interview may be conducted at a place appropriate for the interview of a child designated by the local welfare agency or law enforcement agency.

(b) When appropriate, the interview ~~may~~ must take place outside the presence of the alleged offender or parent, legal custodian, guardian, or school official~~.~~ and may take place prior to any interviews of the alleged offender or parent, legal custodian, guardian, foster parent, or school official.

~~(c) For a family assessment, it is the preferred practice to request a parent or guardian's permission to interview the child before conducting the child interview, unless doing so would compromise the safety assessment.~~

Sec. 28. Minnesota Statutes 2020, section 260E.24, subdivision 2, is amended to read:

Subd. 2. **Determination after family assessment.** After conducting a family assessment, the local welfare agency shall determine whether child protective services are needed to address the safety of the child and other family members and the risk of subsequent maltreatment. The local welfare agency must document the information collected under section 260E.20, subdivision 3, related to the completed family assessment in the child's or family's case notes.

Sec. 29. Minnesota Statutes 2020, section 260E.34, is amended to read:

260E.34 IMMUNITY.

(a) The following persons, including persons under the age of 18, are immune from any civil or criminal liability that otherwise might result from the person's actions if the person is acting in good faith:

(1) a person making a voluntary or mandated report under this chapter or assisting in an assessment under this chapter;

(2) a person with responsibility for performing duties under this section or supervisor employed by a local welfare agency, the commissioner of an agency responsible for operating or supervising a licensed or unlicensed day care facility, residential facility, agency, hospital, sanitarium, or other facility or institution required to be licensed or certified under sections 144.50 to 144.58; 241.021; 245A.01 to 245A.16; or chapter 245B or 245H; or a school as defined in section 120A.05, subdivisions 9, 11, and 13; and chapter 124E; or a nonlicensed

personal care provider organization as defined in section 256B.0625, subdivision 19a, complying with sections 260E.23, subdivisions 2 and 3, and 260E.30; and

(3) a public or private school, facility as defined in section 260E.03, or the employee of any public or private school or facility who permits access by a local welfare agency, the Department of Education, or a local law enforcement agency and assists in an investigation or assessment pursuant to this chapter.

(b) A person who is a supervisor or person with responsibility for performing duties under this chapter employed by a local welfare agency, the commissioner of human services, or the commissioner of education complying with this chapter or any related rule or provision of law is immune from any civil or criminal liability that might otherwise result from the person's actions if the person is (1) acting in good faith and exercising due care, or (2) acting in good faith and following the information collection procedures established under section 260E.20, subdivision 3.

(c) Any physician or other medical personnel administering a toxicology test under section 260E.32 to determine the presence of a controlled substance in a pregnant woman, in a woman within eight hours after delivery, or in a child at birth or during the first month of life is immune from civil or criminal liability arising from administration of the test if the physician ordering the test believes in good faith that the test is required under this section and the test is administered in accordance with an established protocol and reasonable medical practice.

(d) This section does not provide immunity to any person for failure to make a required report or for committing maltreatment.

(e) If a person who makes a voluntary or mandatory report under section 260E.06 prevails in a civil action from which the person has been granted immunity under this section, the court may award the person attorney fees and costs.

Sec. 30. Minnesota Statutes 2020, section 626.557, subdivision 4, is amended to read:

Subd. 4. **Reporting.** (a) Except as provided in paragraph (b), a mandated reporter shall immediately make ~~an oral~~ a report to the common entry point. ~~The common entry point may accept electronic reports submitted through a web-based reporting system established by the commissioner. Use of a telecommunications device for the deaf or other similar device shall be considered an oral report. The common entry point may not require written reports.~~ To the extent possible, the report must be of sufficient content to identify the vulnerable adult, the caregiver, the nature and extent of the suspected maltreatment, any

evidence of previous maltreatment, the name and address of the reporter, the time, date, and location of the incident, and any other information that the reporter believes might be helpful in investigating the suspected maltreatment. A mandated reporter may disclose not public data, as defined in section 13.02, and medical records under sections 144.291 to 144.298, to the extent necessary to comply with this subdivision.

(b) A boarding care home that is licensed under sections 144.50 to 144.58 and certified under Title 19 of the Social Security Act, a nursing home that is licensed under section 144A.02 and certified under Title 18 or Title 19 of the Social Security Act, or a hospital that is licensed under sections 144.50 to 144.58 and has swing beds certified under Code of Federal Regulations, title 42, section 482.66, may submit a report electronically to the common entry point instead of submitting an oral report. The report may be a duplicate of the initial report the facility submits electronically to the commissioner of health to comply with the reporting requirements under Code of Federal Regulations, title 42, section 483.12. The commissioner of health may modify these reporting requirements to include items required under paragraph (a) that are not currently included in the electronic reporting form.

Sec. 31. Minnesota Statutes 2020, section 626.557, subdivision 9, is amended to read:

Subd. 9. **Common entry point designation.** (a) ~~Each county board shall designate a common entry point for reports of suspected maltreatment, for use until the commissioner of human services establishes a common entry point. Two or more county boards may jointly designate a single common entry point.~~ The commissioner of human services shall establish a common entry point ~~effective July 1, 2015~~. The common entry point is the unit responsible for receiving the report of suspected maltreatment under this section.

(b) The common entry point must be available 24 hours per day to take calls from reporters of suspected maltreatment. The common entry point shall use a standard intake form that includes:

(1) the time and date of the report;

(2) the name, relationship, and identifying and contact information for the person believed to be a vulnerable adult and the individual or facility alleged responsible for maltreatment;

(3) the name, ~~address, and telephone number of the person reporting;~~ relationship, and contact information for the:

(i) reporter;

(ii) initial reporter, witnesses, and persons who may have knowledge about the maltreatment; and

(iii) legal surrogate and persons who may provide support to the vulnerable adult;

(4) the basis of vulnerability for the vulnerable adult;

~~(3)~~ (5) the time, date, and location of the incident;

~~(4) the names of the persons involved, including but not limited to, perpetrators, alleged victims, and witnesses;~~

~~(5) whether there was a risk of imminent danger to the alleged victim;~~

(6) the immediate safety risk to the vulnerable adult;

~~(6)~~ (7) a description of the suspected maltreatment;

~~(7) the disability, if any, of the alleged victim;~~

~~(8) the relationship of the alleged perpetrator to the alleged victim;~~

(8) the impact of the suspected maltreatment on the vulnerable adult;

(9) whether a facility was involved and, if so, which agency licenses the facility;

~~(10) any action taken by the common entry point;~~

~~(11) whether law enforcement has been notified;~~

(10) the actions taken to protect the vulnerable adult;

(11) the required notifications and referrals made by the common entry point; and

(12) whether the reporter wishes to receive notification of the ~~initial and final reports; and~~ disposition.

~~(13) if the report is from a facility with an internal reporting procedure, the name, mailing address, and telephone number of the person who initiated the report internally.~~

(c) The common entry point is not required to complete each item on the form prior to dispatching the report to the appropriate lead investigative agency.

(d) The common entry point shall immediately report to a law enforcement agency any incident in which there is reason to believe a crime has been committed.

(e) If a report is initially made to a law enforcement agency or a lead investigative agency, those agencies shall take the report on the appropriate common entry point intake forms and immediately forward a copy to the common entry point.

(f) The common entry point staff must receive training on how to screen and dispatch reports efficiently and in accordance with this section.

(g) The commissioner of human services shall maintain a centralized database for the collection of common entry point data, lead investigative agency data including maltreatment report disposition, and appeals data. The common entry point shall have access to the centralized database and must log the reports into the database ~~and immediately identify and locate prior reports of abuse, neglect, or exploitation~~.

(h) When appropriate, the common entry point staff must refer calls that do not allege the abuse, neglect, or exploitation of a vulnerable adult to other organizations that might resolve the reporter's concerns.

(i) A common entry point must be operated in a manner that enables the commissioner of human services to:

(1) track critical steps in the reporting, evaluation, referral, response, disposition, and investigative process to ensure compliance with all requirements for all reports;

(2) maintain data to facilitate the production of aggregate statistical reports for monitoring patterns of abuse, neglect, or exploitation;

(3) serve as a resource for the evaluation, management, and planning of preventative and remedial services for vulnerable adults who have been subject to abuse, neglect, or exploitation;

(4) set standards, priorities, and policies to maximize the efficiency and effectiveness of the common entry point; and

(5) track and manage consumer complaints related to the common entry point.

(j) The commissioners of human services and health shall collaborate on the creation of a system for referring reports to the lead investigative agencies. This system shall enable the commissioner of human services to track critical steps in the reporting, evaluation, referral, response, disposition, investigation, notification, determination, and appeal processes.

Sec. 32. Minnesota Statutes 2020, section 626.557, subdivision 9b, is amended to read:

Subd. 9b. **Response to reports.** Law enforcement is the primary agency to conduct investigations of any incident in which there is reason to believe a crime has been committed. Law enforcement shall initiate a response immediately. If the common entry point notified a county agency for emergency adult protective services, law enforcement shall cooperate with that county agency when both agencies are involved and shall exchange data to the extent authorized in subdivision 12b, paragraph (g). County adult protection shall initiate a response immediately. Each lead investigative agency shall complete the investigative

process for reports within its jurisdiction. A lead investigative agency, county, adult protective agency, licensed facility, or law enforcement agency shall cooperate with other agencies in the provision of protective services, coordinating its investigations, and assisting another agency within the limits of its resources and expertise and shall exchange data to the extent authorized in subdivision 12b, paragraph (g). The lead investigative agency shall obtain the results of any investigation conducted by law enforcement officials. The lead investigative agency has the right to enter facilities and inspect and copy records as part of investigations. The lead investigative agency has access to not public data, as defined in section 13.02, and medical records under sections 144.291 to 144.298, that are maintained by facilities to the extent necessary to conduct its investigation. Each lead investigative agency shall develop guidelines for prioritizing reports for investigation. When a county acts as a lead investigative agency, the county shall make guidelines available to the public regarding which reports the county prioritizes for investigation and adult protective services.

Sec. 33. Minnesota Statutes 2020, section 626.557, subdivision 9c, is amended to read:

Subd. 9c. **Lead investigative agency; notifications, dispositions, determinations.** (a) Upon request of the reporter, the lead investigative agency shall notify the reporter that it has received the report, and provide information on the initial disposition of the report within five business days of receipt of the report, provided that the notification will not endanger the vulnerable adult or hamper the investigation.

(b) In making the initial disposition of a report alleging maltreatment of a vulnerable adult, the lead investigative agency may consider previous reports of suspected maltreatment and may request and consider public information, records maintained by a lead investigative agency or licensed providers, and information from any person who may have knowledge regarding the alleged maltreatment and the basis for the adult's vulnerability.

(c) Unless the lead investigative agency believes that: (1) the information would endanger the well-being of the vulnerable adult; or (2) it would not be in the best interests of the vulnerable adult, the lead investigative agency shall inform the vulnerable adult, or vulnerable adult's guardian or health care agent, if known and when applicable to the authority of the vulnerable adult's guardian or health care agent, of all reports accepted by the agency for investigation, including the maltreatment allegation, investigation guidelines, time frame, and evidence standards that the agency uses for determinations. If the allegation is applicable to the guardian or health care agent, the lead investigative agency must also inform the vulnerable adult's guardian or health care agent of all reports accepted for investigation by

the agency, including the maltreatment allegation, investigation guidelines, time frame, and evidence standards that the agency uses for determinations.

(d) When the county social service agency does not accept a report for adult protective services or investigation, the agency may offer assistance to the reporter or the person who was the subject of the report.

(e) When the county is the lead investigative agency or the agency responsible for adult protective services, the agency may coordinate and share data with the Native American Tribes and case management agencies as allowed under chapter 13 to support a vulnerable adult's health, safety, or comfort or to prevent, stop, or remediate maltreatment. The identity of the reporter shall not be disclosed, except as provided in subdivision 12b.

(f) While investigating reports and providing adult protective services, the lead investigative agency may coordinate with entities identified under subdivision 12b, paragraph (g), and may coordinate with support persons to safeguard the welfare of the vulnerable adult and prevent further maltreatment of the vulnerable adult.

~~(b)~~ (g) Upon conclusion of every investigation it conducts, the lead investigative agency shall make a final disposition as defined in section 626.5572, subdivision 8.

~~(c)~~ (h) When determining whether the facility or individual is the responsible party for substantiated maltreatment or whether both the facility and the individual are responsible for substantiated maltreatment, the lead investigative agency shall consider at least the following mitigating factors:

(1) whether the actions of the facility or the individual caregivers were in accordance with, and followed the terms of, an erroneous physician order, prescription, resident care plan, or directive. This is not a mitigating factor when the facility or caregiver is responsible for the issuance of the erroneous order, prescription, plan, or directive or knows or should have known of the errors and took no reasonable measures to correct the defect before administering care;

(2) the comparative responsibility between the facility, other caregivers, and requirements placed upon the employee, including but not limited to, the facility's compliance with related regulatory standards and factors such as the adequacy of facility policies and procedures, the adequacy of facility training, the adequacy of an individual's participation in the training, the adequacy of caregiver supervision, the adequacy of facility staffing levels, and a consideration of the scope of the individual employee's authority; and

(3) whether the facility or individual followed professional standards in exercising professional judgment.

~~(d)~~ (i) When substantiated maltreatment is determined to have been committed by an individual who is also the facility license holder, both the individual and the facility must be determined responsible for the maltreatment, and both the background study disqualification standards under section 245C.15, subdivision 4, and the licensing actions under section 245A.06 or 245A.07 apply.

~~(e)~~ (j) The lead investigative agency shall complete its final disposition within 60 calendar days. If the lead investigative agency is unable to complete its final disposition within 60 calendar days, the lead investigative agency shall notify the following persons provided that the notification will not endanger the vulnerable adult or hamper the investigation: (1) the vulnerable adult or the vulnerable adult's guardian or health care agent, when known, if the lead investigative agency knows them to be aware of the investigation; and (2) the facility, where applicable. The notice shall contain the reason for the delay and the projected completion date. If the lead investigative agency is unable to complete its final disposition by a subsequent projected completion date, the lead investigative agency shall again notify the vulnerable adult or the vulnerable adult's guardian or health care agent, when known if the lead investigative agency knows them to be aware of the investigation, and the facility, where applicable, of the reason for the delay and the revised projected completion date provided that the notification will not endanger the vulnerable adult or hamper the investigation. The lead investigative agency must notify the health care agent of the vulnerable adult only if the health care agent's authority to make health care decisions for the vulnerable adult is currently effective under section 145C.06 and not suspended under section 524.5-310 and the investigation relates to a duty assigned to the health care agent by the principal. A lead investigative agency's inability to complete the final disposition within 60 calendar days or by any projected completion date does not invalidate the final disposition.

~~(f) Within ten calendar days of completing the final disposition~~ (k) When the lead investigative agency is the Department of Health or the Department of Human Services, the lead investigative agency shall provide a copy of the public investigation memorandum under subdivision 12b, paragraph (b), clause (1), ~~when required to be completed under this section,~~ within ten calendar days of completing the final disposition to the following persons:

(1) the vulnerable adult, or the vulnerable adult's guardian or health care agent, if known, unless the lead investigative agency knows that the notification would endanger the well-being of the vulnerable adult;

(2) the reporter, if the reporter requested notification when making the report, provided this notification would not endanger the well-being of the vulnerable adult;

(3) the ~~alleged perpetrator~~ person or facility alleged responsible for maltreatment, if known;

(4) the facility; and

(5) the ombudsman for long-term care, or the ombudsman for mental health and developmental disabilities, as appropriate.

(l) When the lead investigative agency is a county agency, within ten calendar days of completing the final disposition, the lead investigative agency shall provide notification of the final disposition to the following persons:

(1) the vulnerable adult, or the vulnerable adult's guardian or health care agent, if known, when the allegation is applicable to the authority of the vulnerable adult's guardian or health care agent, unless the agency knows that the notification would endanger the well-being of the vulnerable adult;

(2) the individual determined responsible for maltreatment, if known; and

(3) when the alleged incident involves a personal care assistant or provider agency, the personal care provider organization under section 256B.0659. Upon implementation of Community First Services and Supports (CFSS), this notification requirement applies to the CFSS support worker or CFSS agency under section 256B.85.

~~(g)~~ (m) If, as a result of a reconsideration, review, or hearing, the lead investigative agency changes the final disposition, or if a final disposition is changed on appeal, the lead investigative agency shall notify the parties specified in paragraph ~~(f)~~ (k).

~~(h)~~ (n) The lead investigative agency shall notify the vulnerable adult who is the subject of the report or the vulnerable adult's guardian or health care agent, if known, and any person or facility determined to have maltreated a vulnerable adult, of their appeal or review rights under this section or section 256.021.

~~(i)~~ (o) The lead investigative agency shall routinely provide investigation memoranda for substantiated reports to the appropriate licensing boards. These reports must include the names of substantiated perpetrators. The lead investigative agency may not provide investigative memoranda for inconclusive or false reports to the appropriate licensing boards unless the lead investigative agency's investigation gives reason to believe that there may have been a violation of the applicable professional practice laws. If the investigation

memorandum is provided to a licensing board, the subject of the investigation memorandum shall be notified and receive a summary of the investigative findings.

~~(j)~~ (p) In order to avoid duplication, licensing boards shall consider the findings of the lead investigative agency in their investigations if they choose to investigate. This does not preclude licensing boards from considering other information.

~~(k)~~ (q) The lead investigative agency must provide to the commissioner of human services its final dispositions, including the names of all substantiated perpetrators. The commissioner of human services shall establish records to retain the names of substantiated perpetrators.

Sec. 34. Minnesota Statutes 2020, section 626.557, subdivision 9d, is amended to read:

Subd. 9d. **Administrative reconsideration; review panel.** (a) Except as provided under paragraph (e), any individual or facility which a lead investigative agency determines has maltreated a vulnerable adult, or the vulnerable adult or an interested person acting on behalf of the vulnerable adult, regardless of the lead investigative agency's determination, who contests the lead investigative agency's final disposition of an allegation of maltreatment, may request the lead investigative agency to reconsider its final disposition. The request for reconsideration must be submitted in writing to the lead investigative agency within 15 calendar days after receipt of notice of final disposition or, if the request is made by an interested person who is not entitled to notice, within 15 days after receipt of the notice by the vulnerable adult or the vulnerable adult's guardian or health care agent. If mailed, the request for reconsideration must be postmarked and sent to the lead investigative agency within 15 calendar days of the individual's or facility's receipt of the final disposition. If the request for reconsideration is made by personal service, it must be received by the lead investigative agency within 15 calendar days of the individual's or facility's receipt of the final disposition. An individual who was determined to have maltreated a vulnerable adult under this section and who was disqualified on the basis of serious or recurring maltreatment under sections 245C.14 and 245C.15, may request reconsideration of the maltreatment determination and the disqualification. The request for reconsideration of the maltreatment determination and the disqualification must be submitted in writing within 30 calendar days of the individual's receipt of the notice of disqualification under sections 245C.16 and 245C.17. If mailed, the request for reconsideration of the maltreatment determination and the disqualification must be postmarked and sent to the lead investigative agency within 30 calendar days of the individual's receipt of the notice of disqualification. If the request for reconsideration is made by personal service, it must be received by the lead investigative agency within 30 calendar days after the individual's receipt of the notice of disqualification.

(b) Except as provided under paragraphs (e) and (f), if the lead investigative agency denies the request or fails to act upon the request within 15 working days after receiving the request for reconsideration, the person or facility entitled to a fair hearing under section 256.045, may submit to the commissioner of human services a written request for a hearing under that statute. The vulnerable adult, or an interested person acting on behalf of the vulnerable adult, may request a review by the Vulnerable Adult Maltreatment Review Panel under section 256.021 if the lead investigative agency denies the request or fails to act upon the request, or if the vulnerable adult or interested person contests a reconsidered disposition. The Vulnerable Adult Maltreatment Review Panel shall not conduct a review if the interested person making the request on behalf of the vulnerable adult is also the individual or facility alleged responsible for the maltreatment of the vulnerable adult. The lead investigative agency shall notify persons who request reconsideration of their rights under this paragraph. The request must be submitted in writing to the review panel and a copy sent to the lead investigative agency within 30 calendar days of receipt of notice of a denial of a request for reconsideration or of a reconsidered disposition. The request must specifically identify the aspects of the lead investigative agency determination with which the person is dissatisfied.

(c) If, as a result of a reconsideration or review, the lead investigative agency changes the final disposition, it shall notify the parties specified in subdivision 9c, paragraph ~~(f)~~ (i).

(d) For purposes of this subdivision, "interested person acting on behalf of the vulnerable adult" means a person designated in writing by the vulnerable adult to act on behalf of the vulnerable adult, or a legal guardian or conservator or other legal representative, a proxy or health care agent appointed under chapter 145B or 145C, or an individual who is related to the vulnerable adult, as defined in section 245A.02, subdivision 13.

(e) If an individual was disqualified under sections 245C.14 and 245C.15, on the basis of a determination of maltreatment, which was serious or recurring, and the individual has requested reconsideration of the maltreatment determination under paragraph (a) and reconsideration of the disqualification under sections 245C.21 to 245C.27, reconsideration of the maltreatment determination and requested reconsideration of the disqualification shall be consolidated into a single reconsideration. If reconsideration of the maltreatment determination is denied and the individual remains disqualified following a reconsideration decision, the individual may request a fair hearing under section 256.045. If an individual requests a fair hearing on the maltreatment determination and the disqualification, the scope of the fair hearing shall include both the maltreatment determination and the disqualification.

(f) If a maltreatment determination or a disqualification based on serious or recurring maltreatment is the basis for a denial of a license under section 245A.05 or a licensing

sanction under section 245A.07, the license holder has the right to a contested case hearing under chapter 14 and Minnesota Rules, parts 1400.8505 to 1400.8612. As provided for under section 245A.08, the scope of the contested case hearing must include the maltreatment determination, disqualification, and licensing sanction or denial of a license. In such cases, a fair hearing must not be conducted under section 256.045. Except for family child care and child foster care, reconsideration of a maltreatment determination under this subdivision, and reconsideration of a disqualification under section 245C.22, must not be conducted when:

(1) a denial of a license under section 245A.05, or a licensing sanction under section 245A.07, is based on a determination that the license holder is responsible for maltreatment or the disqualification of a license holder based on serious or recurring maltreatment;

(2) the denial of a license or licensing sanction is issued at the same time as the maltreatment determination or disqualification; and

(3) the license holder appeals the maltreatment determination or disqualification, and denial of a license or licensing sanction.

Notwithstanding clauses (1) to (3), if the license holder appeals the maltreatment determination or disqualification, but does not appeal the denial of a license or a licensing sanction, reconsideration of the maltreatment determination shall be conducted under sections 260E.33 and 626.557, subdivision 9d, and reconsideration of the disqualification shall be conducted under section 245C.22. In such cases, a fair hearing shall also be conducted as provided under sections 245C.27, 260E.33, and 626.557, subdivision 9d.

If the disqualified subject is an individual other than the license holder and upon whom a background study must be conducted under chapter 245C, the hearings of all parties may be consolidated into a single contested case hearing upon consent of all parties and the administrative law judge.

(g) Until August 1, 2002, an individual or facility that was determined by the commissioner of human services or the commissioner of health to be responsible for neglect under section 626.5572, subdivision 17, after October 1, 1995, and before August 1, 2001, that believes that the finding of neglect does not meet an amended definition of neglect may request a reconsideration of the determination of neglect. The commissioner of human services or the commissioner of health shall mail a notice to the last known address of individuals who are eligible to seek this reconsideration. The request for reconsideration must state how the established findings no longer meet the elements of the definition of neglect. The commissioner shall review the request for reconsideration and make a

determination within 15 calendar days. The commissioner's decision on this reconsideration is the final agency action.

(1) For purposes of compliance with the data destruction schedule under subdivision 12b, paragraph (d), when a finding of substantiated maltreatment has been changed as a result of a reconsideration under this paragraph, the date of the original finding of a substantiated maltreatment must be used to calculate the destruction date.

(2) For purposes of any background studies under chapter 245C, when a determination of substantiated maltreatment has been changed as a result of a reconsideration under this paragraph, any prior disqualification of the individual under chapter 245C that was based on this determination of maltreatment shall be rescinded, and for future background studies under chapter 245C the commissioner must not use the previous determination of substantiated maltreatment as a basis for disqualification or as a basis for referring the individual's maltreatment history to a health-related licensing board under section 245C.31.

Sec. 35. Minnesota Statutes 2020, section 626.557, subdivision 10, is amended to read:

Subd. 10. **Duties of county social service agency.** (a) When the common entry point refers a report to the county social service agency as the lead investigative agency or makes a referral to the county social service agency for emergency adult protective services, or when another lead investigative agency requests assistance from the county social service agency for adult protective services, the county social service agency shall immediately assess and offer emergency and continuing protective social services for purposes of preventing further maltreatment and for safeguarding the welfare of the maltreated vulnerable adult. The county shall use ~~a~~ standardized ~~tool~~ tools and the data system made available by the commissioner. The information entered by the county into the standardized tool must be accessible to the Department of Human Services. In cases of suspected sexual abuse, the county social service agency shall immediately arrange for and make available to the vulnerable adult appropriate medical examination and treatment. When necessary in order to protect the vulnerable adult from further harm, the county social service agency shall seek authority to remove the vulnerable adult from the situation in which the maltreatment occurred. The county social service agency may also investigate to determine whether the conditions which resulted in the reported maltreatment place other vulnerable adults in jeopardy of being maltreated and offer protective social services that are called for by its determination.

(b) Within five business days of receipt of a report screened in by the county social service agency for investigation, the county social service agency shall determine whether,

in addition to an assessment and services for the vulnerable adult, to also conduct an investigation for final disposition of the individual or facility alleged to have maltreated the vulnerable adult.

(c) The county social service agency must investigate for a final disposition the individual or facility alleged to have maltreated a vulnerable adult for each report accepted as lead investigative agency involving an allegation of abuse, caregiver neglect that resulted in harm to the vulnerable adult, financial exploitation that may be criminal, or an allegation against a caregiver under chapter 256B.

(d) An investigating county social service agency must make a final disposition for any allegation when the county social service agency determines that a final disposition may safeguard a vulnerable adult or may prevent further maltreatment.

(e) If the county social service agency learns of an allegation listed in paragraph (c) after the determination in paragraph (a), the county social service agency must change the initial determination and conduct an investigation for final disposition of the individual or facility alleged to have maltreated the vulnerable adult.

~~(b)~~ (f) County social service agencies may enter facilities and inspect and copy records as part of an investigation. The county social service agency has access to not public data, as defined in section 13.02, and medical records under sections 144.291 to 144.298, that are maintained by facilities to the extent necessary to conduct its investigation. The inquiry is not limited to the written records of the facility, but may include every other available source of information.

~~(c)~~ (g) When necessary in order to protect a vulnerable adult from serious harm, the county social service agency shall immediately intervene on behalf of that adult to help the family, vulnerable adult, or other interested person by seeking any of the following:

(1) a restraining order or a court order for removal of the perpetrator from the residence of the vulnerable adult pursuant to section 518B.01;

(2) the appointment of a guardian or conservator pursuant to sections 524.5-101 to 524.5-502, or guardianship or conservatorship pursuant to chapter 252A;

(3) replacement of a guardian or conservator suspected of maltreatment and appointment of a suitable person as guardian or conservator, pursuant to sections 524.5-101 to 524.5-502; or

(4) a referral to the prosecuting attorney for possible criminal prosecution of the perpetrator under chapter 609.

The expenses of legal intervention must be paid by the county in the case of indigent persons, under section 524.5-502 and chapter 563.

In proceedings under sections 524.5-101 to 524.5-502, if a suitable relative or other person is not available to petition for guardianship or conservatorship, a county employee shall present the petition with representation by the county attorney. The county shall contract with or arrange for a suitable person or organization to provide ongoing guardianship services. If the county presents evidence to the court exercising probate jurisdiction that it has made a diligent effort and no other suitable person can be found, a county employee may serve as guardian or conservator. The county shall not retaliate against the employee for any action taken on behalf of the ~~ward or protected~~ person subject to guardianship or conservatorship, even if the action is adverse to the county's interest. Any person retaliated against in violation of this subdivision shall have a cause of action against the county and shall be entitled to reasonable attorney fees and costs of the action if the action is upheld by the court.

Sec. 36. Minnesota Statutes 2020, section 626.557, subdivision 10b, is amended to read:

Subd. 10b. **Investigations; guidelines.** (a) Each lead investigative agency shall develop guidelines for prioritizing reports for investigation.

(b) When investigating a report, the lead investigative agency shall conduct the following activities~~,~~ as appropriate:

(1) interview of the ~~alleged victim~~ vulnerable adult;

(2) interview of the reporter and others who may have relevant information;

(3) interview of the ~~alleged perpetrator~~ individual or facility alleged responsible for maltreatment; and

~~(4) examination of the environment surrounding the alleged incident;~~

~~(5)~~ (4) review of records and pertinent documentation of the alleged incident~~; and~~.

~~(6) consultation with professionals.~~

(c) The lead investigative agency shall conduct the following activities as appropriate to further the investigation, to prevent further maltreatment, or to safeguard the vulnerable adult:

(1) examining the environment surrounding the alleged incident;

(2) consulting with professionals; and

(3) communicating with state, federal, tribal, and other agencies including:

(i) service providers;

(ii) case managers;

(iii) ombudsmen; and

(iv) support persons for the vulnerable adult.

(d) The lead investigative agency may decide not to conduct an interview of a vulnerable adult, reporter, or witness under paragraph (b) if:

(1) the vulnerable adult, reporter, or witness declines to have an interview with the agency or is unable to be contacted despite the agency's diligent attempts;

(2) an interview of the vulnerable adult or reporter was conducted by law enforcement or a professional trained in forensic interview and an additional interview will not further the investigation;

(3) an interview of the witness will not further the investigation; or

(4) the agency has a reason to believe that the interview will endanger the vulnerable adult.

Sec. 37. Minnesota Statutes 2020, section 626.557, subdivision 12b, is amended to read:

Subd. 12b. **Data management.** (a) In performing any of the duties of this section as a lead investigative agency, the county social service agency shall maintain appropriate records. Data collected by the county social service agency under this section while providing adult protective services are welfare data under section 13.46. Investigative data collected under this section are confidential data on individuals or protected nonpublic data as defined under section 13.02. Notwithstanding section 13.46, subdivision 1, paragraph (a), data under this paragraph that are inactive investigative data on an individual who is a vendor of services are private data on individuals, as defined in section 13.02. The identity of the reporter may only be disclosed as provided in paragraph (c).

Data maintained by the common entry point are confidential data on individuals or protected nonpublic data as defined in section 13.02. Notwithstanding section 138.163, the common entry point shall maintain data for three calendar years after date of receipt and then destroy the data unless otherwise directed by federal requirements.

(b) The commissioners of health and human services shall prepare an investigation memorandum for each report alleging maltreatment investigated under this section. County

social service agencies must maintain private data on individuals but are not required to prepare an investigation memorandum. During an investigation by the commissioner of health or the commissioner of human services, data collected under this section are confidential data on individuals or protected nonpublic data as defined in section 13.02. Upon completion of the investigation, the data are classified as provided in clauses (1) to (3) and paragraph (c).

(1) The investigation memorandum must contain the following data, which are public:

(i) the name of the facility investigated;

(ii) a statement of the nature of the alleged maltreatment;

(iii) pertinent information obtained from medical or other records reviewed;

(iv) the identity of the investigator;

(v) a summary of the investigation's findings;

(vi) statement of whether the report was found to be substantiated, inconclusive, false, or that no determination will be made;

(vii) a statement of any action taken by the facility;

(viii) a statement of any action taken by the lead investigative agency; and

(ix) when a lead investigative agency's determination has substantiated maltreatment, a statement of whether an individual, individuals, or a facility were responsible for the substantiated maltreatment, if known.

