..... moves to amend H.F. No. 2435 as follows:

Delete everything after the enacting clause and insert:

"ARTICLE 1

DEPARTMENT OF HEALTH FINANCE

Section 1. **[144.063] DEMENTIA SERVICES PROGRAM ESTABLISHED.**

The commissioner of health shall establish the dementia services program to:

(1) facilitate the coordination and support of:

(i) state-funded policies and programs that relate to Alzheimer's disease or related forms of dementia;

(ii) outreach programs and services between state agencies, local public health departments, Tribal Nations, educational institutions, and community groups for the purpose of fostering public awareness and education regarding Alzheimer's disease and related forms of dementia; and

(iii) services and activities between groups that are interested in dementia research, programs, and services, including area agencies on aging, service providers, advocacy groups, legal services, emergency personnel, law enforcement, local public health departments, Tribal Nations, and state colleges and universities;

(2) facilitate the coordination, review, publication, and implementation of and updates to the Alzheimer's Disease State Plan;

(3) collect and analyze data related to the impact of Alzheimer's disease in Minnesota; and

(4) incorporate early detection and risk reduction strategies into existing department-led public health programs.

Sec. 2. Minnesota Statutes 2024, section 144.0758, subdivision 3, is amended to read:

Subd. 3. **Eligible grantees.** (a) Organizations eligible to receive grant funding under this section are Minnesota's Tribal Nations in accordance with paragraph (b) and urban American Indian community-based organizations in accordance with paragraph (c).

(b) Minnesota's Tribal Nations may choose to receive funding under this section according to a noncompetitive funding formula specified by the commissioner.

(c) Urban American Indian community-based organizations are eligible to apply for funding under this section by submitting a proposal for consideration by the commissioner.

Sec. 3. Minnesota Statutes 2024, section 144.1222, subdivision 2d, is amended to read:

Subd. 2d. **~~Hot tubs~~ Spa pools on rental ~~houseboats~~ property.** (a) For purposes of this subdivision, "spa pool" has the meaning given in Minnesota Rules, part 4717.0250, subpart 9.

(b) Except as provided in paragraph (c), a ~~hot water~~ spa pool intended for seated recreational use, including a hot tub or whirlpool, that is located on ~~a houseboat that is rented to the public~~ the property of a stand-alone, single-unit rental property, offered for rent by the property owner or through a resort, and that is only intended to be used by the occupants of the rental property:

(1) is not a public pool ~~and~~;

(2) is exempt from the requirements for public pools under subdivisions 1 to 2c, 4, and 5 and Minnesota Rules, chapter 4717, except as otherwise provided in this paragraph; and

(3) may be used by renters so long as:

(i) the water temperature in the spa pool does not exceed 106 degrees Fahrenheit;

(ii) prior to check-in by each new rental party, the resort or property owner tests the water in the spa pool for the concentration of chlorine or bromine, pH, and alkalinity, and the water in the spa pool meets the requirements for disinfection residual, pH, and alkalinity in Minnesota Rules, part 4717.1750, subparts 4, 5, and 6; and

(iii) at check-in, the resort or property owner provides each rental party with a notice that there is a spa pool on the property and that the spa pool is not subject to all of the requirements in state law and rules for public pools.

~~(b)~~ (c) A spa pool intended for seated recreational use, including a hot tub or whirlpool, that is located on a houseboat that is rented to the public:

(1) is not a public pool;

(2) is exempt from the requirements for public pools under subdivisions 1 to 2c, 4, and 5 and Minnesota Rules, chapter 4717; and

(3) is exempt from the requirements under paragraph (b), clause (3).

(d) A political subdivision must not adopt a local law, rule, or ordinance that prohibits the operation of, or establishes additional requirements for, a spa pool that meets the criteria in paragraph (b) or (c).

(e) A ~~hot water~~ spa pool under this subdivision must be conspicuously posted with the following notice to renters:

"NOTICE

This spa is exempt from certain state and local sanitary requirements that prevent disease transmission.

USE AT YOUR OWN RISK

This notice is required under Minnesota Statutes, section 144.1222, subdivision 2d."

Sec. 4. **[144.124] EDUCATION ON RECOGNIZING SIGNS OF PHYSICAL ABUSE IN INFANTS.**

Subdivision 1. **Education by health care providers.** Family practice physicians, pediatricians, and other pediatric primary care providers must provide parents and primary caregivers of infants up to the age of six months with materials on how to recognize the signs of physical abuse in infants and how to report suspected physical abuse of infants. These materials must be identified and approved by the commissioner of health according to subdivision 2, and must be provided to an infant's parents or primary caregivers at the infant's first well-baby visit after birth.

Subd. 2. **Materials.** The commissioner of health, in consultation with the commissioner of children, youth, and families, must identify, approve, and make available to pediatric primary care providers, materials for pediatric primary care providers to use at well-baby visits to educate parents and primary caregivers of infants up to six months of age on recognizing the signs of physical abuse in infants and how to report suspected physical abuse of infants. The commissioner must make these materials available for download from the Department of Health website.

Sec. 5. Minnesota Statutes 2024, section 144.125, subdivision 1, is amended to read:

Subdivision 1. **Duty to perform testing.** (a) It is the duty of (1) the administrative officer or other person in charge of each institution caring for infants 28 days or less of age, (2) the person required in pursuance of the provisions of section 144.215, to register the birth of a child, or (3) the nurse midwife or midwife in attendance at the birth, to arrange to have administered to every infant or child in its care tests for heritable and congenital disorders according to subdivision 2 and rules prescribed by the state commissioner of health.

(b) Testing, recording of test results, reporting of test results, and follow-up of infants with heritable congenital disorders, including hearing loss detected through the early hearing detection and intervention program in section 144.966, shall be performed at the times and in the manner prescribed by the commissioner of health.

(c) The fee to support the newborn screening program, including tests administered under this section and section 144.966, shall be ~~$177~~ $184 per specimen. This fee amount shall be deposited in the state treasury and credited to the state government special revenue fund.

(d) The fee to offset the cost of the support services provided under section 144.966, subdivision 3a, shall be $15 per specimen. This fee shall be deposited in the state treasury and credited to the general fund.

Sec. 6. Minnesota Statutes 2024, section 144.125, subdivision 2, is amended to read:

Subd. 2. **Determination of tests to be administered.** (a) The commissioner shall periodically revise the list of tests to be administered for determining the presence of a heritable or congenital disorder. Revisions to the list shall reflect advances in medical science, new and improved testing methods, or other factors that will improve the public health. In determining whether a test must be administered, the commissioner shall take into consideration the adequacy of analytical methods to detect the heritable or congenital disorder, the ability to treat or prevent medical conditions caused by the heritable or congenital disorder, and the severity of the medical conditions caused by the heritable or congenital disorder. The list of tests to be performed may be revised if the changes are recommended by the advisory committee established under section 144.1255, approved by the commissioner, and published in the State Register. The revision is exempt from the rulemaking requirements in chapter 14, and sections 14.385 and 14.386 do not apply.

(b) The commissioner shall revise the list of tests to be administered for determining the presence of a heritable or congenital disorder to include metachromatic leukodystrophy (MLD).

Sec. 7. Minnesota Statutes 2024, section 144.562, subdivision 2, is amended to read:

Subd. 2. **Eligibility for license condition.** (a) A hospital is not eligible to receive a license condition for swing beds unless (1) it either has a licensed bed capacity of less than 50 beds defined in the federal Medicare regulations, Code of Federal Regulations, title 42, section 482.66, or it has a licensed bed capacity of 50 beds or more and has swing beds that were approved for Medicare reimbursement before May 1, 1985, or it has a licensed bed capacity of less than 65 beds and the available nursing homes within 50 miles have had, in the aggregate, an average occupancy rate of 96 percent or higher in the most recent two years as documented on the statistical reports to the Department of Health; and (2) it is located in a rural area as defined in the federal Medicare regulations, Code of Federal Regulations, title 42, section 482.66.

(b) Except for those critical access hospitals 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 have an attached nursing home or that owned a nursing home located in the same municipality as of May 1, 2005, eligible hospitals are allowed a total number of days of swing bed use per year as provided in paragraph (c). Critical access hospitals that have an attached nursing home or that owned a nursing home located in the same municipality as of May 1, 2005, are allowed swing bed use as provided in federal law. A critical access hospital described in section 144.5621 is allowed an unlimited number of days of swing bed use per year.

(c) An eligible hospital is allowed a total of 3,000 days of swing bed use in calendar year 2020. Beginning in calendar year 2021, and for each subsequent calendar year until calendar year 2027, the total number of days of swing bed use per year is increased by 200 swing bed use days. Beginning in calendar year 2028, an eligible hospital is allowed a total of 4,500 days of swing bed use per year.

(d) Days of swing bed use for medical care that an eligible hospital has determined are charity care shall not count toward the applicable limit in paragraph (b) or (c). For purposes of this paragraph, "charity care" means care that an eligible hospital provided for free or at a discount to persons who cannot afford to pay and for which the eligible hospital did not expect payment.

(e) Days of swing bed use for care of a person who has been denied admission to every Medicare-certified skilled nursing facility within 25 miles of the eligible hospital shall not count toward the applicable limit in paragraphs (b) and (c). Eligible hospitals must maintain documentation that they have contacted each skilled nursing facility within 25 miles to determine if any skilled nursing facility beds are available and if the skilled nursing facilities are willing to admit the patient. Skilled nursing facilities that are contacted must admit the patient or deny admission within 24 hours of being contacted by the eligible hospital. Failure to respond within 24 hours is deemed a denial of admission.

~~(f) Except for critical access hospitals that have an attached nursing home or that owned a nursing home located in the same municipality as of May 1, 2005, the commissioner of health may approve swing bed use beyond 2,000 days as long as there are no Medicare certified skilled nursing facility beds available within 25 miles of that hospital that are willing to admit the patient and the patient agrees to the referral being sent to the skilled nursing facility. Critical access hospitals exceeding 2,000 swing bed days must maintain documentation that they have contacted skilled nursing facilities within 25 miles to determine if any skilled nursing facility beds are available that are willing to admit the patient and the patient agrees to the referral being sent to the skilled nursing facility. This paragraph expires January 1, 2020.~~

~~(g) After reaching 2,000 days of swing bed use in a year, an eligible hospital to which this limit applies may admit six additional patients to swing beds each year without seeking approval from the commissioner or being in violation of this subdivision. These six swing bed admissions are exempt from the limit of 2,000 annual swing bed days for hospitals subject to this limit. This paragraph expires January 1, 2020.~~

~~(h) A health care system that is in full compliance with this subdivision may allocate its total limit of swing bed days among the hospitals within the system, provided that no hospital in the system without an attached nursing home may exceed 2,000 swing bed days per year. This paragraph expires January 1, 2020.~~

EFFECTIVE DATE. This section is effective January 1, 2026, or upon federal approval, whichever is later. The commissioners of health and human services shall inform the revisor of statutes when federal approval is obtained.

Sec. 8. Minnesota Statutes 2024, section 144.562, subdivision 3, is amended to read:

Subd. 3. **Approval of license condition.** (a) The commissioner of health shall approve a license condition for swing beds if the hospital meets all of the criteria of this subdivision.

(b) The hospital must meet the eligibility criteria in subdivision 2.

(c) The hospital must be in compliance with the Medicare conditions of participation for swing beds under Code of Federal Regulations, title 42, section 482.66.

(d) Except as provided in section 144.5621, the hospital must agree, in writing, to limit the length of stay of a patient receiving services in a swing bed to not more than 40 days, or the duration of Medicare eligibility, unless the commissioner of health approves a greater length of stay in an emergency situation. To determine whether an emergency situation exists, the commissioner shall require the hospital to provide documentation that continued services in the swing bed are required by the patient; that no skilled nursing facility beds are available within 25 miles from the patient's home, or in some more remote facility of the resident's choice, that can provide the appropriate level of services required by the patient; and that other alternative services are not available to meet the needs of the patient. If the commissioner approves a greater length of stay, the hospital shall develop a plan providing for the discharge of the patient upon the availability of a nursing home bed or other services that meet the needs of the patient. Permission to extend a patient's length of stay must be requested by the hospital at least ten days prior to the end of the maximum length of stay.

(e) Except as provided in section 144.5621, the hospital must agree, in writing, to limit admission to a swing bed only to (1) patients who have been hospitalized and not yet discharged from the facility, or (2) patients who are transferred directly from an acute care hospital.

(f) The hospital must agree, in writing, to report to the commissioner of health by December 1, 1985, and annually thereafter, in a manner required by the commissioner (1) the number of patients readmitted to a swing bed within 60 days of a patient's discharge from the facility, (2) the hospital's charges for care in a swing bed during the reporting period with a description of the care provided for the rate charged, and (3) the number of beds used by the hospital for transitional care and similar subacute inpatient care.

(g) The hospital must agree, in writing, to report statistical data on the utilization of the swing beds on forms supplied by the commissioner. The data must include the number of swing beds, the number of admissions to and discharges from swing beds, Medicare reimbursed patient days, total patient days, and other information required by the commissioner to assess the utilization of swing beds.

EFFECTIVE DATE. This section is effective January 1, 2026, or upon federal approval, whichever is later. The commissioners of health and human services shall inform the revisor of statutes when federal approval is obtained.

Sec. 9. **[144.5621] SWING BED APPROVAL; EXCEPTIONS.**

Subdivision 1. **Swing bed exemption.** (a) The conditions and limitations in section 144.562, paragraphs (d) and (e), do not apply to any hospital located in Cook County that:

(1) is designated as a critical access hospital under section 144.1483, clause (9), and United States Code, title 42, section 1395i-4; and

(2) has an attached nursing home.

(b) Any swing bed located in a hospital described in this section may be used to provide nursing care without requiring a prior hospital stay.

(c) The nursing care provided to a patient in a swing bed is a covered medical assistance service under section 256B.0625, subdivision 2b.

Subd. 2. **Application of the health care bill of rights.** A patient in a swing bed located in a hospital described in this section is a resident of a nursing home for the purposes of section 144.651.

Subd. 3. **Comprehensive resident assessment.** A patient in a swing bed located in a hospital described in this section is a resident of a nursing home for the purposes of Minnesota Rules, part 4658.0400.

EFFECTIVE DATE. This section is effective January 1, 2026, or upon federal approval, whichever is later. The commissioners of health and human services shall inform the revisor of statutes when federal approval is obtained.