The investigation memorandum must be written in a manner which protects the identity of the reporter and of the vulnerable adult and may not contain the names or, to the extent possible, data on individuals or private data listed in clause (2).

(2) Data on individuals collected and maintained in the investigation memorandum are private data, including:

(i) the name of the vulnerable adult;

(ii) the identity of the individual alleged to be the perpetrator;

(iii) the identity of the individual substantiated as the perpetrator; and

(iv) the identity of all individuals interviewed as part of the investigation.

(3) Other data on individuals maintained as part of an investigation under this section are private data on individuals upon completion of the investigation.

(c) ~~After the assessment or investigation is completed,~~ The name of the reporter must be confidential. The subject of the report may compel disclosure of the name of the reporter only with the consent of the reporter or upon a written finding by a court that the report was false and there is evidence that the report was made in bad faith. This subdivision does not alter disclosure responsibilities or obligations under the Rules of Criminal Procedure, except that where the identity of the reporter is relevant to a criminal prosecution, the district court shall do an in-camera review prior to determining whether to order disclosure of the identity of the reporter.

(d) Notwithstanding section 138.163, data maintained under this section by the commissioners of health and human services must be maintained under the following schedule and then destroyed unless otherwise directed by federal requirements:

(1) data from reports determined to be false, maintained for three years after the finding was made;

(2) data from reports determined to be inconclusive, maintained for four years after the finding was made;

(3) data from reports determined to be substantiated, maintained for seven years after the finding was made; and

(4) data from reports which were not investigated by a lead investigative agency and for which there is no final disposition, maintained for three years from the date of the report.

(e) The commissioners of health and human services shall annually publish on their websites the number and type of reports of alleged maltreatment involving licensed facilities reported under this section, the number of those requiring investigation under this section, and the resolution of those investigations. On a biennial basis, the commissioners of health and human services shall jointly report the following information to the legislature and the governor:

(1) the number and type of reports of alleged maltreatment involving licensed facilities reported under this section, the number of those requiring investigations under this section, the resolution of those investigations, and which of the two lead agencies was responsible;

(2) trends about types of substantiated maltreatment found in the reporting period;

(3) if there are upward trends for types of maltreatment substantiated, recommendations for addressing and responding to them;

(4) efforts undertaken or recommended to improve the protection of vulnerable adults;

(5) whether and where backlogs of cases result in a failure to conform with statutory time frames and recommendations for reducing backlogs if applicable;

(6) recommended changes to statutes affecting the protection of vulnerable adults; and

(7) any other information that is relevant to the report trends and findings.

(f) Each lead investigative agency must have a record retention policy.

(g) Lead investigative agencies, county agencies responsible for adult protective services, prosecuting authorities, and law enforcement agencies may exchange not public data, as defined in section 13.02, with a tribal agency, facility, service provider, vulnerable adult, primary support person for a vulnerable adult, state licensing board, federal or state agency, the ombudsman for long-term care, or the ombudsman for mental health and developmental disabilities, if the agency or authority ~~requesting~~ providing the data determines that the data are pertinent and necessary ~~to the requesting agency in initiating, furthering, or completing~~ to prevent further maltreatment of a vulnerable adult, to safeguard a vulnerable adult, or for an investigation under this section. Data collected under this section must be made available to prosecuting authorities and law enforcement officials, local county agencies, and licensing agencies investigating the alleged maltreatment under this section. The lead investigative agency shall exchange not public data with the vulnerable adult maltreatment review panel established in section 256.021 if the data are pertinent and necessary for a review requested under that section. Notwithstanding section 138.17, upon completion of the review, not public data received by the review panel must be destroyed.

(h) Each lead investigative agency shall keep records of the length of time it takes to complete its investigations.

(i) A lead investigative agency may notify other affected parties and their authorized representative if the lead investigative agency has reason to believe maltreatment has occurred and determines the information will safeguard the well-being of the affected parties or dispel widespread rumor or unrest in the affected facility.

(j) Under any notification provision of this section, where federal law specifically prohibits the disclosure of patient identifying information, a lead investigative agency may not provide any notice unless the vulnerable adult has consented to disclosure in a manner which conforms to federal requirements.

Sec. 38. Minnesota Statutes 2020, section 626.5571, subdivision 1, is amended to read:

Subdivision 1. **Establishment of team.** A county may establish a multidisciplinary adult protection team comprised of the director of the local welfare agency or designees, the

county attorney or designees, the county sheriff or designees, and representatives of health care. In addition, representatives of mental health or other appropriate human service agencies, representatives from local tribal governments, ~~and~~ adult advocate groups, and any other organization with relevant expertise may be added to the adult protection team.

Sec. 39. Minnesota Statutes 2020, section 626.5571, subdivision 2, is amended to read:

Subd. 2. **Duties of team.** A multidisciplinary adult protection team may provide public and professional education, develop resources for prevention, intervention, and treatment, and provide case consultation to the local welfare agency to better enable the agency to carry out its ~~adult protection~~ functions under section 626.557 and to meet the community's needs ~~for adult protection services~~. Case consultation may be performed by a committee of the team composed of the team members representing social services, law enforcement, the county attorney, health care, and persons directly involved in an individual case as determined by the case consultation committee. Case consultation ~~is~~ includes a case review process that results in recommendations about services to be provided to the identified adult and family.

Sec. 40. Minnesota Statutes 2020, section 626.5572, subdivision 2, is amended to read:

Subd. 2. **Abuse.** "Abuse" means:

(a) An act against a vulnerable adult that constitutes a violation of, an attempt to violate, or aiding and abetting a violation of:

(1) assault in the first through fifth degrees as defined in sections 609.221 to 609.224;

(2) the use of drugs to injure or facilitate crime as defined in section 609.235;

(3) the solicitation, inducement, and promotion of prostitution as defined in section 609.322; and

(4) criminal sexual conduct in the first through fifth degrees as defined in sections 609.342 to 609.3451.

A violation includes any action that meets the elements of the crime, regardless of whether there is a criminal proceeding or conviction.

(b) Conduct which is not an accident or therapeutic conduct as defined in this section, which produces or could reasonably be expected to produce physical pain or injury or emotional distress including, but not limited to, the following:

(1) hitting, slapping, kicking, pinching, biting, or corporal punishment of a vulnerable adult;

(2) use of repeated or malicious oral, written, or gestured language toward a vulnerable adult or the treatment of a vulnerable adult which would be considered by a reasonable person to be disparaging, derogatory, humiliating, harassing, or threatening; or

(3) use of any aversive or deprivation procedure, unreasonable confinement, or involuntary seclusion, including the forced separation of the vulnerable adult from other persons against the will of the vulnerable adult or the legal representative of the vulnerable adult~~; and~~ unless authorized under applicable licensing requirements or Minnesota Rules, chapter 9544.

~~(4) use of any aversive or deprivation procedures for persons with developmental disabilities or related conditions not authorized under section 245.825.~~

(c) Any sexual contact or penetration as defined in section 609.341, between a facility staff person or a person providing services in the facility and a resident, patient, or client of that facility.

(d) The act of forcing, compelling, coercing, or enticing a vulnerable adult against the vulnerable adult's will to perform services for the advantage of another.

(e) For purposes of this section, a vulnerable adult is not abused for the sole reason that the vulnerable adult or a person with authority to make health care decisions for the vulnerable adult under sections 144.651, 144A.44, chapter 145B, 145C or 252A, or section 253B.03 or 524.5-313, refuses consent or withdraws consent, consistent with that authority and within the boundary of reasonable medical practice, to any therapeutic conduct, including any care, service, or procedure to diagnose, maintain, or treat the physical or mental condition of the vulnerable adult or, where permitted under law, to provide nutrition and hydration parenterally or through intubation. This paragraph does not enlarge or diminish rights otherwise held under law by:

(1) a vulnerable adult or a person acting on behalf of a vulnerable adult, including an involved family member, to consent to or refuse consent for therapeutic conduct; or

(2) a caregiver to offer or provide or refuse to offer or provide therapeutic conduct.

(f) For purposes of this section, a vulnerable adult is not abused for the sole reason that the vulnerable adult, a person with authority to make health care decisions for the vulnerable adult, or a caregiver in good faith selects and depends upon spiritual means or prayer for treatment or care of disease or remedial care of the vulnerable adult in lieu of medical care, provided that this is consistent with the prior practice or belief of the vulnerable adult or with the expressed intentions of the vulnerable adult.

(g) For purposes of this section, a vulnerable adult is not abused for the sole reason that the vulnerable adult, who is not impaired in judgment or capacity by mental or emotional dysfunction or undue influence, engages in consensual sexual contact with:

(1) a person, including a facility staff person, when a consensual sexual personal relationship existed prior to the caregiving relationship; or

(2) a personal care attendant, regardless of whether the consensual sexual personal relationship existed prior to the caregiving relationship.

Sec. 41. Minnesota Statutes 2020, section 626.5572, subdivision 4, is amended to read:

Subd. 4. **Caregiver.** "Caregiver" means an individual or facility who has responsibility for all or a portion of the care of a vulnerable adult ~~as a result of a family relationship, or who has assumed responsibility for all or a portion of the care of a vulnerable adult~~ voluntarily, by contract, or by agreement.

Sec. 42. Minnesota Statutes 2020, section 626.5572, subdivision 17, is amended to read:

Subd. 17. **Neglect.** ~~"Neglect" means:~~ Neglect means neglect by a caregiver or self-neglect.

(a) "Caregiver neglect" means the failure or omission by a caregiver to supply a vulnerable adult with care or services, including but not limited to, food, clothing, shelter, health care, or supervision which is:

(1) reasonable and necessary to obtain or maintain the vulnerable adult's physical or mental health or safety, considering the physical and mental capacity or dysfunction of the vulnerable adult; and

(2) which is not the result of an accident or therapeutic conduct.

(b) ~~The absence or likelihood of absence of care or services, including but not limited to, food, clothing, shelter, health care, or supervision necessary to maintain the physical and mental health of the vulnerable adult~~ "Self-neglect" means neglect by a vulnerable adult of the vulnerable adult's own food, clothing, shelter, health care, or other services that are not the responsibility of a caregiver which a reasonable person would deem essential to obtain or maintain the vulnerable adult's health, safety, or comfort ~~considering the physical or mental capacity or dysfunction of the vulnerable adult~~.

(c) For purposes of this section, a vulnerable adult is not neglected for the sole reason that:

(1) the vulnerable adult or a person with authority to make health care decisions for the vulnerable adult under sections 144.651, 144A.44, chapter 145B, 145C, or 252A, or sections 253B.03 or 524.5-101 to 524.5-502, refuses consent or withdraws consent, consistent with that authority and within the boundary of reasonable medical practice, to any therapeutic conduct, including any care, service, or procedure to diagnose, maintain, or treat the physical or mental condition of the vulnerable adult, or, where permitted under law, to provide nutrition and hydration parenterally or through intubation; this paragraph does not enlarge or diminish rights otherwise held under law by:

(i) a vulnerable adult or a person acting on behalf of a vulnerable adult, including an involved family member, to consent to or refuse consent for therapeutic conduct; or

(ii) a caregiver to offer or provide or refuse to offer or provide therapeutic conduct; or

(2) the vulnerable adult, a person with authority to make health care decisions for the vulnerable adult, or a caregiver in good faith selects and depends upon spiritual means or prayer for treatment or care of disease or remedial care of the vulnerable adult in lieu of medical care, provided that this is consistent with the prior practice or belief of the vulnerable adult or with the expressed intentions of the vulnerable adult;

(3) the vulnerable adult, who is not impaired in judgment or capacity by mental or emotional dysfunction or undue influence, engages in consensual sexual contact with:

(i) a person including a facility staff person when a consensual sexual personal relationship existed prior to the caregiving relationship; or

(ii) a personal care attendant, regardless of whether the consensual sexual personal relationship existed prior to the caregiving relationship; or

(4) an individual makes an error in the provision of therapeutic conduct to a vulnerable adult which does not result in injury or harm which reasonably requires medical or mental health care; or

(5) an individual makes an error in the provision of therapeutic conduct to a vulnerable adult that results in injury or harm, which reasonably requires the care of a physician, and:

(i) the necessary care is provided in a timely fashion as dictated by the condition of the vulnerable adult;

(ii) if after receiving care, the health status of the vulnerable adult can be reasonably expected, as determined by the attending physician, to be restored to the vulnerable adult's preexisting condition;

(iii) the error is not part of a pattern of errors by the individual;

(iv) if in a facility, the error is immediately reported as required under section 626.557, and recorded internally in the facility;

(v) if in a facility, the facility identifies and takes corrective action and implements measures designed to reduce the risk of further occurrence of this error and similar errors; and

(vi) if in a facility, the actions required under items (iv) and (v) are sufficiently documented for review and evaluation by the facility and any applicable licensing, certification, and ombudsman agency.

(d) Nothing in this definition requires a caregiver, if regulated, to provide services in excess of those required by the caregiver's license, certification, registration, or other regulation.

(e) If the findings of an investigation by a lead investigative agency result in a determination of substantiated maltreatment for the sole reason that the actions required of a facility under paragraph (c), clause (5), item (iv), (v), or (vi), were not taken, then the facility is subject to a correction order. An individual will not be found to have neglected or maltreated the vulnerable adult based solely on the facility's not having taken the actions required under paragraph (c), clause (5), item (iv), (v), or (vi). This must not alter the lead investigative agency's determination of mitigating factors under section 626.557, subdivision 9c, paragraph ~~(e)~~ (f).

ARTICLE 14
CHILD PROTECTION

Section 1. Minnesota Statutes 2020, section 242.19, subdivision 2, is amended to read:

Subd. 2. **Dispositions.** When a child has been committed to the commissioner of corrections by a juvenile court, upon a finding of delinquency, the commissioner may for the purposes of treatment and rehabilitation:

(1) order the child's confinement to the Minnesota Correctional Facility-Red Wing, which shall accept the child, or to a group foster home under the control of the commissioner of corrections, or to private facilities or facilities established by law or incorporated under the laws of this state that may care for delinquent children;

(2) order the child's release on parole under such supervisions and conditions as the commissioner believes conducive to law-abiding conduct, treatment and rehabilitation;

(3) order reconfinement or renewed parole as often as the commissioner believes to be desirable;

(4) revoke or modify any order, except an order of discharge, as often as the commissioner believes to be desirable;

(5) discharge the child when the commissioner is satisfied that the child has been rehabilitated and that such discharge is consistent with the protection of the public;

(6) if the commissioner finds that the child is eligible for probation or parole and it appears from the commissioner's investigation that conditions in the child's or the guardian's home are not conducive to the child's treatment, rehabilitation, or law-abiding conduct, refer the child, together with the commissioner's findings, to a local social services agency or a licensed child-placing agency for placement in a foster care or, when appropriate, for initiation of child in need of protection or services proceedings as provided in sections 260C.001 to 260C.421. The commissioner of corrections shall reimburse local social services agencies for foster care costs they incur for the child while on probation or parole to the extent that funds for this purpose are made available to the commissioner by the legislature. ~~The juvenile court shall order the parents of a child on probation or parole to pay the costs of foster care under section 260B.331, subdivision 1, according to their ability to pay, and to the extent that the commissioner of corrections has not reimbursed the local social services agency.~~

Sec. 2. Minnesota Statutes 2021 Supplement, section 256N.26, subdivision 11, is amended to read:

Subd. 11. **Child income or income attributable to the child.** (a) A monthly Northstar kinship assistance or adoption assistance payment must be considered as income and resources attributable to the child. Northstar kinship assistance and adoption assistance are exempt from garnishment, except as permissible under the laws of the state where the child resides.

(b) When a child is placed into foster care, any income and resources attributable to the child are treated as provided in ~~sections~~ section 252.27 ~~and 260C.331, or 260B.331~~, as applicable to the child being placed.

(c) Supplemental Security Income (SSI), retirement survivor's disability insurance (RSDI), veteran's benefits, railroad retirement benefits, and black lung benefits are considered income and resources attributable to the child.

Sec. 3. Minnesota Statutes 2020, section 256N.26, subdivision 14, is amended to read:

Subd. 14. **Treatment of child support and Minnesota family investment program.** (a) If a child placed in foster care who receives federal Title IV-E foster care maintenance payments also receives child support, the child support payment may be redirected to the financially responsible agency for the duration of the child's placement in foster care. In cases where the child qualifies for Northstar Care for Children by meeting the adoption assistance eligibility criteria or the Northstar kinship assistance eligibility criteria, any court-ordered child support must not be considered income attributable to the child and must have no impact on the monthly payment.

(b) Consistent with section 256J.24, a child eligible for Northstar Care for Children whose caregiver receives a payment on the child's behalf is excluded from a Minnesota family investment program assistance unit.

Sec. 4. Minnesota Statutes 2020, section 260.761, subdivision 2, is amended to read:

Subd. 2. **Agency and court notice to tribes.** (a) When a local social services agency has information that a family assessment ~~or~~, investigation, or noncaregiver sex trafficking assessment being conducted may involve an Indian child, the local social services agency shall notify the Indian child's tribe of the family assessment ~~or~~, investigation, or noncaregiver sex trafficking assessment according to section 260E.18. The local social services agency shall provide initial notice ~~shall be provided~~ by telephone and by e-mail or facsimile. The local social services agency shall request that the tribe or a designated tribal representative participate in evaluating the family circumstances, identifying family and tribal community resources, and developing case plans.

(b) When a local social services agency has information that a child receiving services may be an Indian child, the local social services agency shall notify the tribe by telephone and by e-mail or facsimile of the child's full name and date of birth, the full names and dates of birth of the child's biological parents, and, if known, the full names and dates of birth of the child's grandparents and of the child's Indian custodian. This notification must be provided ~~so~~ for the tribe ~~can~~ to determine if the child is enrolled in the tribe or eligible for tribal membership, and ~~must be provided~~ the agency must provide this notification to the tribe within seven days of receiving information that the child may be an Indian child. If information regarding the child's grandparents or Indian custodian is not available within the seven-day period, the local social services agency shall continue to request this information and shall notify the tribe when it is received. Notice shall be provided to all tribes to which the child may have any tribal lineage. If the identity or location of the child's

parent or Indian custodian and tribe cannot be determined, the local social services agency shall provide the notice required in this paragraph to the United States secretary of the interior.

(c) In accordance with sections 260C.151 and 260C.152, when a court has reason to believe that a child placed in emergency protective care is an Indian child, the court administrator or a designee shall, as soon as possible and before a hearing takes place, notify the tribal social services agency by telephone and by e-mail or facsimile of the date, time, and location of the emergency protective case hearing. The court shall make efforts to allow appearances by telephone for tribal representatives, parents, and Indian custodians.

(d) A local social services agency must provide the notices required under this subdivision at the earliest possible time to facilitate involvement of the Indian child's tribe. Nothing in this subdivision is intended to hinder the ability of the local social services agency and the court to respond to an emergency situation. Lack of participation by a tribe shall not prevent the tribe from intervening in services and proceedings at a later date. A tribe may participate in a case at any time. At any stage of the local social services agency's involvement with an Indian child, the agency shall provide full cooperation to the tribal social services agency, including disclosure of all data concerning the Indian child. Nothing in this subdivision relieves the local social services agency of satisfying the notice requirements in the Indian Child Welfare Act.

Sec. 5. Minnesota Statutes 2020, section 260B.331, subdivision 1, is amended to read:

Subdivision 1. **Care, examination, or treatment.** (a)(1) Whenever legal custody of a child is transferred by the court to a local social services agency, or

(2) whenever legal custody is transferred to a person other than the local social services agency, but under the supervision of the local social services agency, and

(3) whenever a child is given physical or mental examinations or treatment under order of the court, and no provision is otherwise made by law for payment for the care, examination, or treatment of the child, these costs are a charge upon the welfare funds of the county in which proceedings are held upon certification of the judge of juvenile court.

~~(b) The court shall order, and the local social services agency shall require, the parents or custodian of a child, while the child is under the age of 18, to use the total income and resources attributable to the child for the period of care, examination, or treatment, except for clothing and personal needs allowance as provided in section 256B.35, to reimburse the county for the cost of care, examination, or treatment. Income and resources attributable to~~

~~the child include, but are not limited to, Social Security benefits, Supplemental Security Income (SSI), veterans benefits, railroad retirement benefits and child support. When the child is over the age of 18, and continues to receive care, examination, or treatment, the court shall order, and the local social services agency shall require, reimbursement from the child for the cost of care, examination, or treatment from the income and resources attributable to the child less the clothing and personal needs allowance.~~

~~(c) If the income and resources attributable to the child are not enough to reimburse the county for the full cost of the care, examination, or treatment, the court shall inquire into the ability of the parents to support the child and, after giving the parents a reasonable opportunity to be heard, the court shall order, and the local social services agency shall require, the parents to contribute to the cost of care, examination, or treatment of the child. Except in delinquency cases where the victim is a member of the child's immediate family, when determining the amount to be contributed by the parents, the court shall use a fee schedule based upon ability to pay that is established by the local social services agency and approved by the commissioner of human services. In delinquency cases where the victim is a member of the child's immediate family, the court shall use the fee schedule but may also take into account the seriousness of the offense and any expenses which the parents have incurred as a result of the offense. The income of a stepparent who has not adopted a child shall be excluded in calculating the parental contribution under this section.~~

~~(d) The court shall order the amount of reimbursement attributable to the parents or custodian, or attributable to the child, or attributable to both sources, withheld under chapter 518A from the income of the parents or the custodian of the child. A parent or custodian who fails to pay without good reason may be proceeded against for contempt, or the court may inform the county attorney, who shall proceed to collect the unpaid sums, or both procedures may be used.~~

~~(e)~~ (b) If the court orders a physical or mental examination for a child, the examination is a medically necessary service for purposes of determining whether the service is covered by a health insurance policy, health maintenance contract, or other health coverage plan. Court-ordered treatment shall be subject to policy, contract, or plan requirements for medical necessity. Nothing in this paragraph changes or eliminates benefit limits, conditions of coverage, co-payments or deductibles, provider restrictions, or other requirements in the policy, contract, or plan that relate to coverage of other medically necessary services.

Sec. 6. Minnesota Statutes 2021 Supplement, section 260C.007, subdivision 14, is amended to read:

Subd. 14. **Egregious harm.** "Egregious harm" means the infliction of bodily harm to a child or neglect of a child which demonstrates a grossly inadequate ability to provide minimally adequate parental care. ~~The egregious harm need not have occurred in the state or in the county where a termination of parental rights action is otherwise properly venued.~~ A district court may still have proper venue over an action to terminate parental rights when the egregious harm did not occur in the state or county where the district court is located. Egregious harm includes, but is not limited to:

(1) conduct ~~towards~~ toward a child that constitutes a violation of sections 609.185 to 609.2114, 609.222, subdivision 2, 609.223, or any other similar law of any other state;

(2) the infliction of "substantial bodily harm" to a child, as defined in section 609.02, subdivision 7a;

(3) conduct ~~towards~~ toward a child that constitutes felony malicious punishment of a child under section 609.377;

(4) conduct ~~towards~~ toward a child that constitutes felony unreasonable restraint of a child under section 609.255, subdivision 3;

(5) conduct ~~towards~~ toward a child that constitutes felony neglect or endangerment of a child under section 609.378;

(6) conduct ~~towards~~ toward a child that constitutes assault under section 609.221, 609.222, or 609.223;

(7) conduct ~~towards~~ toward a child that constitutes sex trafficking, solicitation, inducement, ~~or~~ promotion of, or receiving profit derived from prostitution under section 609.322;

(8) conduct ~~towards~~ toward a child that constitutes murder or voluntary manslaughter as defined by United States Code, title 18, section 1111(a) or 1112(a);

(9) conduct ~~towards~~ toward a child that constitutes aiding or abetting, attempting, conspiring, or soliciting to commit a murder or voluntary manslaughter that constitutes a violation of United States Code, title 18, section 1111(a) or 1112(a); or

(10) conduct toward a child that constitutes criminal sexual conduct under sections 609.342 to 609.345 or sexual extortion under section 609.3458.

Sec. 7. Minnesota Statutes 2020, section 260C.331, subdivision 1, is amended to read:

Subdivision 1. **Care, examination, or treatment.** (a) Except where parental rights are terminated,

(1) whenever legal custody of a child is transferred by the court to a responsible social services agency,

(2) whenever legal custody is transferred to a person other than the responsible social services agency, but under the supervision of the responsible social services agency, or

(3) whenever a child is given physical or mental examinations or treatment under order of the court, and no provision is otherwise made by law for payment for the care, examination, or treatment of the child, these costs are a charge upon the welfare funds of the county in which proceedings are held upon certification of the judge of juvenile court.

~~(b) The court shall order, and the responsible social services agency shall require, the parents or custodian of a child, while the child is under the age of 18, to use the total income and resources attributable to the child for the period of care, examination, or treatment, except for clothing and personal needs allowance as provided in section 256B.35, to reimburse the county for the cost of care, examination, or treatment. Income and resources attributable to the child include, but are not limited to, Social Security benefits, Supplemental Security Income (SSI), veterans benefits, railroad retirement benefits and child support. When the child is over the age of 18, and continues to receive care, examination, or treatment, the court shall order, and the responsible social services agency shall require, reimbursement from the child for the cost of care, examination, or treatment from the income and resources attributable to the child less the clothing and personal needs allowance. Income does not include earnings from a child over the age of 18 who is working as part of a plan under section 260C.212, subdivision 1, paragraph (c), clause (12), to transition from foster care, or the income and resources from sources other than Supplemental Security Income and child support that are needed to complete the requirements listed in section 260C.203.~~

~~(c) If the income and resources attributable to the child are not enough to reimburse the county for the full cost of the care, examination, or treatment, the court shall inquire into the ability of the parents to support the child and, after giving the parents a reasonable opportunity to be heard, the court shall order, and the responsible social services agency shall require, the parents to contribute to the cost of care, examination, or treatment of the child. When determining the amount to be contributed by the parents, the court shall use a fee schedule based upon ability to pay that is established by the responsible social services agency and approved by the commissioner of human services. The income of a stepparent~~

~~who has not adopted a child shall be excluded in calculating the parental contribution under this section.~~

~~(d) The court shall order the amount of reimbursement attributable to the parents or custodian, or attributable to the child, or attributable to both sources, withheld under chapter 518A from the income of the parents or the custodian of the child. A parent or custodian who fails to pay without good reason may be proceeded against for contempt, or the court may inform the county attorney, who shall proceed to collect the unpaid sums, or both procedures may be used.~~

~~(e)~~ (b) If the court orders a physical or mental examination for a child, the examination is a medically necessary service for purposes of determining whether the service is covered by a health insurance policy, health maintenance contract, or other health coverage plan. Court-ordered treatment shall be subject to policy, contract, or plan requirements for medical necessity. Nothing in this paragraph changes or eliminates benefit limits, conditions of coverage, co-payments or deductibles, provider restrictions, or other requirements in the policy, contract, or plan that relate to coverage of other medically necessary services.

~~(f) Notwithstanding paragraph (b), (c), or (d),~~ (c) A parent, custodian, or guardian of the child is not required to use income and resources attributable to the child to reimburse the county for costs of care and is not required to contribute to the cost of care of the child during any period of time when the child is returned to the home of that parent, custodian, or guardian pursuant to a trial home visit under section 260C.201, subdivision 1, paragraph (a).

Sec. 8. Minnesota Statutes 2020, section 260C.451, subdivision 8, is amended to read:

Subd. 8. **Notice of termination of foster care.** When a child in foster care between the ages of 18 and 21 ceases to meet one of the eligibility criteria of subdivision 3a, the responsible social services agency shall give the child written notice that foster care will terminate 30 days from the date the notice is sent. The child or the child's guardian ad litem may file a motion asking the court to review the agency's determination within 15 days of receiving the notice. The child ~~shall~~ must not be discharged from foster care until the motion is heard. The agency shall work with the child to prepare for the child's transition out of foster care ~~as~~. The agency must provide the court with the child's personalized transition plan required to be developed under section ~~260C.203, paragraph (d), clause (2)~~ 260C.452, subdivision 4, if the motion is filed. The written notice of termination of benefits shall be on a form prescribed by the commissioner and shall also give notice of the right to have the agency's determination reviewed by the court in the proceeding where the court conducts

the reviews required under section 260C.203, 260C.317, or 260C.515, subdivision 5 or 6. A copy of the termination notice shall be sent to the child and the child's attorney, if any, the foster care provider, the child's guardian ad litem, and the court. The agency is not responsible for paying foster care benefits for any period of time after the child actually leaves foster care.

Sec. 9. Minnesota Statutes 2020, section 260C.451, is amended by adding a subdivision to read:

Subd. 8a. **Transition planning.** For a youth who will be discharged from foster care at 18 years of age or older, the responsible social services agency must develop a personalized transition plan as directed by the youth during the 180-day period immediately prior to the expected date of discharge according to section 260C.452, subdivision 4. A youth's personalized transition plan must include the support beyond 21 program under subdivision 8b for eligible youth. With a youth's consent, the responsible social services agency may share the youth's personalized transition plan with a contracted agency providing case management services under section 260C.452.

Sec. 10. Minnesota Statutes 2020, section 260C.451, is amended by adding a subdivision to read:

Subd. 8b. **Support beyond 21 program.** For a youth who was eligible for extended foster care under subdivision 3 and is discharged at age 21, the responsible social services agency must ensure that the youth is referred to the support beyond 21 program. The support beyond 21 program must provide a youth with one additional year of financial support for housing and basic needs to assist the youth aging out of extended foster care at age 21. A youth receiving benefits under the support beyond 21 program is also eligible for the successful transition to adulthood program for additional support under section 260C.452. A youth who transitions to residential services under sections 256B.092 and 256B.49 is not eligible for the support beyond 21 program.

Sec. 11. Minnesota Statutes 2020, section 260E.01, is amended to read:

260E.01 POLICY.

(a) The legislature hereby declares that the public policy of this state is to protect children whose health or welfare may be jeopardized through maltreatment. While it is recognized that most parents want to keep their children safe, sometimes circumstances or conditions interfere with their ability to do so. When this occurs, the health and safety of the children

must be of paramount concern. Intervention and prevention efforts must address immediate concerns for child safety and the ongoing risk of maltreatment and should engage the protective capacities of families. In furtherance of this public policy, it is the intent of the legislature under this chapter to:

(1) protect children and promote child safety;

(2) strengthen the family;

(3) make the home, school, and community safe for children by promoting responsible child care in all settings; and

(4) provide, when necessary, a safe temporary or permanent home environment for maltreated children.

(b) In addition, it is the policy of this state to:

(1) require the reporting of maltreatment of children in the home, school, and community settings;

(2) provide for ~~the~~ voluntary reporting of maltreatment of children;

(3) require an investigation when the report alleges sexual abuse or substantial child endangerment, except when the report alleges sex trafficking by a noncaregiver sex trafficker;

(4) provide a family assessment, if appropriate, when the report does not allege sexual abuse or substantial child endangerment; ~~and~~

(5) provide a noncaregiver sex trafficking assessment when the report alleges sex trafficking by a noncaregiver sex trafficker; and

(6) provide protective, family support, and family preservation services when needed in appropriate cases.

Sec. 12. Minnesota Statutes 2020, section 260E.02, subdivision 1, is amended to read:

Subdivision 1. **Establishment of team.** A county shall establish a multidisciplinary child protection team that may include, but is not ~~be~~ limited to, the director of the local welfare agency or designees, the county attorney or designees, the county sheriff or designees, representatives of health and education, representatives of mental health, representatives of agencies providing specialized services or responding to youth who experience or are at risk of experiencing sex trafficking or sexual exploitation, or other appropriate human services or community-based agencies, and parent groups. As used in this section, a "community-based agency" may include, but is not limited to, schools, social services

agencies, family service and mental health collaboratives, children's advocacy centers, early childhood and family education programs, Head Start, or other agencies serving children and families. A member of the team must be designated as the lead person of the team responsible for the planning process to develop standards for the team's activities with battered women's and domestic abuse programs and services.

Sec. 13. Minnesota Statutes 2020, section 260E.03, is amended by adding a subdivision to read:

Subd. 15a. **Noncaregiver sex trafficker.** "Noncaregiver sex trafficker" means an individual who is alleged to have engaged in the act of sex trafficking a child and who is not a person responsible for the child's care, who does not have a significant relationship with the child as defined in section 609.341, and who is not a person in a current or recent position of authority as defined in section 609.341, subdivision 10.

Sec. 14. Minnesota Statutes 2020, section 260E.03, is amended by adding a subdivision to read:

Subd. 15b. **Noncaregiver sex trafficking assessment.** "Noncaregiver sex trafficking assessment" is a comprehensive assessment of child safety, the risk of subsequent child maltreatment, and strengths and needs of the child and family. The local welfare agency shall only perform a noncaregiver sex trafficking assessment when a maltreatment report alleges sex trafficking of a child by someone other than the child's caregiver. A noncaregiver sex trafficking assessment does not include a determination of whether child maltreatment occurred. A noncaregiver sex trafficking assessment includes a determination of a family's need for services to address the safety of a child or children, the safety of family members, and the risk of subsequent child maltreatment.

Sec. 15. Minnesota Statutes 2021 Supplement, section 260E.03, subdivision 22, is amended to read:

Subd. 22. **Substantial child endangerment.** "Substantial child endangerment" means that a person responsible for a child's care, by act or omission, commits or attempts to commit an act against a child ~~under their~~ in the person's care that constitutes any of the following:

(1) egregious harm under subdivision 5;

(2) abandonment under section 260C.301, subdivision 2;

(3) neglect under subdivision 15, paragraph (a), clause (2), that substantially endangers the child's physical or mental health, including a growth delay, which may be referred to as failure to thrive, that has been diagnosed by a physician and is due to parental neglect;

(4) murder in the first, second, or third degree under section 609.185, 609.19, or 609.195;

(5) manslaughter in the first or second degree under section 609.20 or 609.205;

(6) assault in the first, second, or third degree under section 609.221, 609.222, or 609.223;

(7) sex trafficking, solicitation, inducement, ~~and~~ or promotion of prostitution under section 609.322;

(8) criminal sexual conduct under sections 609.342 to 609.3451;

(9) sexual extortion under section 609.3458;

(10) solicitation of children to engage in sexual conduct under section 609.352;

(11) malicious punishment or neglect or endangerment of a child under section 609.377 or 609.378;

(12) use of a minor in sexual performance under section 617.246; or

(13) parental behavior, status, or condition ~~that mandates that~~ requiring the county attorney to file a termination of parental rights petition under section 260C.503, subdivision 2.

Sec. 16. Minnesota Statutes 2020, section 260E.14, subdivision 2, is amended to read:

Subd. 2. **Sexual abuse.** (a) The local welfare agency is the agency responsible for investigating an allegation of sexual abuse if the alleged offender is the parent, guardian, sibling, or an individual functioning within the family unit as a person responsible for the child's care, or a person with a significant relationship to the child if that person resides in the child's household.

(b) The local welfare agency is also responsible for assessing or investigating when a child is identified as a victim of sex trafficking.

Sec. 17. Minnesota Statutes 2020, section 260E.14, subdivision 5, is amended to read:

Subd. 5. **Law enforcement.** (a) The local law enforcement agency is the agency responsible for investigating a report of maltreatment if a violation of a criminal statute is alleged.

(b) Law enforcement and the responsible agency must coordinate their investigations or assessments as required under this chapter when ~~the~~: (1) a report alleges maltreatment that is a violation of a criminal statute by a person who is a parent, guardian, sibling, person responsible for the child's care ~~functioning~~ within the family unit, or by a person who lives in the child's household and who has a significant relationship to the child~~,~~ in a setting other than a facility as defined in section 260E.03; or (2) a report alleges sex trafficking of a child.

Sec. 18. Minnesota Statutes 2020, section 260E.17, subdivision 1, is amended to read:

Subdivision 1. **Local welfare agency.** (a) Upon receipt of a report, the local welfare agency shall determine whether to conduct a family assessment ~~or~~, an investigation, or a noncaregiver sex trafficking assessment as appropriate to prevent or provide a remedy for maltreatment.

(b) The local welfare agency shall conduct an investigation when the report involves sexual abuse, except as indicated in paragraph (f), or substantial child endangerment.

(c) The local welfare agency shall begin an immediate investigation ~~if,~~ at any time when the local welfare agency is ~~using~~ responding with a family assessment ~~response,~~ and the local welfare agency determines that there is reason to believe that sexual abuse ~~or~~, substantial child endangerment, or a serious threat to the child's safety exists.

(d) The local welfare agency may conduct a family assessment for reports that do not allege sexual abuse, except as indicated in paragraph (f), or substantial child endangerment. In determining that a family assessment is appropriate, the local welfare agency may consider issues of child safety, parental cooperation, and the need for an immediate response.

(e) The local welfare agency may conduct a family assessment ~~on~~ for a report that was initially screened and assigned for an investigation. In determining that a complete investigation is not required, the local welfare agency must document the reason for terminating the investigation and notify the local law enforcement agency if the local law enforcement agency is conducting a joint investigation.

(f) The local welfare agency shall conduct a noncaregiver sex trafficking assessment when a maltreatment report alleges sex trafficking of a child and the alleged offender is a noncaregiver sex trafficker as defined by section 260E.03, subdivision 15a.

(g) During a noncaregiver sex trafficking assessment, the local welfare agency shall initiate an immediate investigation if there is reason to believe that a child's parent, caregiver, or household member allegedly engaged in the act of sex trafficking a child or is alleged to have engaged in any conduct requiring the agency to conduct an investigation.

Sec. 19. Minnesota Statutes 2020, section 260E.18, is amended to read:

260E.18 NOTICE TO CHILD'S TRIBE.

The local welfare agency shall provide immediate notice, according to section 260.761, subdivision 2, to an Indian child's tribe when the agency has reason to believe that the family assessment ~~or~~, investigation, or noncaregiver sex trafficking assessment may involve an Indian child. For purposes of this section, "immediate notice" means notice provided within 24 hours.

Sec. 20. Minnesota Statutes 2021 Supplement, section 260E.20, subdivision 2, is amended to read:

Subd. 2. **Face-to-face contact.** (a) Upon receipt of a screened in report, the local welfare agency shall ~~conduct a~~ have face-to-face contact with the child reported to be maltreated and with the child's primary caregiver sufficient to complete a safety assessment and ensure the immediate safety of the child.

(b) Except in a noncaregiver sex trafficking assessment, the local welfare agency shall have face-to-face contact with the child and primary caregiver ~~shall occur~~ immediately after the agency screens in a report if sexual abuse or substantial child endangerment is alleged and within five calendar days of a screened in report for all other reports. If the alleged offender was not already interviewed as the primary caregiver, the local welfare agency shall also conduct a face-to-face interview with the alleged offender in the early stages of the assessment or investigation, except in a noncaregiver sex trafficking assessment. Face-to-face contact with the child and primary caregiver in response to a report alleging sexual abuse or substantial child endangerment may be postponed for no more than five calendar days if the child is residing in a location that is confirmed to restrict contact with the alleged offender as established in guidelines issued by the commissioner, or if the local welfare agency is pursuing a court order for the child's caregiver to produce the child for questioning under section 260E.22, subdivision 5.

(c) At the initial contact with the alleged offender, the local welfare agency or the agency responsible for assessing or investigating the report must inform the alleged offender of the complaints or allegations made against the individual in a manner consistent with laws protecting the rights of the person who made the report. The interview with the alleged offender may be postponed if it would jeopardize an active law enforcement investigation. When conducting a noncaregiver sex trafficking assessment, the local child welfare agency is not required to inform or interview the alleged offender.

(d) The local welfare agency or the agency responsible for assessing or investigating the report must provide the alleged offender with an opportunity to make a statement, except when conducting a noncaregiver sex trafficking assessment. The alleged offender may submit supporting documentation relevant to the assessment or investigation.

Sec. 21. Minnesota Statutes 2020, section 260E.24, subdivision 2, is amended to read:

Subd. 2. **Determination after family assessment or a noncaregiver sex trafficking assessment.** After conducting a family assessment or a noncaregiver sex trafficking assessment, the local welfare agency shall determine whether child protective services are needed to address the safety of the child and other family members and the risk of subsequent maltreatment.

Sec. 22. Minnesota Statutes 2020, section 260E.24, subdivision 7, is amended to read:

Subd. 7. **Notification at conclusion of family assessment or a noncaregiver sex trafficking assessment.** Within ten working days of the conclusion of a family assessment or a noncaregiver sex trafficking assessment, the local welfare agency shall notify the parent or guardian of the child of the need for services to address child safety concerns or significant risk of subsequent maltreatment. The local welfare agency and the family may also jointly agree that family support and family preservation services are needed.

Sec. 23. Minnesota Statutes 2020, section 260E.33, subdivision 1, is amended to read:

Subdivision 1. **Following a family assessment or a noncaregiver sex trafficking assessment.** Administrative reconsideration is not applicable to a family assessment or a noncaregiver sex trafficking assessment since no determination concerning maltreatment is made.

Sec. 24. Minnesota Statutes 2020, section 260E.35, subdivision 6, is amended to read:

Subd. 6. **Data retention.** (a) Notwithstanding sections 138.163 and 138.17, a record maintained or a record derived from a report of maltreatment by a local welfare agency, agency responsible for assessing or investigating the report, court services agency, or school under this chapter shall be destroyed as provided in paragraphs (b) to (e) by the responsible authority.

(b) For a report alleging maltreatment that was not accepted for an assessment or an investigation, a family assessment case, a noncaregiver sex trafficking assessment case, and a case where an investigation results in no determination of maltreatment or the need for

child protective services, the record must be maintained for a period of five years after the date that the report was not accepted for assessment or investigation or the date of the final entry in the case record. A record of a report that was not accepted must contain sufficient information to identify the subjects of the report, the nature of the alleged maltreatment, and the reasons ~~as to~~ why the report was not accepted. Records under this paragraph may not be used for employment, background checks, or purposes other than to assist in future screening decisions and risk and safety assessments.

(c) All records relating to reports that, upon investigation, indicate ~~either~~ maltreatment or a need for child protective services shall be maintained for ten years after the date of the final entry in the case record.

(d) All records regarding a report of maltreatment, including a notification of intent to interview that was received by a school under section 260E.22, subdivision 7, shall be destroyed by the school when ordered to do so by the agency conducting the assessment or investigation. The agency shall order the destruction of the notification when other records relating to the report under investigation or assessment are destroyed under this subdivision.

(e) Private or confidential data released to a court services agency under subdivision 3, paragraph (d), must be destroyed by the court services agency when ordered to do so by the local welfare agency that released the data. The local welfare agency or agency responsible for assessing or investigating the report shall order destruction of the data when other records relating to the assessment or investigation are destroyed under this subdivision.

Sec. 25. **DIRECTION TO COMMISSIONER OF HUMAN SERVICES; FOSTER CARE FEDERAL CASH ASSISTANCE BENEFITS PRESERVATION.**

(a) The commissioner of human services shall develop a plan to implement procedures and policies necessary to cease allowing a financially responsible agency to use the federal cash assistance benefits of a child in foster care to pay for out-of-home placement costs for the child. The plan must ensure that federal cash assistance benefits are preserved and made available to meet the best interests of the child and must include recommendations on the following, in compliance with all applicable federal laws and Minnesota Statutes, chapters 260C and 256N:

(1) policies for youth and caregiver access to preserved federal cash assistance benefit payments;

(2) representative payees for children in voluntary foster care for treatment pursuant to Minnesota Statutes, chapter 260D; and

(3) family preservation and reunification.

(b) For purposes of this section, "federal cash assistance benefits" means all benefits from programs administered by the Social Security Administration, including from the Supplemental Security Income and the Retirement, Survivors, Disability Insurance programs.

(c) When developing the plan under this section, the commissioner shall consult or engage with:

(1) individuals or entities with experience managing trusts and investment;

(2) individuals or entities with expertise in providing tax advice;

(3) individuals or entities with expertise in preserving assets to avoid negative impacts on public assistance eligibility;

(4) other relevant state agencies;

(5) Tribal nations that have joined or are in the formal planning process to join the American Indian Child Welfare Initiative;

(6) counties;

(7) the Children's Justice Initiative;

(8) organizations that serve and advocate for children and families in the child protection system;

(9) parents, legal custodians, foster families, and kinship caregivers, to the extent possible;

(10) youth who have been or are currently in out-of-home placement; and

(11) other relevant stakeholders.

(d) By December 15, 2022, each county shall provide the following data for fiscal years 2019 and 2020 to the commissioner in a form prescribed by the commissioner:

(1) the nonduplicated number of children in foster care in the county who received federal cash assistance benefits;

(2) the number of children for whom the county was the representative payee for federal cash assistance benefits; and

(3) the amount of money that the county collected in federal cash assistance benefits as the representative payee for children in the county.

(e) By January 15, 2024, the commissioner shall submit a report to the chairs and ranking minority members of the legislative committees with jurisdiction over human services and

child welfare outlining the plan developed under this section. The report must include a projected timeline for implementation of the plan, estimated implementation costs, and any legislative recommendations that may be required to implement the plan.

ARTICLE 15
ECONOMIC ASSISTANCE POLICY

Section 1. Minnesota Statutes 2020, section 256P.04, subdivision 11, is amended to read:

Subd. 11. **Participant's completion of household report form.** (a) When a participant is required to complete a household report form, the following paragraphs apply.

(b) If the agency receives an incomplete household report form, the agency must immediately ~~return the incomplete form and clearly state what the participant must do for the form to be complete~~ contact the participant by phone or in writing to acquire the necessary information to complete the form.

(c) The automated eligibility system must send a notice of proposed termination of assistance to the participant if a complete household report form is not received by the agency. The automated notice must be mailed to the participant by approximately the 16th of the month. When a participant submits an incomplete form on or after the date a notice of proposed termination has been sent, the termination is valid unless the participant submits a complete form before the end of the month.

(d) The submission of a household report form is considered to have continued the participant's application for assistance if a complete household report form is received within a calendar month after the month in which the form was due. Assistance shall be paid for the period beginning with the first day of that calendar month.

(e) An agency must allow good cause exemptions for a participant required to complete a household report form when any of the following factors cause a participant to fail to submit a completed household report form before the end of the month in which the form is due:

(1) an employer delays completion of employment verification;

(2) the agency does not help a participant complete the household report form when the participant asks for help;

(3) a participant does not receive a household report form due to a mistake on the part of the department or the agency or a reported change in address;

(4) a participant is ill or physically or mentally incapacitated; or

(5) some other circumstance occurs that a participant could not avoid with reasonable care which prevents the participant from providing a completed household report form before the end of the month in which the form is due.

Sec. 2. Minnesota Statutes 2021 Supplement, section 256P.06, subdivision 3, is amended to read:

Subd. 3. **Income inclusions.** The following must be included in determining the income of an assistance unit:

(1) earned income; and

(2) unearned income, which includes:

(i) interest and dividends from investments and savings;

(ii) capital gains as defined by the Internal Revenue Service from any sale of real property;

(iii) proceeds from rent and contract for deed payments in excess of the principal and interest portion owed on property;

(iv) income from trusts, excluding special needs and supplemental needs trusts;

(v) interest income from loans made by the participant or household;

(vi) cash prizes and winnings;

(vii) unemployment insurance income that is received by an adult member of the assistance unit unless the individual receiving unemployment insurance income is:

(A) 18 years of age and enrolled in a secondary school; or

(B) 18 or 19 years of age, a caregiver, and is enrolled in school at least half-time;

(viii) retirement, survivors, and disability insurance payments;

(ix) nonrecurring income over $60 per quarter unless the nonrecurring income is: (A) from tax refunds, tax rebates, or tax credits; (B) a reimbursement, rebate, award, grant, or refund of personal or real property or costs or losses incurred when these payments are made by: a public agency; a court; solicitations through public appeal; a federal, state, or local unit of government; or a disaster assistance organization; (C) provided as an in-kind benefit; or (D) earmarked and used for the purpose for which it was intended, subject to verification requirements under section 256P.04;

(x) retirement benefits;

(xi) cash assistance benefits, as defined by each program in chapters 119B, 256D, 256I, and 256J;

(xii) Tribal per capita payments unless excluded by federal and state law;

~~(xiii) income and payments from service and rehabilitation programs that meet or exceed the state's minimum wage rate;~~

~~(xiv)~~ (xiii) income from members of the United States armed forces unless excluded from income taxes according to federal or state law;

~~(xv)~~ (xiv) all child support payments for programs under chapters 119B, 256D, and 256I;

~~(xvi)~~ (xv) the amount of child support received that exceeds $100 for assistance units with one child and $200 for assistance units with two or more children for programs under chapter 256J;

~~(xvii)~~ (xvi) spousal support; and

~~(xviii)~~ (xvii) workers' compensation.

Sec. 3. Minnesota Statutes 2020, section 268.19, subdivision 1, is amended to read:

Subdivision 1. **Use of data.** (a) Except as provided by this section, data gathered from any person under the administration of the Minnesota Unemployment Insurance Law are private data on individuals or nonpublic data not on individuals as defined in section 13.02, subdivisions 9 and 12, and may not be disclosed except according to a district court order or section 13.05. A subpoena is not considered a district court order. These data may be disseminated to and used by the following agencies without the consent of the subject of the data:

(1) state and federal agencies specifically authorized access to the data by state or federal law;

(2) any agency of any other state or any federal agency charged with the administration of an unemployment insurance program;

(3) any agency responsible for the maintenance of a system of public employment offices for the purpose of assisting individuals in obtaining employment;

(4) the public authority responsible for child support in Minnesota or any other state in accordance with section 256.978;

(5) human rights agencies within Minnesota that have enforcement powers;

(6) the Department of Revenue to the extent necessary for its duties under Minnesota laws;

(7) public and private agencies responsible for administering publicly financed assistance programs for the purpose of monitoring the eligibility of the program's recipients;

(8) the Department of Labor and Industry and the Commerce Fraud Bureau in the Department of Commerce for uses consistent with the administration of their duties under Minnesota law;

(9) the Department of Human Services and the Office of Inspector General and its agents within the Department of Human Services, including county fraud investigators, for investigations related to recipient or provider fraud and employees of providers when the provider is suspected of committing public assistance fraud;

(10) local and state welfare agencies for monitoring the eligibility of the data subject for assistance programs, or for any employment or training program administered by those agencies, whether alone, in combination with another welfare agency, or in conjunction with the department or to monitor and evaluate the statewide Minnesota family investment program and other cash assistance programs, the Supplemental Nutrition Assistance Program, and the Supplemental Nutrition Assistance Program Employment and Training program by providing data on recipients and former recipients of Supplemental Nutrition Assistance Program (SNAP) benefits, cash assistance under chapter 256, 256D, 256J, or 256K, child care assistance under chapter 119B, or medical programs under chapter 256B or 256L or formerly codified under chapter 256D;

(11) local and state welfare agencies for the purpose of identifying employment, wages, and other information to assist in the collection of an overpayment debt in an assistance program;

(12) local, state, and federal law enforcement agencies for the purpose of ascertaining the last known address and employment location of an individual who is the subject of a criminal investigation;

(13) the United States Immigration and Customs Enforcement has access to data on specific individuals and specific employers provided the specific individual or specific employer is the subject of an investigation by that agency;

(14) the Department of Health for the purposes of epidemiologic investigations;

(15) the Department of Corrections for the purposes of case planning and internal research for preprobation, probation, and postprobation employment tracking of offenders sentenced

to probation and preconfinement and postconfinement employment tracking of committed offenders;

(16) the state auditor to the extent necessary to conduct audits of job opportunity building zones as required under section 469.3201; and

(17) the Office of Higher Education for purposes of supporting program improvement, system evaluation, and research initiatives including the Statewide Longitudinal Education Data System.

(b) Data on individuals and employers that are collected, maintained, or used by the department in an investigation under section 268.182 are confidential as to data on individuals and protected nonpublic data not on individuals as defined in section 13.02, subdivisions 3 and 13, and must not be disclosed except under statute or district court order or to a party named in a criminal proceeding, administrative or judicial, for preparation of a defense.

(c) Data gathered by the department in the administration of the Minnesota unemployment insurance program must not be made the subject or the basis for any suit in any civil proceedings, administrative or judicial, unless the action is initiated by the department.

Sec. 4. **REVISOR INSTRUCTION.**

The revisor of statutes shall renumber each section of Minnesota Statutes listed in column A with the number listed in column B. The revisor shall also make necessary grammatical and cross-reference changes consistent with the renumbering.

Column A	Column B
256D.051, subdivision 20	256D.60, subdivision 1
256D.051, subdivision 21	256D.60, subdivision 2
256D.051, subdivision 22	256D.60, subdivision 3
256D.051, subdivision 23	256D.60, subdivision 4
256D.051, subdivision 24	256D.60, subdivision 5
256D.0512	256D.61
256D.0515	256D.62
256D.0516	256D.63
256D.053	256D.64

Sec. 5. **REPEALER.**

Minnesota Statutes 2020, section 256D.055, is repealed.

ARTICLE 16
ECONOMIC ASSISTANCE

Section 1. Minnesota Statutes 2020, section 119B.011, subdivision 15, is amended to read:

Subd. 15. **Income.** (a) "Income" means earned income as defined under section 256P.01, subdivision 3, unearned income as defined under section 256P.01, subdivision 8, and public assistance cash benefits, including the Minnesota family investment program, diversionary work program, work benefit, Minnesota supplemental aid, general assistance, refugee cash assistance, at-home infant child care subsidy payments, ~~and~~ child support and maintenance distributed to ~~the~~ a family under section 256.741, subdivision 2a~~.~~, and nonrecurring income over $60 per quarter unless the nonrecurring income is:

(1) from tax refunds, tax rebates, or tax credits;

(2) from a reimbursement, rebate, award, grant, or refund of personal or real property or costs or losses incurred when these payments are made by a public agency, a court, a solicitation through public appeal, the federal government, a state or local unit of government, or a disaster assistance organization;

(3) provided as an in-kind benefit; or

(4) earmarked and used for the purpose for which it was intended.

(b) The following are deducted from income: funds used to pay for health insurance premiums for family members, and child or spousal support paid to or on behalf of a person or persons who live outside of the household. Income sources not included in this subdivision and section 256P.06, subdivision 3, are not counted as income.

Sec. 2. Minnesota Statutes 2020, section 119B.025, subdivision 4, is amended to read:

Subd. 4. **Changes in eligibility.** (a) The county shall process a change in eligibility factors according to paragraphs (b) to (g).

(b) A family is subject to the reporting requirements in section 256P.07, subdivision 6.

(c) If a family reports a change or a change is known to the agency before the family's regularly scheduled redetermination, the county must act on the change. The commissioner shall establish standards for verifying a change.

(d) A change in income occurs on the day the participant received the first payment reflecting the change in income.

(e) During a family's 12-month eligibility period, if the family's income increases and remains at or below 85 percent of the state median income, adjusted for family size, there is no change to the family's eligibility. The county shall not request verification of the change. The co-payment fee shall not increase during the remaining portion of the family's 12-month eligibility period.

(f) During a family's 12-month eligibility period, if the family's income increases and exceeds 85 percent of the state median income, adjusted for family size, the family is not eligible for child care assistance. The family must be given 15 calendar days to provide verification of the change. If the required verification is not returned or confirms ineligibility, the family's eligibility ends following a subsequent 15-day adverse action notice.

(g) Notwithstanding Minnesota Rules, parts 3400.0040, subpart 3, and 3400.0170, subpart 1, if an applicant or participant reports that employment ended, the agency may accept a signed statement from the applicant or participant as verification that employment ended.

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

Sec. 3. Minnesota Statutes 2020, section 256D.03, is amended by adding a subdivision to read:

Subd. 2b. **Budgeting and reporting.** Every county agency shall determine eligibility and calculate benefit amounts for general assistance according to chapter 256P.

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

Sec. 4. Minnesota Statutes 2020, section 256D.0515, is amended to read:

256D.0515 ASSET LIMITATIONS FOR SUPPLEMENTAL NUTRITION ASSISTANCE PROGRAM HOUSEHOLDS.

All Supplemental Nutrition Assistance Program (SNAP) households must be determined eligible for the benefit discussed under section 256.029. SNAP households must demonstrate that their gross income is equal to or less than ~~165~~ 200 percent of the federal poverty guidelines for the same family size.

Sec. 5. Minnesota Statutes 2020, section 256D.0516, subdivision 2, is amended to read:

Subd. 2. **SNAP reporting requirements.** The commissioner of human services shall implement simplified reporting as permitted under the Food and Nutrition Act of 2008, as amended, and the SNAP regulations in Code of Federal Regulations, title 7, part 273. SNAP

benefit recipient households required to report periodically shall not be required to report more often than one time every six months. ~~This provision shall not apply to households receiving food benefits under the Minnesota family investment program waiver.~~

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

Sec. 6. Minnesota Statutes 2020, section 256D.06, subdivision 1, is amended to read:

Subdivision 1. **Eligibility; amount of assistance.** General assistance shall be granted to an individual or married couple in an amount ~~that when added to the countable income as determined to be actually~~ equal to the difference between the countable income available ~~to the assistance unit~~ under section 256P.06~~, the total amount equals the applicable standard of assistance for general assistance~~ and the standard for the individual or married couple using the MFIP transitional standard cash portion described in section 256J.24, subdivision 5, paragraph (a). In determining eligibility for and the amount of assistance for an individual or married couple, the agency shall apply the earned income disregard as determined in section 256P.03.

EFFECTIVE DATE. This section is effective October 1, 2023.

Sec. 7. Minnesota Statutes 2020, section 256D.06, subdivision 2, is amended to read:

Subd. 2. **Emergency need.** (a) Notwithstanding the provisions of subdivision 1, a grant of emergency general assistance shall, to the extent funds are available, be made to an eligible single adult, married couple, or family for an emergency need where the recipient requests temporary assistance not exceeding 30 days if an emergency situation appears to exist under written criteria adopted by the county agency. If an applicant or recipient relates facts to the county agency which may be sufficient to constitute an emergency situation, the county agency shall, to the extent funds are available, advise the person of the procedure for applying for assistance according to this subdivision.

(b) The applicant must be ineligible for assistance under chapter 256J, must have annual net income no greater than 200 percent of the federal poverty guidelines for the previous calendar year, and may only receive an emergency assistance grant ~~not more than~~ once in any 12-month period.

(c) Funding for an emergency general assistance program is limited to the appropriation. Each fiscal year, the commissioner shall allocate to counties the money appropriated for emergency general assistance grants based on each county agency's average share of state's emergency general expenditures for the immediate past three fiscal years as determined by

the commissioner, and may reallocate any unspent amounts to other counties. The commissioner may disregard periods of pandemic or other disaster, including fiscal years 2021 and 2022, when determining the amount allocated to counties. No county shall be allocated less than $1,000 for a fiscal year.

(d) Any emergency general assistance expenditures by a county above the amount of the commissioner's allocation to the county must be made from county funds.

Sec. 8. Minnesota Statutes 2020, section 256D.06, subdivision 5, is amended to read:

Subd. 5. **Eligibility; requirements.** (a) Any applicant, otherwise eligible for general assistance and possibly eligible for maintenance benefits from any other source shall (1) make application for those benefits within ~~30~~ 90 days of the general assistance application, unless an applicant had good cause to not apply within that period; and (2) execute an interim assistance agreement on a form as directed by the commissioner.

(b) The commissioner shall review a denial of an application for other maintenance benefits and may require a recipient of general assistance to file an appeal of the denial if appropriate. If found eligible for benefits from other sources, and a payment received from another source relates to the period during which general assistance was also being received, the recipient shall be required to reimburse the county agency for the interim assistance paid. Reimbursement shall not exceed the amount of general assistance paid during the time period to which the other maintenance benefits apply and shall not exceed the state standard applicable to that time period.

(c) The commissioner may contract with the county agencies, qualified agencies, organizations, or persons to provide advocacy and support services to process claims for federal disability benefits for applicants or recipients of services or benefits supervised by the commissioner using money retained under this section.

(d) The commissioner may provide methods by which county agencies shall identify, refer, and assist recipients who may be eligible for benefits under federal programs for people with a disability.

(e) The total amount of interim assistance recoveries retained under this section for advocacy, support, and claim processing services shall not exceed 35 percent of the interim assistance recoveries in the prior fiscal year.

Sec. 9. Minnesota Statutes 2020, section 256E.36, subdivision 1, is amended to read:

Subdivision 1. **Definitions.** (a) The definitions in this subdivision apply to this section.

(b) "Commissioner" means the commissioner of human services.

(c) "Eligible organization" means a local governmental unit, federally recognized Tribal Nation, or nonprofit organization providing or seeking to provide emergency services for homeless persons.

(d) "Emergency services" means:

(1) providing emergency shelter for homeless persons; and

(2) assisting homeless persons in obtaining essential services, including:

(i) access to permanent housing;

(ii) medical and psychological help;

(iii) employment counseling and job placement;

(iv) substance abuse treatment;

(v) financial assistance available from other programs;

(vi) emergency child care;

(vii) transportation; and

(viii) other services needed to stabilize housing.

EFFECTIVE DATE. This section is effective July 1, 2022.

Sec. 10. **[256E.361] EMERGENCY SHELTER FACILITIES GRANTS.**

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 human services.

(c) "Eligible organization" means a local governmental unit, federally recognized Tribal Nation, or nonprofit organization seeking to acquire, construct, renovate, furnish, or equip facilities for emergency homeless shelters for individuals and families experiencing homelessness.

(d) "Emergency services" has the meaning given in section 256E.36, subdivision 1, paragraph (d).

(e) "Emergency shelter facility" or "facility" means a facility that provides a safe, sanitary, accessible, and suitable emergency shelter for individuals and families experiencing

homelessness, regardless of whether the facility provides emergency shelter for emergency services during the day, overnight, or both.

Subd. 2. **Program established; purpose.** An emergency shelter facilities grant program is established to help eligible organizations acquire, construct, renovate, furnish, or equip emergency shelter facilities for individuals and families experiencing homelessness. The program shall be administered by the commissioner.

Subd. 3. **Distribution of grants.** The commissioner must make grants with the purpose of ensuring that emergency shelter facilities are available to meet the needs of individuals and families experiencing homelessness statewide.

Subd. 4. **Applications.** An eligible organization may apply to the commissioner for a grant to acquire, construct, renovate, furnish, or equip an emergency shelter facility providing or seeking to provide emergency services for individuals and families experiencing homelessness. The commissioner shall use a competitive request for proposal process to identify potential projects and eligible organizations on a statewide basis.

Subd. 5. **Criteria for grant awards.** The commissioner shall award grants based on the following criteria:

(1) whether the application is for a grant to acquire, construct, renovate, furnish, or equip an emergency shelter facility for individuals and families experiencing homelessness;

(2) evidence of the applicant's need for state assistance and the need for the particular facility to be funded; and

(3) the applicant's long-range plans for future funding if the need continues to exist for the emergency services provided at the facility.