Sec. 10. Minnesota Statutes 2024, section 144.563, is amended to read:

144.563 NURSING SERVICES PROVIDED IN A HOSPITAL; PROHIBITED PRACTICES.

A hospital that has been granted a license condition under section 144.562 or 144.5621 must not provide to patients not reimbursed by Medicare or medical assistance the types of services that would be usually and customarily provided and reimbursed under medical assistance or Medicare as services of a skilled nursing facility or intermediate care facility for more than 42 days and only for patients who have been hospitalized and no longer require an acute level of care. Permission to extend a patient's length of stay may be granted by the

commissioner if requested by the physician at least ten days prior to the end of the maximum length of stay.

EFFECTIVE DATE. This section is effective January 1, 2026, or upon federal approval, whichever is later. The commissioners of health and human services shall inform the revisor of statutes when federal approval is obtained.

Sec. 11. Minnesota Statutes 2024, section 144.608, subdivision 2, is amended to read:

Subd. 2. **Council administration.** (a) The council must meet at least twice a year but may meet more frequently at the call of the chair, a majority of the council members, or the commissioner.

(b) The terms, compensation, and removal of members of the council are governed by section 15.059. The council expires June 30, ~~2025~~ 2035.

(c) The council may appoint subcommittees and work groups. Subcommittees shall consist of council members. Work groups may include noncouncil members. Noncouncil members shall be compensated for work group activities under section 15.059, subdivision 3, but shall receive expenses only.

Sec. 12. Minnesota Statutes 2024, section 144.966, subdivision 2, is amended to read:

Subd. 2. **Newborn Hearing Screening Advisory Committee.** (a) The commissioner of health shall establish a Newborn Hearing Screening Advisory Committee to advise and assist the Department of Health; Department of Children, Youth, and Families; and the Department of Education in:

(1) developing protocols and timelines for screening, rescreening, and diagnostic audiological assessment and early medical, audiological, and educational intervention services for children who are deaf or hard-of-hearing;

(2) designing protocols for tracking children from birth through age three that may have passed newborn screening but are at risk for delayed or late onset of permanent hearing loss;

(3) designing a technical assistance program to support facilities implementing the screening program and facilities conducting rescreening and diagnostic audiological assessment;

(4) designing implementation and evaluation of a system of follow-up and tracking; and

(5) evaluating program outcomes to increase effectiveness and efficiency and ensure culturally appropriate services for children with a confirmed hearing loss and their families.

(b) The commissioner of health shall appoint at least one member from each of the following groups with no less than two of the members being deaf or hard-of-hearing:

(1) a representative from a consumer organization representing culturally deaf persons;

(2) a parent with a child with hearing loss representing a parent organization;

(3) a consumer from an organization representing oral communication options;

(4) a consumer from an organization representing cued speech communication options;

(5) an audiologist who has experience in evaluation and intervention of infants and young children;

(6) a speech-language pathologist who has experience in evaluation and intervention of infants and young children;

(7) two primary care providers who have experience in the care of infants and young children, one of which shall be a pediatrician;

(8) a representative from the early hearing detection intervention teams;

(9) a representative from the Department of Education resource center for the deaf and hard-of-hearing or the representative's designee;

(10) a representative of the Commission of the Deaf, DeafBlind and Hard of Hearing;

(11) a representative from the Department of Human Services Deaf and Hard-of-Hearing Services Division;

(12) one or more of the Part C coordinators from the Department of Education; the Department of Health; the Department of Children, Youth, and Families; or the Department of Human Services or the department's designees;

(13) the Department of Health early hearing detection and intervention coordinators;

(14) two birth hospital representatives from one rural and one urban hospital;

(15) a pediatric geneticist;

(16) an otolaryngologist;

(17) a representative from the Newborn Screening Advisory Committee under this subdivision;

(18) a representative of the Department of Education regional low-incidence facilitators;

(19) a representative from the deaf mentor program; and

(20) a representative of the Minnesota State Academy for the Deaf from the Minnesota State Academies staff.

The commissioner must complete the initial appointments required under this subdivision by September 1, 2007, and the initial appointments under clauses (19) and (20) by September 1, 2019.

(c) The Department of Health member shall chair the first meeting of the committee. At the first meeting, the committee shall elect a chair from its membership. The committee shall meet at the call of the chair, at least four times a year. The committee shall adopt written bylaws to govern its activities. The Department of Health shall provide technical and administrative support services as required by the committee. These services shall include technical support from individuals qualified to administer infant hearing screening, rescreening, and diagnostic audiological assessments.

Members of the committee shall receive no compensation for their service, but shall be reimbursed as provided in section 15.059 for expenses incurred as a result of their duties as members of the committee.

(d) By February 15, 2015, and by February 15 of the odd-numbered years after that date, the commissioner shall report to the chairs and ranking minority members of the legislative committees with jurisdiction over health and data privacy on the activities of the committee that have occurred during the past two years.

~~(e) This subdivision expires June 30, 2025.~~

EFFECTIVE DATE. This section is effective the day following final enactment or June 30, 2025, whichever is earlier.

Sec. 13. Minnesota Statutes 2024, section 145.8811, is amended to read:

145.8811 MATERNAL AND CHILD HEALTH ADVISORY ~~TASK FORCE~~ COMMITTEE.

Subdivision 1. **Composition of ~~task force~~ committee.** The commissioner shall establish and appoint a Maternal and Child Health Advisory ~~Task Force~~ Committee consisting of 15 members who will provide equal representation from:

(1) professionals with expertise in maternal and child health services;

(2) representatives of community health boards as defined in section 145A.02, subdivision 5; and

(3) consumer representatives interested in the health of mothers and children.

No members shall be employees of the Minnesota Department of Health. Section 15.059 governs the Maternal and Child Health Advisory ~~Task Force~~ Committee. Notwithstanding section 15.059, the Maternal and Child Health Advisory ~~Task Force~~ Committee does not expire.

Subd. 2. **Duties.** The advisory ~~task force~~ committee shall meet on a regular basis to perform the following duties:

(1) review and report on the health care needs of mothers and children throughout the state of Minnesota;

(2) review and report on the type, frequency, and impact of maternal and child health care services provided to mothers and children under existing maternal and child health care programs, including programs administered by the commissioner of health;

(3) establish, review, and report to the commissioner a list of program guidelines and criteria which the advisory ~~task force~~ committee considers essential to providing an effective maternal and child health care program to low-income populations and high-risk persons and fulfilling the purposes defined in section 145.88;

(4) make recommendations to the commissioner for the use of other federal and state funds available to meet maternal and child health needs;

(5) make recommendations to the commissioner of health on priorities for funding the following maternal and child health services:

(i) prenatal, delivery, and postpartum care;

(ii) comprehensive health care for children, especially from birth through five years of age;

(iii) adolescent health services;

(iv) family planning services;

(v) preventive dental care;

(vi) special services for chronically ill and disabled children; and

(vii) any other services that promote the health of mothers and children; and

(6) establish in consultation with the commissioner statewide outcomes that will improve the health status of mothers and children.

Sec. 14. Minnesota Statutes 2024, section 256B.0625, subdivision 2, is amended to read:

Subd. 2. **Skilled and intermediate nursing care.** ~~(a)~~ Medical assistance covers skilled nursing home services and services of intermediate care facilities, including training and habilitation services, as defined in section 252.41, subdivision 3, for persons with developmental disabilities who are residing in intermediate care facilities for persons with developmental disabilities. ~~Medical assistance must not be used to pay the costs of nursing care provided to a patient in a swing bed as defined in section 144.562, unless (1) the facility in which the swing bed is located is eligible as a sole community provider, as defined in Code of Federal Regulations, title 42, section 412.92, or the facility is a public hospital owned by a governmental entity with 15 or fewer licensed acute care beds; (2) the Centers for Medicare and Medicaid Services approves the necessary state plan amendments; (3) the patient was screened as provided by law; (4) the patient no longer requires acute care services; and (5) no nursing home beds are available within 25 miles of the facility. The commissioner shall exempt a facility from compliance with the sole community provider requirement in clause (1) if, as of January 1, 2004, the facility had an agreement with the commissioner to provide medical assistance swing bed services.~~

~~(b) Medical assistance also covers up to ten days of nursing care provided to a patient in a swing bed if: (1) the patient's physician, advanced practice registered nurse, or physician assistant certifies that the patient has a terminal illness or condition that is likely to result in death within 30 days and that moving the patient would not be in the best interests of the patient and patient's family; (2) no open nursing home beds are available within 25 miles of the facility; and (3) no open beds are available in any Medicare hospice program within 50 miles of the facility. The daily medical assistance payment for nursing care for the patient in the swing bed is the statewide average medical assistance skilled nursing care per diem as computed annually by the commissioner on July 1 of each year.~~

EFFECTIVE DATE. This section is effective January 1, 2026, or upon federal approval, whichever is later. The commissioners of health and human services shall inform the revisor of statutes when federal approval is obtained.

Sec. 15. Minnesota Statutes 2024, section 256B.0625, is amended by adding a subdivision to read:

Subd. 2b. **Nursing care provided to a patient in a swing bed.** (a) Medical assistance must not be used to pay the costs of nursing care provided to a patient in a swing bed as defined in section 144.562, unless:

(1) the facility in which the swing bed is located is eligible as a sole community provider, as defined in Code of Federal Regulations, title 42, section 412.92, or the facility is a public hospital owned by a governmental entity with 25 or fewer licensed acute care beds;

(2) the Centers for Medicare and Medicaid Services approves the necessary state plan amendments;

(3) the patient was screened as provided by law;

(4) the patient no longer requires acute care services; and

(5) no nursing home beds are available within 25 miles of the facility.

(b) The commissioner shall exempt a facility from compliance with the sole community provider requirement in paragraph (a), clause (1), if, as of January 1, 2004, the facility had an agreement with the commissioner to provide medical assistance swing bed services.

(c) Medical assistance also covers up to ten days of nursing care provided to a patient in a swing bed if:

(1) the patient's physician, advanced practice registered nurse, or physician assistant certifies that the patient has a terminal illness or condition that is likely to result in death within 30 days and that moving the patient would not be in the best interests of the patient and patient's family;

(2) no open nursing home beds are available within 25 miles of the facility; and

(3) no open beds are available in any Medicare hospice program within 50 miles of the facility.

(d) The commissioner shall exempt any facility described under section 144.5621 from compliance with the requirements of paragraph (a), clauses (3) and (5), and paragraph (c), and medical assistance covers an unlimited number of days of nursing care provided to a patient in a swing bed at a facility described under section 144.5621.

(e) The daily medical assistance payment for nursing care for the patient in the swing bed is the statewide average medical assistance skilled nursing care per diem as computed annually by the commissioner on July 1 of each year.

EFFECTIVE DATE. This section is effective January 1, 2026, or upon federal approval, whichever is later. The commissioners of health and human services shall inform the revisor of statutes when federal approval is obtained.

Sec. 16. Minnesota Statutes 2024, section 256R.01, is amended by adding a subdivision to read:

Subd. 1a. **Payment rates for nursing care provided to a patient in a swing bed.** Payment rates paid to any hospital for nursing care provided to a patient in a swing bed must be those rates established pursuant section 256B.0625, subdivision 2b.

EFFECTIVE DATE. This section is effective January 1, 2026, or upon federal approval, whichever is later. The commissioners of health and human services shall inform the revisor of statutes when federal approval is obtained.

Sec. 17. **SPOKEN LANGUAGE HEALTH CARE INTERPRETER WORK GROUP.**

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

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

(c) "Common languages" means the 15 most common languages without regard to dialect in Minnesota.

(d) "Registered interpreter" means a spoken language interpreter who is listed on the Department of Health's spoken language health care interpreter roster.

(e) "Work group" means the spoken language health care interpreter work group established in this section.

Subd. 2. **Composition.** The commissioner, after receiving work group candidate applications, must appoint 15 members to the work group consisting of the following members:

(1) three members who are interpreters listed on the Department of Health's spoken language health care interpreter roster and who are Minnesota residents. Of these members:

(i) each must be an interpreter for a different language;

(ii) at least one must have a national certification credential; and

(iii) at least one must have been listed on the roster as an interpreter in a language other than the common languages and must have completed a nationally recognized training program for health care interpreters that is, at a minimum, 40 hours in length;

(2) three members representing limited English proficiency (LEP) individuals. Of these members, two must represent LEP individuals who are proficient in a common language

other than English and one must represent LEP individuals who are proficient in a language that is not one of the common languages;

(3) one member representing a health plan company;

(4) one member who is not an interpreter and who is representing a Minnesota health system;

(5) two members representing interpreter agencies, including one member representing agencies whose main office is located outside the seven-county metropolitan area and one member representing agencies whose main office is located within the seven-county metropolitan area;

(6) one member representing the Department of Health;

(7) one member representing the Department of Human Services;

(8) one member representing an interpreter training program or postsecondary educational institution program providing interpreter courses or skills assessment;

(9) one member who is affiliated with a Minnesota-based or Minnesota chapter of a national or international organization representing interpreters; and

(10) one member who is a licensed health care provider.

Subd. 3. **Duties.** The work group must compile a list of recommendations to support and improve access to the critical health care interpreting services provided across the state, including but not limited to:

(1) changing requirements for registered and certified interpreters to reflect changing needs of the Minnesota health care community and emerging national standards of training, competency, and testing;

(2) addressing barriers for interpreters to gain access to the roster, including barriers for interpreters of languages other than common languages and interpreters in rural areas;

(3) reimbursing spoken language health care interpreting;

(4) identifying gaps in interpreter services in rural areas and recommending ways to address interpreter training and funding needs;

(5) training, certification, and continuing education programs;

(6) convening a meeting of public and private sector representatives of the spoken language health care interpreter community to identify ongoing sources of financial assistance to aid individual interpreters in meeting interpreter training and testing requirements;

(7) conducting surveys of people receiving and providing interpreter services to understand changing needs and consumer quality of care; and

(8) suggesting changes in requirements and qualifications on telehealth or remote interpreting.

Subd. 4. **Compensation; expense reimbursement.** Compensation shall be offered to work group members not being compensated for their participation in work group activities as part of their existing job duties. Work group members shall be compensated and reimbursed for expenses for work group activities under Minnesota Statutes, section 15.059, subdivision 3.

Subd. 5. **Administrative support; meeting space, meeting facilitation.** The commissioner must provide meeting space and administrative support for the work group. The commissioner may contract with a neutral independent consultant to provide this administrative support and to facilitate and lead the meetings of the work group.

Subd. 6. **Deadline for appointments.** The commissioner must appoint members to the work group by August 15, 2025.