Subd. 6. **Availability of appropriations.** Appropriations under this section are available for a four-year period that begins on July 1 of the fiscal year in which the appropriation occurs. Unspent funds at the end of the four-year period shall be returned back to the general fund.

Sec. 11. Minnesota Statutes 2020, section 256I.03, subdivision 13, is amended to read:

Subd. 13. **Prospective budgeting.** "Prospective budgeting" ~~means estimating the amount of monthly income a person will have in the payment month~~ has the meaning given in section 256P.01, subdivision 9.

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

Sec. 12. Minnesota Statutes 2020, section 256I.06, subdivision 6, is amended to read:

Subd. 6. **Reports.** Recipients must report changes in circumstances according to section 256P.07 ~~that affect eligibility or housing support payment amounts, other than changes in earned income, within ten days of the change~~. Recipients with countable earned income must complete a household report form ~~at least~~ once every six months according to section 256P.10. ~~If the report form is not received before the end of the month in which it is due, the county agency must terminate eligibility for housing support payments. The termination shall be effective on the first day of the month following the month in which the report was due. If a complete report is received within the month eligibility was terminated, the individual is considered to have continued an application for housing support payment effective the first day of the month the eligibility was terminated.~~

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

Sec. 13. Minnesota Statutes 2021 Supplement, section 256I.06, subdivision 8, is amended to read:

Subd. 8. **Amount of housing support payment.** (a) The amount of a room and board payment to be made on behalf of an eligible individual is determined by subtracting the individual's countable income under section 256I.04, subdivision 1, for a whole calendar month from the room and board rate for that same month. The housing support payment is determined by multiplying the housing support rate times the period of time the individual was a resident or temporarily absent under section 256I.05, subdivision 2a.

(b) For an individual with earned income under paragraph (a), prospective budgeting under section 256P.09 must be used ~~to determine the amount of the individual's payment for the following six-month period. An increase in income shall not affect an individual's eligibility or payment amount until the month following the reporting month. A decrease in income shall be effective the first day of the month after the month in which the decrease is reported~~.

(c) For an individual who receives housing support payments under section 256I.04, subdivision 1, paragraph (c), the amount of the housing support payment is determined by multiplying the housing support rate times the period of time the individual was a resident.

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

Sec. 14. Minnesota Statutes 2020, section 256I.09, is amended to read:

256I.09 COMMUNITY LIVING INFRASTRUCTURE.

The commissioner shall award grants to agencies through an annual competitive process. Grants awarded under this section may be used for: (1) outreach to locate and engage people who are homeless or residing in segregated settings to screen for basic needs and assist with referral to community living resources; (2) building capacity to provide technical assistance and consultation on housing and related support service resources for persons with both disabilities and low income; ~~or~~ (3) streamlining the administration and monitoring activities related to housing support funds; or (4) direct assistance to individuals to access or maintain housing in community settings. Agencies may collaborate and submit a joint application for funding under this section.

Sec. 15. Minnesota Statutes 2020, section 256J.08, subdivision 71, is amended to read:

Subd. 71. **Prospective budgeting.** "Prospective budgeting" ~~means a method of determining the amount of the assistance payment in which the budget month and payment month are the same~~ has the meaning given in section 256P.01, subdivision 9.

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

Sec. 16. Minnesota Statutes 2020, section 256J.08, subdivision 79, is amended to read:

Subd. 79. **Recurring income.** "Recurring income" means a form of income which is:

(1) received periodically, and may be received irregularly when receipt can be anticipated even though the date of receipt cannot be predicted; and

(2) from the same source or of the same type that is received and budgeted in a prospective month ~~and is received in one or both of the first two retrospective months~~.

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

Sec. 17. Minnesota Statutes 2021 Supplement, section 256J.21, subdivision 3, is amended to read:

Subd. 3. **Initial income test.** (a) The agency shall determine initial eligibility by considering all earned and unearned income as defined in section 256P.06. To be eligible for MFIP, the assistance unit's countable income minus the earned income disregards in paragraph (a) and section 256P.03 must be below the family wage level according to section 256J.24, subdivision 7, for that size assistance unit.

~~(a)~~ (b) The initial eligibility determination must disregard the following items:

(1) the earned income disregard as determined in section 256P.03;

(2) dependent care costs must be deducted from gross earned income for the actual amount paid for dependent care up to a maximum of $200 per month for each child less than two years of age, and $175 per month for each child two years of age and older;

(3) all payments made according to a court order for spousal support or the support of children not living in the assistance unit's household shall be disregarded from the income of the person with the legal obligation to pay support; and

(4) an allocation for the unmet need of an ineligible spouse or an ineligible child under the age of 21 for whom the caregiver is financially responsible and who lives with the caregiver according to section 256J.36.

~~(b) After initial eligibility is established,~~ (c) The income test is for a six-month period. The assistance payment calculation is based on ~~the monthly income test~~ prospective budgeting according to section 256P.09.

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

Sec. 18. Minnesota Statutes 2020, section 256J.21, subdivision 4, is amended to read:

Subd. 4. **~~Monthly~~ Income test and determination of assistance payment.** ~~The county agency shall determine ongoing eligibility and the assistance payment amount according to the monthly income test.~~ To be eligible for MFIP, the result of the computations in paragraphs (a) to (e) applied to prospective budgeting must be at least $1.

(a) Apply an income disregard as defined in section 256P.03, to gross earnings and subtract this amount from the family wage level. If the difference is equal to or greater than the MFIP transitional standard, the assistance payment is equal to the MFIP transitional standard. If the difference is less than the MFIP transitional standard, the assistance payment is equal to the difference. The earned income disregard in this paragraph must be deducted every month there is earned income.

(b) All payments made according to a court order for spousal support or the support of children not living in the assistance unit's household must be disregarded from the income of the person with the legal obligation to pay support.

(c) An allocation for the unmet need of an ineligible spouse or an ineligible child under the age of 21 for whom the caregiver is financially responsible and who lives with the caregiver must be made according to section 256J.36.

(d) Subtract unearned income dollar for dollar from the MFIP transitional standard to determine the assistance payment amount.

(e) When income is both earned and unearned, the amount of the assistance payment must be determined by first treating gross earned income as specified in paragraph (a). After determining the amount of the assistance payment under paragraph (a), unearned income must be subtracted from that amount dollar for dollar to determine the assistance payment amount.

~~(f) When the monthly income is greater than the MFIP transitional standard after deductions and the income will only exceed the standard for one month, the county agency must suspend the assistance payment for the payment month.~~

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

Sec. 19. Minnesota Statutes 2021 Supplement, section 256J.33, subdivision 1, is amended to read:

Subdivision 1. **Determination of eligibility.** (a) A county agency must determine MFIP eligibility prospectively ~~for a payment month~~ based on ~~retrospectively~~ assessing income and the county agency's best estimate of the circumstances that will exist in the payment month.

(b) ~~Except as described in section 256J.34, subdivision 1, when prospective eligibility exists,~~ A county agency must calculate the amount of the assistance payment using ~~retrospective~~ prospective budgeting. To determine MFIP eligibility and the assistance payment amount, a county agency must apply countable income, described in sections 256P.06 and 256J.37, subdivisions 3 to ~~10~~ 9, received by members of an assistance unit or by other persons whose income is counted for the assistance unit, described under sections 256J.37, subdivisions 1 to 2, and 256P.06, subdivision 1.

(c) This income must be applied to the MFIP standard of need or family wage level subject to this section and sections 256J.34 to 256J.36. Countable income as described in section 256P.06, subdivision 3, received ~~in a calendar month~~ must be applied to the needs of an assistance unit.

(d) An assistance unit is not eligible when the countable income equals or exceeds the MFIP standard of need or the family wage level for the assistance unit.

EFFECTIVE DATE. This section is effective March 1, 2024, except that the amendment to paragraph (b) striking "10" and inserting "9" is effective July 1, 2023.

Sec. 20. Minnesota Statutes 2020, section 256J.33, subdivision 2, is amended to read:

Subd. 2. **Prospective eligibility.** An agency must determine whether the eligibility requirements that pertain to an assistance unit, including those in sections 256J.11 to 256J.15 and 256P.02, will be met prospectively for the payment ~~month~~ period. ~~Except for the provisions in section 256J.34, subdivision 1,~~ The income test will be applied ~~retrospectively~~ prospectively.

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

Sec. 21. Minnesota Statutes 2020, section 256J.37, subdivision 3, is amended to read:

Subd. 3. **Earned income of wage, salary, and contractual employees.** The agency must include gross earned income less any disregards in the initial ~~and monthly~~ income test. Gross earned income received by persons employed on a contractual basis must be prorated over the period covered by the contract even when payments are received over a lesser period of time.

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

Sec. 22. Minnesota Statutes 2020, section 256J.37, subdivision 3a, is amended to read:

Subd. 3a. **Rental subsidies; unearned income.** (a) Effective July 1, 2003, the agency shall count $50 of the value of public and assisted rental subsidies provided through the Department of Housing and Urban Development (HUD) as unearned income to the cash portion of the MFIP grant. The full amount of the subsidy must be counted as unearned income when the subsidy is less than $50. The income from this subsidy shall be budgeted according to section ~~256J.34~~ 256P.09.

(b) The provisions of this subdivision shall not apply to an MFIP assistance unit which includes a participant who is:

(1) age 60 or older;

(2) a caregiver who is suffering from an illness, injury, or incapacity that has been certified by a qualified professional when the illness, injury, or incapacity is expected to continue for more than 30 days and severely limits the person's ability to obtain or maintain suitable employment; or

(3) a caregiver whose presence in the home is required due to the illness or incapacity of another member in the assistance unit, a relative in the household, or a foster child in the household when the illness or incapacity and the need for the participant's presence in the

home has been certified by a qualified professional and is expected to continue for more than 30 days.

(c) The provisions of this subdivision shall not apply to an MFIP assistance unit where the parental caregiver is an SSI participant.

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

Sec. 23. Minnesota Statutes 2020, section 256J.95, subdivision 19, is amended to read:

Subd. 19. **DWP overpayments and underpayments.** DWP benefits are subject to overpayments and underpayments. Anytime an overpayment or an underpayment is determined for DWP, the correction shall be calculated using prospective budgeting. Corrections shall be determined based on the policy in section ~~256J.34, subdivision 1, paragraphs (a), (b), and (c)~~ 256P.09, subdivisions 1 to 4. ATM errors must be recovered as specified in section 256P.08, subdivision 7. Cross program recoupment of overpayments cannot be assigned to or from DWP.

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

Sec. 24. Minnesota Statutes 2020, section 256K.45, subdivision 3, is amended to read:

Subd. 3. **Street and community outreach and drop-in program.** Youth drop-in centers must provide walk-in access to crisis intervention and ongoing supportive services including one-to-one case management services on a self-referral basis. Street and community outreach programs must locate, contact, and provide information, referrals, and services to homeless youth, youth at risk of homelessness, and runaways. Information, referrals, and services provided may include, but are not limited to:

(1) family reunification services;

(2) conflict resolution or mediation counseling;

(3) assistance in obtaining temporary emergency shelter;

(4) assistance in obtaining food, clothing, medical care, or mental health counseling;

(5) counseling regarding violence, sexual exploitation, substance abuse, sexually transmitted diseases, and pregnancy;

(6) referrals to other agencies that provide support services to homeless youth, youth at risk of homelessness, and runaways;

(7) assistance with education, employment, and independent living skills;

(8) aftercare services;

(9) specialized services for highly vulnerable runaways and homeless youth, including ~~teen~~ but not limited to youth at risk of discrimination based on sexual orientation or gender identity, young parents, emotionally disturbed and mentally ill youth, and sexually exploited youth; and

(10) homelessness prevention.

EFFECTIVE DATE. This section is effective July 1, 2022.

Sec. 25. Minnesota Statutes 2020, section 256P.01, is amended by adding a subdivision to read:

Subd. 9. **Prospective budgeting.** "Prospective budgeting" means estimating the amount of monthly income that an assistance unit will have in the payment month.

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

Sec. 26. Minnesota Statutes 2021 Supplement, section 256P.04, subdivision 4, is amended to read:

Subd. 4. **Factors to be verified.** (a) The agency shall verify the following at application:

(1) identity of adults;

(2) age, if necessary to determine eligibility;

(3) immigration status;

(4) income;

(5) spousal support and child support payments made to persons outside the household;

(6) vehicles;

(7) checking and savings accounts, including but not limited to any business accounts used to pay expenses not related to the business;

(8) inconsistent information, if related to eligibility;

(9) residence; and

(10) Social Security number~~; and~~.

~~(11) use of nonrecurring income under section 256P.06, subdivision 3, clause (2), item (ix), for the intended purpose for which it was given and received.~~

(b) Applicants who are qualified noncitizens and victims of domestic violence as defined under section 256J.08, subdivision 73, clauses (8) and (9), are not required to verify the information in paragraph (a), clause (10). When a Social Security number is not provided to the agency for verification, this requirement is satisfied when each member of the assistance unit cooperates with the procedures for verification of Social Security numbers, issuance of duplicate cards, and issuance of new numbers which have been established jointly between the Social Security Administration and the commissioner.

EFFECTIVE DATE. This section is effective July 1, 2023.

Sec. 27. Minnesota Statutes 2021 Supplement, section 256P.04, subdivision 8, is amended to read:

Subd. 8. **Recertification.** The agency shall recertify eligibility annually. During recertification and reporting under section 256P.10, the agency shall verify the following:

(1) income, unless excluded, including self-employment earnings;

(2) assets when the value is within $200 of the asset limit; and

(3) inconsistent information, if related to eligibility.

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

Sec. 28. Minnesota Statutes 2021 Supplement, section 256P.06, subdivision 3, is amended to read:

Subd. 3. **Income inclusions.** The following must be included in determining the income of an assistance unit:

(1) earned income; and

(2) unearned income, which includes:

(i) interest and dividends from investments and savings;

(ii) capital gains as defined by the Internal Revenue Service from any sale of real property;

(iii) proceeds from rent and contract for deed payments in excess of the principal and interest portion owed on property;

(iv) income from trusts, excluding special needs and supplemental needs trusts;

(v) interest income from loans made by the participant or household;

(vi) cash prizes and winnings;

(vii) unemployment insurance income that is received by an adult member of the assistance unit unless the individual receiving unemployment insurance income is:

(A) 18 years of age and enrolled in a secondary school; or

(B) 18 or 19 years of age, a caregiver, and is enrolled in school at least half-time;

(viii) for the purposes of programs under chapters 256D and 256I, retirement, survivors, and disability insurance payments;

~~(ix) nonrecurring income over $60 per quarter unless the nonrecurring income is: (A) from tax refunds, tax rebates, or tax credits; (B) a reimbursement, rebate, award, grant, or refund of personal or real property or costs or losses incurred when these payments are made by: a public agency; a court; solicitations through public appeal; a federal, state, or local unit of government; or a disaster assistance organization; (C) provided as an in-kind benefit; or (D) earmarked and used for the purpose for which it was intended, subject to verification requirements under section 256P.04;~~

~~(x)~~ (ix) retirement benefits;

~~(xi)~~ (x) cash assistance benefits, as defined by each program in chapters 119B, 256D, 256I, and 256J;

~~(xii)~~ (xi) Tribal per capita payments unless excluded by federal and state law;

~~(xiii)~~ (xii) income and payments from service and rehabilitation programs that meet or exceed the state's minimum wage rate;

~~(xiv)~~ (xiii) income from members of the United States armed forces unless excluded from income taxes according to federal or state law;

~~(xv)~~ (xiv) for the purposes of programs under chapters 119B, 256D, and 256I, all child support payments ~~for programs under chapters 119B, 256D, and 256I~~;

~~(xvi)~~ (xv) for the purposes of programs under chapter 256J, the amount of child support received that exceeds $100 for assistance units with one child and $200 for assistance units with two or more children ~~for programs under chapter 256J~~;

~~(xvii)~~ (xvi) spousal support; ~~and~~

~~(xviii)~~ (xvii) workers' compensation~~.~~; and

(xviii) for the purposes of programs under chapters 119B and 256J, the amount of retirement, survivors, and disability insurance payments that exceeds the applicable monthly federal maximum Supplemental Security Income payments.

EFFECTIVE DATE. This section is effective July 1, 2022, except the amendment removing nonrecurring income over $60 per quarter is effective July 1, 2023.

Sec. 29. Minnesota Statutes 2020, section 256P.07, subdivision 1, is amended to read:

Subdivision 1. **Exempted programs.** Participants who receive Supplemental Security Income and qualify for Minnesota supplemental aid under chapter 256D ~~and~~ or for housing support under chapter 256I ~~on the basis of eligibility for Supplemental Security Income~~ are exempt from ~~this section~~ reporting income under this chapter.

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

Sec. 30. Minnesota Statutes 2020, section 256P.07, is amended by adding a subdivision to read:

Subd. 1a. **Child care assistance programs.** Participants who qualify for child care assistance programs under chapter 119B are exempt from this section except the reporting requirements in subdivision 6.

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

Sec. 31. Minnesota Statutes 2020, section 256P.07, subdivision 2, is amended to read:

Subd. 2. **Reporting requirements.** An applicant or participant must provide information on an application and any subsequent reporting forms about the assistance unit's circumstances that affect eligibility or benefits. An applicant or assistance unit must report changes that affect eligibility or benefits as identified in ~~subdivision~~ subdivisions 3, 4, 5, 7, 8, and 9, during the application period or by the tenth of the month following the month the assistance unit's circumstances changed. When information is not accurately reported, both an overpayment and a referral for a fraud investigation may result. When information or documentation is not provided, the receipt of any benefit may be delayed or denied, depending on the type of information required and its effect on eligibility.

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

Sec. 32. Minnesota Statutes 2020, section 256P.07, subdivision 3, is amended to read:

Subd. 3. **Changes that must be reported.** ~~An assistance unit must report the changes or anticipated changes specified in clauses (1) to (12) within ten days of the date they occur, at the time of recertification of eligibility under section 256P.04, subdivisions 8 and 9, or within eight calendar days of a reporting period, whichever occurs first. An assistance unit~~

~~must report other changes at the time of recertification of eligibility under section 256P.04, subdivisions 8 and 9, or at the end of a reporting period, as applicable. When an agency could have reduced or terminated assistance for one or more payment months if a delay in reporting a change specified under clauses (1) to (12) had not occurred, the agency must determine whether a timely notice could have been issued on the day that the change occurred. When a timely notice could have been issued, each month's overpayment subsequent to that notice must be considered a client error overpayment under section 119B.11, subdivision 2a, or 256P.08. Changes in circumstances that must be reported within ten days must also be reported for the reporting period in which those changes occurred. Within ten days, an assistance unit must report:~~

~~(1) a change in earned income of $100 per month or greater with the exception of a program under chapter 119B;~~

~~(2) a change in unearned income of $50 per month or greater with the exception of a program under chapter 119B;~~

~~(3) a change in employment status and hours with the exception of a program under chapter 119B;~~

~~(4) a change in address or residence;~~

~~(5) a change in household composition with the exception of programs under chapter 256I;~~

~~(6) a receipt of a lump-sum payment with the exception of a program under chapter 119B;~~

~~(7) an increase in assets if over $9,000 with the exception of programs under chapter 119B;~~

~~(8) a change in citizenship or immigration status;~~

~~(9) a change in family status with the exception of programs under chapter 256I;~~

~~(10) a change in disability status of a unit member, with the exception of programs under chapter 119B;~~

~~(11) a new rent subsidy or a change in rent subsidy with the exception of a program under chapter 119B; and~~

~~(12) a sale, purchase, or transfer of real property with the exception of a program under chapter 119B.~~

(a) An assistance unit must report changes or anticipated changes as described in this subdivision.

(b) An assistance unit must report:

(1) a change in eligibility for Supplemental Security Income, Retirement Survivors Disability Insurance, or another federal income support;

(2) a change in address or residence;

(3) a change in household composition with the exception of programs under chapter 256I;

(4) cash prizes and winnings according to guidance provided for the Supplemental Nutrition Assistance Program;

(5) a change in citizenship or immigration status;

(6) a change in family status with the exception of programs under chapter 256I; and

(7) a change that makes the value of the unit's assets at or above the asset limit.

(c) When an agency could have reduced or terminated assistance for one or more payment months if a delay in reporting a change specified under paragraph (b) had not occurred, the agency must determine the first month that the agency could have reduced or terminated assistance following a timely notice given on the date of the change in income. Each month's overpayment starting with that month must be considered a client error overpayment under section 256P.08.

EFFECTIVE DATE. This section is effective March 1, 2024, except that the amendment striking clause (6) is effective July 1, 2023.

Sec. 33. Minnesota Statutes 2020, section 256P.07, subdivision 4, is amended to read:

Subd. 4. **MFIP-specific reporting.** In addition to subdivision 3, an assistance unit under chapter 256J~~, within ten days of the change,~~ must report:

(1) a pregnancy not resulting in birth when there are no other minor children; ~~and~~

(2) a change in school attendance of a parent under 20 years of age ~~or of an employed child.~~; and

(3) an individual in the household who is 18 or 19 years of age attending high school who graduates or drops out of school.

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

Sec. 34. Minnesota Statutes 2020, section 256P.07, subdivision 6, is amended to read:

Subd. 6. **Child care assistance programs-specific reporting.** (a) ~~In addition to subdivision 3,~~ An assistance unit under chapter 119B, within ten days of the change, must report:

(1) a change in a parentally responsible individual's custody schedule for any child receiving child care assistance program benefits;

(2) a permanent end in a parentally responsible individual's authorized activity; ~~and~~

(3) if the unit's family's annual included income exceeds 85 percent of the state median income, adjusted for family size~~.~~;

(4) a change in address or residence;

(5) a change in household composition;

(6) a change in citizenship or immigration status; and

(7) a change in family status.

(b) An assistance unit subject to section 119B.095, subdivision 1, paragraph (b), must report a change in the unit's authorized activity status.

(c) An assistance unit must notify the county when the unit wants to reduce the number of authorized hours for children in the unit.

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

Sec. 35. Minnesota Statutes 2020, section 256P.07, subdivision 7, is amended to read:

Subd. 7. **Minnesota supplemental aid-specific reporting.** (a) In addition to subdivision 3, an assistance unit participating in the Minnesota supplemental aid program under ~~section 256D.44, subdivision 5, paragraph (g), within ten days of the change,~~ chapter 256D and not receiving Supplemental Security Income must report ~~shelter expenses.~~:

(1) a change in unearned income of $50 per month or greater; and

(2) a change in earned income of $100 per month or greater.

(b) An assistance unit receiving housing assistance under section 256D.44, subdivision 5, paragraph (g), including assistance units that also receive Supplemental Security Income, must report:

(1) a change in shelter expenses; and

(2) a new rent subsidy or a change in rent subsidy.

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

Sec. 36. Minnesota Statutes 2020, section 256P.07, is amended by adding a subdivision to read:

Subd. 8. **Housing support-specific reporting.** (a) In addition to subdivision 3, an assistance unit participating in the housing support program under chapter 256I and not receiving Supplemental Security Income must report:

(1) a change in unearned income of $50 per month or greater; and

(2) a change in earned income of $100 per month or greater, unless the assistance unit is already subject to six-month reporting requirements in section 256P.10.

(b) Notwithstanding the exemptions in subdivisions 1 and 3, an assistance unit receiving housing support under chapter 256I, including an assistance unit that receives Supplemental Security Income, must report:

(1) a new rent subsidy or a change in rent subsidy;

(2) a change in the disability status of a unit member; and

(3) a change in household composition if the assistance unit is a participant in housing support under section 256I.04, subdivision 3, paragraph (a), clause (3).

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

Sec. 37. Minnesota Statutes 2020, section 256P.07, is amended by adding a subdivision to read:

Subd. 9. **General assistance-specific reporting.** In addition to subdivision 3, an assistance unit participating in the general assistance program under chapter 256D must report:

(1) a change in unearned income of $50 per month or greater;

(2) a change in earned income of $100 per month or greater, unless the assistance unit is already subject to six-month reporting requirements in section 256P.10; and

(3) changes in any condition that would result in the loss of basis for eligibility in section 256D.05, subdivision 1, paragraph (a).

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

Sec. 38. **[256P.09] PROSPECTIVE BUDGETING OF BENEFITS.**

Subdivision 1. **Exempted programs.** Assistance units that qualify for child care assistance programs under chapter 119B, assistance units that receive housing support under chapter 256I and are not subject to reporting under section 256P.10, and assistance units that qualify for Minnesota supplemental aid under chapter 256D are exempt from this section.

Subd. 2. **Prospective budgeting of benefits.** An agency subject to this chapter must use prospective budgeting to calculate the assistance payment amount.

Subd. 3. **Initial income.** For the purpose of determining an assistance unit's level of benefits, an agency must take into account the income already received by the assistance unit during or anticipated to be received during the application period. Income anticipated to be received only in the initial month of eligibility should only be counted in the initial month.

Subd. 4. **Income determination.** An agency must use prospective budgeting to determine the amount of the assistance unit's benefit for the eligibility period based on the best information available at the time of approval. An agency shall only count anticipated income when the participant and the agency are reasonably certain of the amount of the payment and the month in which the payment will be received. If the exact amount of the income is not known, the agency shall consider only the amounts that can be anticipated as income.

Subd. 5. **Income changes.** An increase in income shall not affect an assistance unit's eligibility or benefit amount until the next review unless otherwise required to be reported in section 256P.07. A decrease in income shall be effective on the date that the change occurs if the change is reported by the tenth of the month following the month when the change occurred. If the assistant unit does not report the change in income by the tenth of the month following the month when the change occurred, the change in income shall be effective on the date the change was reported.

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

Sec. 39. **[256P.10] SIX-MONTH REPORTING.**

Subdivision 1. **Exempted programs.** Assistance units that qualify for child care assistance programs under chapter 119B, assistance units that qualify for Minnesota supplemental aid under chapter 256D, and assistance units that qualify for housing support under chapter 256I and also receive Supplemental Security Income are exempt from this section.

Subd. 2. **Reporting.** (a) An assistance unit that qualifies for the Minnesota family investment program under chapter 256J, an assistance unit that qualifies for general assistance under chapter 256D with an earned income of $100 per month or greater, or an assistance unit that qualifies for housing support under chapter 256I with an earned income of $100 per month or greater is subject to six-month reviews. The initial reporting period may be shorter than six months in order to align with other programs' reporting periods.

(b) An assistance unit that qualifies for the Minnesota family investment program or an assistance unit that qualifies for general assistance with an earned income of $100 per month or greater must complete household report forms as required by the commissioner for redetermination of benefits.

(c) An assistance unit that qualifies for housing support with an earned income of $100 per month or greater must complete household report forms as prescribed by the commissioner to provide information about earned income.

(d) An assistance unit that qualifies for housing support and also receives assistance through the Minnesota family investment program shall be subject to requirements of this section for purposes of the Minnesota family investment program but not for housing support.

(e) An assistance unit covered by this section must submit a household report form in compliance with the provisions in section 256P.04, subdivision 11.

(f) An assistance unit covered by this section may choose to report changes under this section at any time.

Subd. 3. **When to terminate assistance.** (a) An agency must terminate benefits when the assistance unit fails to submit the household report form before the end of the six-month review period as described in subdivision 2, paragraph (a). If the assistance unit submits the household report form within 30 days of the termination of benefits and remains eligible, benefits must be reinstated and made available retroactively for the full benefit month.

(b) When an assistance unit is determined to be ineligible for assistance according to this section and chapter 256D, 256I, or 256J, the commissioner must terminate assistance.

Sec. 40. **PILOT PROGRAM FOR CHOSEN FAMILY HOSTING TO PREVENT YOUTH HOMELESSNESS.**

Subdivision 1. **Establishment.** The commissioner of human services must establish a pilot program for providers seeking to establish or expand services for homeless youth that formalize situations where a caring adult who a youth considers chosen family allows a youth to stay at the adult's residence to avoid being homeless.

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

(b) "Chosen family" means any individual, related by blood or affinity, whose close association fulfills the need of a familial relationship.

(c) "Set of participants" means a youth aged 18 to 24 and (1) an adult host who is the youth's chosen family and with whom the youth is living in an intergenerational hosting arrangement to avoid being homeless, or (2) a relative with whom the youth is living to avoid being homeless.

Subd. 3. **Administration.** (a) The commissioner of human services, as authorized by Minnesota Statutes, section 256.01, subdivision 2, paragraph (a), clause (6), shall 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.

(b) When developing the criteria for awarding funds, the commissioner must include a requirement that all funding recipients:

(1) partner with sets of participants, with a case manager caseload consistent with existing norms for homeless youth;

(2) mediate agreements within each set of participants about shared expectations regarding the living arrangement;

(3) provide monthly stipends to sets of participants to offset the costs created by the living arrangement;

(4) connect sets of participants to community resources;

(5) if the adult host is a renter, help facilitate ongoing communication between the property owner and adult host;

(6) offer strategies to address barriers faced by adult hosts who are renters;

(7) assist the youth in identifying and strengthening their circle of support, giving focused attention to adults who can serve as permanent connections and provide ongoing support throughout the youth's life; and

(8) actively participate in monthly cohort meetings.

Subd. 4. **Technical assistance provider.** The commissioner must select a technical assistance provider to provide assistance to funding recipients. In order to be selected, the technical assistance provider must:

(1) have in-depth experience with research on and evaluation of youth homelessness from a holistic perspective that addresses the four core outcomes developed by the United States Interagency Council on Homelessness to prevent and end youth homelessness;

(2) offer education and have previous experience providing technical assistance on supporting chosen family hosting arrangements to organizations that serve homeless youth;

(3) have expertise on how to address barriers faced by chosen family hosts who are renters; and

(4) be located in Minnesota.

Subd. 5. **Eligible applicants.** To be eligible for funding under this section, an applicant must be a provider serving homeless youth in Minnesota. The money must be awarded to funding recipients beginning no later than March 31, 2023.

Subd. 6. **Applications.** Providers seeking funding under this section shall apply to the commissioner. The applicant must include a description of the project that the applicant is proposing, the amount of money that the applicant is seeking, and a proposed budget describing how the applicant will spend the money.

Subd. 7. **Reporting.** The technical assistance provider must submit annual updates and a final report to the commissioner in a manner specified by the commissioner on the technical assistance provider's findings regarding the efficacy and cost-effectiveness of the pilot program.

Sec. 41. **DIRECTION TO COMMISSIONER; INCOME AND ASSET EXCLUSION FOR LOCAL GUARANTEED INCOME DEMONSTRATION PROJECTS.**

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

(b) "Commissioner" means the commissioner of human services unless specified otherwise.

(c) "Guaranteed income demonstration project" means a local demonstration project to evaluate how unconditional cash payments have a causal effect on income volatility, financial well-being, and early childhood development in infants and toddlers.

Subd. 2. **Commissioner; income and asset exclusion.** (a) During the duration of the guaranteed income demonstration project, the commissioner shall not count payments made to families by the guaranteed income demonstration project as income or assets for purposes of determining or redetermining eligibility for the following programs:

(1) child care assistance programs under Minnesota Statutes, chapter 119B; and

(2) the Minnesota family investment program, work benefit program, or diversionary work program under Minnesota Statutes, chapter 256J.

(b) During the duration of the guaranteed income demonstration project, the commissioner shall not count payments made to families by the guaranteed income demonstration project as income or assets for purposes of determining or redetermining eligibility for the following programs:

(1) medical assistance under Minnesota Statutes, chapter 256B; and

(2) MinnesotaCare under Minnesota Statutes, chapter 256L.

EFFECTIVE DATE. This section is effective July 1, 2022, except for subdivision 2, paragraph (b), which is effective July 1, 2022, or upon federal approval, whichever is later.

Sec. 42. **REPEALER.**

(a) Minnesota Statutes 2020, sections 256J.08, subdivisions 10, 61, 62, 81, and 83; 256J.30, subdivisions 5 and 7; 256J.33, subdivisions 3 and 5; 256J.34, subdivisions 1, 2, 3, and 4; and 256J.37, subdivision 10, are repealed.

(b) Minnesota Statutes 2021 Supplement, sections 256J.08, subdivision 53; 256J.30, subdivision 8; and 256J.33, subdivision 4, are repealed.

EFFECTIVE DATE. This section is effective March 1, 2024, except the repeal of Minnesota Statutes 2020, sections 256J.08, subdivision 62, and 256J.37, subdivision 10, and Minnesota Statutes 2021 Supplement, section 256J.08, subdivision 53, is effective July 1, 2023.

ARTICLE 17
DIRECT CARE AND TREATMENT POLICY

Section 1. Minnesota Statutes 2020, section 253B.18, subdivision 6, is amended to read:

Subd. 6. **Transfer.** (a) A patient who is a person who has a mental illness and is dangerous to the public shall not be transferred out of a secure treatment facility unless it appears to the satisfaction of the commissioner, after a hearing and favorable recommendation

by a majority of the special review board, that the transfer is appropriate. Transfer may be to another state-operated treatment program. In those instances where a commitment also exists to the Department of Corrections, transfer may be to a facility designated by the commissioner of corrections.

(b) The following factors must be considered in determining whether a transfer is appropriate:

(1) the person's clinical progress and present treatment needs;

(2) the need for security to accomplish continuing treatment;

(3) the need for continued institutionalization;

(4) which facility can best meet the person's needs; and

(5) whether transfer can be accomplished with a reasonable degree of safety for the public.

(c) If a committed person has been transferred out of a secure treatment facility pursuant to this subdivision, that committed person may voluntarily return to a secure treatment facility for a period of up to 60 days with the consent of the head of the treatment facility.

(d) If the committed person is not returned to the original, nonsecure transfer facility within 60 days of being readmitted to a secure treatment facility, the transfer is revoked and the committed person shall remain in a secure treatment facility. The committed person shall immediately be notified in writing of the revocation.

(e) Within 15 days of receiving notice of the revocation, the committed person may petition the special review board for a review of the revocation. The special review board shall review the circumstances of the revocation and shall recommend to the commissioner whether or not the revocation shall be upheld. The special review board may also recommend a new transfer at the time of the revocation hearing.

(f) No action by the special review board is required if the transfer has not been revoked and the committed person is returned to the original, nonsecure transfer facility with no substantive change to the conditions of the transfer ordered under this subdivision.

(g) The head of the treatment facility may revoke a transfer made under this subdivision and require a committed person to return to a secure treatment facility if:

(1) remaining in a nonsecure setting does not provide a reasonable degree of safety to the committed person or others; or

(2) the committed person has regressed clinically and the facility to which the committed person was transferred does not meet the committed person's needs.

(h) Upon the revocation of the transfer, the committed person shall be immediately returned to a secure treatment facility. A report documenting the reasons for revocation shall be issued by the head of the treatment facility within seven days after the committed person is returned to the secure treatment facility. Advance notice to the committed person of the revocation is not required.

(i) The committed person must be provided a copy of the revocation report and informed, orally and in writing, of the rights of a committed person under this section. The revocation report shall be served upon the committed person, the committed person's counsel, and the designated agency. The report shall outline the specific reasons for the revocation, including but not limited to the specific facts upon which the revocation is based.

(j) If a committed person's transfer is revoked, the committed person may re-petition for transfer according to subdivision 5.

(k) A committed person aggrieved by a transfer revocation decision may petition the special review board within seven business days after receipt of the revocation report for a review of the revocation. The matter shall be scheduled within 30 days. The special review board shall review the circumstances leading to the revocation and, after considering the factors in paragraph (b), shall recommend to the commissioner whether or not the revocation shall be upheld. The special review board may also recommend a new transfer out of a secure facility at the time of the revocation hearing.

Sec. 2. Minnesota Statutes 2021 Supplement, section 256.01, subdivision 42, is amended to read:

Subd. 42. **Expiration of report mandates.** (a) If the submission of a report by the commissioner of human services to the legislature is mandated by statute and the enabling legislation does not include a date for the submission of a final report or an expiration date, the mandate to submit the report shall expire in accordance with this section.

(b) If the mandate requires the submission of an annual or more frequent report and the mandate was enacted before January 1, 2021, the mandate shall expire on January 1, 2023. If the mandate requires the submission of a biennial or less frequent report and the mandate was enacted before January 1, 2021, the mandate shall expire on January 1, 2024.

(c) Any reporting mandate enacted on or after January 1, 2021, shall expire three years after the date of enactment if the mandate requires the submission of an annual or more

frequent report and shall expire five years after the date of enactment if the mandate requires the submission of a biennial or less frequent report unless the enacting legislation provides for a different expiration date.

(d) By January 15 of each year, the commissioner shall submit a list ~~to the chairs and ranking minority members of the legislative committees with jurisdiction over human services by February 15 of each year, beginning February 15, 2022,~~ of all reports set to expire during the following calendar year ~~in accordance with this section~~ to the chairs and ranking minority members of the legislative committees with jurisdiction over human services. Notwithstanding paragraph (c), this paragraph does not expire.

Sec. 3. Laws 2009, chapter 79, article 13, section 3, subdivision 10, as amended by Laws 2009, chapter 173, article 2, section 1, is amended to read:

Subd. 10. **State-Operated Services**

The amounts that may be spent from the appropriation for each purpose are as follows:

Transfer Authority Related to State-Operated Services. Money appropriated to finance state-operated services may be transferred between the fiscal years of the biennium with the approval of the commissioner of finance.

County Past Due Receivables. The commissioner is authorized to withhold county federal administrative reimbursement when the county of financial responsibility for cost-of-care payments due the state under Minnesota Statutes, section 246.54 or 253B.045, is 90 days past due. The commissioner shall deposit the withheld federal administrative earnings for the county into the general fund to settle the claims with the county of financial responsibility. The process for withholding funds is governed by Minnesota Statutes, section 256.017.

Forecast and Census Data. The commissioner shall include census data and fiscal projections for state-operated services and Minnesota sex offender services with the ~~November and~~ February budget ~~forecasts. Notwithstanding any contrary provision in this article, this paragraph shall not expire~~ forecast.

(a) Adult Mental Health Services	106,702,000	107,201,000

Appropriation Limitation. No part of the appropriation in this article to the commissioner for mental health treatment services provided by state-operated services shall be used for the Minnesota sex offender program.

Community Behavioral Health Hospitals. Under Minnesota Statutes, section 246.51, subdivision 1, a determination order for the clients served in a community behavioral health hospital operated by the commissioner of human services is only required when a client's third-party coverage has been exhausted.

Base Adjustment. The general fund base is decreased by $500,000 for fiscal year 2012 and by $500,000 for fiscal year 2013.

(b) Minnesota Sex Offender Services

	Appropriations by Fund	
General	38,348,000	67,503,000
Federal Fund	26,495,000	0

Use of Federal Stabilization Funds. Of this appropriation, $26,495,000 in fiscal year 2010 is from the fiscal stabilization account in the federal fund to the commissioner. This appropriation must not be used for any activity

or service for which federal reimbursement is claimed. This is a onetime appropriation.

(c) Minnesota Security Hospital and METO Services

	Appropriations by Fund	
General	230,000	83,735,000
Federal Fund	83,505,000	0

Minnesota Security Hospital. For the purposes of enhancing the safety of the public, improving supervision, and enhancing community-based mental health treatment, state-operated services may establish additional community capacity for providing treatment and supervision of clients who have been ordered into a less restrictive alternative of care from the state-operated services transitional services program consistent with Minnesota Statutes, section 246.014.

Use of Federal Stabilization Funds. $83,505,000 in fiscal year 2010 is appropriated from the fiscal stabilization account in the federal fund to the commissioner. This appropriation must not be used for any activity or service for which federal reimbursement is claimed. This is a onetime appropriation.

Sec. 4. **REPEALER.**

Minnesota Statutes 2020, sections 246.0136; 252.025, subdivision 7; and 252.035, are repealed.

ARTICLE 18

PREVENTING HOMELESSNESS

Section 1. Minnesota Statutes 2020, section 145.4716, is amended by adding a subdivision to read:

Subd. 4. **Funding.** The commissioner must prioritize providing trauma-informed, culturally inclusive services for sexually exploited youth or youth at risk of sexual exploitation under this section.

Sec. 2. Minnesota Statutes 2020, section 256E.33, subdivision 1, is amended to read:

Subdivision 1. **Definitions.** (a) The definitions in this subdivision apply to this section.

(b) "Transitional housing" means housing designed for independent living and provided to a homeless person or family at a rental rate of at least 25 percent of the family income for a period of up to ~~24~~ 36 months. If a transitional housing program is associated with a licensed facility or shelter, it must be located in a separate facility or a specified section of the main facility where residents can be responsible for their own meals and other daily needs.

(c) "Support services" means an assessment service that identifies the needs of individuals for independent living and arranges or provides for the appropriate educational, social, legal, advocacy, child care, employment, financial, health care, or information and referral services to meet these needs.

Sec. 3. Minnesota Statutes 2020, section 256E.33, subdivision 2, is amended to read:

Subd. 2. **Establishment and administration.** A transitional housing program is established to be administered by the commissioner. The commissioner may make grants to eligible recipients or enter into agreements with community action agencies or other public or private nonprofit agencies to make grants to eligible recipients to initiate, maintain, or expand programs to provide transitional housing and support services for persons in need of transitional housing, which may include up to six months of follow-up support services for persons who complete transitional housing as they stabilize in permanent housing. The commissioner must ensure that money appropriated to implement this section is distributed as soon as practicable. The commissioner may make grants directly to eligible recipients. The commissioner may extend use ~~up to ten percent of the appropriation available for~~ of this program for persons needing assistance longer than ~~24~~ 36 months.

Sec. 4. Minnesota Statutes 2020, section 256I.03, subdivision 7, is amended to read:

Subd. 7. **Countable income.** "Countable income" means all income received by an applicant or recipient as described under section 256P.06, less any applicable exclusions or disregards. For a recipient of any cash benefit from the SSI program who does not live in a setting as described in section 256I.04, subdivision 2a, paragraph (b), clause (2), countable income means the SSI benefit limit in effect at the time the person is a recipient of housing support, less the medical assistance personal needs allowance under section 256B.35. ~~If the SSI limit or benefit is reduced for a person due to events other than receipt of additional income, countable income means actual income less any applicable exclusions and disregards.~~ If there is a reduction in a housing support recipient's benefit due to circumstances other than receipt of additional income, applicable exclusions and disregards apply when determining countable income. For a recipient of any cash benefit from the RSDI program, SSI program, or veterans' programs who lives in a setting as described in section 256I.04, subdivision 2a, paragraph (b), clause (2), countable income means 30 percent of the recipient's total benefit amount from these programs, after applicable exclusions or disregards, at the time the person is a recipient of housing support. For these recipients, the medical assistance personal needs allowance, as described in section 256I.04, subdivision 1, paragraph (a), clause (2), does not apply.

Sec. 5. Minnesota Statutes 2020, section 256K.45, is amended by adding a subdivision to read:

Subd. 7. **Awarding of grants.** (a) Grants shall be awarded under this section only after a review of the grant recipient's application materials, including past performance and utilization of grant money. The commissioner shall not reduce an existing grant award amount unless the commissioner first determines that the grant recipient has failed to meet performance measures or has used grant money improperly.

(b) For grants awarded pursuant to a two-year grant contract, the commissioner shall permit grant recipients to carry over any unexpended amount from the first contract year to the second contract year.

Sec. 6. Laws 2021, First Special Session chapter 8, article 6, section 1, subdivision 7, is amended to read:

Subd. 7. **Report.** (a) No later than February 1, 2022, the task force shall submit an initial report to the chairs and ranking minority members of the house of representatives and senate

committees and divisions with jurisdiction over housing and preventing homelessness on its findings and recommendations.

(b) No later than ~~August 31, 2022~~ December 15, 2022, the task force shall submit a final report to the chairs and ranking minority members of the house of representatives and senate committees and divisions with jurisdiction over housing and preventing homelessness on its findings and recommendations.

Sec. 7. **PREGNANT AND PARENTING HOMELESS YOUTH STUDY.**

(a) The commissioner of human services must conduct a study of the prevalence of pregnancy and parenting among homeless youth and youth who are at risk of homelessness.

(b) The commissioner shall submit a final report by December 31, 2023, to the chairs and ranking minority members of the legislative committees with jurisdiction over human services finance and policy.

Sec. 8. **SEXUAL EXPLOITATION AND TRAFFICKING STUDY.**

(a) The commissioner of health must conduct a prevalence study on youth and adult victim survivors of sexual exploitation and trafficking.

(b) The commissioner shall submit a final report by June 30, 2024, to the chairs and ranking minority members of the legislative committees with jurisdiction over human services finance and policy.

Sec. 9. **EMERGENCY SHELTER FACILITIES.**

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

(b) "Commissioner" means the commissioner of human services.

(c) "Eligible applicant" means a statutory or home rule charter city, county, Tribal government, not-for-profit corporation under section 501(c)(3) of the Internal Revenue Code, or housing and redevelopment authority established under Minnesota Statutes, section 469.003.

(d) "Emergency shelter facility" or "facility" means a facility that provides a safe, sanitary, accessible, and suitable emergency shelter for individuals and families experiencing homelessness, regardless of whether the facility provides emergency shelter during the day, overnight, or both.

Subd. 2. **Project criteria.** (a) The commissioner shall prioritize grants under this section for projects that improve or expand emergency shelter facility options by:

(1) adding additional emergency shelter facilities by renovating existing facilities not currently operating as emergency shelter facilities;

(2) adding additional emergency shelter facility beds by renovating existing emergency shelter facilities, including major projects that address an accumulation of deferred maintenance or repair or replacement of mechanical, electrical, and safety systems and components in danger of failure;

(3) adding additional emergency shelter facility beds through acquisition and construction of new emergency shelter facilities; and

(4) improving the safety, sanitation, accessibility, and habitability of existing emergency shelter facilities, including major projects that address an accumulation of deferred maintenance or repair or replacement of mechanical, electrical, and safety systems and components in danger of failure.

(b) A grant under this section may be used to pay for 100 percent of total project capital expenditures, or a specified project phase, up to $10,000,000 per project.

(c) All projects funded with a grant under this section must meet all applicable state and local building codes at the time of project completion.

(d) The commissioner must use a competitive request for proposal process to identify potential projects and eligible applicants on a statewide basis.

EFFECTIVE DATE. This section is effective July 1, 2022.

ARTICLE 19
DHS LICENSING AND OPERATIONS POLICY

Section 1. Minnesota Statutes 2020, section 245A.02, subdivision 5a, is amended to read:

Subd. 5a. **Controlling individual.** (a) "Controlling individual" means an owner of a program or service provider licensed under this chapter and the following individuals, if applicable:

(1) each officer of the organization, including the chief executive officer and chief financial officer;

(2) the individual designated as the authorized agent under section 245A.04, subdivision 1, paragraph (b);

(3) the individual designated as the compliance officer under section 256B.04, subdivision 21, paragraph (g); ~~and~~

(4) each managerial official whose responsibilities include the direction of the management or policies of a program~~.~~; and

(5) the individual designated as the primary provider of care for a special family child care program under section 245A.14, subdivision 4, paragraph (i).

(b) Controlling 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 operates a program directly or through a subsidiary;

(2) an individual who is a state or federal official, or state or federal employee, or a member or employee of the governing body of a political subdivision of the state or federal government that operates one or more programs, unless the individual is also an officer, owner, or managerial official of the program, receives remuneration from the program, or owns any of the beneficial interests not excluded in this subdivision;

(3) an individual who owns less than five percent of the outstanding common shares of a corporation:

(i) whose securities are exempt under section 80A.45, clause (6); or

(ii) whose transactions are exempt under section 80A.46, clause (2);

(4) an individual who is a member of an organization exempt from taxation under section 290.05, unless the individual is also an officer, owner, or managerial official of the program or owns any of the beneficial interests not excluded in this subdivision. This clause does not exclude from the definition of controlling individual an organization that is exempt from taxation; or

(5) an employee stock ownership plan trust, or a participant or board member of an employee stock ownership plan, unless the participant or board member is a controlling individual according to paragraph (a).

(c) For purposes of this subdivision, "managerial official" means an individual who has the decision-making authority related to the operation of the program, and the responsibility for the ongoing management of or direction of the policies, services, or employees of the program. A site director who has no ownership interest in the program is not considered to be a managerial official for purposes of this definition.

EFFECTIVE DATE. This section is effective July 1, 2022.

Sec. 2. Minnesota Statutes 2020, section 245A.04, subdivision 4, is amended to read:

Subd. 4. **Inspections; waiver.** (a) Before issuing a license under this chapter, the commissioner shall conduct an inspection of the program. The inspection must include but is not limited to:

(1) an inspection of the physical plant;

(2) an inspection of records and documents;

(3) observation of the program in operation; and

(4) an inspection for the health, safety, and fire standards in licensing requirements for a child care license holder.

(b) The observation in paragraph (a), clause (3), is not required prior to issuing a license under subdivision 7. If the commissioner issues a license under this chapter, these requirements must be completed within one year after the issuance of the license.

(c) Before completing a licensing inspection in a family child care program or child care center, the licensing agency must offer the license holder an exit interview to discuss violations or potential violations of law or rule observed during the inspection and offer technical assistance on how to comply with applicable laws and rules. The commissioner shall not issue a correction order or negative licensing action for violations of law or rule not discussed in an exit interview, unless a license holder chooses not to participate in an exit interview or not to complete the exit interview. If the license holder is unable to complete the exit interview, the licensing agency must offer an alternate time for the license holder to complete the exit interview.

(d) If a family child care license holder disputes a county licensor's interpretation of a licensing requirement during a licensing inspection or exit interview, the license holder may, within five business days after the exit interview or licensing inspection, request clarification from the commissioner, in writing, in a manner prescribed by the commissioner. The license holder's request must describe the county licensor's interpretation of the licensing requirement at issue, and explain why the license holder believes the county licensor's interpretation is inaccurate. The commissioner and the county must include the license holder in all correspondence regarding the disputed interpretation, and must provide an opportunity for the license holder to contribute relevant information that may impact the commissioner's decision. The county licensor must not issue a correction order related to

the disputed licensing requirement until the commissioner has provided clarification to the license holder about the licensing requirement.

(e) The commissioner or the county shall inspect at least ~~annually~~ once each calendar year a child care provider licensed under this chapter and Minnesota Rules, chapter 9502 or 9503, for compliance with applicable licensing standards.

(f) No later than November 19, 2017, the commissioner shall make publicly available on the department's website the results of inspection reports of all child care providers licensed under this chapter and under Minnesota Rules, chapter 9502 or 9503, and the number of deaths, serious injuries, and instances of substantiated child maltreatment that occurred in licensed child care settings each year.

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

Sec. 3. Minnesota Statutes 2020, section 245A.07, subdivision 2a, is amended to read:

Subd. 2a. **Immediate suspension expedited hearing.** (a) Within five working days of receipt of the license holder's timely appeal, the commissioner shall request assignment of an administrative law judge. The request must include a proposed date, time, and place of a hearing. A hearing must be conducted by an administrative law judge within 30 calendar days of the request for assignment, unless an extension is requested by either party and granted by the administrative law judge for good cause. The commissioner shall issue a notice of hearing by certified mail or personal service at least ten working days before the hearing. The scope of the hearing shall be limited solely to the issue of whether the temporary immediate suspension should remain in effect pending the commissioner's final order under section 245A.08, regarding a licensing sanction issued under subdivision 3 following the immediate suspension. For suspensions under subdivision 2, paragraph (a), clause (1), the burden of proof in expedited hearings under this subdivision shall be limited to the commissioner's demonstration that reasonable cause exists to believe that the license holder's actions or failure to comply with applicable law or rule poses, or the actions of other individuals or conditions in the program poses an imminent risk of harm to the health, safety, or rights of persons served by the program. "Reasonable cause" means there exist specific articulable facts or circumstances which provide the commissioner with a reasonable suspicion that there is an imminent risk of harm to the health, safety, or rights of persons served by the program. When the commissioner has determined there is reasonable cause to order the temporary immediate suspension of a license based on a violation of safe sleep requirements, as defined in section 245A.1435, the commissioner is not required to demonstrate that an infant died or was injured as a result of the safe sleep violations. For

suspensions under subdivision 2, paragraph (a), clause (2), the burden of proof in expedited hearings under this subdivision shall be limited to the commissioner's demonstration by a preponderance of the evidence that, since the license was revoked, the license holder committed additional violations of law or rule which may adversely affect the health or safety of persons served by the program.

(b) The administrative law judge shall issue findings of fact, conclusions, and a recommendation within ten working days from the date of hearing. The parties shall have ten calendar days to submit exceptions to the administrative law judge's report. The record shall close at the end of the ten-day period for submission of exceptions. The commissioner's final order shall be issued within ten working days from the close of the record. When an appeal of a temporary immediate suspension is withdrawn or dismissed, the commissioner shall issue a final order affirming the temporary immediate suspension within ten calendar days of the commissioner's receipt of the withdrawal or dismissal. Within 90 calendar days after an immediate suspension has been issued and the license holder has not submitted a timely appeal under subdivision 2, paragraph (b), or within 90 calendar days after a final order affirming an immediate suspension, the commissioner shall ~~make a determination regarding~~ determine:

(1) whether a final licensing sanction shall be issued under subdivision 3, paragraph (a), clauses (1) to (5). The license holder shall continue to be prohibited from operation of the program during this 90-day period~~.~~; or

(2) whether the outcome of related, ongoing investigations or judicial proceedings are necessary to determine if a final licensing sanction under subdivision 3, paragraph (a), clauses (1) to (5), will be issued, and persons served by the program remain at an imminent risk of harm during the investigation period or proceedings. If so, the commissioner shall issue a suspension in accordance with subdivision 3.

(c) When the final order under paragraph (b) affirms an immediate suspension or the license holder does not submit a timely appeal of the immediate suspension, and a final licensing sanction is issued under subdivision 3 and the license holder appeals that sanction, the license holder continues to be prohibited from operation of the program pending a final commissioner's order under section 245A.08, subdivision 5, regarding the final licensing sanction.

(d) The license holder shall continue to be prohibited from operation of the program while a suspension order issued under paragraph (b), clause (2), remains in effect.

~~(d)~~ (e) For suspensions under subdivision 2, paragraph (a), clause (3), the burden of proof in expedited hearings under this subdivision shall be limited to the commissioner's demonstration by a preponderance of the evidence that a criminal complaint and warrant or summons was issued for the license holder that was not dismissed, and that the criminal charge is an offense that involves fraud or theft against a program administered by the commissioner.

Sec. 4. Minnesota Statutes 2020, section 245A.07, subdivision 3, is amended to read:

Subd. 3. **License suspension, revocation, or fine.** (a) The commissioner may suspend or revoke a license, or impose a fine if:

(1) a license holder fails to comply fully with applicable laws or rules including but not limited to the requirements of this chapter and chapter 245C;

(2) a license holder, a controlling individual, or an individual living in the household where the licensed services are provided or is otherwise subject to a background study has been disqualified and the disqualification was not set aside and no variance has been granted;

(3) a license holder knowingly withholds relevant information from or gives false or misleading information to the commissioner in connection with an application for a license, in connection with the background study status of an individual, during an investigation, or regarding compliance with applicable laws or rules;

(4) a license holder is excluded from any program administered by the commissioner under section 245.095; ~~or~~

(5) revocation is required under section 245A.04, subdivision 7, paragraph (d)~~.~~; or

(6) suspension is necessary under subdivision 2a, paragraph (b), clause (2).

A license holder who has had a license issued under this chapter suspended, revoked, or has been ordered to pay a fine must be given notice of the action by certified mail or personal service. If mailed, the notice must be mailed to the address shown on the application or the last known address of the license holder. The notice must state in plain language the reasons the license was suspended or revoked, or a fine was ordered.

(b) If the license was suspended or revoked, the notice must inform the license holder of the right to a contested case hearing under chapter 14 and Minnesota Rules, parts 1400.8505 to 1400.8612. The license holder may appeal an order suspending or revoking a license. The appeal of an order suspending or revoking a license must be made in writing by certified mail or personal service. If mailed, the appeal must be postmarked and sent to

the commissioner within ten calendar days after the license holder receives notice that the license has been suspended or revoked. If a request is made by personal service, it must be received by the commissioner within ten calendar days after the license holder received the order. Except as provided in subdivision 2a, paragraph (c), if a license holder submits a timely appeal of an order suspending or revoking a license, the license holder may continue to operate the program as provided in section 245A.04, subdivision 7, paragraphs (f) and (g), until the commissioner issues a final order on the suspension or revocation.

(c)(1) If the license holder was ordered to pay a fine, the notice must inform the license holder of the responsibility for payment of fines and the right to a contested case hearing under chapter 14 and Minnesota Rules, parts 1400.8505 to 1400.8612. The appeal of an order to pay a fine must be made in writing by certified mail or personal service. If mailed, the appeal must be postmarked and sent to the commissioner within ten calendar days after the license holder receives notice that the fine has been ordered. If a request is made by personal service, it must be received by the commissioner within ten calendar days after the license holder received the order.

(2) The license holder shall pay the fines assessed on or before the payment date specified. If the license holder fails to fully comply with the order, the commissioner may issue a second fine or suspend the license until the license holder complies. If the license holder receives state funds, the state, county, or municipal agencies or departments responsible for administering the funds shall withhold payments and recover any payments made while the license is suspended for failure to pay a fine. A timely appeal shall stay payment of the fine until the commissioner issues a final order.

(3) A license holder shall promptly notify the commissioner of human services, in writing, when a violation specified in the order to forfeit a fine is corrected. If upon reinspection the commissioner determines that a violation has not been corrected as indicated by the order to forfeit a fine, the commissioner may issue a second fine. The commissioner shall notify the license holder by certified mail or personal service that a second fine has been assessed. The license holder may appeal the second fine as provided under this subdivision.

(4) Fines shall be assessed as follows:

(i) the license holder shall forfeit $1,000 for each determination of maltreatment of a child under chapter 260E or the maltreatment of a vulnerable adult under section 626.557 for which the license holder is determined responsible for the maltreatment under section 260E.30, subdivision 4, paragraphs (a) and (b), or 626.557, subdivision 9c, paragraph (c);

(ii) if the commissioner determines that a determination of maltreatment for which the license holder is responsible is the result of maltreatment that meets the definition of serious maltreatment as defined in section 245C.02, subdivision 18, the license holder shall forfeit $5,000;

(iii) for a program that operates out of the license holder's home and a program licensed under Minnesota Rules, parts 9502.0300 to 9502.0445, the fine assessed against the license holder shall not exceed $1,000 for each determination of maltreatment;

(iv) the license holder shall forfeit $200 for each occurrence of a violation of law or rule governing matters of health, safety, or supervision, including but not limited to the provision of adequate staff-to-child or adult ratios, and failure to comply with background study requirements under chapter 245C; and

(v) the license holder shall forfeit $100 for each occurrence of a violation of law or rule other than those subject to a $5,000, $1,000, or $200 fine in items (i) to (iv).

For purposes of this section, "occurrence" means each violation identified in the commissioner's fine order. Fines assessed against a license holder that holds a license to provide home and community-based services, as identified in section 245D.03, subdivision 1, and a community residential setting or day services facility license under chapter 245D where the services are provided, may be assessed against both licenses for the same occurrence, but the combined amount of the fines shall not exceed the amount specified in this clause for that occurrence.

(5) When a fine has been assessed, the license holder may not avoid payment by closing, selling, or otherwise transferring the licensed program to a third party. In such an event, the license holder will be personally liable for payment. In the case of a corporation, each controlling individual is personally and jointly liable for payment.

(d) Except for background study violations involving the failure to comply with an order to immediately remove an individual or an order to provide continuous, direct supervision, the commissioner shall not issue a fine under paragraph (c) relating to a background study violation to a license holder who self-corrects a background study violation before the commissioner discovers the violation. A license holder who has previously exercised the provisions of this paragraph to avoid a fine for a background study violation may not avoid a fine for a subsequent background study violation unless at least 365 days have passed since the license holder self-corrected the earlier background study violation.

Sec. 5. Minnesota Statutes 2021 Supplement, section 245A.14, subdivision 4, is amended to read:

Subd. 4. **Special family child care homes.** Nonresidential child care programs serving 14 or fewer children that are conducted at a location other than the license holder's own residence shall be licensed under this section and the rules governing family child care or group family child care if:

(a) the license holder is the primary provider of care and the nonresidential child care program is conducted in a dwelling that is located on a residential lot;

(b) the license holder is an employer who may or may not be the primary provider of care, and the purpose for the child care program is to provide child care services to children of the license holder's employees;

(c) the license holder is a church or religious organization;

(d) the license holder is a community collaborative child care provider. For purposes of this subdivision, a community collaborative child care provider is a provider participating in a cooperative agreement with a community action agency as defined in section 256E.31;

(e) the license holder is a not-for-profit agency that provides child care in a dwelling located on a residential lot and the license holder maintains two or more contracts with community employers or other community organizations to provide child care services. The county licensing agency may grant a capacity variance to a license holder licensed under this paragraph to exceed the licensed capacity of 14 children by no more than five children during transition periods related to the work schedules of parents, if the license holder meets the following requirements:

(1) the program does not exceed a capacity of 14 children more than a cumulative total of four hours per day;

(2) the program meets a one to seven staff-to-child ratio during the variance period;

(3) all employees receive at least an extra four hours of training per year than required in the rules governing family child care each year;

(4) the facility has square footage required per child under Minnesota Rules, part 9502.0425;

(5) the program is in compliance with local zoning regulations;

(6) the program is in compliance with the applicable fire code as follows:

(i) if the program serves more than five children older than 2-1/2 years of age, but no more than five children 2-1/2 years of age or less, the applicable fire code is educational occupancy, as provided in Group E Occupancy under the Minnesota State Fire Code 2015, Section 202; or

(ii) if the program serves more than five children 2-1/2 years of age or less, the applicable fire code is Group I-4 Occupancies, as provided in the Minnesota State Fire Code 2015, Section 202, unless the rooms in which the children are cared for are located on a level of exit discharge and each of these child care rooms has an exit door directly to the exterior, then the applicable fire code is Group E occupancies, as provided in the Minnesota State Fire Code 2015, Section 202; and

(7) any age and capacity limitations required by the fire code inspection and square footage determinations shall be printed on the license; or

(f) the license holder is the primary provider of care and has located the licensed child care program in a commercial space, if the license holder meets the following requirements:

(1) the program is in compliance with local zoning regulations;

(2) the program is in compliance with the applicable fire code as follows:

(i) if the program serves more than five children older than 2-1/2 years of age, but no more than five children 2-1/2 years of age or less, the applicable fire code is educational occupancy, as provided in Group E Occupancy under the Minnesota State Fire Code 2015, Section 202; or

(ii) if the program serves more than five children 2-1/2 years of age or less, the applicable fire code is Group I-4 Occupancies, as provided under the Minnesota State Fire Code 2015, Section 202;

(3) any age and capacity limitations required by the fire code inspection and square footage determinations are printed on the license; and

(4) the license holder prominently displays the license issued by the commissioner which contains the statement "This special family child care provider is not licensed as a child care center."

(g) Notwithstanding Minnesota Rules, part 9502.0335, subpart 12, the commissioner may issue up to four licenses to an organization licensed under paragraph (b), (c), or (e). Each license must have its own primary provider of care as required under paragraph (i). Each license must operate as a distinct and separate program in compliance with all applicable laws and regulations.