Subd. 7. **Expiration.** The work group and this section expire on November 2, 2026, or upon submission of the report required under subdivision 9, whichever is earlier.

Subd. 8. **Initial work group meetings.** The commissioner must convene the first meeting of the work group by October 1, 2025. Prior to the first meeting, work group members must receive survey results and evidence-based research on interpreter services in Minnesota. During the first meetings, work group members must receive survey results and consult with subject matter experts, including but not limited to signed language interpreting experts, academic experts with knowledge of interpreting research, and academic health experts to address specific gaps in spoken language health care interpreting. The work group must provide a minimum of two opportunities for public comment. These opportunities shall be announced with at least four weeks' notice, with publicity in the five most common languages in Minnesota. Interpreters for those same languages shall be provided during the public comment opportunities.

Subd. 9. **Report.** By November 1, 2026, the commissioner must provide the chairs and ranking minority members of the legislative committees with jurisdiction over health care interpreter services with recommendations, including draft legislation and any statutory changes needed to implement the recommendations, to improve and support access to health care interpreting services statewide.

Sec. 18. **TITLE.**

The amendments to Minnesota Statutes, section 144.1222, subdivision 2d, in this act may be cited as the Free the Hot Tub Act.

Sec. 19. **REPEALER.**

Minnesota Statutes 2024, section 145.361, is repealed.

ARTICLE 2
DEPARTMENT OF HEALTH POLICY

Section 1. Minnesota Statutes 2024, section 62J.51, subdivision 19a, is amended to read:

Subd. 19a. **Uniform explanation of benefits ~~document~~.** "Uniform explanation of benefits ~~document~~" means either the document associated with and explaining the details of a group purchaser's claim adjudication for services rendered or its electronic equivalent under section 62J.581, which is sent to a patient.

Sec. 2. Minnesota Statutes 2024, section 62J.581, is amended to read:

62J.581 STANDARDS FOR MINNESOTA UNIFORM HEALTH CARE REIMBURSEMENT DOCUMENTS.

Subdivision 1. **Minnesota uniform remittance advice.** All group purchasers shall provide a uniform claim payment/advice transaction to health care providers when a claim is adjudicated. The uniform claim payment/advice transaction shall comply with section 62J.536, subdivision 1, paragraph (b), and rules adopted under section 62J.536, subdivision 2.

Subd. 2. **Minnesota uniform explanation of benefits ~~document~~.** (a) All group purchasers shall provide a uniform explanation of benefits ~~document~~ to health care patients when an explanation of benefits ~~document~~ is provided as otherwise required or permitted by law. The uniform explanation of benefits ~~document~~ shall comply with the standards prescribed in this section.

(b) Notwithstanding paragraph (a), this section does not apply to group purchasers not included as covered entities under United States Code, title 42, sections 1320d to 1320d-8, as amended from time to time, and the regulations promulgated under those sections.

Subd. 3. **Scope.** For purposes of sections 62J.50 to 62J.61, the ~~uniform claim payment/advice transaction and~~ uniform explanation of benefits ~~document~~ format specified in subdivision 4 shall apply to all health care services delivered by a health care provider

or health care provider organization in Minnesota, regardless of the location of the payer. Health care services not paid on an individual claims basis, such as capitated payments, are not included in this section. A health plan company is excluded from the requirements in ~~subdivisions 1 and~~ subdivision 2 if they comply with section 62A.01, subdivisions 2 and 3.

Subd. 4. **Specifications.** (a) The uniform explanation of benefits ~~document~~ shall be provided by use of a paper document conforming to the specifications in this section or its electronic equivalent under paragraph (b).

(b) Group purchasers may make the uniform explanation of benefits available in a version that can be accessed by health care patients electronically if:

(1) the group purchaser making the uniform explanation of benefits available electronically provides health care patients the ability to choose whether to receive paper, electronic, or both paper and electronic versions of their uniform explanation of benefits;

(2) the group purchaser provides clear, readily accessible information and instructions for the patient to communicate their choice; and

(3) health care patients not responding to the opportunity to make a choice will receive at a minimum a paper uniform explanation of benefits.

(c) The commissioner, after consulting with the Administrative Uniformity Committee, shall specify the data elements and definitions for the paper uniform explanation of benefits ~~document. The commissioner and the Administrative Uniformity Committee must consult with the Minnesota Dental Association and Delta Dental Plan of Minnesota before requiring under this section the use of a paper document for the uniform explanation of benefits document or the uniform claim payment/advice transaction for dental care services.~~ Any electronic version of the uniform explanation of benefits must use the same data elements and definitions as the paper uniform explanation of benefits.

~~Subd. 5. **Effective date.** The requirements in subdivisions 1 and 2 are effective June 30, 2007. The requirements in subdivisions 1 and 2 apply regardless of when the health care service was provided to the patient.~~

Sec. 3. Minnesota Statutes 2024, section 144.50, is amended by adding a subdivision to read:

Subd. 8. **Controlling person.** (a) For hospitals licensed under sections 144.50 to 144.56, "controlling person" means 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 hospital administrator;

(3) any managerial official; and

(4) any individual or entity who has a direct or indirect ownership interest in:

(i) any corporation, partnership, or other business association which is a controlling person;

(ii) the land on which a hospital is located;

(iii) the structure in which a hospital is located;

(iv) any entity with at least a five percent mortgage, contract for deed, deed of trust, or other security interest in the land or structure comprising a hospital; or

(v) any lease or sublease of the land, structure, or facilities comprising a hospital.

(b) "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 hospital;

(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;

(3) an individual who is a state or federal official, a 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 hospitals, unless the individual is also an officer, owner, or managerial official of the hospital, receives any remuneration from the hospital, or is a controlling person not otherwise excluded in this subdivision;

(4) an individual who is a member of a tax-exempt organization under section 290.05, subdivision 2, unless the individual is also a controlling person not otherwise excluded in this subdivision; or

(5) an individual 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).

Sec. 4. Minnesota Statutes 2024, section 144.555, subdivision 1a, is amended to read:

Subd. 1a. **Notice of closing, curtailing operations, relocating services, or ceasing to offer certain services; hospitals.** (a) The controlling persons of a hospital licensed under sections 144.50 to 144.56 or a hospital campus must notify the commissioner of health, the public, and others at least 182 days before the hospital or hospital campus voluntarily plans to implement one of the scheduled actions listed in paragraph (b), unless the controlling persons can demonstrate to the commissioner that meeting the advanced notice requirement is not feasible and the commissioner approves a shorter advanced notice.

(b) The following scheduled actions require advanced notice under paragraph (a):

(1) ceasing operations;

(2) curtailing operations to the extent that patients receiving inpatient health services or emergency department services must be relocated;

(3) relocating the provision of inpatient health services or emergency department services to another hospital or ~~another~~ hospital campus; or

(4) ceasing to offer inpatient maternity care and inpatient newborn care services, inpatient intensive care unit services, inpatient mental health services, or inpatient substance use disorder treatment services.

(c) A notice required under this subdivision must comply with the requirements in subdivision 1d.

(d) The commissioner shall cooperate with the controlling persons and advise them about relocating the patients.

(e) For purposes of this subdivision, "inpatient" means services provided to an individual admitted to a hospital for bed occupancy.

Sec. 5. Minnesota Statutes 2024, section 144.555, subdivision 1b, is amended to read:

Subd. 1b. **Public hearing.** Within 30 days after receiving notice under subdivision 1a, the commissioner shall conduct a public hearing on the scheduled cessation of operations, curtailment of operations, relocation of health services, or cessation in offering health services. The commissioner must provide adequate public notice of the hearing in a time and manner determined by the commissioner. The commissioner must ensure that video conferencing technology is used at the public hearing to allow members of the public to

view and participate in the hearing. The controlling persons of the hospital or hospital campus must participate in the public hearing. The public hearing must be held at a location that is within ten miles of the hospital or hospital campus or with the commissioner's approval as close as is practicable, that can accommodate the hearing's anticipated public attendance, and that is provided or arranged by the hospital or hospital campus. ~~Video conferencing technology must be used to allow members of the public to view and participate in the hearing.~~ The public hearing must include:

(1) an explanation by the controlling persons of the reasons for ceasing or curtailing operations, relocating health services, or ceasing to offer any of the listed health services;

(2) a description of the actions that controlling persons will take to ensure that residents in the hospital's or campus's service area have continued access to the health services being eliminated, curtailed, or relocated;

(3) an opportunity for at least one hour of public testimony on the scheduled cessation or curtailment of operations, relocation of health services, or cessation in offering any of the listed health services, and on the hospital's or campus's plan to ensure continued access to those health services being eliminated, curtailed, or relocated; and

(4) an opportunity for the controlling persons to respond to questions from interested persons.

ARTICLE 3
HEALTH LICENSING BOARDS

Section 1. Minnesota Statutes 2024, section 144.99, subdivision 1, is amended to read:

Subdivision 1. **Remedies available.** The provisions of chapters 103I and 157 and sections 115.71 to 115.77; 144.12, subdivision 1, paragraphs (1), (2), (5), (6), (10), (12), (13), (14), and (15); 144.1201 to 144.1204; 144.121; 144.1215; 144.1222; 144.35; 144.381 to 144.385; 144.411 to 144.417; 144.495; 144.71 to 144.74; 144.9501 to 144.9512; 144.97 to 144.98; 144.992; 147.037, subdivision 1b, paragraph (d); 326.70 to 326.785; 327.10 to 327.131; and 327.14 to 327.28 and all rules, orders, stipulation agreements, settlements, compliance agreements, licenses, registrations, certificates, and permits adopted or issued by the department or under any other law now in force or later enacted for the preservation of public health may, in addition to provisions in other statutes, be enforced under this section.

EFFECTIVE DATE. This section is effective January 1, 2026.

Sec. 2. Minnesota Statutes 2024, section 147.01, subdivision 7, is amended to2 read:

Subd. 7. **Physician application and license fees.** (a) The board may charge the following nonrefundable application and license fees processed pursuant to sections 147.02, 147.03, 147.037, 147.0375, and 147.38:

(1) physician application fee, $200;

(2) physician annual registration renewal fee, $192;

(3) physician endorsement to other states, $40;

(4) physician emeritus license, $50;

(5) physician late fee, $60;

(6) nonrenewable 24-month limited license, $392;

(7) initial physician license for limited license holder, $192;

~~(6)~~ (8) duplicate license fee, $20;

~~(7)~~ (9) certification letter fee, $25;

~~(8)~~ (10) education or training program approval fee, $100;

~~(9)~~ (11) report creation and generation fee, $60 per hour;

~~(10)~~ (12) examination administration fee (half day), $50;

~~(11)~~ (13) examination administration fee (full day), $80;

~~(12)~~ (14) fees developed by the Interstate Commission for determining physician qualification to register and participate in the interstate medical licensure compact, as established in rules authorized in and pursuant to section 147.38, not to exceed $1,000; and

~~(13)~~ (15) verification fee, $25.

(b) The board may prorate the initial annual license fee. All licensees are required to pay the full fee upon license renewal. The revenue generated from the fee must be deposited in an account in the state government special revenue fund.

Sec. 3. Minnesota Statutes 2024, section 147.037, is amended by adding a subdivision to read:

Subd. 1b. **Limited license.** (a) A limited license under this subdivision is valid for one 24-month period and is not renewable or eligible for reapplication. The board may issue a

limited license, valid for 24 months, to any person who satisfies the requirements of subdivision 1, paragraphs (a) to (c) and (e) to (g), and who:

(1) pursuant to a license or other authorization to practice, has practiced medicine, as defined in section 147.081, subdivision 3, clauses (2) to (4), for at least 60 months in the previous 12 years outside of the United States;

(2) submits sufficient evidence of an offer to practice within the context of a collaborative agreement within a hospital or clinical setting where the limited license holder and physicians work together to provide patient care;

(3) provides services in a designated rural area or underserved urban community as defined in section 144.1501; and

(4) submits two letters of recommendation in support of a limited license, which must include one letter from a physician with whom the applicant previously worked and one letter from an administrator of the hospital or clinical setting in which the applicant previously worked. The letters of recommendation must attest to the applicant's good medical standing. The board may accept alternative forms of proof that demonstrate good medical standing where there are extenuating circumstances that prevent an applicant from providing letters.

(b) For purposes of this subdivision, a person has satisfied the requirements of subdivision 1, paragraph (e), if the person has passed steps or levels one and two of the USMLE or the COMLEX-USA with passing scores as recommended by the USMLE program or National Board of Osteopathic Medical Examiners within three attempts.

(c) A person issued a limited license under this subdivision must not be required to present evidence satisfactory to the board of the completion of one year of graduate clinical medical training in a program accredited by a national accrediting organization approved by the board.

(d) An employer of a limited license holder must pay the limited license holder at least an amount equivalent to a medical resident in a comparable field. The employer must carry medical malpractice insurance covering a limited license holder for the duration of the employment. The commissioner of health may issue a correction order under section 144.99, subdivision 3, requiring an employer to comply with this paragraph. An employer must not retaliate against or discipline an employee for raising a complaint or pursuing enforcement relating to this paragraph.

(e) The board may issue a full and unrestricted license to practice medicine to a person who holds a limited license issued pursuant to paragraph (a) and who has:

(1) held the limited license for two years and is in good standing to practice medicine in this state;

(2) practiced for a minimum of 1,692 hours per year for each of the previous two years;

(3) submitted a letter of recommendation in support of a full and unrestricted license containing all attestations required under paragraph (i) from any physician who participated in the collaborative agreement;

(4) passed steps or levels one, two, and three of the USMLE or COMLEX-USA with passing scores as recommended by the USMLE program or National Board of Osteopathic Medical Examiners within three attempts; and

(5) completed 20 hours of continuing medical education.

(f) A limited license holder must submit to the board, every six months or upon request, a statement certifying whether the person is still employed as a physician in this state and whether the person has been subjected to professional discipline as a result of the person's practice. The board may suspend or revoke a limited license if a majority of the board determines that the limited license holder is no longer employed as a physician in this state by an employer. The limited license holder must be granted an opportunity to be heard prior to the board's determination. Upon request by the limited license holder, the limited license holder may have 90 days to regain employment. A limited license holder may change employers during the duration of the limited license if the limited license holder has another offer of employment. In the event that a change of employment occurs, the limited license holder must still work the number of hours required under paragraph (e), clause (2), to be eligible for a full and unrestricted license to practice medicine.

(g) In addition to any other remedy provided by law, the board may, without a hearing, temporarily suspend the license of a limited license holder if the board finds that the limited license holder has violated a statute or rule that the board is empowered to enforce and continued practice by the limited license holder would create a serious risk of harm to the public. The suspension shall take effect upon written notice to the limited license holder, specifying the statute or rule violated. The suspension shall remain in effect until the board issues a final order in the matter after a hearing. At the time it issues the suspension notice, the board shall schedule a disciplinary hearing to be held pursuant to the Administrative Procedure Act. The limited license holder shall be provided with at least 20 days' notice of any hearing held pursuant to this subdivision. The hearing shall be scheduled to begin no later than 30 days after the issuance of the suspension order.

(h) For purposes of this subdivision, "collaborative agreement" means a mutually agreed upon plan for the overall working relationship and collaborative arrangement between a holder of a limited license and one or more physicians licensed under this chapter that designates the scope of services that can be provided to manage the care of patients. The limited license holder and one of the collaborating physicians must have experience in providing care to patients with the same or similar medical conditions. Under the collaborative agreement, the limited license holder must shadow the collaborating physician for four weeks, after which time the limited license holder must staff all patient encounters with the collaborating physician for an additional four weeks. After that time, the collaborating physician has discretion to allow the limited license holder to see patients independently and may, at the discretion of the collaborating physician, require the limited license holder to present patients. However, the limited license holder must be supervised by the collaborating physician for a minimum of two hours per week. A limited license holder may practice medicine without a collaborating physician physically present, but the limited license holder and collaborating physicians must be able to easily contact each other by radio, telephone, or other telecommunication device while the limited license holder practices medicine. The limited license holder must have one-on-one practice reviews with each collaborating physician, provided in person or through eye-to-eye electronic media while maintaining visual contact, for at least two hours per week.

(i) At least one collaborating physician must submit a letter to the board, after the limited license holder has practiced under the license for 12 months, attesting to the following:

(1) that the limited license holder has a basic understanding of federal and state laws regarding the provision of health care, including but not limited to:

(i) medical licensing obligations and standards; and

(ii) the Health Insurance Portability and Accountability Act, Public Law 104-191;

(2) that the limited license holder has a basic understanding of documentation standards;

(3) that the limited license holder has a thorough understanding of which medications are available and unavailable in the United States;

(4) that the limited license holder has a thorough understanding of American medical standards of care;

(5) that the limited license holder has demonstrated mastery of each of the following:

(i) gathering a history and performing a physical exam;

(ii) developing and prioritizing a differential diagnosis following a clinical encounter and selecting a working diagnosis;

(iii) recommending and interpreting common diagnostic and screening tests;

(iv) entering and discussing orders and prescriptions;

(v) providing an oral presentation of a clinical encounter;

(vi) giving a patient handover to transition care responsibly;

(vii) recognizing a patient requiring urgent care and initiating an evaluation; and

(viii) obtaining informed consent for tests, procedures, and treatments; and

(6) that the limited license holder is providing appropriate medical care.

(j) The board must not grant a license under this section unless the applicant possesses federal immigration status that allows the applicant to practice as a physician in the United States.

EFFECTIVE DATE. This section is effective January 1, 2026.

Sec. 4. Minnesota Statutes 2024, section 147D.03, subdivision 1, is amended to read:

Subdivision 1. **General.** Within the meaning of sections 147D.01 to 147D.27, a person who shall publicly profess to be a traditional midwife and who, for a fee, shall assist or attend to a woman in pregnancy, childbirth outside a hospital, and postpartum, shall be regarded as practicing traditional midwifery. Effective July 1, 2026, a certified midwife licensed by the Board of Nursing under chapter 148G is not subject to the provisions of this chapter.

Sec. 5. Minnesota Statutes 2024, section 148.241, is amended to read:

148.241 EXPENSES.

Subdivision 1. **Appropriation.** The expenses of administering sections 148.171 to 148.285 and chapter 148G shall be paid from the appropriation made to the Minnesota Board of Nursing.

Subd. 2. **Expenditure.** All amounts appropriated to the board shall be held subject to the order of the board to be used only for the purpose of meeting necessary expenses incurred in the performance of the purposes of sections 148.171 to 148.285 and chapter 148G, and the duties imposed thereby as well as the promotion of nursing or certified midwifery education and standards of nursing or certified midwifery care in this state.

Sec. 6. **[148G.01] TITLE.**

This chapter shall be referred to as the Minnesota Certified Midwife Practice Act.

Sec. 7. **[148G.02] SCOPE; EFFECTIVE DATE.**

This chapter is effective July 1, 2026, and applies to all applicants and licensees, all persons who use the title certified midwife, and all persons in or out of this state who provide certified midwifery services to patients who reside in this state, unless there are specific applicable exemptions provided by law.

Sec. 8. **[148G.03] DEFINITIONS.**

Subdivision 1. **Scope.** For purposes of this chapter, the definitions in this section have the meanings given.

Subd. 2. **Board.** "Board" means the Minnesota Board of Nursing.

Subd. 3. **Certification.** "Certification" means the formal recognition by the American Midwifery Certification Board of the knowledge, skills, and experience demonstrated by the achievement of standards identified by the American College of Nurse Midwives or any successor organization.

Subd. 4. **Certified midwife.** "Certified midwife" means an individual who holds a current and valid national certification as a certified midwife from the American Midwifery Certification Board or any successor organization, and who is licensed by the board under this chapter.

Subd. 5. **Certified midwifery practice.** "Certified midwifery practice" means:

(1) managing, diagnosing, and treating women's primary health care beginning in adolescence, including pregnancy, childbirth, postpartum period, care of the newborn, family planning, partner care management relating to sexual health, and gynecological care of women;

(2) ordering, performing, supervising, and interpreting diagnostic studies within the scope of certified midwifery practice, excluding:

(i) interpreting and performing specialized ultrasound examinations; and

(ii) interpreting computed tomography scans, magnetic resonance imaging scans, positron emission tomography scans, nuclear scans, and mammography;

(3) prescribing pharmacologic and nonpharmacologic therapies appropriate to midwifery practice;

(4) consulting with, collaborating with, or referring to other health care providers as warranted by the needs of the patient; and

(5) performing the role of educator in the theory and practice of midwifery.

Subd. 6. **Collaborating.** "Collaborating" means the process in which two or more health care professionals work together to meet the health care needs of a patient, as warranted by the needs of the patient.

Subd. 7. **Consulting.** "Consulting" means the process in which a certified midwife who maintains primary management responsibility for a patient's care seeks advice or opinion of a physician, an advanced practice registered nurse, or another member of the health care team.

Subd. 8. **Encumbered.** "Encumbered" means:

(1) a license or other credential that is revoked, is suspended, or contains limitations on the full and unrestricted practice of certified midwifery when the revocation, suspension, or limitation is imposed by a state licensing board or other state regulatory entity; or

(2) a license or other credential that is voluntarily surrendered.

Subd. 9. **Licensure period.** "Licensure period" means the interval of time during which the certified midwife is authorized to engage in certified midwifery. The initial licensure period is from six to 29 full calendar months starting on the day of licensure and ending on the last day of the certified midwife's month of birth in an even-numbered year if the year of birth is an even-numbered year, or in an odd-numbered year if the year of birth is in an odd-numbered year. Subsequent licensure renewal periods are 24 months. For licensure renewal, the period starts on the first day of the month following expiration of the previous licensure period. The period ends the last day of the certified midwife's month of birth in an even- or odd-numbered year according to the certified midwife's year of birth.

Subd. 10. **Licensed practitioner.** "Licensed practitioner" means a physician licensed under chapter 147, an advanced practice registered nurse licensed under sections 148.171 to 148.235, or a certified midwife licensed under this chapter.

Subd. 11. **Midwifery education program.** "Midwifery education program" means a program of theory and practice, offered by a university or college, that leads to the preparation and eligibility for certification in midwifery and is accredited by the Accreditation

Commission for Midwifery Education or any successor organization recognized by the United States Department of Education or the Council for Higher Education Accreditation.

Subd. 12. **Patient.** "Patient" means a recipient of care provided by a certified midwife within the scope of certified midwifery practice, including an individual, family, group, or community.

Subd. 13. **Prescribing.** "Prescribing" means the act of generating a prescription for the preparation of, use of, or manner of using a drug or therapeutic device under section 148G.09. Prescribing does not include recommending the use of a drug or therapeutic device that is not required by the federal Food and Drug Administration to meet the labeling requirements for prescription drugs and devices.

Subd. 14. **Prescription.** "Prescription" means a written direction or an oral direction reduced to writing provided to or for a patient for the preparation or use of a drug or therapeutic device. The requirements of section 151.01, subdivisions 16, 16a, and 16b, apply to prescriptions for drugs.

Subd. 15. **Referral.** "Referral" means the process in which a certified midwife directs a patient to a physician or another health care professional for management of a particular problem or aspect of the patient's care.

Subd. 16. **Supervision.** "Supervision" means monitoring and establishing the initial direction, setting expectations, directing activities and courses of action, evaluating, and changing a course of action in certified midwifery care.

Sec. 9. **[148G.04] CERTIFIED MIDWIFE LICENSING.**

Subdivision 1. **Licensure.** (a) No person shall practice as a certified midwife or serve as the faculty of record for clinical instruction in a midwifery distance learning program unless the person is licensed by the board under this chapter.

(b) An applicant for a license to practice as a certified midwife must apply to the board in a format prescribed by the board and pay a fee in an amount determined under section 148G.11.

(c) To be eligible for licensure, an applicant must:

(1) not hold an encumbered license or other credential as a certified midwife or equivalent professional designation in any state or territory;

(2) hold a current and valid certification as a certified midwife from the American Midwifery Certification Board or any successor organization acceptable to the board and

provide primary source verification of certification to the board in a format prescribed by the board;

(3) have completed a graduate level midwifery education program that includes clinical experience, is accredited by the Accreditation Commission for Midwifery Education or any successor organization recognized by the United States Department of Education or the Council for Higher Education Accreditation, and leads to a graduate degree. The applicant must submit primary source verification of program completion to the board in a format prescribed by the board. The primary source verification must verify the applicant completed three separate graduate-level courses in physiology and pathophysiology; advanced health assessment; and advanced pharmacology, including pharmacodynamics, pharmacokinetics, and pharmacotherapeutics of all broad categories of agents;

(4) report any criminal conviction, nolo contendere plea, Alford plea, or other plea arrangement in lieu of conviction; and

(5) not have committed any acts or omissions that are grounds for disciplinary action in another jurisdiction or, if these acts were committed and would be grounds for disciplinary action as set forth in section 148G.13, the board has found after an investigation that sufficient remediation was made.

Subd. 2. **Clinical practice component.** If more than five years have elapsed since the applicant has practiced in the certified midwife role, the applicant must complete a reorientation plan as a certified midwife. The plan must include supervision during the clinical component by a licensed practitioner with experience in providing care to patients with the same or similar health care needs. The applicant must submit the plan and the name of the practitioner to the board. The plan must include a minimum of 500 hours of supervised certified midwifery practice. The certified midwife must submit verification of completion of the clinical reorientation to the board when the reorientation is complete.

Sec. 10. **[148G.05] LICENSURE RENEWAL; RELICENSURE.**

Subdivision 1. **Renewal; current applicants.** (a) A certified midwife must apply for renewal of the certified midwife's license before the certified midwife's licensure period ends. To be considered timely, the board must receive the certified midwife's application on or before the last day of the certified midwife's licensure period. A certified midwife's license lapses if the certified midwife's application is untimely.

(b) An applicant for license renewal must provide the board evidence of current certification or recertification as a certified midwife by the American Midwifery Certification Board or any successor organization.

(c) An applicant for license renewal must submit to the board the fee under section 148G.11, subdivision 2.

Subd. 2. **Clinical practice component.** If more than five years have elapsed since the applicant has practiced as a certified midwife, the applicant must complete a reorientation plan as a certified midwife. The plan must include supervision during the clinical component by a licensed practitioner with experience in providing care to patients with the same or similar health care needs. The licensee must submit the plan and the name of the practitioner to the board. The plan must include a minimum of 500 hours of supervised certified midwifery practice. The certified midwife must submit verification of completion of the clinical reorientation to the board when the reorientation is complete.

Subd. 3. **Relicensure; lapsed applicants.** A person whose license has lapsed and who desires to resume practice as a certified midwife must apply for relicensure, submit to the board satisfactory evidence of compliance with the procedures and requirements established by the board, and pay the board the relicensure fee under section 148G.11, subdivision 4, for the current licensure period. A penalty fee under section 148G.11, subdivision 4, is required from a person who practiced certified midwifery without current licensure. The board must relicense a person who meets the requirements of this subdivision.

Sec. 11. **[148G.06] FAILURE OR REFUSAL TO PROVIDE INFORMATION.**

Subdivision 1. **Notification requirement.** An individual licensed as a certified midwife must notify the board when the individual renews their certification. If a licensee fails to provide notification, the licensee is prohibited from practicing as a certified midwife.

Subd. 2. **Denial of license.** Refusal of an applicant to supply information necessary to determine the applicant's qualifications, failure to demonstrate qualifications, or failure to satisfy the requirements for a license contained in this chapter or rules of the board may result in denial of a license. The burden of proof is upon the applicant to demonstrate the qualifications and satisfaction of the requirements.

Sec. 12. **[148G.07] NAME CHANGE AND CHANGE OF ADDRESS.**

A certified midwife must maintain a current name and address with the board and must notify the board in writing within 30 days of any change in name or address. All notices or

other correspondence mailed to or served upon a certified midwife by the board at the licensee's address on file with the board are considered received by the licensee.

Sec. 13. **[148G.08] IDENTIFICATION OF CERTIFIED MIDWIVES.**

Only those persons who hold a current license to practice certified midwifery in this state may use the title of certified midwife. A certified midwife licensed by the board must use the designation of "CM" for professional identification and in documentation of services provided.

Sec. 14. **[148G.09] PRESCRIBING DRUGS AND THERAPEUTIC DEVICES.**

Subdivision 1. **Diagnosing, prescribing, and ordering.** Certified midwives, within the scope of certified midwifery practice, are authorized to:

(1) diagnose, prescribe, and institute therapy or referrals of patients to health care agencies and providers;

(2) prescribe, procure, sign for, record, administer, and dispense over-the-counter, legend, and controlled substances, including sample drugs; and

(3) plan and initiate a therapeutic regimen that includes ordering and prescribing durable medical devices and equipment, nutrition, diagnostic services, and supportive services, including but not limited to home health care, physical therapy, and occupational therapy.