(h) For licenses issued under paragraph (b), (c), (d), (e), or (f), the commissioner may approve up to four licenses at the same location or under one contiguous roof if each license holder is able to demonstrate compliance with all applicable rules and laws. Each licensed program must operate as a distinct program and within the capacity, age, and ratio distributions of each license.

(i) For a license issued under paragraph (b), (c), or (e), the license holder must designate a person to be the primary provider of care at the licensed location on a form and in a manner prescribed by the commissioner. The license holder shall notify the commissioner in writing before there is a change of the person designated to be the primary provider of care. The primary provider of care:

(1) must be the person who will be the provider of care at the program and present during the hours of operation;

(2) must operate the program in compliance with applicable laws and regulations under chapter 245A and Minnesota Rules, chapter 9502;

(3) is considered a child care background study subject as defined in section 245C.02, subdivision 6a, and must comply with background study requirements in chapter 245C; ~~and~~

(4) must complete the training that is required of license holders in section 245A.50~~.~~;

(5) is authorized to communicate with the county licensing agency and the department on matters related to licensing; and

(6) must meet the requirements of Minnesota Rules, part 9502.0355, subpart 3, before providing group family child care.

(j) For any license issued under this subdivision, the license holder must ensure that any other caregiver, substitute, or helper who assists in the care of children meets the training requirements in section 245A.50 and background study requirements under chapter 245C.

EFFECTIVE DATE. This section is effective July 1, 2022.

Sec. 6. Minnesota Statutes 2020, section 245A.1435, is amended to read:

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

(a) When a license holder is placing an infant to sleep, the license holder must place the infant on the infant's back, unless the license holder has documentation from the infant's physician or advanced practice registered nurse directing an alternative sleeping position for the infant. The physician or advanced practice registered nurse directive must be on a

form ~~approved~~ developed by the commissioner and must remain on file at the licensed location.

An infant who independently rolls onto its stomach after being placed to sleep on its back may be allowed to remain sleeping on its stomach if the infant is at least six months of age or the license holder has a signed statement from the parent indicating that the infant regularly rolls over at home.

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

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

(d) When a license holder places an infant under one year of age down to sleep, the infant's clothing or sleepwear must not have weighted materials, a hood, or a bib.

(e) A license holder may place an infant under one year of age down to sleep wearing a helmet if the license holder has signed documentation by a physician, advanced practice registered nurse, licensed occupational therapist, or a licensed physical therapist on a form developed by the commissioner.

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

~~securely only across the upper torso, with no constriction of the hips or legs, to create a~~ swaddle. A swaddle is defined as one-piece sleepwear that wraps over the infant's arms, fastens securely only across the infant's upper torso, and does not constrict the infant's hips or legs. If a swaddle is used by a license holder, the license holder must ensure that it meets the requirements of paragraph (d) and is not so tight that it restricts the infant's ability to breathe or so loose that the fabric could cover the infant's nose and mouth. Prior to any use of swaddling for sleep by a provider licensed under this chapter, the license holder must obtain informed written consent for the use of swaddling from the parent or guardian of the infant on a form ~~provided~~ developed by the commissioner ~~and prepared in partnership with the Minnesota Sudden Infant Death Center~~.

(g) A license holder may request a variance to this section to permit the use of a cradleboard when requested by a parent or guardian for a cultural accommodation. A variance for the use of a cradleboard may be issued only by the commissioner. The variance request must be submitted on a form developed by the commissioner in partnership with Tribal welfare agencies and the Minnesota Department of Health.

EFFECTIVE DATE. This section is effective January 1, 2023.

Sec. 7. Minnesota Statutes 2020, section 245A.1443, is amended to read:

245A.1443 ~~CHEMICAL DEPENDENCY~~ SUBSTANCE USE DISORDER TREATMENT LICENSED PROGRAMS THAT SERVE PARENTS WITH THEIR CHILDREN.

Subdivision 1. **Application.** This section applies to ~~chemical dependency~~ residential substance use disorder treatment facilities that are licensed under this chapter and ~~Minnesota Rules,~~ chapter ~~9530,~~ 245G and that provide services in accordance with section 245G.19.

Subd. 2. **Requirements for providing education.** (a) On or before the date of a child's initial physical presence at the facility, the license holder must provide education to the child's parent related to safe bathing and reducing the risk of sudden unexpected infant death and abusive head trauma from shaking infants and young children. The license holder must use the educational material developed by the commissioner to comply with this requirement. At a minimum, the education must address:

(1) instruction that a child or infant should never be left unattended around water, a tub should be filled with only two to four inches of water for infants, and an infant should never be put into a tub when the water is running; and

(2) the risk factors related to sudden unexpected infant death and abusive head trauma from shaking infants and young children, and means of reducing the risks, including the safety precautions identified in section 245A.1435 and the ~~dangers~~ risks of co-sleeping.

(b) The license holder must document the parent's receipt of the education and keep the documentation in the parent's file. The documentation must indicate whether the parent agrees to comply with the safeguards. If the parent refuses to comply, program staff must provide additional education to the parent ~~at appropriate intervals, at least weekly~~ as described in the parental supervision plan. The parental supervision plan must include the intervention, frequency, and staff responsible for the duration of the parent's participation in the program or until the parent agrees to comply with the safeguards.

Subd. 3. **Parental supervision of children.** (a) On or before the date of a child's initial physical presence at the facility, the license holder must ~~complete and~~ document ~~an assessment of~~ the parent's capacity to meet the health and safety needs of the child while on the facility premises~~, including identifying circumstances when the parent may be unable to adequately care for their child due to~~ considering the following factors:

(1) the parent's physical ~~or~~ and mental health;

(2) the parent being under the influence of drugs, alcohol, medications, or other chemicals;

~~(3) the parent being unable to provide appropriate supervision for the child; or~~

(3) the child's physical and mental health; and

(4) any other information available to the license holder that indicates the parent may not be able to adequately care for the child.

(b) The license holder must have written procedures specifying the actions to be taken by staff if a parent is or becomes unable to adequately care for the parent's child.

(c) If the parent refuses to comply with the safeguards described in subdivision 2 or is unable to adequately care for the child, the license holder must develop a parental supervision plan in conjunction with the client. The plan must account for any factors in paragraph (a) that contribute to the parent's inability to adequately care for the child. The plan must be dated and signed by the staff person who completed the plan.

Subd. 4. **Alternative supervision arrangements.** The license holder must have written procedures addressing whether the program permits a parent to arrange for supervision of the parent's child by another client in the program. If permitted, the facility must have a procedure that requires staff approval of the supervision arrangement before the supervision by the nonparental client occurs. The procedure for approval must include an assessment

of the nonparental client's capacity to assume the supervisory responsibilities using the criteria in subdivision 3. The license holder must document the license holder's approval of the supervisory arrangement and the assessment of the nonparental client's capacity to supervise the child, and must keep this documentation in the file of the parent of the child being supervised.

EFFECTIVE DATE. This section is effective January 1, 2023.

Sec. 8. Minnesota Statutes 2020, section 245A.146, subdivision 3, is amended to read:

Subd. 3. **License holder documentation of cribs.** (a) Annually, from the date printed on the license, all license holders shall check all their cribs' brand names and model numbers against the United States Consumer Product Safety Commission website listing of unsafe cribs.

(b) The license holder shall maintain written documentation to be reviewed on site for each crib showing that the review required in paragraph (a) has been completed, and which of the following conditions applies:

(1) the crib was not identified as unsafe on the United States Consumer Product Safety Commission website;

(2) the crib was identified as unsafe on the United States Consumer Product Safety Commission website, but the license holder has taken the action directed by the United States Consumer Product Safety Commission to make the crib safe; or

(3) the crib was identified as unsafe on the United States Consumer Product Safety Commission website, and the license holder has removed the crib so that it is no longer used by or accessible to children in care.

(c) Documentation of the review completed under this subdivision shall be maintained by the license holder on site and made available to parents or guardians of children in care and the commissioner.

(d) Notwithstanding Minnesota Rules, part 9502.0425, a family child care provider that complies with this section may use a mesh-sided or fabric-sided play yard, pack and play, or playpen or crib that has not been identified as unsafe on the United States Consumer Product Safety Commission website for the care or sleeping of infants.

(e) On at least a monthly basis, the family child care license holder shall perform safety inspections of every mesh-sided or fabric-sided play yard, pack and play, or playpen used by or that is accessible to any child in care, and must document the following:

(1) there are no tears, holes, or loose or unraveling threads in mesh or fabric sides of crib;

(2) the weave of the mesh on the crib is no larger than one-fourth of an inch;

(3) no mesh fabric is unsecure or unattached to top rail and floor plate of crib;

(4) no tears or holes to top rail of crib;

(5) the mattress floor board is not soft and does not exceed one inch thick;

(6) the mattress floor board has no rips or tears in covering;

(7) the mattress floor board in use is ~~a waterproof~~ an original mattress or replacement mattress provided by the manufacturer of the crib;

(8) there are no protruding or loose rivets, metal nuts, or bolts on the crib;

(9) there are no knobs or wing nuts on outside crib legs;

(10) there are no missing, loose, or exposed staples; and

(11) the latches on top and side rails used to collapse crib are secure, they lock properly, and are not loose.

(f) If a cradleboard is used in a licensed setting, the license holder must check the cradleboard not less than monthly to ensure the cradleboard is structurally sound and does not have loose or protruding parts. The license holder shall maintain written documentation of the review.

EFFECTIVE DATE. This section is effective January 1, 2023.

Sec. 9. Minnesota Statutes 2020, section 245A.16, subdivision 1, is amended to read:

Subdivision 1. **Delegation of authority to agencies.** (a) County agencies and private agencies that have been designated or licensed by the commissioner to perform licensing functions and activities under section 245A.04 and background studies for family child care under chapter 245C; to recommend denial of applicants under section 245A.05; to issue correction orders, to issue variances, and recommend a conditional license under section 245A.06; or to recommend suspending or revoking a license or issuing a fine under section 245A.07, shall comply with rules and directives of the commissioner governing those functions and with this section. The following variances are excluded from the delegation of variance authority and may be issued only by the commissioner:

(1) dual licensure of family child care and child foster care, dual licensure of child and adult foster care, and adult foster care and family child care;

(2) adult foster care maximum capacity;

(3) adult foster care minimum age requirement;

(4) child foster care maximum age requirement;

(5) variances regarding disqualified individuals except that, before the implementation of NETStudy 2.0, county agencies may issue variances under section 245C.30 regarding disqualified individuals when the county is responsible for conducting a consolidated reconsideration according to sections 245C.25 and 245C.27, subdivision 2, clauses (a) and (b), of a county maltreatment determination and a disqualification based on serious or recurring maltreatment;

(6) the required presence of a caregiver in the adult foster care residence during normal sleeping hours;

(7) variances to requirements relating to chemical use problems of a license holder or a household member of a license holder; ~~and~~

(8) variances to section 245A.53 for a time-limited period. If the commissioner grants a variance under this clause, the license holder must provide notice of the variance to all parents and guardians of the children in care~~.~~; and

(9) variances to section 245A.1435 for the use of a cradleboard for a cultural accommodation.

Except as provided in section 245A.14, subdivision 4, paragraph (e), a county agency must not grant a license holder a variance to exceed the maximum allowable family child care license capacity of 14 children.

(b) A county agency that has been designated by the commissioner to issue family child care variances must:

(1) publish the county agency's policies and criteria for issuing variances on the county's public website and update the policies as necessary; and

(2) annually distribute the county agency's policies and criteria for issuing variances to all family child care license holders in the county.

(c) Before the implementation of NETStudy 2.0, county agencies must report information about disqualification reconsiderations under sections 245C.25 and 245C.27, subdivision 2, paragraphs (a) and (b), and variances granted under paragraph (a), clause (5), to the commissioner at least monthly in a format prescribed by the commissioner.

(d) For family child care programs, the commissioner shall require a county agency to conduct one unannounced licensing review at least annually.

(e) For family adult day services programs, the commissioner may authorize licensing reviews every two years after a licensee has had at least one annual review.

(f) A license issued under this section may be issued for up to two years.

(g) During implementation of chapter 245D, the commissioner shall consider:

(1) the role of counties in quality assurance;

(2) the duties of county licensing staff; and

(3) the possible use of joint powers agreements, according to section 471.59, with counties through which some licensing duties under chapter 245D may be delegated by the commissioner to the counties.

Any consideration related to this paragraph must meet all of the requirements of the corrective action plan ordered by the federal Centers for Medicare and Medicaid Services.

(h) Licensing authority specific to section 245D.06, subdivisions 5, 6, 7, and 8, or successor provisions; and section 245D.061 or successor provisions, for family child foster care programs providing out-of-home respite, as identified in section 245D.03, subdivision 1, paragraph (b), clause (1), is excluded from the delegation of authority to county and private agencies.

(i) A county agency shall report to the commissioner, in a manner prescribed by the commissioner, the following information for a licensed family child care program:

(1) the results of each licensing review completed, including the date of the review, and any licensing correction order issued;

(2) any death, serious injury, or determination of substantiated maltreatment; and

(3) any fires that require the service of a fire department within 48 hours of the fire. The information under this clause must also be reported to the state fire marshal within two business days of receiving notice from a licensed family child care provider.

Sec. 10. Minnesota Statutes 2020, section 245F.15, subdivision 1, is amended to read:

Subdivision 1. **Qualifications for all staff who have direct patient contact.** ~~(a)~~ All staff who have direct patient contact must be at least 18 years of age ~~and must, at the time of hiring, document that they meet the requirements in paragraph (b), (c), or (d)~~.

~~(b) Program directors, supervisors, nurses, and alcohol and drug counselors must be free of substance use problems for at least two years immediately preceding their hiring and must sign a statement attesting to that fact.~~

~~(c) Recovery peers must be free of substance use problems for at least one year immediately preceding their hiring and must sign a statement attesting to that fact.~~

~~(d) Technicians and other support staff must be free of substance use problems for at least six months immediately preceding their hiring and must sign a statement attesting to that fact.~~

EFFECTIVE DATE. This section is effective January 1, 2023.

Sec. 11. Minnesota Statutes 2020, section 245F.16, subdivision 1, is amended to read:

Subdivision 1. **Policy requirements.** A license holder must have written personnel policies and must make them available to staff members at all times. The personnel policies must:

(1) ensure that a staff member's retention, promotion, job assignment, or pay are not affected by a good-faith communication between the staff member and the Department of Human Services, Department of Health, Ombudsman for Mental Health and Developmental Disabilities, law enforcement, or local agencies that investigate complaints regarding patient rights, health, or safety;

(2) include a job description for each position that specifies job responsibilities, degree of authority to execute job responsibilities, standards of job performance related to specified job responsibilities, and qualifications;

(3) provide for written job performance evaluations for staff members of the license holder at least annually;

(4) describe ~~behavior that constitutes grounds~~ the process for disciplinary action, suspension, or dismissal~~, including policies that address substance use problems and meet the requirements of section 245F.15, subdivisions 1 and 2. The policies and procedures must list behaviors or incidents that are considered substance use problems. The list must include:~~ of a staff person for violating the drug and alcohol policy described in section 245A.04, subdivision 1, paragraph (c);

~~(i) receiving treatment for substance use disorder within the period specified for the position in the staff qualification requirements;~~

~~(ii) substance use that has a negative impact on the staff member's job performance;~~

~~(iii) substance use that affects the credibility of treatment services with patients, referral sources, or other members of the community; and~~

~~(iv) symptoms of intoxication or withdrawal on the job;~~

(5) include policies prohibiting personal involvement with patients and policies prohibiting patient maltreatment as specified under sections 245A.65, 626.557, and 626.5572 and chapters 260E and 604;

(6) include a chart or description of organizational structure indicating the lines of authority and responsibilities;

(7) include a written plan for new staff member orientation that, at a minimum, includes training related to the specific job functions for which the staff member was hired, program policies and procedures, patient needs, and the areas identified in subdivision 2, paragraphs (b) to (e); and

(8) include a policy on the confidentiality of patient information.

EFFECTIVE DATE. This section is effective January 1, 2023.

Sec. 12. Minnesota Statutes 2020, section 245G.01, subdivision 4, is amended to read:

Subd. 4. **Alcohol and drug counselor.** "Alcohol and drug counselor" ~~has the meaning given in section 148F.01, subdivision 5~~ means a person who is qualified according to section 245G.11, subdivision 5.

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

Sec. 13. Minnesota Statutes 2020, section 245G.01, subdivision 17, is amended to read:

Subd. 17. **Licensed professional in private practice.** (a) "Licensed professional in private practice" means an individual who:

(1) is licensed under chapter 148F, or is exempt from licensure under that chapter but is otherwise licensed to provide alcohol and drug counseling services;

(2) practices solely within the permissible scope of the individual's license as defined in the law authorizing licensure; and

(3) does not affiliate with other licensed or unlicensed professionals to provide alcohol and drug counseling services. ~~Affiliation does not include conferring with another professional or making a client referral.~~

(b) For purposes of this subdivision, affiliate includes but is not limited to:

(1) using the same electronic record system as another professional, except when the system prohibits each professional from accessing the records of another professional;

(2) advertising the services of more than one professional together;

(3) accepting client referrals made to a group of professionals;

(4) providing services to another professional's clients when that professional is absent; or

(5) appearing in any way to be a group practice or program.

(c) For purposes of this subdivision, affiliate does not include:

(1) conferring with another professional;

(2) making a client referral to another professional;

(3) contracting with the same agency as another professional for billing services;

(4) using the same waiting area for clients in an office as another professional; or

(5) using the same receptionist as another professional if the receptionist supports each professional independently.

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

Sec. 14. Minnesota Statutes 2020, section 245G.06, is amended by adding a subdivision to read:

Subd. 2a. **Documentation of treatment services.** The license holder must ensure that the staff member who provides the treatment service documents in the client record the date, type, and amount of each treatment service provided to a client and the client's response to each treatment service within seven days of providing the treatment service.

EFFECTIVE DATE. This section is effective August 1, 2022.

Sec. 15. Minnesota Statutes 2020, section 245G.06, is amended by adding a subdivision to read:

Subd. 2b. **Client record documentation requirements.** (a) The license holder must document in the client record any significant event that occurs at the program on the day the event occurs. A significant event is an event that impacts the client's relationship with other clients, staff, or the client's family, or the client's treatment plan.

(b) A residential treatment program must document in the client record the following items on the day that each occurs:

(1) medical and other appointments the client attended;

(2) concerns related to medications that are not documented in the medication administration record; and

(3) concerns related to attendance for treatment services, including the reason for any client absence from a treatment service.

(c) Each entry in a client's record must be accurate, legible, signed, dated, and include the job title or position of the staff person that made the entry. A late entry must be clearly labeled "late entry." A correction to an entry must be made in a way in which the original entry can still be read.

EFFECTIVE DATE. This section is effective August 1, 2022.

Sec. 16. Minnesota Statutes 2020, section 245G.06, subdivision 3, is amended to read:

Subd. 3. **~~Documentation of treatment services;~~ Treatment plan review.** ~~(a) A review of all treatment services must be documented weekly and include a review of:~~

~~(1) care coordination activities;~~

~~(2) medical and other appointments the client attended;~~

~~(3) issues related to medications that are not documented in the medication administration record; and~~

~~(4) issues related to attendance for treatment services, including the reason for any client absence from a treatment service.~~

~~(b) A note must be entered immediately following any significant event. A significant event is an event that impacts the client's relationship with other clients, staff, the client's family, or the client's treatment plan.~~

~~(c)~~ A treatment plan review must be entered in a client's file weekly or after each treatment service, whichever is less frequent, by the ~~staff member providing the service~~ alcohol and drug counselor responsible for the client's treatment plan. The review must indicate the span of time covered by the review and each of the six dimensions listed in section 245G.05, subdivision 2, paragraph (c). The review must:

~~(1) indicate the date, type, and amount of each treatment service provided and the client's response to each service;~~

~~(2)~~ (1) address each goal in the treatment plan and whether the methods to address the goals are effective;

~~(3)~~ (2) include monitoring of any physical and mental health problems;

~~(4)~~ (3) document the participation of others;

~~(5)~~ (4) document staff recommendations for changes in the methods identified in the treatment plan and whether the client agrees with the change; and

~~(6)~~ (5) include a review and evaluation of the individual abuse prevention plan according to section 245A.65.

~~(d) Each entry in a client's record must be accurate, legible, signed, and dated. A late entry must be clearly labeled "late entry." A correction to an entry must be made in a way in which the original entry can still be read.~~

EFFECTIVE DATE. This section is effective August 1, 2022.

Sec. 17. Minnesota Statutes 2020, section 245G.08, subdivision 5, is amended to read:

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

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

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

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

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

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

(1) a provision that a delegation of administration of medication is limited to a method a staff member has been trained to administer and limited to ~~the administration of~~:

(i) a medication that is administered orally, topically, or as a suppository, an eye drop, an ear drop, ~~or~~ an inhalant, or an intranasal; and

(ii) an intramuscular injection of naloxone or epinephrine;

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

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

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

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

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

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

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

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

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

Sec. 18. Minnesota Statutes 2020, section 245G.09, subdivision 3, is amended to read:

Subd. 3. **Contents.** Client records must contain the following:

(1) documentation that the client was given information on client rights and responsibilities, grievance procedures, tuberculosis, and HIV, and that the client was provided an orientation to the program abuse prevention plan required under section 245A.65, subdivision 2, paragraph (a), clause (4). If the client has an opioid use disorder, the record must contain documentation that the client was provided educational information according to section 245G.05, subdivision 1, paragraph (b);

(2) an initial services plan completed according to section 245G.04;

(3) a comprehensive assessment completed according to section 245G.05;

(4) an assessment summary completed according to section 245G.05, subdivision 2;

(5) an individual abuse prevention plan according to sections 245A.65, subdivision 2, and 626.557, subdivision 14, when applicable;

(6) an individual treatment plan according to section 245G.06, subdivisions 1 and 2;

(7) documentation of treatment services, significant events, appointments, concerns, and treatment plan ~~review~~ reviews according to section 245G.06, ~~subdivision~~ subdivisions 2a, 2b, and 3; and

(8) a summary at the time of service termination according to section 245G.06, subdivision 4.

EFFECTIVE DATE. This section is effective August 1, 2022.

Sec. 19. Minnesota Statutes 2020, section 245G.11, subdivision 1, is amended to read:

Subdivision 1. **General qualifications.** (a) All staff members who have direct contact must be 18 years of age or older. ~~At the time of employment, each staff member must meet the qualifications in this subdivision. For purposes of this subdivision, "problematic substance use" means a behavior or incident listed by the license holder in the personnel policies and procedures according to section 245G.13, subdivision 1, clause (5).~~

~~(b) A treatment director, supervisor, nurse, counselor, student intern, or other professional must be free of problematic substance use for at least the two years immediately preceding employment and must sign a statement attesting to that fact.~~

~~(c) A paraprofessional, recovery peer, or any other staff member with direct contact must be free of problematic substance use for at least one year immediately preceding employment and must sign a statement attesting to that fact.~~

EFFECTIVE DATE. This section is effective January 1, 2023.

Sec. 20. Minnesota Statutes 2020, section 245G.11, subdivision 10, is amended to read:

Subd. 10. **Student interns.** A qualified staff member must supervise and be responsible for a treatment service performed by a student intern and must review and sign each assessment, ~~progress note, and~~ individual treatment plan, and treatment plan review prepared by a student intern. A student intern must receive the orientation and training required in section 245G.13, subdivisions 1, clause (7), and 2. No more than 50 percent of the treatment staff may be students or licensing candidates with time documented to be directly related to the provision of treatment services for which the staff are authorized.

EFFECTIVE DATE. This section is effective January 1, 2023.

Sec. 21. Minnesota Statutes 2020, section 245G.13, subdivision 1, is amended to read:

Subdivision 1. **Personnel policy requirements.** A license holder must have written personnel policies that are available to each staff member. The personnel policies must:

(1) ensure that staff member retention, promotion, job assignment, or pay are not affected by a good faith communication between a staff member and the department, the Department of Health, the ombudsman for mental health and developmental disabilities, law enforcement, or a local agency for the investigation of a complaint regarding a client's rights, health, or safety;

(2) contain a job description for each staff member position specifying responsibilities, degree of authority to execute job responsibilities, and qualification requirements;

(3) provide for a job performance evaluation based on standards of job performance conducted on a regular and continuing basis, including a written annual review;

(4) describe behavior that constitutes grounds for disciplinary action, suspension, or dismissal, including ~~policies that address staff member problematic substance use and the requirements of section 245G.11, subdivision 1,~~ policies prohibiting personal involvement with a client in violation of chapter 604, and policies prohibiting client abuse described in sections 245A.65, 626.557, and 626.5572, and chapter 260E;

~~(5) identify how the program will identify whether behaviors or incidents are problematic substance use, including a description of how the facility must address:~~

~~(i) receiving treatment for substance use within the period specified for the position in the staff qualification requirements, including medication-assisted treatment;~~

~~(ii) substance use that negatively impacts the staff member's job performance;~~

~~(iii) substance use that affects the credibility of treatment services with a client, referral source, or other member of the community;~~

~~(iv) symptoms of intoxication or withdrawal on the job; and~~

~~(v) the circumstances under which an individual who participates in monitoring by the health professional services program for a substance use or mental health disorder is able to provide services to the program's clients;~~

(5) describe the process for disciplinary action, suspension, or dismissal of a staff person for violating the drug and alcohol policy described in section 245A.04, subdivision 1, paragraph (c);

(6) include a chart or description of the organizational structure indicating lines of authority and responsibilities;

(7) include orientation within 24 working hours of starting for each new staff member based on a written plan that, at a minimum, must provide training related to the staff member's specific job responsibilities, policies and procedures, client confidentiality, HIV minimum standards, and client needs; and

(8) include policies outlining the license holder's response to a staff member with a behavior problem that interferes with the provision of treatment service.

EFFECTIVE DATE. This section is effective January 1, 2023.

Sec. 22. Minnesota Statutes 2020, section 245G.20, is amended to read:

245G.20 LICENSE HOLDERS SERVING PERSONS WITH CO-OCCURRING DISORDERS.

A license holder specializing in the treatment of a person with co-occurring disorders must:

(1) demonstrate that staff levels are appropriate for treating a client with a co-occurring disorder, and that there are adequate staff members with mental health training;

(2) have continuing access to a medical provider with appropriate expertise in prescribing psychotropic medication;

(3) have a mental health professional available for staff member supervision and consultation;

(4) determine group size, structure, and content considering the special needs of a client with a co-occurring disorder;

(5) have documentation of active interventions to stabilize mental health symptoms present in the individual treatment plans and ~~progress notes~~ treatment plan reviews;

(6) have continuing documentation of collaboration with continuing care mental health providers, and involvement of the providers in treatment planning meetings;

(7) have available program materials adapted to a client with a mental health problem;

(8) have policies that provide flexibility for a client who may lapse in treatment or may have difficulty adhering to established treatment rules as a result of a mental illness, with the goal of helping a client successfully complete treatment; and

(9) have individual psychotherapy and case management available during treatment service.

EFFECTIVE DATE. This section is effective January 1, 2023.

Sec. 23. Minnesota Statutes 2020, section 245G.22, subdivision 7, is amended to read:

Subd. 7. **Restrictions for unsupervised use of methadone hydrochloride.** (a) If a medical director or prescribing practitioner assesses and determines that a client meets the criteria in subdivision 6 and may be dispensed a medication used for the treatment of opioid addiction, the restrictions in this subdivision must be followed when the medication to be dispensed is methadone hydrochloride. The results of the assessment must be contained in the client file. The number of unsupervised use medication doses per week in paragraphs (b) to (d) is in addition to the number of unsupervised use medication doses a client may receive for days the clinic is closed for business as allowed by subdivision 6, paragraph (a).

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

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

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

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

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

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

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

Sec. 24. Minnesota Statutes 2020, section 245H.05, is amended to read:

245H.05 MONITORING AND INSPECTIONS.

(a) The commissioner must conduct an on-site inspection of a certified license-exempt child care center at least ~~annually~~ once each calendar year to determine compliance with the health, safety, and fire standards specific to a certified license-exempt child care center.

(b) No later than November 19, 2017, the commissioner shall make publicly available on the department's website the results of inspection reports for all certified centers including the number of deaths, serious injuries, and instances of substantiated child maltreatment that occurred in certified centers each year.

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

Sec. 25. Minnesota Statutes 2020, section 245H.08, is amended by adding a subdivision to read:

Subd. 6. **Authority to modify requirements.** (a) Notwithstanding subdivisions 4 and 5, for children in kindergarten through 13 years old, the commissioner may increase the maximum group size to no more than 40 children and may increase the minimally acceptable staff-to-child ratio to one to 20 during a national security or peacetime emergency declared under section 12.31, or during a public health emergency declared due to a pandemic by the United States Secretary of Health and Human Services under section 319 of the Public Health Service Act, United States Code, title 42, section 247d.

(b) If the commissioner modifies requirements under this subdivision, a certified center operating under the modified requirements must have at least one staff person who is at least 18 years old with each group of 40 children.

Sec. 26. Laws 2020, First Special Session chapter 7, section 1, subdivision 5, as amended by Laws 2021, First Special Session chapter 7, article 2, section 73, is amended to read:

Subd. 5. **Waivers and modifications; extension ~~for 365 days~~.** 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, waiver CV23: modifying background study requirements, issued by the commissioner of human services pursuant to Executive

Orders 20-11 and 20-12, including any amendments to the modification issued before the peacetime emergency expires, shall remain in effect ~~for 365 days after the peacetime emergency ends~~ until January 1, 2023.

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

Sec. 27. **CHILD CARE REGULATION MODERNIZATION; PILOT PROJECTS.**

The commissioner of human services may conduct and administer pilot projects to test methods and procedures for the projects to modernize regulation of child care centers and family child care allowed under Laws 2021, First Special Session chapter 7, article 2, sections 75 and 81. To carry out the pilot projects, the commissioner of human services may, by issuing a commissioner's order, waive enforcement of existing specific statutory program requirements, rules, and standards in one or more counties. The commissioner's order establishing the waiver must provide alternative methods and procedures of administration and must not be in conflict with the basic purposes, coverage, or benefits provided by law. In no event may a pilot project under this section extend beyond February 1, 2024. Pilot projects must comply with the requirements of the child care and development fund plan.

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

Sec. 28. **DIRECTION TO COMMISSIONER OF HUMAN SERVICES; AMENDING CHILDREN'S RESIDENTIAL FACILITY AND DETOXIFICATION PROGRAM RULES.**

(a) The commissioner of human services must amend Minnesota Rules, part 2960.0460, to remove all references to repealed Minnesota Rules, part 2960.0460, subpart 2.

(b) The commissioner must amend Minnesota Rules, part 2960.0470, to require license holders to have written personnel policies that describe the process for disciplinary action, suspension, or dismissal of a staff person for violating the drug and alcohol policy described in Minnesota Statutes, section 245A.04, subdivision 1, paragraph (c), and Minnesota Rules, part 2960.0030, subpart 9.

(c) The commissioner must amend Minnesota Rules, part 9530.6565, subpart 1, to remove items A and B and the documentation requirement that references these items.

(d) The commissioner must amend Minnesota Rules, part 9530.6570, subpart 1, item D, to remove the existing language and insert language to require license holders to have written personnel policies that describe the process for disciplinary action, suspension, or

dismissal of a staff person for violating the drug and alcohol policy described in Minnesota Statutes, section 245A.04, subdivision 1, paragraph (c).

(e) For purposes of this section, the commissioner may use the good cause exempt process under Minnesota Statutes, section 14.388, subdivision 1, clause (3), and Minnesota Statutes, section 14.386, does not apply.