Subd. 2. **Drug Enforcement Administration requirements.** (a) Certified midwives must:

(1) comply with federal Drug Enforcement Administration (DEA) requirements related to controlled substances; and

(2) file the certified midwife's DEA registrations and numbers, if any, with the board.

(b) The board must maintain current records of all certified midwives with a DEA registration and number.

Sec. 15. **[148G.10] FEES.**

The fees specified in section 148G.11 are nonrefundable and must be deposited in the state government special revenue fund.

Sec. 16. **[148G.11] FEE AMOUNTS.**

Subdivision 1. **Licensure.** The fee for licensure is $105.

Subd. 2. **Renewal.** The fee for licensure renewal is $85.

Subd. 3. **Practicing without current certification.** The penalty fee for a person who practices certified midwifery without a current certification or recertification, or who practices certified midwifery without current certification or recertification on file with the board, is $200 for the first month or part of a month and an additional $100 for each subsequent month or parts of months of practice. The penalty fee must be calculated from the first day the certified midwife practiced without a current certification to the last day of practice without a current certification, or from the first day the certified midwife practiced without a current certification or recertification on file with the board until the day the current certification or recertification is filed with the board.

Subd. 4. **Relicensure.** The fee for relicensure is $105. The fee for practicing without current licensure is two times the amount of the current renewal fee for any part of the first calendar month, plus the current renewal fee for any part of each subsequent month up to 24 months.

Subd. 5. **Dishonored check fee.** The service fee for a dishonored check is as provided in section 604.113.

Sec. 17. **[148G.12] APPROVED MIDWIFERY EDUCATION PROGRAM.**

Subdivision 1. **Initial approval.** A university or college desiring to conduct a certified midwifery education program must submit evidence to the board that the university or college is prepared to:

(1) provide a program of theory and practice in certified midwifery leading to eligibility for certification in midwifery;

(2) achieve preaccreditation and eventual full accreditation by the American Commission for Midwifery Education or any successor organization recognized by the United States Department of Education or the Council for Higher Education Accreditation. Instruction and required experience may be obtained in one or more institutions or agencies outside the applying university or college if the program retains accountability for all clinical and nonclinical teaching; and

(3) meet other standards established by law and by the board.

Subd. 2. **Continuing approval.** The board must, through the board's representative, annually survey all midwifery education programs in the state for current accreditation status by the American Commission for Midwifery Education or any successor organization recognized by the United States Department of Education or the Council for Higher Education

Accreditation. If the results of the survey show that a certified midwifery education program meets all standards for continuing accreditation, the board must continue approval of the certified midwifery education program.

Subd. 3. **Loss of approval.** If the board determines that an accredited certified midwifery education program is not maintaining the standards required by the American Commission on Midwifery Education or any successor organization, the board must obtain the defect in writing from the accrediting body. If a program fails to correct the defect to the satisfaction of the accrediting body and the accrediting body revokes the program's accreditation, the board must remove the program from the list of approved certified midwifery education programs.

Subd. 4. **Reinstatement of approval.** The board must reinstate approval of a certified midwifery education program upon submission of satisfactory evidence that the certified midwifery education program of theory and practice meets the standards required by the accrediting body.

Sec. 18. **[148G.13] GROUNDS FOR DISCIPLINARY ACTION.**

Subdivision 1. **Grounds listed.** The board may deny, revoke, suspend, limit, or condition the license of any person to practice certified midwifery under this chapter or otherwise discipline a licensee or applicant as described in section 148G.14. The following are grounds for disciplinary action:

(1) failure to demonstrate the qualifications or satisfy the requirements for a license contained in this chapter or rules of the board. In the case of an applicant for licensure, the burden of proof is upon the applicant to demonstrate the qualifications or satisfaction of the requirements;

(2) employing fraud or deceit in procuring or attempting to procure a license to practice certified midwifery;

(3) conviction of a felony or gross misdemeanor reasonably related to the practice of certified midwifery. Conviction, as used in this subdivision, includes a conviction of an offense that if committed in this state would be considered a felony or gross misdemeanor 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;

(4) revocation, suspension, limitation, conditioning, or other disciplinary action against the person's certified midwife credential in another state, territory, or country; failure to

report to the board that charges regarding the person's certified midwifery license, certification, or other credential are pending in another state, territory, or country; or failure to report to the board having been refused a license or other credential by another state, territory, or country;

(5) failure or inability to practice as a certified midwife with reasonable skill and safety, or departure from or failure to conform to standards of acceptable and prevailing certified midwifery, including failure of a certified midwife to adequately supervise or monitor the performance of acts by any person working at the certified midwife's direction;

(6) engaging in unprofessional conduct, including but not limited to a departure from or failure to conform to statutes relating to certified midwifery practice or to the minimal standards of acceptable and prevailing certified midwifery practice, or engaging in any certified midwifery practice that may create unnecessary danger to a patient's life, health, or safety. Actual injury to a patient need not be established under this clause;

(7) supervision or accepting the supervision of a midwifery function or a prescribed health care function when the acceptance could reasonably be expected to result in unsafe or ineffective patient care;

(8) actual or potential inability to practice certified midwifery with reasonable skill and safety to patients by reason of illness; by reason of the use of alcohol, drugs, chemicals, or any other material; or as a result of any mental or physical condition;

(9) adjudication as mentally incompetent, mentally ill, a chemically dependent person, or a person dangerous to the public by a court of competent jurisdiction, within or outside of this state;

(10) engaging in any unethical conduct, including but not limited to 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. Actual injury need not be established under this clause;

(11) engaging in conduct with a patient that is sexual or may reasonably be interpreted by the patient as sexual, in any verbal behavior that is seductive or sexually demeaning to a patient, or in sexual exploitation of a patient or former patient;

(12) obtaining money, property, or services from a patient, other than reasonable fees for services provided to the patient, through the use of undue influence, harassment, duress, deception, or fraud;

(13) revealing a privileged communication from or relating to a patient except when otherwise required or permitted by law;

(14) engaging in abusive or fraudulent billing practices, including violations of federal Medicare and Medicaid laws or state medical assistance laws;

(15) 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;

(16) knowingly aiding, assisting, advising, or allowing an unlicensed person to engage in the unlawful practice of certified midwifery;

(17) violating a rule adopted by the board, an order of the board, a state or federal law relating to the practice of certified midwifery, or a state or federal narcotics or controlled substance law;

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

(19) 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;

(20) practicing outside the scope of certified midwifery practice as defined under section 148G.03, subdivision 5;

(21) making a false statement or knowingly providing false information to the board, failing to make reports as required by section 148G.15, or failing to cooperate with an investigation of the board as required by section 148G.17;

(22) engaging in false, fraudulent, deceptive, or misleading advertising;

(23) failure to inform the board of the person's certification or recertification status as a certified midwife;

(24) engaging in certified midwifery practice without a license and current certification or recertification by the American Midwifery Certification Board or any successor organization; or

(25) failure to maintain appropriate professional boundaries with a patient. A certified midwife must not engage in practices that create an unacceptable risk of patient harm or of the impairment of a certified midwife's objectivity or professional judgment. A certified midwife must not act or fail to act in a way that, as judged by a reasonable and prudent certified midwife, inappropriately encourages the patient to relate to the certified midwife outside of the boundaries of the professional relationship, or in a way that interferes with the patient's ability to benefit from certified midwife services. A certified midwife must not use the professional relationship with a patient, student, supervisee, or intern to further the certified midwife's personal, emotional, financial, sexual, religious, political, or business benefit or interests.

Subd. 2. **Conviction of a felony-level criminal sexual offense.** (a) Except as provided in paragraph (e), the board must not grant or renew a license to practice certified midwifery to any person who has been convicted on or after August 1, 2014, of any of the provisions of section 609.342, subdivision 1 or 1a; 609.343, subdivision 1 or 1a; 609.344, subdivision 1 or 1a, paragraphs (c) to (g); or 609.345, subdivision 1 or 1a, paragraphs (c) to (g); or a similar statute in another jurisdiction.

(b) A license to practice certified midwifery is automatically revoked if the licensee is convicted of an offense listed in paragraph (a).

(c) A license to practice certified midwifery that has been denied or revoked under this subdivision is not subject to chapter 364.

(d) For purposes of this subdivision, "conviction" means a plea of guilty, a verdict of guilty by a jury, or a finding of guilty by the court, unless the court stays imposition or execution of the sentence and final disposition of the case is accomplished at a nonfelony level.

(e) The board may establish criteria whereby an individual convicted of an offense listed in paragraph (a) may become licensed if the criteria:

(1) utilize a rebuttable presumption that the applicant is not suitable for licensing;

(2) provide a standard for overcoming the presumption; and

(3) require that a minimum of ten years has elapsed since the applicant's sentence was discharged.

(f) The board must not consider an application under paragraph (e) if the board determines that the victim involved in the offense was a patient or a client of the applicant at the time of the offense.

Subd. 3. **Evidence.** In disciplinary actions alleging a violation of subdivision 1, clause (3) or (4), or 2, a copy of the judgment or proceeding under the seal of the court administrator or of the administrative agency that entered the same is admissible into evidence without further authentication and constitutes prima facie evidence of the violation concerned.

Subd. 4. **Examination; access to medical data.** (a) If the board has probable cause to believe that grounds for disciplinary action exist under subdivision 1, clause (8) or (9), it may direct the applicant or certified midwife to submit to a mental or physical examination or chemical dependency evaluation. For the purpose of this subdivision, when a certified midwife licensed under this chapter is directed in writing by the board to submit to a mental or physical examination or chemical dependency evaluation, that person is considered to have consented and to have waived all objections to admissibility on the grounds of privilege. Failure of the applicant or certified midwife to submit to an examination when directed constitutes an admission of the allegations against the applicant or certified midwife, unless the failure was due to circumstances beyond the person's control, and the board may enter a default and final order without taking testimony or allowing evidence to be presented. A certified midwife affected under this paragraph must, at reasonable intervals, be given an opportunity to demonstrate that the competent practice of certified midwifery can be resumed with reasonable skill and safety to patients. Neither the record of proceedings nor the orders entered by the board in a proceeding under this paragraph may be used against a certified midwife in any other proceeding.

(b) Notwithstanding sections 13.384, 144.651, and 595.02, or any other law limiting access to medical or other health data, the board may obtain medical data and health records relating to a certified midwife or applicant for a license without that person's consent if the board has probable cause to believe that grounds for disciplinary action exist under subdivision 1, clause (8) or (9). The medical data may be requested from a provider, as defined in section 144.291, subdivision 2; an insurance company; or a government agency, including the Department of Human Services or Direct Care and Treatment. A provider, insurance company, or government agency must comply with any written request of the board under this subdivision and is not liable in any action for damages for releasing the data requested by the board if the data are released pursuant to a written request under this

subdivision, unless the information is false and the provider giving the information knew or had reason to believe the information was false. Information obtained under this subdivision is classified as private data on individuals as defined in section 13.02.

Sec. 19. **[148G.14] FORMS OF DISCIPLINARY ACTION; AUTOMATIC SUSPENSION; TEMPORARY SUSPENSION; REISSUANCE.**

Subdivision 1. **Forms of disciplinary action.** If the board finds that grounds for disciplinary action exist under section 148G.13, it may take one or more of the following actions:

(1) deny the license application or application for license renewal;

(2) revoke the license;

(3) suspend the license;

(4) impose limitations on the certified midwife's practice of certified midwifery, including but not limited to limitation of scope of practice or the requirement of practice under supervision;

(5) impose conditions on the retention of the license, including but not limited to the imposition of retraining or rehabilitation requirements or the conditioning of continued practice on demonstration of knowledge or skills by appropriate examination, monitoring, or other review;

(6) impose a civil penalty not exceeding $10,000 for each separate violation. The amount of the civil penalty must be fixed so as to deprive the certified midwife of any economic advantage gained by reason of the violation charged; to reimburse the board for the cost of counsel, investigation, and proceeding; and to discourage repeated violations;

(7) order the certified midwife to provide unremunerated service;

(8) censure or reprimand the certified midwife; or

(9) any other action justified by the facts in the case.

Subd. 2. **Automatic suspension of license.** (a) Unless the board orders otherwise, a license to practice certified midwifery is automatically suspended if:

(1) a guardian of a certified midwife is appointed by order of a court under sections 524.5-101 to 524.5-502;

(2) the certified midwife is committed by order of a court under chapter 253B; or

(3) the certified midwife is determined to be mentally incompetent, mentally ill, chemically dependent, or a person dangerous to the public by a court of competent jurisdiction within or outside of this state.

(b) The license remains suspended until the certified midwife is restored to capacity by a court and, upon petition by the certified midwife, the suspension is terminated by the board after a hearing or upon agreement between the board and the certified midwife.

Subd. 3. **Temporary suspension of license.** In addition to any other remedy provided by law, the board may, through its designated board member under section 214.10, subdivision 2, temporarily suspend the license of a certified midwife without a hearing if the board finds that there is probable cause to believe the certified midwife has violated a statute or rule the board is empowered to enforce and continued practice by the certified midwife would create a serious risk of harm to others. The suspension takes effect upon written notice to the certified midwife, served by first-class mail, specifying the statute or rule violated. The suspension must remain in effect until the board issues a temporary stay of suspension or a final order in the matter after a hearing or upon agreement between the board and the certified midwife. At the time it issues the suspension notice, the board must schedule a disciplinary hearing to be held under the Administrative Procedure Act. The board must provide the certified midwife at least 20 days' notice of any hearing held under this subdivision. The board must schedule the hearing to begin no later than 30 days after the issuance of the suspension order.

Subd. 4. **Reissuance.** The board may reinstate and reissue a license to practice certified midwifery, but as a condition may impose any disciplinary or corrective measure that it might originally have imposed. Any person whose license has been revoked, suspended, or limited may have the license reinstated and a new license issued when, at the discretion of the board, the action is warranted, provided that the board must require the person to pay the costs of the proceedings resulting in the revocation, suspension, or limitation of the license; the relicensure fee; and the fee for the current licensure period. The cost of proceedings includes but is not limited to the cost paid by the board to the Office of Administrative Hearings and the Office of the Attorney General for legal and investigative services; the costs of a court reporter and witnesses, reproduction of records, board staff time, travel, and expenses; and the costs of board members' per diem reimbursements, travel costs, and expenses.

Sec. 20. **[148G.15] REPORTING OBLIGATIONS.**

Subdivision 1. **Permission to report.** A person who has knowledge of any conduct constituting grounds for discipline under section 148G.13 may report the alleged violation to the board.

Subd. 2. **Institutions.** The chief nursing executive or chief administrative officer of any hospital, clinic, prepaid medical plan, or other health care institution or organization located in this state must report to the board any action taken by the institution or organization or any of its administrators or committees to revoke, suspend, limit, or condition a certified midwife's privilege to practice in the institution, or as part of the organization, any denial of privileges, any dismissal from employment, or any other disciplinary action. The institution or organization must also report the resignation of any certified midwife before the conclusion of any disciplinary proceeding, or before commencement of formal charges, but after the certified midwife had knowledge that formal charges were contemplated or in preparation. The reporting described by this subdivision is required only if the action pertains to grounds for disciplinary action under section 148G.13.

Subd. 3. **Licensed professionals.** A person licensed by a health-related licensing board as defined in section 214.01, subdivision 2, must report to the board personal knowledge of any conduct the person reasonably believes constitutes grounds for disciplinary action under section 148G.13 by any certified midwife, including conduct indicating that the certified midwife may be incompetent, may have engaged in unprofessional or unethical conduct, or may be mentally or physically unable to engage safely in the practice of certified midwifery.

Subd. 4. **Insurers.** (a) By the first day of February, May, August, and November, each insurer authorized to sell insurance described in section 60A.06, subdivision 1, clause (13), and providing professional liability insurance to certified midwives must submit to the board a report concerning any certified midwife against whom a malpractice award has been made or who has been a party to a settlement. The report must contain at least the following information:

(1) the total number of settlements or awards;

(2) the date a settlement or award was made;

(3) the allegations contained in the claim or complaint leading to the settlement or award;

(4) the dollar amount of each malpractice settlement or award and whether that amount was paid as a result of a settlement or of an award; and

(5) the name and address of the practice of the certified midwife against whom an award was made or with whom a settlement was made.

(b) An insurer must also report to the board any information it possesses that tends to substantiate a charge that a certified midwife may have engaged in conduct in violation of this chapter.

Subd. 5. **Courts.** The court administrator of district court or another court of competent jurisdiction must report to the board any judgment or other determination of the court that adjudges or includes a finding that a certified midwife is a person who is mentally ill, mentally incompetent, chemically dependent, dangerous to the public, guilty of a felony or gross misdemeanor, guilty of a violation of federal or state narcotics laws or controlled substances act, guilty of operating a motor vehicle while under the influence of alcohol or a controlled substance, or guilty of an abuse or fraud under Medicare or Medicaid; or if the court appoints a guardian of the certified midwife under sections 524.5-101 to 524.5-502 or commits a certified midwife under chapter 253B.

Subd. 6. **Deadlines; forms.** Reports required by subdivisions 2, 3, and 5 must be submitted no later than 30 days after the occurrence of the reportable event or transaction. The board may provide forms for the submission of reports required by this section, may require that the reports be submitted on the forms provided, and may adopt rules necessary to ensure prompt and accurate reporting. The board must review all reports, including those submitted after the deadline.

Subd. 7. **Failure to report.** Any person, institution, insurer, or organization that fails to report as required under subdivisions 2 to 6 is subject to civil penalties for failing to report as required by law.

Sec. 21. **[148G.16] IMMUNITY.**

Subdivision 1. **Reporting.** Any person, health care facility, business, or organization is immune from civil liability and criminal prosecution for submitting in good faith a report to the board under section 148G.15 or for otherwise reporting in good faith to the board violations or alleged violations of this chapter. All such reports are investigative data as defined in chapter 13.

Subd. 2. **Investigation.** (a) Members of the board and persons employed by the board or engaged in the investigation of violations and in the preparation and management of charges of violations of this chapter on behalf of the board, or persons participating in the investigation or testifying regarding charges of violations, are immune from civil liability

and criminal prosecution for any actions, transactions, or publications in the execution of, or relating to, their duties under this chapter.

(b) Members of the board and persons employed by the board or engaged in maintaining records and making reports regarding adverse health care events are immune from civil liability and criminal prosecution for any actions, transactions, or publications in the execution of, or relating to, their duties under this chapter.

Sec. 22. **[148G.17] CERTIFIED MIDWIFE COOPERATION.**

A certified midwife who is the subject of an investigation by or on behalf of the board must cooperate fully with the investigation. Cooperation includes responding fully and promptly to any question raised by or on behalf of the board relating to the subject of the investigation and providing copies of patient or other records in the certified midwife's possession, as reasonably requested by the board, to assist the board in its investigation and to appear at conferences and hearings scheduled by the board. The board must pay for copies requested. If the board does not have written consent from a patient permitting access to the patient's records, the certified midwife must delete any data in the record that identify the patient before providing it to the board. The board must maintain any records obtained pursuant to this section as investigative data under chapter 13. The certified midwife must not be excused from giving testimony or producing any documents, books, records, or correspondence on the grounds of self-incrimination, but the testimony or evidence must not be used against the certified midwife in any criminal case.

Sec. 23. **[148G.18] DISCIPLINARY RECORD ON JUDICIAL REVIEW.**

Upon judicial review of any board disciplinary action taken under this chapter, the reviewing court must seal the administrative record, except for the board's final decision, and must not make the administrative record available to the public.

Sec. 24. **[148G.19] EXEMPTIONS.**

The provisions of this chapter do not prohibit:

(1) the furnishing of certified midwifery assistance in an emergency;

(2) the practice of certified midwifery by any legally qualified certified midwife of another state who is employed by the United States government or any bureau, division, or agency thereof while in the discharge of official duties;

(3) the practice of any profession or occupation licensed by the state, other than certified midwifery, by any person licensed to practice the profession or occupation, or the performance by a person of any acts properly coming within the scope of the profession, occupation, or license;

(4) the practice of traditional midwifery as specified under section 147D.03;

(5) certified midwifery practice by a student practicing under the supervision of an instructor while the student is enrolled in an approved certified midwifery education program; or

(6) certified midwifery practice by a certified midwife licensed in another state, territory, or jurisdiction who is in Minnesota temporarily:

(i) providing continuing or in-service education;

(ii) serving as a guest lecturer;

(iii) presenting at a conference; or

(iv) teaching didactic content via distance education to a student located in Minnesota who is enrolled in a formal, structured course of study, such as a course leading to a higher degree in midwifery.

Sec. 25. **[148G.20] VIOLATIONS; PENALTY.**

Subdivision 1. **Violations described.** It is unlawful for any person, corporation, firm, or association to:

(1) sell or fraudulently obtain or furnish any certified midwifery diploma, license, or record, or aid or abet therein;

(2) practice certified midwifery under cover of any diploma, permit, license, certified midwife credential, or record illegally or fraudulently obtained or signed or issued unlawfully or under fraudulent representation;

(3) practice certified midwifery unless the person is licensed to do so under this chapter;

(4) use the professional title certified midwife or licensed certified midwife unless licensed to practice certified midwifery under this chapter;

(5) use any abbreviation or other designation tending to imply licensure as a certified midwife unless licensed to practice certified midwifery under this chapter;

(6) practice certified midwifery in a manner prohibited by the board in any limitation of a license issued under this chapter;

(7) practice certified midwifery during the time a license issued under this chapter is suspended or revoked;

(8) knowingly employ persons in the practice of certified midwifery who have not been issued a current license to practice as a certified midwife in this state; or

(9) conduct a certified midwifery program for the education of persons to become certified midwives unless the program has been approved by the board.

Subd. 2. **Penalty.** Any person, corporation, or association violating any provision of subdivision 1 is guilty of a gross misdemeanor and must be punished according to law.

Subd. 3. **Penalty; certified midwives.** In addition to subdivision 2, a person who practices certified midwifery without a current license and certification or recertification, or without current certification or recertification on file with the board, is subject to the applicable penalties in section 148G.11.

Sec. 26. **[148G.21] UNAUTHORIZED PRACTICE OF MIDWIFERY.**

The practice of certified midwifery by any person who is not licensed to practice certified midwifery under this chapter, whose license has been suspended or revoked, or whose national certification credential has expired, is inimical to the public health and welfare and constitutes a public nuisance. Upon a complaint being made by the board or any prosecuting officer, and upon a proper showing of the facts, the district court of the county where such practice occurred may enjoin such acts and practice. The injunction proceeding is in addition to, and not in lieu of, all other penalties and remedies provided by law.

Sec. 27. Minnesota Statutes 2024, 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, licensed certified midwife effective July 1, 2026, 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. 28. Minnesota Statutes 2024, section 151.555, subdivision 6, is amended to read:

Subd. 6. **Standards and procedures for accepting donations of drugs and supplies and purchasing drugs from licensed wholesalers.** (a) Notwithstanding any other law or rule, a donor may donate 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 drug is eligible for donation under the medication repository program if the following requirements are met:

(1) 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;

(2) 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;

(3) the drug or the packaging does not have any physical signs of tampering, misbranding, deterioration, compromised integrity, or adulteration;

(4) 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

(5) the drug is not a controlled substance.

(c) A medical supply is eligible for donation under the 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; and

(3) 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 medication repository donor form and make it available on the board's website. Prior to the first donation from a new donor, a central repository or local repository shall verify and record the following information on the donor form:

(1) the donor's name, address, phone number, and license number, if applicable;

(2) that the donor will only make donations in accordance with the program;

(3) to the best of the donor's knowledge, only drugs or supplies that have been properly stored under appropriate temperature and humidity conditions will be donated; and

(4) to the best of the donor's knowledge, only drugs or supplies that have never been opened, used, tampered with, adulterated, or misbranded will be donated.

(e) Notwithstanding any other law or rule, a central repository or a local repository may receive donated drugs from donors. 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 prior to dispensing. A drop box must not be used to deliver or accept donations.

(f) The central repository and local repository shall maintain a written or electronic inventory of all drugs and supplies donated to the repository upon acceptance of each drug or supply. 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. The board may waive the requirement under this paragraph if an entity is under common ownership or control with a central repository or local repository and either the entity or the repository maintains an inventory containing all the information required under this paragraph.

(g) The central repository may purchase a drug from a wholesaler licensed by the board to fill prescriptions for eligible patients when the repository does not have a sufficient supply of donated drugs to fill the prescription. The central repository may use any purchased drugs remaining after filling the prescriptions for which the drugs were initially purchased to fill other prescriptions. Whenever possible, the repository must use donated drugs to fill prescriptions.

Sec. 29. Minnesota Statutes 2024, section 151.555, subdivision 10, is amended to read:

Subd. 10. **Distribution of donated drugs and supplies.** (a) The central repository and local repositories may distribute drugs and supplies donated under the medication 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 that are suitable for donation and dispensing must transfer ~~all~~ those 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. A local repository must dispose of drugs and supplies in its possession that are not suitable for donation or dispensing pursuant to subdivision 7.

Sec. 30. Minnesota Statutes 2024, section 152.12, subdivision 1, is amended to read:

Subdivision 1. **Prescribing, dispensing, administering controlled substances in Schedules II through V.** A licensed doctor of medicine, a doctor of osteopathic medicine, duly licensed to practice medicine, a doctor of dental surgery, a doctor of dental medicine, a licensed doctor of podiatry, a licensed advanced practice registered nurse, a licensed certified midwife effective July 1, 2026, a licensed physician assistant, or a licensed doctor of optometry limited to Schedules IV and V, and in the course of professional practice only, may prescribe, administer, and dispense a controlled substance included in Schedules II through V of section 152.02, may cause the same to be administered by a nurse, an intern or an assistant under the direction and supervision of the doctor, and may cause a person who is an appropriately certified and licensed health care professional to prescribe and administer the same within the expressed legal scope of the person's practice as defined in Minnesota Statutes.

Sec. 31. Minnesota Statutes 2024, section 256B.0625, is amended by adding a subdivision to read:

Subd. 28c. **Certified midwifery practice services.** Effective January 1, 2026, or upon federal approval, whichever is later, medical assistance covers services performed by a licensed certified midwife if:

(1) the service provided on an inpatient basis is not included as part of the cost for inpatient services included in the facility payment;

(2) the service is otherwise covered under this chapter as a physician service; and

(3) the service is within the scope of practice of the certified midwife's license as defined under chapter 148G.

ARTICLE 4
PHARMACY BENEFITS

Section 1. Minnesota Statutes 2024, section 256B.0625, subdivision 13c, is amended to read:

Subd. 13c. **Formulary Committee.** The commissioner, after receiving recommendations from professional medical associations and professional pharmacy associations, and consumer groups shall designate a Formulary Committee to carry out duties as described in subdivisions 13 to 13g. The Formulary Committee shall be comprised of at least five licensed physicians actively engaged in the practice of medicine in Minnesota, one of whom is an actively practicing psychiatrist, one of whom specializes in the diagnosis and treatment of rare diseases, one of whom specializes in pediatrics, and one of whom actively treats persons with disabilities; at least three licensed pharmacists actively engaged in the practice of pharmacy in Minnesota, one of whom practices outside the metropolitan counties listed in section 473.121, subdivision 4, one of whom practices in the metropolitan counties listed in section 473.121, subdivision 4, and one of whom is a practicing hospital pharmacist; at least two consumer representatives, all of whom must have a personal or professional connection to medical assistance; and one representative designated by the Minnesota Rare Disease Advisory Council established under section 256.4835; the remainder to be made up of health care professionals who are licensed in their field and have recognized knowledge in the clinically appropriate prescribing, dispensing, and monitoring of covered outpatient drugs. Members of the Formulary Committee shall not be employed by the Department of Human Services or have a personal interest in a pharmaceutical company, pharmacy benefits manager, health plan company, or their affiliate organizations, but the committee shall be staffed by an employee of the department who shall serve as an ex officio, nonvoting member of the committee. For the purposes of this subdivision, "personal interest" means that a person owns at least five percent of the voting interest or equity interest in the entity, the equity interest owned by a person represents at least five percent of that person's net worth, or more than five percent of a person's gross income for the preceding year was derived from the entity. A committee member must notify the committee of any potential conflict of interest and recuse themselves from any communications, discussion, or vote on any matter where a conflict of interest exists. A conflict of interest alone, without a personal interest, does not preclude an applicant from serving as a member of the Formulary

Committee. Members may be removed from the committee for cause after a recommendation for removal by a majority of the committee membership. For the purposes of this subdivision, "cause" does not include offering a differing or dissenting clinical opinion on a drug or drug class. The department's medical director shall also serve as an ex officio, nonvoting member for the committee. Committee members shall serve three-year terms and may be reappointed twice by the commissioner. The committee members shall vote on a chair and vice chair from among their membership. The chair shall preside over all committee meetings, and the vice chair shall preside over the meetings if the chair is not present. The Formulary Committee shall meet at least three times per year. The commissioner may require more frequent Formulary Committee meetings as needed. An honorarium of $100 per meeting and reimbursement for mileage shall be paid to each committee member in attendance. The Formulary Committee expires June 30, ~~2027~~ 2029. The Formulary Committee is subject to the Open Meeting Law under chapter 13D. For purposes of establishing a quorum to transact business, vacant committee member positions do not count in the calculation as long as at least 60 percent of the committee member positions are filled.