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

Sec. 29. **REPEALER.**

(a) Minnesota Statutes 2020, sections 245F.15, subdivision 2; and 245G.11, subdivision 2, are repealed.

(b) Minnesota Rules, parts 2960.0460, subpart 2; and 9530.6565, subpart 2, are repealed.

EFFECTIVE DATE. This section is effective January 1, 2023.

ARTICLE 20
OPIOID SETTLEMENT

Section 1. **[3.757] RELEASE OF OPIOID-RELATED CLAIMS.**

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

(b) "Municipality" has the meaning provided in section 466.01, subdivision 1.

(c) "Opioid litigation" means any civil litigation, demand, or settlement in lieu of litigation alleging unlawful conduct related to the marketing, sale, or distribution of opioids in this state or other alleged illegal actions that contributed to the excessive use of opioids.

(d) "Released claim" means any cause of action or other claim that has been released in a statewide opioid settlement agreement, including matters identified as a released claim as that term or a comparable term is defined in a statewide opioid settlement agreement.

(e) "Settling defendant" means Johnson & Johnson, AmerisourceBergen Corporation, Cardinal Health, Inc., and McKesson Corporation, as well as related subsidiaries, affiliates, officers, directors, and other related entities specifically named as a released entity in a statewide opioid settlement agreement.

(f) "Statewide opioid settlement agreement" means an agreement, including consent judgments, assurances of discontinuance, and related agreements or documents, between the attorney general, on behalf of the state, and a settling defendant, to provide or allocate

remuneration for conduct related to the marketing, sale, or distribution of opioids in this state or other alleged illegal actions that contributed to the excessive use of opioids.

Subd. 2. **Release of claims.** (a) No municipality shall have the authority to assert, file, or enforce a released claim against a settling defendant.

(b) Any claim in pending opioid litigation filed by a municipality against a settling defendant that is within the scope of a released claim is extinguished by operation of law.

(c) The attorney general shall have authority to appear or intervene in opioid litigation where a municipality has asserted, filed, or enforced a released claim against a settling defendant and release with prejudice any released claims.

(d) This section does not limit any causes of action, claims, or remedies, nor the authority to assert, file, or enforce such causes of action, claims, or remedies, by a party other than a municipality.

(e) This section does not limit any causes of action, claims, or remedies, nor the authority to assert, file, or enforce such causes of action, claims, or remedies by a municipality against entities and individuals other than a released claim against a settling defendant.

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

Sec. 2. Minnesota Statutes 2021 Supplement, section 16A.151, subdivision 2, is amended to read:

Subd. 2. **Exceptions.** (a) If a state official litigates or settles a matter on behalf of specific injured persons or entities, this section does not prohibit distribution of money to the specific injured persons or entities on whose behalf the litigation or settlement efforts were initiated. If money recovered on behalf of injured persons or entities cannot reasonably be distributed to those persons or entities because they cannot readily be located or identified or because the cost of distributing the money would outweigh the benefit to the persons or entities, the money must be paid into the general fund.

(b) Money recovered on behalf of a fund in the state treasury other than the general fund may be deposited in that fund.

(c) This section does not prohibit a state official from distributing money to a person or entity other than the state in litigation or potential litigation in which the state is a defendant or potential defendant.

(d) State agencies may accept funds as directed by a federal court for any restitution or monetary penalty under United States Code, title 18, section 3663(a)(3), or United States

Code, title 18, section 3663A(a)(3). Funds received must be deposited in a special revenue account and are appropriated to the commissioner of the agency for the purpose as directed by the federal court.

(e) Tobacco settlement revenues as defined in section 16A.98, subdivision 1, paragraph (t), may be deposited as provided in section 16A.98, subdivision 12.

(f) Any money received by the state resulting from a settlement agreement or an assurance of discontinuance entered into by the attorney general of the state, or a court order in litigation brought by the attorney general of the state, on behalf of the state or a state agency, related to alleged violations of consumer fraud laws in the marketing, sale, or distribution of opioids in this state or other alleged illegal actions that contributed to the excessive use of opioids, must be deposited in ~~a separate account in the state treasury and the commissioner shall notify the chairs and ranking minority members of the Finance Committee in the senate and the Ways and Means Committee in the house of representatives that an account has been created. Notwithstanding section 11A.20, all investment income and all investment losses attributable to the investment of this account shall be credited to the account~~ the settlement account established in the opiate epidemic response fund under section 256.043, subdivision 1. This paragraph does not apply to attorney fees and costs awarded to the state or the Attorney General's Office, to contract attorneys hired by the state or Attorney General's Office, or to other state agency attorneys. ~~If the licensing fees under section 151.065, subdivision 1, clause (16), and subdivision 3, clause (14), are reduced and the registration fee under section 151.066, subdivision 3, is repealed in accordance with section 256.043, subdivision 4, then the commissioner shall transfer from the separate account created in this paragraph to the opiate epidemic response fund under section 256.043 an amount that ensures that $20,940,000 each fiscal year is available for distribution in accordance with section 256.043, subdivision 3.~~

(g) Notwithstanding paragraph (f), if money is received from a settlement agreement or an assurance of discontinuance entered into by the attorney general of the state or a court order in litigation brought by the attorney general of the state on behalf of the state or a state agency against a consulting firm working for an opioid manufacturer or opioid wholesale drug distributor ~~and deposited into the separate account created under paragraph (f)~~, the commissioner shall ~~annually transfer from the separate account to the opiate epidemic response fund under section 256.043 an amount equal to the estimated amount submitted to the commissioner by the Board of Pharmacy in accordance with section 151.066, subdivision 3, paragraph (b). The amount transferred shall be included in the amount available for distribution in accordance with section 256.043, subdivision 3. This transfer shall occur~~

~~each year until the registration fee under section 151.066, subdivision 3, is repealed in accordance with section 256.043, subdivision 4, or the money deposited in the account in accordance with this paragraph has been transferred, whichever occurs first~~ deposit any money received into the settlement account established within the opiate epidemic response fund under section 256.042, subdivision 1. Notwithstanding section 256.043, subdivision 3a, paragraph (a), any amount deposited into the settlement account in accordance with this paragraph shall be appropriated to the commissioner of human services to award as grants as specified by the opiate epidemic response advisory council in accordance with section 256.043, subdivision 3a, paragraph (d).

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

Sec. 3. Minnesota Statutes 2021 Supplement, section 151.066, subdivision 3, is amended to read:

Subd. 3. **Determination of an opiate product registration fee.** (a) The board shall annually assess an opiate product registration fee on any manufacturer of an opiate that annually sells, delivers, or distributes an opiate within or into the state 2,000,000 or more units as reported to the board under subdivision 2.

(b) For purposes of assessing the annual registration fee under this section and determining the number of opiate units a manufacturer sold, delivered, or distributed within or into the state, the board shall not consider any opiate that is used for medication-assisted therapy for substance use disorders. ~~If there is money deposited into the separate account as described in section 16A.151, subdivision 2, paragraph (g), The board shall submit to the commissioner of management and budget an estimate of the difference in the annual fee revenue collected under this section due to this exception.~~

(c) The annual registration fee for each manufacturer meeting the requirement under paragraph (a) is $250,000.

(d) In conjunction with the data reported under this section, and notwithstanding section 152.126, subdivision 6, the board may use the data reported under section 152.126, subdivision 4, to determine which manufacturers meet the requirement under paragraph (a) and are required to pay the registration fees under this subdivision.

(e) By April 1 of each year, beginning April 1, 2020, the board shall notify a manufacturer that the manufacturer meets the requirement in paragraph (a) and is required to pay the annual registration fee in accordance with section 151.252, subdivision 1, paragraph (b).

(f) A manufacturer may dispute the board's determination that the manufacturer must pay the registration fee no later than 30 days after the date of notification. However, the manufacturer must still remit the fee as required by section 151.252, subdivision 1, paragraph (b). The dispute must be filed with the board in the manner and using the forms specified by the board. A manufacturer must submit, with the required forms, data satisfactory to the board that demonstrates that the assessment of the registration fee was incorrect. The board must make a decision concerning a dispute no later than 60 days after receiving the required dispute forms. If the board determines that the manufacturer has satisfactorily demonstrated that the fee was incorrectly assessed, the board must refund the amount paid in error.

(g) For purposes of this subdivision, a unit means the individual dosage form of the particular drug product that is prescribed to the patient. One unit equals one tablet, capsule, patch, syringe, milliliter, or gram.

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

Sec. 4. Minnesota Statutes 2021 Supplement, section 256.042, subdivision 4, is amended to read:

Subd. 4. **Grants.** (a) The commissioner of human services shall submit a report of the grants proposed by the advisory council to be awarded for the upcoming calendar year to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services policy and finance, by December 1 of each year, beginning March 1, 2020.

(b) The grants shall be awarded to proposals selected by the advisory council that address the priorities in subdivision 1, paragraph (a), clauses (1) to (4), unless otherwise appropriated by the legislature. The advisory council shall determine grant awards and funding amounts based on the funds appropriated to the commissioner under section 256.043, subdivision 3, paragraph ~~(e)~~ (h), and subdivision 3a, paragraph (d). The commissioner shall award the grants from the opiate epidemic response fund and administer the grants in compliance with section 16B.97. No more than ten percent of the grant amount may be used by a grantee for administration.

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

Sec. 5. Minnesota Statutes 2020, section 256.043, subdivision 1, is amended to read:

Subdivision 1. **Establishment.** (a) The opiate epidemic response fund is established in the state treasury. ~~The registration fees assessed by the Board of Pharmacy under section~~

~~151.066 and the license fees identified in section 151.065, subdivision 7, paragraphs (b) and (c), shall be deposited into the fund.~~ The commissioner of management and budget shall establish within the opiate epidemic response fund two accounts: (1) a registration and license fee account; and (2) a settlement account. Beginning in fiscal year 2021, for each fiscal year, the fund shall be administered according to this section.

(b) The commissioner of management and budget shall deposit into the registration and license fee account the registration fee assessed by the Board of Pharmacy under section 151.066 and the license fees identified in section 151.065, subdivision 7, paragraphs (b) and (c).

(c) The commissioner of management and budget shall deposit into the settlement account any money received by the state resulting from a settlement agreement or an assurance of discontinuance entered into by the attorney general of the state, or a court order in litigation brought by the attorney general of the state, on behalf of the state or a state agency, related to alleged violations of consumer fraud laws in the marketing, sale, or distribution of opioids in this state or other alleged illegal actions that contributed to the excessive use of opioids, pursuant to section 16A.151, subdivision 2, paragraph (f).

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

Sec. 6. Minnesota Statutes 2021 Supplement, section 256.043, subdivision 3, is amended to read:

Subd. 3. **Appropriations from ~~fund~~ registration and license fee account.** (a) The appropriations in paragraphs (b) to (h) shall be made from the registration and license fee account on a fiscal year basis in the order specified.

~~After~~ (b) The appropriations specified in Laws 2019, chapter 63, article 3, section 1, ~~paragraph (e), are made, $249,000 is appropriated to the commissioner of human services for the provision of administrative services to the Opiate Epidemic Response Advisory Council and for the administration of the grants awarded under paragraph (e).~~ paragraphs (b), (f), (g), and (h), as amended by Laws 2020, chapter 115, article 3, section 35, shall be made accordingly.

(c) $300,000 is appropriated to the commissioner of management and budget for evaluation activities under section 256.042, subdivision 1, paragraph (c).

(d) $249,000 is appropriated to the commissioner of human services for the provision of administrative services to the Opiate Epidemic Response Advisory Council and for the administration of the grants awarded under paragraph (h).

~~(b)~~ (e) $126,000 is appropriated to the Board of Pharmacy for the collection of the registration fees under section 151.066.

~~(c)~~ (f) $672,000 is appropriated to the commissioner of public safety for the Bureau of Criminal Apprehension. Of this amount, $384,000 is for drug scientists and lab supplies and $288,000 is for special agent positions focused on drug interdiction and drug trafficking.

~~(d)~~ (g) After the appropriations in paragraphs ~~(a)~~ (b) to ~~(c)~~ (f) are made, 50 percent of the remaining amount is appropriated to the commissioner of human services for distribution to county social service ~~and tribal social service~~ agencies and Tribal social service agency initiative projects authorized under section 256.01, subdivision 14b, to provide child protection services to children and families who are affected by addiction. The commissioner shall distribute this money proportionally to ~~counties and tribal~~ county social service agencies and Tribal social service agency initiative projects based on out-of-home placement episodes where parental drug abuse is the primary reason for the out-of-home placement using data from the previous calendar year. County ~~and tribal~~ social service agencies and Tribal social service agency initiative projects receiving funds from the opiate epidemic response fund must annually report to the commissioner on how the funds were used to provide child protection services, including measurable outcomes, as determined by the commissioner. County social service agencies and Tribal social service ~~agencies~~ agency initiative projects must not use funds received under this paragraph to supplant current state or local funding received for child protection services for children and families who are affected by addiction.

~~(e)~~ (h) After ~~making~~ the appropriations in paragraphs ~~(a)~~ (b) to ~~(d)~~ (g) are made, the remaining amount in the ~~fund~~ account is appropriated to the commissioner of human services to award grants as specified by the Opiate Epidemic Response Advisory Council in accordance with section 256.042, unless otherwise appropriated by the legislature.

~~(f)~~ (i) Beginning in fiscal year 2022 and each year thereafter, funds for county social service ~~and tribal social service~~ agencies and Tribal social service agency initiative projects under paragraph ~~(d)~~ (g) and grant funds specified by the Opiate Epidemic Response Advisory Council under paragraph ~~(e) shall~~ (h) may be distributed on a calendar year basis.

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

Sec. 7. Minnesota Statutes 2020, section 256.043, is amended by adding a subdivision to read:

Subd. 3a. **Appropriations from settlement account.** (a) The appropriations in paragraphs (b) to (e) shall be made from the settlement account on a fiscal year basis in the order specified.

(b) If the balance in the registration and license fee account is not sufficient to fully fund the appropriations specified in subdivision 3, paragraphs (b) to (f), an amount necessary to meet any insufficiency shall be transferred from the settlement account to the registration and license fee account to fully fund the required appropriations.

(c) $209,000 in fiscal year 2023 and $239,000 in fiscal year 2024 and subsequent fiscal years are appropriated to the commissioner of human services for the administration of grants awarded under paragraph (e). $276,000 in fiscal year 2023 and $246,000 in fiscal year 2024 and subsequent fiscal years are appropriated to the commissioner of human services for data collection and analysis of settlement funds as required under section 256.042, subdivision 5, paragraph (d).

(d) After any appropriations necessary under paragraphs (b) and (c) are made, an amount equal to the calendar year allocation to Tribal social service agency initiative projects under subdivision 3, paragraph (g), is appropriated from the settlement account to the commissioner of human services for distribution to Tribal social service agency initiative projects to provide child protection services to children and families who are affected by addiction. The requirements related to proportional distribution, annual reporting, and maintenance of effort specified in subdivision 3, paragraph (g), also apply to the appropriations made under this paragraph.

(e) After making the appropriations in paragraphs (b) to (d), the remaining amount in the account is appropriated to the commissioner of human services to award grants as specified by the Opiate Epidemic Response Advisory Council in accordance with section 256.042.

(f) Funds for Tribal social service agency initiative projects under paragraph (d) and grant funds specified by the Opiate Epidemic Response Advisory Council under paragraph (e) may be distributed on a calendar year basis.

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

Sec. 8. Minnesota Statutes 2021 Supplement, section 256.043, subdivision 4, is amended to read:

Subd. 4. **Settlement; sunset.** (a) If the state receives a total sum of $250,000,000 either as a result of a settlement agreement or an assurance of discontinuance entered into by the attorney general of the state, or resulting from a court order in litigation brought by the attorney general of the state on behalf of the state or a state agency related to alleged violations of consumer fraud laws in the marketing, sale, or distribution of opioids in this state, or other alleged illegal actions that contributed to the excessive use of opioids, or from the fees collected under sections 151.065, subdivisions 1 and 3, and 151.066, that are deposited into the opiate epidemic response fund established in this section, or from a combination of both, the fees specified in section 151.065, subdivisions 1, clause (16), and 3, clause (14), shall be reduced to $5,260, and the opiate registration fee in section 151.066, subdivision 3, shall be repealed. For purposes of this paragraph, any money received as a result of a settlement agreement specified in this paragraph and directly allocated or distributed and received by either the state or a municipality as defined in section 466.01, subdivision 1, shall be counted toward determining when the $250,000,000 is reached.

(b) The commissioner of management and budget shall inform the Board of Pharmacy, the governor, and the legislature when the amount specified in paragraph (a) has been reached. The board shall apply the reduced license fee for the next licensure period.

(c) Notwithstanding paragraph (a), the reduction of the license fee in section 151.065, subdivisions 1 and 3, and the repeal of the registration fee in section 151.066 shall not occur before July 1, ~~2024~~ 2031.

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

Sec. 9. Laws 2019, chapter 63, article 3, section 1, as amended by Laws 2020, chapter 115, article 3, section 35, is amended to read:

Section 1. **APPROPRIATIONS.**

(a) **Board of Pharmacy; administration.** $244,000 in fiscal year 2020 is appropriated from the general fund to the Board of Pharmacy for onetime information technology and operating costs for administration of licensing activities under Minnesota Statutes, section 151.066. This is a onetime appropriation.

(b) **Commissioner of human services; administration.** $309,000 in fiscal year 2020 is appropriated from the general fund and $60,000 in fiscal year 2021 is appropriated from

the opiate epidemic response fund to the commissioner of human services for the provision of administrative services to the Opiate Epidemic Response Advisory Council and for the administration of the grants awarded under paragraphs (f), (g), and (h). The opiate epidemic response fund base for this appropriation is $60,000 in fiscal year 2022, $60,000 in fiscal year 2023, $60,000 in fiscal year 2024, and ~~$0~~ $60,000 in fiscal year 2025.

(c) **Board of Pharmacy; administration.** $126,000 in fiscal year 2020 is appropriated from the general fund to the Board of Pharmacy for the collection of the registration fees under section 151.066.

(d) **Commissioner of public safety; enforcement activities.** $672,000 in fiscal year 2020 is appropriated from the general fund to the commissioner of public safety for the Bureau of Criminal Apprehension. Of this amount, $384,000 is for drug scientists and lab supplies and $288,000 is for special agent positions focused on drug interdiction and drug trafficking.

(e) **Commissioner of management and budget; evaluation activities.** $300,000 in fiscal year 2020 is appropriated from the general fund and $300,000 in fiscal year 2021 is appropriated from the opiate epidemic response fund to the commissioner of management and budget for evaluation activities under Minnesota Statutes, section 256.042, subdivision 1, paragraph (c). ~~The opiate epidemic response fund base for this appropriation is $300,000 in fiscal year 2022, $300,000 in fiscal year 2023, $300,000 in fiscal year 2024, and $0 in fiscal year 2025.~~

(f) **Commissioner of human services; grants for Project ECHO.** $400,000 in fiscal year 2020 is appropriated from the general fund and $400,000 in fiscal year 2021 is appropriated from the opiate epidemic response fund to the commissioner of human services for grants of $200,000 to CHI St. Gabriel's Health Family Medical Center for the opioid-focused Project ECHO program and $200,000 to Hennepin Health Care for the opioid-focused Project ECHO program. The opiate epidemic response fund base for this appropriation is $400,000 in fiscal year 2022, $400,000 in fiscal year 2023, $400,000 in fiscal year 2024, and $0 in fiscal year 2025.

(g) **Commissioner of human services; opioid overdose prevention grant.** $100,000 in fiscal year 2020 is appropriated from the general fund and $100,000 in fiscal year 2021 is appropriated from the opiate epidemic response fund to the commissioner of human services for a grant to a nonprofit organization that has provided overdose prevention programs to the public in at least 60 counties within the state, for at least three years, has received federal funding before January 1, 2019, and is dedicated to addressing the opioid

epidemic. The grant must be used for opioid overdose prevention, community asset mapping, education, and overdose antagonist distribution. The opiate epidemic response fund base for this appropriation is $100,000 in fiscal year 2022, $100,000 in fiscal year 2023, $100,000 in fiscal year 2024, and ~~$0~~ $100,000 in fiscal year 2025.

(h) **Commissioner of human services; traditional healing.** $2,000,000 in fiscal year 2020 is appropriated from the general fund and $2,000,000 in fiscal year 2021 is appropriated from the opiate epidemic response fund to the commissioner of human services to award grants to Tribal nations and 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. The opiate epidemic response fund base for this appropriation is $2,000,000 in fiscal year 2022, $2,000,000 in fiscal year 2023, $2,000,000 in fiscal year 2024, and ~~$0~~ $2,000,000 in fiscal year 2025.

(i) **Board of Dentistry; continuing education.** $11,000 in fiscal year 2020 is appropriated from the state government special revenue fund to the Board of Dentistry to implement the continuing education requirements under Minnesota Statutes, section 214.12, subdivision 6.

(j) **Board of Medical Practice; continuing education.** $17,000 in fiscal year 2020 is appropriated from the state government special revenue fund to the Board of Medical Practice to implement the continuing education requirements under Minnesota Statutes, section 214.12, subdivision 6.

(k) **Board of Nursing; continuing education.** $17,000 in fiscal year 2020 is appropriated from the state government special revenue fund to the Board of Nursing to implement the continuing education requirements under Minnesota Statutes, section 214.12, subdivision 6.

(l) **Board of Optometry; continuing education.** $5,000 in fiscal year 2020 is appropriated from the state government special revenue fund to the Board of Optometry to implement the continuing education requirements under Minnesota Statutes, section 214.12, subdivision 6.

(m) **Board of Podiatric Medicine; continuing education.** $5,000 in fiscal year 2020 is appropriated from the state government special revenue fund to the Board of Podiatric Medicine to implement the continuing education requirements under Minnesota Statutes, section 214.12, subdivision 6.

(n) **Commissioner of health; nonnarcotic pain management and wellness.** $1,250,000 is appropriated in fiscal year 2020 from the general fund to the commissioner of health, to provide funding for:

(1) statewide mapping and assessment of community-based nonnarcotic pain management and wellness resources; and

(2) up to five demonstration projects in different geographic areas of the state to provide community-based nonnarcotic pain management and wellness resources to patients and consumers.

The demonstration projects must include an evaluation component and scalability analysis. The commissioner shall award the grant for the statewide mapping and assessment, and the demonstration project grants, through a competitive request for proposal process. Grants for statewide mapping and assessment and demonstration projects may be awarded simultaneously. In awarding demonstration project grants, the commissioner shall give preference to proposals that incorporate innovative community partnerships, are informed and led by people in the community where the project is taking place, and are culturally relevant and delivered by culturally competent providers. This is a onetime appropriation.

(o) **Commissioner of health; administration.** $38,000 in fiscal year 2020 is appropriated from the general fund to the commissioner of health for the administration of the grants awarded in paragraph (n).

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

Sec. 10. Laws 2021, First Special Session chapter 7, article 16, section 12, is amended to read:

Sec. 12. **COMMISSIONER OF MANAGEMENT AND BUDGET** **$ 300,000 $ ~~300,000~~ 0**

(a) This appropriation is from the opiate epidemic response fund.

(b) **Evaluation.** $300,000 in fiscal year 2022 ~~and $300,000 in fiscal year 2023~~ is for evaluation activities under Minnesota Statutes, section 256.042, subdivision 1, paragraph (c).

~~(c) **Base Level Adjustment.** The opiate epidemic response fund base is $300,000 in~~

~~fiscal year 2024 and $300,000 in fiscal year~~
~~2025.~~

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

Sec. 11. **TRANSFER; ELIMINATION OF ACCOUNT.**

(a) The commissioner of management and budget shall transfer any money in the separate account established in the state treasury under Minnesota Statutes, section 16A.151, subdivision 2, paragraph (f), to the settlement account in the opiate epidemic response fund established under Minnesota Statutes, section 256.043, subdivision 1. Notwithstanding section 256.043, subdivision 3a, paragraph (a), money transferred into the account under this paragraph shall be appropriated to the commissioner of human services to award as grants as specified by the Opiate Epidemic Response Advisory Council in accordance with Minnesota Statutes, section 256.043, subdivision 3a, paragraph (d).

(b) Once the money is transferred as required in paragraph (a), the commissioner of management and budget shall eliminate the separate account established under Minnesota Statutes, section 16A.151, subdivision 2, paragraph (f).

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

ARTICLE 21
CHILD CARE POLICY

Section 1. Minnesota Statutes 2020, section 119B.011, subdivision 2, is amended to read:

Subd. 2. **Applicant.** "Child care fund applicants" means all parents~~,~~; stepparents~~,~~; legal guardians~~, or~~; eligible relative caregivers ~~who are~~; relative custodians who accepted a transfer of permanent legal and physical custody of a child under section 260C.515, subdivision 4, or similar permanency disposition in Tribal code; successor custodians or guardians as established by section 256N.22, subdivision 10; or foster parents providing care to a child placed in a family foster home under section 260C.007, subdivision 16b. Applicants must be members of the family and reside in the household that applies for child care assistance under the child care fund.

EFFECTIVE DATE. This section is effective August 7, 2023.

Sec. 2. Minnesota Statutes 2020, section 119B.011, subdivision 5, is amended to read:

Subd. 5. **Child care.** "Child care" means the care of a child by someone other than a parent~~,~~; stepparent~~,~~; legal guardian~~,~~; eligible relative caregiver~~,~~; relative custodian who

accepted a transfer of permanent legal and physical custody of a child under section 260C.515, subdivision 4, or similar permanency disposition in Tribal code; successor custodian or guardian as established according to section 256N.22, subdivision 10; foster parent providing care to a child placed in a family foster home under section 260C.007, subdivision 16b; or ~~the spouses~~ spouse of any of the foregoing in or outside the child's own home for gain or otherwise, on a regular basis, for any part of a 24-hour day.

EFFECTIVE DATE. This section is effective August 7, 2023.

Sec. 3. Minnesota Statutes 2020, section 119B.011, subdivision 13, is amended to read:

Subd. 13. **Family.** "Family" means parents~~,~~; stepparents~~,~~; guardians and their spouses~~,~~ ~~or~~; other eligible relative caregivers and their spouses~~,~~; relative custodians who accepted a transfer of permanent legal and physical custody of a child under section 260C.515, subdivision 4, or similar permanency disposition in Tribal code, and their spouses; successor custodians or guardians as established according to section 256N.22, subdivision 10, and their spouses; or foster parents providing care to a child placed in a family foster home under section 260C.007, subdivision 16b, and their spouses; and ~~their blood related~~ the blood-related dependent children and adoptive siblings under the age of 18 years living in the same home ~~including~~ of the above. This definition includes children temporarily absent from the household in settings such as schools, foster care, and residential treatment facilities ~~or parents, stepparents, guardians and their spouses, or other relative caregivers and their spouses~~ and adults temporarily absent from the household in settings such as schools, military service, or rehabilitation programs. An adult family member who is not in an authorized activity under this chapter may be temporarily absent for up to 60 days. When a minor parent or parents and his, her, or their child or children are living with other relatives, and the minor parent or parents apply for a child care subsidy, "family" means only the minor parent or parents and their child or children. An adult age 18 or older who meets this definition of family and is a full-time high school or postsecondary student may be considered a dependent member of the family unit if 50 percent or more of the adult's support is provided by the parents~~,~~; stepparents~~,~~; guardians~~,~~ and their spouses; relative custodians who accepted a transfer of permanent legal and physical custody of a child under section 260C.515, subdivision 4, or similar permanency disposition in Tribal code, and their spouses; successor custodians or guardians as established according to section 256N.22, subdivision 10, and their spouses; foster parents providing care to a child placed in a family foster home under section 260C.007, subdivision 16b, and their spouses; or eligible relative caregivers and their spouses residing in the same household.

EFFECTIVE DATE. This section is effective August 7, 2023.

Sec. 4. Minnesota Statutes 2021 Supplement, section 119B.03, subdivision 4a, is amended to read:

Subd. 4a. ~~**Temporary reprioritization**~~ **Funding priorities.** (a) ~~Notwithstanding subdivision 4~~ In the event that inadequate funding necessitates the use of waiting lists, priority for child care assistance under the basic sliding fee assistance program shall be determined according to this subdivision ~~beginning July 1, 2021, through May 31, 2024~~.

(b) First priority must be given to eligible non-MFIP families who do not have a high school diploma or commissioner of education-selected high school equivalency certification or who need remedial and basic skill courses in order to pursue employment or to pursue education leading to employment and who need child care assistance to participate in the education program. This includes student parents as defined under section 119B.011, subdivision 19b. Within this priority, the following subpriorities must be used:

(1) child care needs of minor parents;

(2) child care needs of parents under 21 years of age; and

(3) child care needs of other parents within the priority group described in this paragraph.

(c) Second priority must be given to families in which at least one parent is a veteran, as defined under section 197.447.

(d) Third priority must be given to eligible families who do not meet the specifications of paragraph (b), (c), (e), or (f).

(e) Fourth priority must be given to families who are eligible for portable basic sliding fee assistance through the portability pool under subdivision 9.

(f) Fifth priority must be given to eligible families receiving services under section 119B.011, subdivision 20a, if the parents have completed their MFIP or DWP transition year, or if the parents are no longer receiving or eligible for DWP supports.

(g) Families under paragraph (f) must be added to the basic sliding fee waiting list on the date they complete their transition year under section 119B.011, subdivision 20.

EFFECTIVE DATE. This section is effective July 1, 2022.

Sec. 5. Minnesota Statutes 2021 Supplement, section 119B.13, subdivision 1, is amended to read:

Subdivision 1. **Subsidy restrictions.** (a) Beginning ~~November 15, 2021~~ October 3, 2022, the maximum rate paid for child care assistance in any county or county price cluster under the child care fund shall be~~:~~

~~(1) for all infants and toddlers,~~ the greater of the ~~40th~~ 75th percentile of the 2021 child care provider rate survey or the rates in effect at the time of the update~~; and~~.

~~(2) for all preschool and school-age children, the greater of the 30th percentile of the 2021 child care provider rate survey or the rates in effect at the time of the update.~~

(b) Beginning the first full service period on or after January 1, 2025, and every three years thereafter, the maximum rate paid for child care assistance in a county or county price cluster under the child care fund shall be~~:~~

~~(1) for all infants and toddlers,~~ the greater of the ~~40th~~ 75th percentile of the ~~2024~~ most recent child care provider rate survey or the rates in effect at the time of the update~~; and~~.

~~(2) for all preschool and school-age children, the greater of the 30th percentile of the 2024 child care provider rate survey or the rates in effect at the time of the update.~~

The rates under paragraph (a) continue until the rates under this paragraph go into effect.

(c) For a child care provider located within the boundaries of a city located in two or more of the counties of Benton, Sherburne, and Stearns, the maximum rate paid for child care assistance shall be equal to the maximum rate paid in the county with the highest maximum reimbursement rates or the provider's charge, whichever is less. The commissioner may: (1) assign a county with no reported provider prices to a similar price cluster; and (2) consider county level access when determining final price clusters.

(d) A rate which includes a special needs rate paid under subdivision 3 may be in excess of the maximum rate allowed under this subdivision.

(e) The department shall monitor the effect of this paragraph on provider rates. The county shall pay the provider's full charges for every child in care up to the maximum established. The commissioner shall determine the maximum rate for each type of care on an hourly, full-day, and weekly basis, including special needs and disability care.

(f) If a child uses one provider, the maximum payment for one day of care must not exceed the daily rate. The maximum payment for one week of care must not exceed the weekly rate.

(g) If a child uses two providers under section 119B.097, the maximum payment must not exceed:

(1) the daily rate for one day of care;

(2) the weekly rate for one week of care by the child's primary provider; and

(3) two daily rates during two weeks of care by a child's secondary provider.