Sec. 2. Minnesota Statutes 2024, section 256B.0625, subdivision 13e, is amended to read:

Subd. 13e. **Payment rates.** (a) The basis for determining the amount of payment shall be the lower of the ingredient costs of the drugs plus the professional dispensing fee; or the usual and customary price charged to the public. The usual and customary price means the lowest price charged by the provider to a patient who pays for the prescription by cash, check, or charge account and includes prices the pharmacy charges to a patient enrolled in a prescription savings club or prescription discount club administered by the pharmacy or pharmacy chain, unless the prescription savings club or prescription discount club is one in which an individual pays a recurring monthly access fee for unlimited access to a defined list of drugs for which the pharmacy does not bill the member or a payer on a per-standard-transaction basis. The amount of payment basis must be reduced to reflect all discount amounts applied to the charge by any third-party provider/insurer agreement or contract for submitted charges to medical assistance programs. The net submitted charge may not be greater than the patient liability for the service. The professional dispensing fee shall be $11.55 for prescriptions filled with legend drugs meeting the definition of "covered outpatient drugs" according to United States Code, title 42, section 1396r-8(k)(2). The dispensing fee for intravenous solutions that must be compounded by the pharmacist shall be $11.55 per claim. The professional dispensing fee for prescriptions filled with over-the-counter drugs meeting the definition of covered outpatient drugs shall be $11.55 for dispensed quantities equal to or greater than the number of units contained in the

manufacturer's original package. The professional dispensing fee shall be prorated based on the percentage of the package dispensed when the pharmacy dispenses a quantity less than the number of units contained in the manufacturer's original package. The pharmacy dispensing fee for prescribed over-the-counter drugs not meeting the definition of covered outpatient drugs shall be $3.65 for quantities equal to or greater than the number of units contained in the manufacturer's original package and shall be prorated based on the percentage of the package dispensed when the pharmacy dispenses a quantity less than the number of units contained in the manufacturer's original package. The ingredient cost for a drug is the lowest of the National Average Drug Acquisition Cost (NADAC) ~~shall be used to determine the ingredient cost of a drug~~; the Minnesota actual acquisition cost (MNAAC), as defined in paragraph (i); or the maximum allowable cost. For drugs for which a NADAC, MNAAC, or maximum allowable cost is not reported, the commissioner shall estimate the ingredient cost at the wholesale acquisition cost minus two percent. The ingredient cost of a drug for a provider participating in the federal 340B Drug Pricing Program shall be ~~either~~ the 340B Drug Pricing Program ceiling price established by the Health Resources and Services Administration ~~or~~, the NADAC, the MNAAC, or the maximum allowable cost, whichever is ~~lower~~ lowest. Wholesale acquisition cost is defined as the manufacturer's list price for a drug or biological to wholesalers or direct purchasers in the United States, not including prompt pay or other discounts, rebates, or reductions in price, for the most recent month for which information is available, as reported in wholesale price guides or other publications of drug or biological pricing data. The maximum allowable cost of a ~~multisource~~ drug may be set by the commissioner and it shall be comparable to the actual acquisition cost of the drug product and no higher than the NADAC of the generic product. Establishment of the amount of payment for drugs shall not be subject to the requirements of the Administrative Procedure Act.

(b) Pharmacies dispensing prescriptions to residents of long-term care facilities using an automated drug distribution system meeting the requirements of section 151.58, or a packaging system meeting the packaging standards set forth in Minnesota Rules, part 6800.2700, that govern the return of unused drugs to the pharmacy for reuse, may employ retrospective billing for prescription drugs dispensed to long-term care facility residents. A retrospectively billing pharmacy must submit a claim only for the quantity of medication used by the enrolled recipient during the defined billing period. A retrospectively billing pharmacy must use a billing period not less than one calendar month or 30 days.

(c) A pharmacy provider using packaging that meets the standards set forth in Minnesota Rules, part 6800.2700, is required to credit the department for the actual acquisition cost

of all unused drugs that are eligible for reuse, unless the pharmacy is using retrospective billing. The commissioner may permit the drug clozapine to be dispensed in a quantity that is less than a 30-day supply.

(d) If a pharmacy dispenses a multisource drug, the ingredient cost shall be the lesser of the NADAC of the generic product, the MNAAC of the generic product, or the maximum allowable cost of the generic product established by the commissioner unless prior authorization for the brand name product has been granted according to the criteria established by the Drug Formulary Committee as required by subdivision 13f, paragraph (a), and the prescriber has indicated "dispense as written" on the prescription in a manner consistent with section 151.21, subdivision 2. If prior authorization is granted, the ingredient cost shall be the lesser of the NADAC of the brand name product, the MNAAC of the brand name product, or the maximum allowable cost of the brand name product. A generic product includes a generic drug, an authorized generic drug, and a biosimilar biological product as defined in Code of Federal Regulations, title 42, section 423.4. A brand name product includes a brand name drug, a brand name biological product, and an unbranded biological product as defined in Code of Federal Regulations, title 42, section 423.4.

(e) The basis for determining the amount of payment for drugs administered in an outpatient setting shall be the lower of the usual and customary cost submitted by the provider, 106 percent of the average sales price as determined by the United States Department of Health and Human Services pursuant to title XVIII, section 1847a of the federal Social Security Act, the ~~specialty pharmacy rate~~ MNAAC, or the maximum allowable cost set by the commissioner. If average sales price ~~is~~, MNAAC, and the maximum allowable cost are unavailable, the amount of payment must be lower of the usual and customary cost submitted by the provider~~,~~ or the wholesale acquisition cost~~, the specialty pharmacy rate, or the maximum allowable cost set by the commissioner~~. The commissioner shall discount the payment rate for drugs obtained through the federal 340B Drug Pricing Program by 28.6 percent. The payment for drugs administered in an outpatient setting shall be made to the administering facility or practitioner. A retail or specialty pharmacy dispensing a drug for administration in an outpatient setting is not eligible for direct reimbursement.

~~(f) The commissioner may establish maximum allowable cost rates for specialty pharmacy products that are lower than the ingredient cost formulas specified in paragraph (a). The commissioner may require individuals enrolled in the health care programs administered by the department to obtain specialty pharmacy products from providers with whom the commissioner has negotiated lower reimbursement rates. Specialty pharmacy products are defined as those used by a small number of recipients or recipients with complex and chronic~~

~~diseases that require expensive and challenging drug regimens. Examples of these conditions include, but are not limited to: multiple sclerosis, HIV/AIDS, transplantation, hepatitis C, growth hormone deficiency, Crohn's Disease, rheumatoid arthritis, and certain forms of cancer. Specialty pharmaceutical products include injectable and infusion therapies, biotechnology drugs, antihemophilic factor products, high-cost therapies, and therapies that require complex care. The commissioner shall consult with the Formulary Committee to develop a list of specialty pharmacy products subject to maximum allowable cost reimbursement. In consulting with the Formulary Committee in developing this list, the commissioner shall take into consideration the population served by specialty pharmacy products, the current delivery system and standard of care in the state, and access to care issues. The commissioner shall have the discretion to adjust the maximum allowable cost to prevent access to care issues.~~

~~(g)~~ (f) Home infusion therapy services provided by home infusion therapy pharmacies must be paid at rates according to subdivision 8d.

~~(h)~~ (g) The commissioner shall contract with a vendor to conduct a cost of dispensing survey for all pharmacies that are physically located in the state of Minnesota that dispense outpatient drugs under medical assistance. The commissioner shall ensure that the vendor has prior experience in conducting cost of dispensing surveys. Each pharmacy enrolled with the department to dispense outpatient prescription drugs to fee-for-service members must respond to the cost of dispensing survey. The commissioner may sanction a pharmacy under section 256B.064 for failure to respond. The commissioner shall require the vendor to measure a single statewide cost of dispensing for specialty prescription drugs and a single statewide cost of dispensing for nonspecialty prescription drugs for all responding pharmacies to measure the mean, mean weighted by total prescription volume, mean weighted by medical assistance prescription volume, median, median weighted by total prescription volume, and median weighted by total medical assistance prescription volume. The commissioner shall post a copy of the final cost of dispensing survey report on the department's website. The initial survey must be completed no later than January 1, 2021, and repeated every three years. The commissioner shall provide a summary of the results of each cost of dispensing survey and provide recommendations for any changes to the dispensing fee to the chairs and ranking minority members of the legislative committees with jurisdiction over medical assistance pharmacy reimbursement. Notwithstanding section 256.01, subdivision 42, this paragraph does not expire.

~~(i)~~ (h) The commissioner shall increase the ingredient cost reimbursement calculated in paragraphs (a) and ~~(f)~~ (e) by ~~1.8 percent~~ the amount of the wholesale drug distributor tax

for prescription and nonprescription drugs subject to the wholesale drug distributor tax under section 295.52.

(i) The commissioner shall contract with a vendor to create the Minnesota actual acquisition cost (MNAAC) through a periodic survey of enrolled pharmacy providers. Each pharmacy enrolled with the department to dispense outpatient prescription drugs must respond to the periodic surveys. The commissioner may sanction a pharmacy under section 256B.064 for failure to respond. The current MNAAC rates must be publicly available on the department's or vendor's website. The commissioner must require that the MNAAC is measured and calculated at least quarterly, but the MNAAC can be measured and calculated more frequently. The commissioner must ensure that the vendor has an appeal process available to providers for the time between the measurement and calculation of the periodically updated MNAAC rates if price fluctuations result in a MNAAC that is lower than what enrolled providers can purchase a drug for. Establishment of the MNAAC and survey reporting requirements shall not be subject to the requirements of the Administrative Procedure Act. Data provided by pharmacies for the measurement and calculation of the MNAAC is nonpublic data as defined under section 13.02, subdivision 9.

EFFECTIVE DATE. This section is effective January 1, 2027, 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 2024, section 256B.064, subdivision 1a, is amended to read:

Subd. 1a. **Grounds for sanctions.** (a) The commissioner may impose sanctions against any individual or entity that receives payments from medical assistance or provides goods or services for which payment is made from medical assistance for any of the following: (1) fraud, theft, or abuse in connection with the provision of goods and services to recipients of public assistance for which payment is made from medical assistance; (2) a pattern of presentment of false or duplicate claims or claims for services not medically necessary; (3) a pattern of making false statements of material facts for the purpose of obtaining greater compensation than that to which the individual or entity is legally entitled; (4) suspension or termination as a Medicare vendor; (5) refusal to grant the state agency access during regular business hours to examine all records necessary to disclose the extent of services provided to program recipients and appropriateness of claims for payment; (6) failure to repay an overpayment or a fine finally established under this section; (7) failure to correct errors in the maintenance of health service or financial records for which a fine was imposed or after issuance of a warning by the commissioner; and (8) any reason for which an

individual or entity could be excluded from participation in the Medicare program under section 1128, 1128A, or 1866(b)(2) of the Social Security Act. For the purposes of this section, goods or services for which payment is made from medical assistance includes but is not limited to care and services identified in section 256B.0625 or provided pursuant to any federally approved waiver.

(b) The commissioner may impose sanctions against a pharmacy provider for failure to respond to a cost of dispensing survey under section 256B.0625, subdivision 13e, paragraph (h).

(c) The commissioner may impose sanctions against a pharmacy provider for failure to respond to a Minnesota drug acquisition cost survey under section 256B.0625, subdivision 13e, paragraph (i).

EFFECTIVE DATE. This section is effective January 1, 2027, 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 2024, section 256B.69, subdivision 6d, is amended to read:

Subd. 6d. **Prescription drugs.** (a) The commissioner may exclude or modify coverage for prescription drugs from the prepaid managed care contracts entered into under this section in order to increase savings to the state by collecting additional prescription drug rebates.

(b) The contracts must maintain incentives for the managed care plan to manage drug costs and utilization and may require that the managed care plans maintain an open drug formulary. In order to manage drug costs and utilization, the contracts may authorize the managed care plans to use preferred drug lists and prior authorization. The contracts must require that the managed care plans enter into contracts with the state pharmacy benefit manager under section 256B.696, to administer the pharmacy benefit.

(c) This subdivision is contingent on federal approval of the managed care contract changes and the collection of additional prescription drug rebates.

Sec. 5. **[256B.696] PRESCRIPTION DRUGS; STATE PHARMACY BENEFIT MANAGER.**

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

(b) "Managed care enrollees" means medical assistance and MinnesotaCare enrollees receiving coverage from managed care plans.

(c) "Managed care plans" means health plans and county-based purchasing organizations providing coverage to medical assistance and MinnesotaCare enrollees under the managed care delivery system.

(d) "State pharmacy benefit manager" means the pharmacy benefit manager that is a prepaid ambulatory plan as defined in Code of Federal Regulations, title 42, section 438.2, selected pursuant to the procurement process in subdivision 2.

Subd. 2. **Procurement process.** (a) The commissioner must, through a competitive procurement process in compliance with paragraph (b), select a single pharmacy benefit manager to comply with the requirements set forth in subdivision 3.

(b) The commissioner must, when selecting the single pharmacy benefit manager, do the following:

(1) accept applications for entities seeking to become the single pharmacy benefit manager;

(2) establish eligibility criteria an entity must meet in order to become the single pharmacy benefit manager; and

(3) enter into a master contract with a single pharmacy benefit manager.

(c) The contract required under paragraph (b), clause (3), must include a prohibition on:

(1) the single pharmacy benefit manager requiring an enrollee to obtain a drug from a pharmacy owned or otherwise affiliated with the single pharmacy benefit manager; and

(2) paying or reimbursing a pharmacy or pharmacist for the ingredient drug product component of pharmacist services, including a prescription drug, less than the lesser of the national average drug acquisition cost, the Minnesota actual acquisition cost (MNAAC), defined in section 256B.0625, subdivision 13e, paragraph (j), or the maximum allowable cost, defined in section 62W.08, of that pharmacy service or prescription drug, or, if the national average drug acquisition cost is unavailable, the wholesale acquisition cost minus two percent at the time the drug is administered or dispensed, plus a professional dispensing fee equal to the amount of the dispensing fee if it were determined pursuant to section 256B.0625, subdivision 13e.