(h) Child care providers receiving reimbursement under this chapter must not be paid activity fees or an additional amount above the maximum rates for care provided during nonstandard hours for families receiving assistance.

(i) If the provider charge is greater than the maximum provider rate allowed, the parent is responsible for payment of the difference in the rates in addition to any family co-payment fee.

(j) Beginning October 3, 2022, the maximum registration fee paid for child care assistance in any county or county price cluster under the child care fund shall be ~~set as follows: (1) beginning November 15, 2021,~~ the greater of the ~~40th~~ 75th percentile of the ~~2021~~ most recent child care provider rate survey or the registration fee in effect at the time of the update~~; and (2) beginning the first full service period on or after January 1, 2025, the maximum registration fee shall be the greater of the 40th percentile of the 2024 child care provider rate survey or the registration fee in effect at the time of the update. The registration fees under clause (1) continue until the registration fees under clause (2) go into effect~~.

(k) Maximum registration fees must be set for licensed family child care and for child care centers. For a child care provider located in the boundaries of a city located in two or more of the counties of Benton, Sherburne, and Stearns, the maximum registration fee paid for child care assistance shall be equal to the maximum registration fee paid in the county with the highest maximum registration fee or the provider's charge, whichever is less.

Sec. 6. Minnesota Statutes 2020, section 119B.19, subdivision 7, is amended to read:

Subd. 7. **Child care resource and referral programs.** Within each region, a child care resource and referral program must:

(1) maintain one database of all existing child care resources and services and one database of family referrals;

(2) provide a child care referral service for families;

(3) develop resources to meet the child care service needs of families;

(4) increase the capacity to provide culturally responsive child care services;

(5) coordinate professional development opportunities for child care and school-age care providers;

(6) administer and award child care services grants;

(7) cooperate with the Minnesota Child Care Resource and Referral Network and its member programs to develop effective child care services and child care resources; ~~and~~

(8) assist in fostering coordination, collaboration, and planning among child care programs and community programs such as school readiness, Head Start, early childhood family education, local interagency early intervention committees, early childhood screening, special education services, and other early childhood care and education services and programs that provide flexible, family-focused services to families with young children to the extent possible~~.~~;

(9) administer the child care one-stop regional assistance network to assist child care providers and individuals interested in becoming child care providers with establishing and sustaining a licensed family child care or group family child care program or a child care center; and

(10) provide supports that enable economically challenged individuals to obtain the job skills training, career counseling, and job placement assistance necessary to begin a career path in child care.

Sec. 7. **[119B.27] SHARED SERVICES GRANTS.**

The commissioner of human services shall establish a grant program to enable family child care providers to implement shared services alliances.

EFFECTIVE DATE. This section is effective July 1, 2023.

Sec. 8. **[119B.28] CHILD CARE PROVIDER ACCESS TO TECHNOLOGY GRANTS.**

The commissioner of human services shall distribute money through grants to one or more organizations to offer grants or other supports to child care providers to improve their access to computers, the Internet, subscriptions to online child care management applications, and other technologies intended to improve business practices. Up to ten percent of the grant funds may be used to administer the program.

Sec. 9. Laws 2021, First Special Session chapter 7, article 14, section 21, subdivision 4, is amended to read:

Subd. 4. **Grant awards.** (a) The commissioner shall award transition grants to all eligible programs on a noncompetitive basis through August 31, 2021.

(b) The commissioner shall award base grant amounts to all eligible programs on a noncompetitive basis beginning September 1, 2021~~, through June 30, 2023~~. The base grant amounts shall be:

(1) based on the full-time equivalent number of staff who regularly care for children in the program, including any employees, sole proprietors, or independent contractors; and

~~(2) reduced between July 1, 2022, and June 30, 2023, with amounts for the final month being no more than 50 percent of the amounts awarded in September 2021; and~~

~~(3)~~ (2) enhanced in amounts determined by the commissioner for any providers receiving payments through the child care assistance program under sections 119B.03 and 119B.05 or early learning scholarships under section 124D.165.

(c) The commissioner may provide grant amounts in addition to any base grants received to eligible programs in extreme financial hardship until all money set aside for that purpose is awarded.

(d) The commissioner may pay any grants awarded to eligible programs under this section in the form and manner established by the commissioner, except that such payments must occur on a monthly basis.

Sec. 10. **DIRECTION TO COMMISSIONER OF HUMAN SERVICES; ALLOCATING BASIC SLIDING FEE FUNDS.**

Notwithstanding Minnesota Statutes, section 119B.03, subdivisions 6, 6a, and 6b, the commissioner of human services must allocate additional basic sliding fee child care money for calendar year 2024 to counties and Tribes to account for the change in the definition of family. In allocating the additional money, the commissioner shall consider:

(1) the number of children in the county or Tribe who receive care from a relative custodian who accepted a transfer of permanent legal and physical custody of a child under section 260C.515, subdivision 4, or similar permanency disposition in Tribal code; successor custodian or guardian as established according to section 256N.22, subdivision 10; or foster parents in a family foster home under section 260C.007, subdivision 16b; and

(2) the average basic sliding fee cost of care in the county or Tribe.

Sec. 11. **DIRECTION TO COMMISSIONER OF HUMAN SERVICES; INCREASE FOR MAXIMUM RATES.**

Notwithstanding Minnesota Statutes, section 119B.03, subdivisions 6, 6a, and 6b, the commissioner of human services shall allocate additional basic sliding fee child care funds for calendar year 2023 to counties and Tribes for updated maximum rates based on relative need to cover maximum rate increases. In distributing the additional funds, the commissioner shall consider the following factors by county and Tribe:

(1) number of children covered by the county or Tribe;

(2) provider types that care for covered children;

(3) age of covered children; and

(4) amount of the increase in maximum rates.

Sec. 12. **DIRECTION TO COMMISSIONER OF HUMAN SERVICES; CHILD CARE AND DEVELOPMENT FUND ALLOCATION.**

The commissioner of human services shall allocate $75,364,000 in fiscal year 2023 from the child care and development fund for rate and registration fee increases under Minnesota Statutes, section 119B.13, subdivision 1, paragraphs (a) and (j). This is a onetime allocation.

Sec. 13. **DIRECTION TO COMMISSIONER OF HUMAN SERVICES; COST ESTIMATION MODEL FOR EARLY CARE AND LEARNING PROGRAMS.**

(a) The commissioner of human services shall develop a cost estimation model for providing early care and learning in the state. In developing the model, the commissioner shall consult with relevant entities and stakeholders, including but not limited to the State Advisory Council on Early Childhood Education and Care under Minnesota Statutes, section 124D.141; county administrators; child care resource and referral organizations under Minnesota Statutes, section 119B.19, subdivision 1; and organizations representing caregivers, teachers, and directors.

(b) The commissioner shall contract with an organization with experience and expertise in early care and learning cost estimation modeling to conduct the work outlined in this section. If practicable, the commissioner shall contract with First Children's Finance.

(c) The commissioner shall ensure that the model can estimate variation in the cost of early care and learning by:

(1) quality of care;

(2) geographic area;

(3) type of child care provider and associated licensing standards;

(4) age of child;

(5) whether the early care and learning is inclusive, caring for children with disabilities alongside children without disabilities;

(6) provider and staff compensation, including benefits such as professional development stipends, health benefits, and retirement benefits;

(7) a provider's fixed costs, including rent and mortgage payments, property taxes, and business-related insurance payments;

(8) a provider's operating expenses, including expenses for training and substitutes; and

(9) a provider's hours of operation.

(d) By January 30, 2024, the commissioner shall report to the legislative committees with jurisdiction over early childhood programs on the development of the cost estimation model. The report shall include:

(1) recommendations for how the model could be used in conjunction with a child care provider wage scale to set provider payment rates for child care assistance under Minnesota Statutes, chapter 119B; and

(2) the department's plan to seek federal approval to use the model for provider payment rates for child care assistance.

Sec. 14. **DIRECTION TO COMMISSIONER OF HUMAN SERVICES; CHILD CARE PROVIDER WAGE SCALE.**

(a) The commissioner of human services shall develop, in consultation with the commissioner of employment and economic development, the commissioner of education, and relevant stakeholders, a child care provider wage scale that:

(1) provides for wages that are equivalent to elementary school educators with similar credentials and experience;

(2) incentivizes child care providers and staff to increase child care-related qualifications;

(3) incorporates payments toward compensation benefits, including professional development stipends, health benefits, and retirement benefits; and

(4) accounts for the business structures of different types of child care providers, including licensed family child care providers and legal, nonlicensed child care providers.

(b) By January 30, 2024, the commissioner shall report to the legislative committees with jurisdiction over early childhood programs on the development of the wage scale and make recommendations for how the wage scale could be used to inform payment rates for child care assistance under Minnesota Statutes, chapter 119B.

Sec. 15. **DIRECTION TO COMMISSIONER OF HUMAN SERVICES; BRAIN BUILDERS BONUS PILOT PROGRAM.**

(a) The commissioner of human services shall develop and implement a brain builders bonus pilot program to provide incentives or other supports to eligible child care providers who provide consistent care for infants and toddlers, as defined in Minnesota Statutes, section 245A.02, subdivision 19, who receive child care assistance under Minnesota Statutes, chapter 119B, or an early learning scholarships under Minnesota Statutes, section 124D.165.

(b) "Eligible child care providers" for purposes of the pilot program are family child care providers and group family child care providers licensed under Minnesota Statutes, chapter 245A, and legally nonlicensed child care providers, as defined in Minnesota Statutes, section 119B.011, subdivision 16.

(c) The commissioner may administer the pilot program and measure the program's outcomes through a grant to a public or private nonprofit organization with the demonstrated ability to manage benefit programs for child care professionals.

(d) By January 31, 2024, the commissioner shall report to the legislative committees with jurisdiction over early childhood on implementation of the pilot program, including: a description of the incentives and supports provided; the number of the providers who received the incentives and supports, disaggregated by provider type; the average length of time a provider who received incentives or supports cared for an infant or toddler; and other outcomes of the program. The report shall also include the commissioner's recommendations on the utility and feasibility of making the pilot program permanent.

Sec. 16. **DIRECTION TO COMMISSIONER OF INFORMATION TECHNOLOGY SERVICES; INFORMATION TECHNOLOGY SYSTEMS FOR EARLY CHILDHOOD PROGRAMS.**

(a) The commissioner of information technology services shall develop and implement, to the extent practicable with the available appropriation, a plan to modernize the information

technology systems that support the programs impacting early childhood, including child care and early learning programs and those serving young children administered by the Departments of Education and Human Services and other departments with programs impacting early childhood as identified by the Children's Cabinet. The commissioner may contract for the services contained in this section.

(b) The plan must support the goal of creating information technology systems for early childhood programs that collect, analyze, share, and report data on program participation, school readiness, early screening, and other childhood indicators. The plan must include strategies to:

(1) increase the efficiency and effectiveness with which early childhood programs serve children and families;

(2) improve coordination among early childhood programs for families; and

(3) assess the impact of early childhood programs on children's outcomes, including school readiness.

(c) In developing and implementing the plan required under this section, the commissioner or the contractor must consult with the commissioners of education and human services, and other departments with programs impacting early childhood as identified by the Children's Cabinet; the Children's Cabinet; and other stakeholders.

(d) By February 1, 2023, the commissioner must provide a preliminary report on the status of the plan's development and implementation to the chairs and ranking minority members of the committees of the legislature with jurisdiction over early childhood programs.

Sec. 17. **REPEALER.**

Minnesota Statutes 2020, section 119B.03, subdivision 4, is repealed effective July 1, 2022.

ARTICLE 22
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 tetrahydrocannabinols does not include any material, compound, mixture, or preparation that qualifies as industrial hemp as defined in section 18K.02, subdivision 3; 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 23

FORECAST ADJUSTMENTS AND CARRYFORWARD AUTHORITY

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.

Sec. 3. 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.

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

Sec. 4. 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.

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

Sec. 5. 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.

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

Sec. 6. 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.

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

Sec. 7. 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.

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

Sec. 8. 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.

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

Sec. 9. 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 and fiscal year 2023 is available through June 30, 2024. 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.

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

Sec. 10. 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.

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

Sec. 11. 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.

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

Sec. 12. Laws 2021, First Special Session chapter 7, article 17, section 19, is amended to read:

Sec. 19. **CENTERS FOR INDEPENDENT LIVING HCBS ACCESS GRANT.**

(a) This act includes $1,200,000 in fiscal year 2022 and $1,200,000 in fiscal year 2023 for grants to expand services to support people with disabilities from underserved communities who are ineligible for medical assistance to live in their own homes and communities by providing accessibility modifications, independent living services, and public health program facilitation. The commissioner of human services must award the grants in equal amounts to ~~the eight organizations~~ eligible grantees. To be eligible, a grantee must be an organization defined in Minnesota Statutes, section 268A.01, subdivision 8. 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 $0 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.

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

ARTICLE 24
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** **$** **32,461,000** **$** **458,374,000**

Appropriations by Fund

	2022	2023
General	34,397,000	477,352,000
Health Care Access	(1,936,000)	(88,036,000)
Federal TANF	-0-	7,000
Opiate Epidemic Response	-0-	551,000

Subd. 2. **Central Office; Operations**

Appropriations by Fund

General	397,000	96,704,000
Health Care Access	-0-	12,183,000

(a) **Background Studies.** (1) $1,779,000 in fiscal year 2023 is from the general fund 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 from the general fund to fund the costs of reprocessing emergency studies conducted under interagency agreements. This is a onetime appropriation.

(b) **Supporting Drug Pricing Litigation Costs.** $270,000 in fiscal year 2022 is from the general fund for costs to comply with litigation requirements related to

pharmaceutical drug price litigation. This is a onetime appropriation.

(c) **Information Technology and Data Sharing Projects.** $113,000 in fiscal year 2023 is from the general fund for staff and costs related to the information technology and data sharing projects for programs impacting early childhood.

(d) **Base Level Adjustment.** The general fund base is increased $12,787,000 in fiscal year 2024 and $9,679,000 in fiscal year 2025. The health care access fund base is increased $1,233,000 in fiscal year 2024 and $2,612,000 in fiscal year 2025.

Subd. 3. **Central Office; Children and Families** -0- 23,398,000

(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) **Pregnant and Parenting Homeless Youth Study.** $108,000 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.

(c) **Chosen Family Hosting to Prevent Youth Homelessness Pilot Program.** $218,000 in fiscal year 2023 is for the chosen family hosting to prevent youth homelessness pilot program 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.

(d) **Ombudsperson for Family Child Care Providers.** The base shall include $125,000 in fiscal year 2025 for the ombudsperson for family child care providers under Minnesota Statutes, section 245.975.

(e) **Information Technology and Data Sharing Projects.** $563,000 in fiscal year 2023 is for staff and costs related to the information technology and data sharing projects for programs impacting early childhood.

(f) **Base Level Adjustment.** The general fund base is increased $8,995,000 in fiscal year 2024 and $8,748,000 in fiscal year 2025.

Subd. 4. **Central Office; Health Care**

Appropriations by Fund		
General	-0-	4,762,000
Health Care Access	-0-	2,475,000

(a) **Interactive Voice Response and Improving Access for Applications and Forms.** $1,350,000 in fiscal year 2023 is from the health care access fund 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 and is available until June 30, 2025.

(b) **Community-Driven Improvements.** $680,000 in fiscal year 2023 is from the health care access fund 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 from the general fund 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). This is a onetime appropriation.

(e) **Base Level Adjustment.** The general fund base is increased $3,698,000 in fiscal year 2024 and $5,214,000 in fiscal year 2025. The health care access fund base is increased $3,197,000 in fiscal year 2024 and $6,458,000 in fiscal year 2025.

Subd. 5. **Central Office; Continuing Care** -0- 3,478,000

(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 and $0 in fiscal year 2025.

(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). This is a onetime appropriation.

(c) **Base Level Adjustment.** The general fund base is increased $168,000 in fiscal year 2024 and $125,000 in fiscal year 2025.

Subd. 6. **Central Office; Community Supports**

Appropriations by Fund		
General	-0-	7,370,000
Opioid Epidemic Response	-0-	551,000

(a) **SEIU Health Care Arbitration Award.** $5,444 in fiscal year 2023 is from the general fund 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 and $0 in fiscal year 2025.

(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) **Online tool accessibility and capacity expansion.** $150,000 in fiscal year 2023 is from the general fund to expand the accessibility and capacity of online tools for people receiving services and direct support workers. The general fund base for this appropriation is $305,000 in fiscal year 2024 and $420,000 in fiscal year 2025.

(e) **Systemic critical incident review team.** $80,000 in fiscal year 2023 is from the general fund to implement the systemic critical incident review process in Minnesota Statutes, section 256.01, subdivision 12b.

(f) **Base Level Adjustment.** The general fund base is increased $8,739,000 in fiscal year 2024 and $9,011,000 in fiscal year 2025. The opiate epidemic response base is increased $511,000 in fiscal year 2024 and $611,000 in fiscal year 2025.

Subd. 7. **Forecasted Programs; MFIP/DWP**

Appropriations by Fund

General	-0-	5,000
Federal TANF	-0-	7,000

Subd. 8. **Forecasted Programs; MFIP Child Care Assistance** -0- (23,000)

Subd. 9. **Forecasted Programs; Minnesota Supplemental Aid** -0- 1,000

Subd. 10. **Forecasted Programs; Housing Supports** -0- 4,304,000

Subd. 11. **Forecasted Programs; MinnesotaCare** -0- 28,724,000

This appropriation is from the health care access fund.

Subd. 12. **Forecasted Programs; Medical Assistance**

Appropriations by Fund

General	-0-	(74,981,000)
Health Care Access	-0-	(135,354,000)

Subd. 13. **Forecasted Programs; Alternative Care** -0- 530,000

Subd. 14. **CD Treatment Fund** -0- 27,000

Subd. 15. **Grant Programs; BSF Child Care Grants** -0- 6,000

Base Level Adjustment. The general fund base is increased $29,620,000 in fiscal year 2024 and $69,470,000 in fiscal year 2025. The TANF base is increased $23,500,000 in fiscal year 2024 and $23,500,000 in fiscal year 2025.

Subd. 16. **Grant Programs; Child Care Development Grants** -0- 67,205,000

(a) **Child Care Provider Access to Technology Grants.** $300,000 in fiscal year 2023 is for child care provider access to technology grants pursuant to Minnesota Statutes, section 119B.28.

(b) **One-Stop Regional Assistance Network.** The base shall include $1,200,000 in fiscal year 2025 for a grant to the statewide child care resource and referral network to administer the child care one-stop shop regional assistance network in accordance with Minnesota Statutes, section 119B.19, subdivision 7, clause (9).

(c) **Child Care Workforce Development Grants.** The base shall include $1,300,000 in fiscal year 2025 for a grant to the statewide child care resource and referral network to administer the child care workforce development grants in accordance with Minnesota Statutes, section 119B.19, subdivision 7, clause (10).

(d) **Shared Services Innovation Grants.** The base shall include $500,000 in fiscal year 2024 and $500,000 in fiscal year 2025 for shared services innovation grants pursuant to Minnesota Statutes, section 119B.27.

(e) **Stabilization Grants for Child Care Providers Experiencing Financial Hardship.** $31,476,000 in fiscal year 2023 is for child care stabilization grants for child care programs in extreme financial hardship. This is a onetime appropriation and is available until June 30, 2025. Use of grant money must be made in accordance with eligibility and compliance requirements established by the commissioner.

(f) **Contract for Cost Estimation Model for Early Care and Learning Programs.** $400,000 in fiscal year 2023 is for a professional technical contract related to

developing a cost estimation model for early care and learning programs.

(g) **Staff for Cost Estimation Model for Early Care and Learning Programs.** $111,000 in fiscal year 2023 is for staff related to developing a cost estimation model for early care and learning programs.

(h) **Brain Builders Bonus Program.** $2,500,000 in fiscal year 2023 is for brain builders bonus grants. The commissioner may use up to ten percent of the appropriation for administration.

(i) **Child Care Stabilization Base Grants.** $29,929,000 in fiscal year 2023 is for child care stabilization base grants under Laws 2021, First Special Session chapter 7, article 14, section 21, subdivision 4, paragraph (b). The base for this appropriation is $78,254,000 in fiscal year 2024 and $80,421,000 in fiscal year 2025.

(j) **Grants for Family, Friend, and Neighbor Caregivers.** $3,167,000 in fiscal year 2023 is for grants to community-based organizations working with family, friend, and neighbor caregivers. In awarding the grants, the commissioner shall prioritize community-based organizations working with family, friend, and neighbor caregivers who serve children from low-income families, families of color, Tribal communities, or families with limited English language proficiency. The commissioner may use up to ten percent of the appropriation for statewide outreach, training initiatives, research, and data collection. The base for this appropriation

is $3,383,000 in fiscal year 2024 and $3,383,000 in fiscal year 2025.

(k) **Base Level Adjustment.** The general fund base is increased $82,183,000 in fiscal year 2024 and $86,850,000 in fiscal year 2025.

Subd. 17. **Grant Programs; Children's Services Grants** -0- 8,984,000

(a) **American Indian Child Welfare Initiative; Mille Lacs Band of Ojibwe Planning.** $1,263,000 in fiscal year 2023 is to support planning activities necessary for the Mille Lacs Band of Ojibwe to join the American Indian child welfare initiative. The base for this appropriation is $2,671,000 in fiscal year 2024 and $0 in fiscal year 2025.

(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.

(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 chairs and ranking minority members of 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 to 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. The base for this appropriation is $1,200,000 in fiscal year 2024 and $1,200,000 in fiscal year 2025.

(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. The base for this appropriation is $2,000,000 in fiscal year 2024 and $2,000,000 in fiscal year 2025.

(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 available 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 partnerships between birth and foster families; 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 determined 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. This is a onetime appropriation.

(m) **Base Level Adjustment.** The general fund base is increased $52,386,000 in fiscal year 2024 and $49,715,000 in fiscal year 2025.

Subd. 18. **Grant Programs; Children and Economic Support Grants** 14,000,000 147,100,000

(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. The base for this appropriation is $12,750,000 in fiscal year 2024 and $20,400,000 in fiscal year 2025.

(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. The base for this appropriation is $2,809,000 in fiscal year 2024 and $1,809,000 in fiscal year 2025.

(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. The base for this appropriation is $3,000,000 in fiscal year 2024 and $0 in fiscal year 2025.

(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.** $31,124,000 in fiscal year 2023 is for emergency services under Minnesota Statutes, section 256E.36. This appropriation is available until June 30, 2025. The base for this appropriation is $25,000,000 in fiscal year 2024 and $25,000,000 in fiscal year 2025.

(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. This appropriation is available until June 30, 2025.

(j) **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.

(k) **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.

(l) **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. This appropriation is available until June 30, 2025.

(m) **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 the 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.

(n) **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. This is a onetime appropriation and is available until June 30, 2027.

(o) **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.

(p) **Base Level Adjustment.** The general fund base is increased $63,209,000 in fiscal year 2024 and $66,859,000 in fiscal year 2025.

Subd. 19. **Grant Programs; Health Care Grants**

Appropriations by Fund		
	2022	2023
General Fund	-0-	3,500,000
Health Care Access	(1,936,000)	3,936,000

(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 and improve access to quality care. The general fund base for this appropriation

is $3,750,000 in fiscal year 2024 and $1,260,000 in fiscal year 2025.

(b) **Grants for Navigator Organizations.**

(1) $1,936,000 in fiscal year 2023 is from the health care access fund for grants to organizations with a MNsure grant services navigator assister contract in good standing as of July 1, 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 2022, as determined by MNsure's navigator payment process. This is a onetime appropriation and is available until June 30, 2025.

(2) $2,000,000 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 health care access fund base for this appropriation is $1,000,000 in fiscal year 2024 and $0 in fiscal year 2025.

(c) **Dental Home Pilot Project.** $1,000,000 in fiscal year 2023 is from the general fund for grants to individual providers and provider networks participating in the dental home pilot project. This is a onetime appropriation.

(d) **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 may 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.** $300,000 in fiscal year 2023 is for the Task Force on Disability Services Accessibility. 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 30,776,000

(a) **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 may 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.

(b) **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.

(c) **Cultural and Ethnic Infrastructure Grant Funding.** $15,000,000 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 $10,000,000 in fiscal year 2024 and $10,000,000 in fiscal year 2025.

(d) **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.

(e) **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 legislative committees with jurisdiction over human services. This is a

onetime appropriation and is available until June 30, 2025.

(f) **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.

(g) **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.

(h) **Base Level Adjustment.** The general fund base is increased $25,792,000 in fiscal year 2024 and $30,916,000 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- 17,359,000

(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 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) **Early Childhood Mental Health Consultation.** $3,759,000 in fiscal year 2023 is for grants to school districts and charter schools for early childhood mental health consultation under Minnesota Statutes, section 245.4889. The commissioner may use up to $409,000 for administration.

(d) **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. The base for this appropriation is $15,000,000 in fiscal year 2024 and $0 in fiscal year 2025.

(e) **Base Level Adjustment.** The general fund base is increased $19,859,000 in fiscal year 2024 and $4,859,000 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) **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.

(c) **Base Level Adjustment.** The opiate epidemic response base is increased $100,000 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** **$** **-0-** **$** **266,557,000**

Appropriations by Fund

	2022	2023
General	-0-	258,938,000
State Government Special Revenue	-0-	6,044,000
Health Care Access	-0-	21,575,000

Subd. 2. **Health Improvement**

Appropriations by Fund

General	-0-	201,635,000
State Government Special Revenue	-0-	1,656,000
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 the 988 suicide prevention lifeline in Minnesota Statutes, section 145.56. Of this appropriation, $671,000 is for administration and $8,000,000 is for grants.

(b) **Address Growing Health Care Costs.** $2,476,000 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 $3,057,000 in fiscal year 2024 and $3,057,000 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 the 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, up to seven percent is for administration and at least 93 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 according to Minnesota Statutes, sections 144.122, paragraph (g), 144.605, and 144.6071.

(p) **Mental Health Providers; Loan Forgiveness, Grants, Information Clearinghouse.** $4,275,000 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) $3,000,000 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) **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.

(t) **Benefit and Cost Analysis of Universal Health Reform Proposal.** $461,000 in fiscal year 2023 is from the general fund 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. Of this appropriation, $250,000 is for a contract with the University of Minnesota

School of Public Health and the Carlson School of Management. The general fund base for this appropriation is $288,000 in fiscal year 2024, of which $250,000 is for a contract with the University of Minnesota School of Public Health and the Carlson School of Management, and $0 in fiscal year 2025.

(u) **Technical Assistance; Health Care Trends and Costs.** $2,506,000 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. The general fund base for this appropriation is $2,753,000 in fiscal year 2024 and $2,694,000 in fiscal year 2025.

(v) **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.

(w) **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.

(x) **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.

(y) **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.

(z) **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.

(aa) **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.

(bb) **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.

(cc) **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.

(dd) **Dignity in Pregnancy and Childbirth Act.** $50,000 in fiscal year 2023 is from the general fund for hosting and maintaining a continuing education curriculum and course under Minnesota Statutes, section 144.1461.

(ee) **Base Level Adjustments.** The general fund base is increased $189,352,000 in fiscal year 2024 and $188,770,000 in fiscal year 2025. The state government special revenue fund base is increased $1,380,000 in fiscal year 2024 and $1,380,000 in fiscal year 2025.

Subd. 3. **Health Protection**

Appropriations by Fund		
General	-0-	57,303,000
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 Testing and Remediation Grant Program; Schools, Child Care Centers, Family Child Care Providers.** $3,054,000 in fiscal year 2023 is from the general fund for a lead testing and remediation grant program for schools, licensed child care centers, and licensed family child care providers under Minnesota Statutes, section 145.9272. Of this appropriation, $454,000 is for administration and $2,600,000 is for grants. The general fund base for this appropriation is $2,540,000 in fiscal year 2024, of which $370,000 is for administration and $2,170,000 is for grants, and $2,540,000 in fiscal year 2025, of which $371,000 is for administration and $2,710,000 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) **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.

(f) **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.

(g) **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.

(h) **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.

(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) **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.

(k) **Base Level Adjustments.** The general fund base is increased $22,269,000 in fiscal year 2024 and $10,064,000 in fiscal year 2025. The state government special revenue fund base is increased $4,299,000 in fiscal year 2024 and $4,228,000 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 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- $ 1,070,000**

(a) **Health Care Affordability Board.** $1,070,000 in fiscal year 2023 is 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 $1,417,000 in fiscal year 2024 and $1,485,000 in fiscal year 2025.

Sec. 9. **COMMISSIONER OF COMMERCE** **$ -0- $ 251,000**

(a) **Prescription Drug Affordability Board.** $197,000 in fiscal year 2023 is 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 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 for costs related to insurance coverage of ectodermal dysplasias. The 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 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. **COMMISSIONER OF EDUCATION** **$** **-0-** **$** **264,000**

Information Technology and Data Sharing Projects for Early Childhood Programs. $264,000 in fiscal year 2023 is for staff and costs related to the information technology project and the data sharing project for programs impacting early childhood. The base for this appropriation is $503,000 in fiscal year 2024 and $493,000 in fiscal year 2025 only.

Sec. 13. **COMMISSIONER OF INFORMATION TECHNOLOGY SERVICES** **$** **-0-** **$** **6,441,000**

Information Technology Project for Early Childhood Programs. $6,441,000 in fiscal year 2023 is for staff and costs related to the information technology project for programs impacting early childhood. This is a onetime

appropriation and is available until June 30, 2027.

Sec. 14. **COMMISSIONER OF MANAGEMENT AND BUDGET** **$ -0- $ 492,000**

Information Technology and Data Sharing Projects for Early Childhood Programs. $492,000 in fiscal year 2023 is for the commissioner of management and budget to: (1) identify any state or federal statutes or administrative rules and practices that prevent or complicate data sharing among child care and early learning programs administered by the Departments of Education and Human Services and other departments with programs impacting early childhood as identified by the Children's Cabinet; (2) support ongoing efforts to address any barriers to data sharing; and (3) support work related to the information technology modernization project for programs impacting early childhood. The commissioner of management and budget must consult with the commissioners of education, human services, and information technology services; the Children's Cabinet; and other stakeholders. The commissioner of management and budget must report preliminary findings to the legislative committees with jurisdiction over early childhood programs by February 1, 2023, and make a final report by February 1, 2024. The base for this appropriation is $192,000 in fiscal year 2024 and $97,000 in fiscal year 2025 only.

Sec. 15. **COMMISSIONER OF EMPLOYMENT AND ECONOMIC DEVELOPMENT** **$ -0- $ 255,000**

Early Childhood Education Workforce Study. $255,000 in fiscal year 2023 is for a study on the early childhood education workforce in Minnesota. The study must provide a consolidated report of current data on the makeup of the early childhood education workforce, including those working in certified and licensed child care centers and family child care homes, Early Head Start and Head Start programs, and school-based programs, including early childhood special education; wages, income, and benefits in the industry; and barriers to entering these careers or retaining workers in the field, along with information on any other relevant issues identified during the research process. At a minimum, the study must replicate the data points published in the study funded by the Department of Human Services titled Child Care Workforce in Minnesota: 2011 Statewide Study of Demographics, Training and Professional Development. The study must be completed within 18 months, and the commissioner may contract with another organization to complete the study. This is a onetime appropriation and is available until December 30, 2023.

Sec. 16. 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. 17. **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. 18. **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. 19. **SUNSET OF UNCODIFIED LANGUAGE.**

All uncodified language contained in this article expires on June 30, 2023, unless a different effective date is explicit.

Sec. 20. **EFFECTIVE DATE.**

This article is effective the day following final enactment."

Amend the title accordingly