(d) Applicants for the single pharmacy benefit manager must disclose to the commissioner the following during the procurement process:

(1) any activity, policy, practice, contract, or arrangement of the single pharmacy benefit manager that may directly or indirectly present any conflict of interest with the pharmacy benefit manager's relationship with or obligation to the Department of Human Services, a health plan company, or county-based purchasing organization;

(2) all common ownership, members of a board of directors, managers, or other control of the pharmacy benefit manager or any of the pharmacy benefit manager's affiliated companies with:

(i) a health plan company administering the medical assistance or MinnesotaCare benefits or an affiliate of the health plan company;

(ii) a county-based purchasing organization;

(iii) an entity that contracts on behalf of a pharmacy or any pharmacy services administration organization and its affiliates;

(iv) a drug wholesaler or distributor and its affiliates;

(v) a third-party payer and its affiliates; or

(vi) a pharmacy and its affiliates that are enrolled to provide medical assistance or MinnesotaCare;

(3) any direct or indirect fees, charges, or any kind of assessments imposed by the pharmacy benefit manager on pharmacies licensed in this state with which the pharmacy benefit manager shares common ownership, management, or control, or that are owned, managed, or controlled by any of the pharmacy benefit manager's affiliated companies;

(4) any direct or indirect fees, charges, or any kind of assessments imposed by the pharmacy benefit manager on pharmacies licensed in this state; and

(5) any financial terms and arrangements between the pharmacy benefit manager and a prescription drug manufacturer or labeler, including formulary management, drug substitution programs, educational support claims processing, or data sales fees.

Subd. 3. **Drug coverage.** (a) The commissioner may require the pharmacy benefit manager to modify utilization review limitations, requirements, and strategies imposed by managed care plans on prescription drug coverage.

(b) The state pharmacy benefit manager is responsible for processing all point of sale outpatient pharmacy claims under the managed care delivery system. Managed care plans must use the state pharmacy benefit manager pursuant to the terms of the master contract required under subdivision 2, paragraph (b), clause (3). The pharmacy benefit manager

selected is the exclusive pharmacy benefit manager used by health plan companies and county-based purchasing organizations when providing coverage to enrollees. The commissioner may require the managed care plans and pharmacy benefit manager to directly exchange data and files for members enrolled with managed care plans.

(c) All payment arrangements between the Department of Human Services, managed care plans, and the state pharmacy benefit manager must comply with state and federal statutes, regulations adopted by the Centers for Medicare and Medicaid Services, and any other agreement between the department and the Centers for Medicare and Medicaid Services. The commissioner may change a payment arrangement to comply with this paragraph.

(d) The commissioner must administer and oversee this section to:

(1) ensure proper administration of prescription drug benefits for managed care enrollees; and

(2) increase the transparency of prescription drug prices and other information for the benefit of pharmacies.

Subd. 4. **Prescription drug disclosures.** (a) The state pharmacy benefit manager must, on request from the commissioner, disclose to the commissioner all sources of payment it receives for prescribed drugs, including any financial benefits including drug rebates, discounts, credits, clawbacks, fees, grants, chargebacks, reimbursements, or other payments related to services provided for a managed care plan.

(b) Each managed care plan must disclose to the commissioner, in the format specified by the commissioner, the entity's administrative costs associated with providing pharmacy services under the managed care delivery system.

(c) The state pharmacy benefit manager must provide a written quarterly report to the commissioner containing the following information from the immediately preceding quarter:

(1) the prices the state pharmacy benefit manager negotiated for prescribed drugs under the managed care delivery system. The price must include any rebates the state pharmacy benefit manager received from the drug manufacturer;

(2) any rebate amounts the state pharmacy benefit manager passed on to individual pharmacies;

(3) any changes to the information previously disclosed that is described in subdivision 2, paragraph (d); and

(4) any other information required by the commissioner, including unredacted copies of contracts between the pharmacy benefit manager and enrolled pharmacies.

(d) The commissioner may request and collect additional information and clinical data from the state pharmacy benefit manager.

(e) At the time of contract execution, renewal, or modification, the commissioner must modify the reporting requirements under its managed care contracts as necessary to meet the requirements of this subdivision.

Subd. 5. **Program authority.** (a) To accomplish the requirements of subdivision 3, the commissioner, in consultation with the Formulary Committee established under section 256B.0625, subdivision 13c, has the authority to:

(1) adopt or develop a preferred drug list for managed care plans;

(2) at the commissioner's discretion, engage in price negotiations with prescription drug manufacturers, wholesalers, or group purchasing organizations in place of the state pharmacy benefit manager to obtain price discounts and rebates for prescription drugs for managed care enrollees; and

(3) develop and manage a drug formulary for managed care plans.

(b) The commissioner may contract with one or more entities to perform any of the functions described in paragraph (a).

Subd. 6. **Pharmacies.** The commissioner may review contracts between the state pharmacy benefit manager and pharmacies for compliance with this section and the master contract required under subdivision 2, paragraph (b), clause (3). The commissioner may amend any term or condition of a contract that does not comply with this section or the master contract.

Subd. 7. **Federal approval.** The commissioner must seek any necessary federal approvals to implement this section.

EFFECTIVE DATE. This section is effective January 1, 2027, 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. **DIRECTION TO THE COMMISSIONER OF HUMAN SERVICES; DIRECTED PHARMACY DISPENSING PAYMENTS.**

(a) For plan year 2026, the commissioner shall provide a directed pharmacy dispensing payment of $1.84 per filled prescription under the medical assistance program to eligible

outpatient retail pharmacies in Minnesota to improve and maintain access to pharmaceutical services in rural and underserved areas of the state. Managed care and county-based purchasing plans delivering services under Minnesota Statutes, sections 256B.69 or 256B.692, and any pharmacy benefit managers under contract with these entities, must pay the directed pharmacy dispensing payment to eligible outpatient retail pharmacies for drugs dispensed to medical assistance enrollees. The directed pharmacy dispensing payment is in addition to, and must not supplant or reduce, any other dispensing fee paid by these entities to the pharmacy. Entities paying the directed pharmacy dispensing payment must not reduce other payments to the pharmacy as a result of payment of the directed pharmacy dispensing payment.

(b) For purposes of this section, "eligible outpatient retail pharmacy" means an outpatient retail pharmacy licensed under chapter 151 that is not owned, either directly or indirectly or through an affiliate or subsidiary, by a pharmacy benefit manager licensed under chapter 62W or a health carrier, as defined in Minnesota Statutes, section 62A.011, subdivision 2, and that:

(1) is located in a medically underserved area or primarily serves a medically underserved population, as defined by the United States Department of Health and Human Services Health Resources and Services Administration under United States Code, title 42, section 254; or

(2) shares common ownership with 13 or fewer Minnesota pharmacies.

(c) In order to receive the directed pharmacy dispensing payment, a pharmacy must submit to the commissioner a form, developed by the commissioner, attesting that the pharmacy meets the requirements of paragraph (b).

(d) The commissioner shall set and adjust the amount of the directed pharmacy dispensing payment to reflect the available state and federal funding.

(e) Managed care and county-based purchasing plans, and any pharmacy benefit managers under contract with these entities, shall pay the directed pharmacy dispensing payment to eligible outpatient retail pharmacies. The commissioner shall monitor the effect of this requirement on access to pharmaceutical services in rural and underserved areas of the state. If, for any contract year, federal approval is not received for this section, the commissioner must adjust the capitation rates paid to managed care plans and county-based purchasing plans for that contract year to reflect removal of this section. Contracts between managed care plans and county-based purchasing plans, and any pharmacy benefit managers under contract with these entities, and providers to whom this section 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 section. This section expires if federal approval is not received for this section at any time.

EFFECTIVE DATE. This section is effective January 1, 2026, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

ARTICLE 5
HEALTH CARE FINANCE

Section 1. Minnesota Statutes 2024, 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 under section 245I.04, subdivision 2; a mental health practitioner under section 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, ~~2025~~ 2028, telehealth also includes audio-only communication between a health care provider and a patient ~~in accordance with subdivision 6, paragraph (b)~~ if the communication is a scheduled appointment and the standard of care for that particular service can be met through the use of audio-only communication or if, for substance use disorder treatment services and mental health care services delivered through telehealth by means of audio-only communication, the communication was initiated by the enrollee while in an emergency or crisis situation and a scheduled appointment was not possible due to the need of an immediate response. Telehealth does not include communication between health care providers that consists solely of a telephone conversation, email, or facsimile transmission. Telehealth does not include communication between a health care provider and a patient that consists solely of an email 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, 2025.

Sec. 2. Minnesota Statutes 2024, section 174.30, subdivision 3, is amended to read:

Subd. 3. **Other standards; wheelchair securement; protected transport.** (a) A special transportation service that transports individuals occupying wheelchairs is subject to the provisions of sections 299A.11 to 299A.17 concerning wheelchair securement devices. The commissioners of transportation and public safety shall cooperate in the enforcement of this section and sections 299A.11 to 299A.17 so that a single inspection is sufficient to ascertain compliance with sections 299A.11 to 299A.17 and with the standards adopted

under this section. Representatives of the Department of Transportation may inspect wheelchair securement devices in vehicles operated by special transportation service providers to determine compliance with sections 299A.11 to 299A.17 and to issue certificates under section 299A.14, subdivision 4.

(b) In place of a certificate issued under section 299A.14, the commissioner may issue a decal under subdivision 4 for a vehicle equipped with a wheelchair securement device if the device complies with sections 299A.11 to 299A.17 and the decal displays the information in section 299A.14, subdivision 4.

(c) For vehicles designated as protected transport under section 256B.0625, subdivision 17, paragraph ~~(l)~~ (n), the commissioner of transportation, during the commissioner's inspection, shall check to ensure the safety provisions contained in that paragraph are in working order.

Sec. 3. Minnesota Statutes 2024, section 256.9657, subdivision 2, is amended to read:

Subd. 2. **Hospital surcharge.** (a) Effective October 1, 1992, each Minnesota hospital except facilities of the federal Indian Health Service and regional treatment centers shall pay to the ~~medical assistance account~~ health care access fund a surcharge equal to 1.4 percent of net patient revenues excluding net Medicare revenues reported by that provider to the health care cost information system according to the schedule in subdivision 4.

(b) Effective July 1, 1994, the surcharge under paragraph (a) is increased to 1.56 percent.

(c) Notwithstanding the Medicare cost finding and allowable cost principles, the hospital surcharge is not an allowable cost for purposes of rate setting under sections 256.9685 to 256.9695.

Sec. 4. Minnesota Statutes 2024, section 256.9657, is amended by adding a subdivision to read:

Subd. 2b. **Hospital assessment.** (a) For purposes of this subdivision, the following terms have the meanings given:

(1) "eligible hospital" means a hospital:

(i) licensed under section 144.50;

(ii) located in Minnesota; and

(iii) with a Medicare cost report filed and showing in the Healthcare Cost Report Information System (HCRIS);

(2) "net outpatient revenue" means the value to reflect total outpatient revenue less Medicare revenue as calculated from Worksheet G of the hospital's Medicare cost report; and

(3) "total patient days" means the value to reflect total hospital inpatient days as reported on Worksheet S-3 of the hospital's Medicare cost report.

(b) Subject to paragraphs (k) to (n), each eligible hospital must pay assessments to the hospital directed payment program account, with an aggregate annual assessment amount equal to the sum of the following:

(1) $120.22 multiplied by total patient days; and

(2) 5.96 percent of the hospital's net outpatient revenue.

(c) The assessment amount for calendar years 2026 and 2027 must be based on the total patient days and net outpatient revenue reflected on an eligible hospital's Medicare cost report as follows:

(1) an eligible hospital with a fiscal year end on March 31 or June 30 must use data from a cost report from hospital fiscal year 2022; and

(2) an eligible hospital with a fiscal year end on September 30 or December 31 must use data from a cost report from hospital fiscal year 2021.

The annual assessment amount for calendar years after 2027 must be set for a two-year period and must be based on the total patient days and net outpatient revenue reflected on an eligible hospital's most recent Medicare cost report filed and showing in HCRIS as of August 1 of the year prior to the subsequent two-year period.

(d) The commissioner may, after consultation with the Minnesota Hospital Association, modify the rates of assessment in paragraph (b) as necessary to comply with federal law, obtain or maintain a waiver under Code of Federal Regulations, title 42, section 433.72, or to otherwise maximize under this section federal financial participation for medical assistance.

(e) Eligible hospitals must pay the annual assessment amount under paragraph (b) to the commissioner by paying four equal, quarterly assessments. Eligible hospitals must pay the quarterly assessments by January 1, April 1, July 1, and October 1 each year. Assessments must be paid in the form and manner specified by the commissioner. An eligible hospital is prohibited from paying a quarterly assessment until the eligible hospital has received the applicable invoice under paragraph (e).

(f) The commissioner must provide eligible hospitals with an invoice by December 1 for the assessment due January 1, March 1 for the assessment due April 1, June 1 for the assessment due July 1, and September 1 for the assessment due October 1 each year.

(g) The commissioner must notify each eligible hospital of its estimated annual assessment amount for the subsequent calendar year by October 15 each year.

(h) If any of the dates for assessments or invoices in paragraphs (d) to (f) falls on a holiday, the applicable date is the next business day.

(i) A hospital that has merged with another hospital must have the hospital's assessment revised at the start of the first full fiscal year after the merger is complete. A closed hospital is retroactively responsible for assessments owed for services provided through the final date of operations.

(j) If the commissioner determines that a hospital has underpaid or overpaid an assessment, the commissioner must notify the hospital of the unpaid assessment or of any refund due.

(k) Revenue from an assessment under this subdivision must only be used by the commissioner to pay the nonfederal share of the directed payment program under section 256B.1974.

(l) The commissioner is prohibited from collecting any assessment under this subdivision during any period of time when:

(1) federal financial participation is unavailable or disallowed, or if the approved federal financial participation for the directed payment under section 256B.1974 is less than 51.0 percent; or

(2) a directed payment under section 256B.1974 is not approved by the Centers for Medicare and Medicaid Services.

(m) The commissioner must make the following discounts from the inpatient portion of the assessment under paragraph (b), clause (1), in the stated amount or as necessary to achieve federal approval of the assessment in this section:

(1) Hennepin Healthcare, with a discount of 25 percent off the inpatient portion of the assessment rate;

(2) Mayo Rochester, with a discount of ten percent off the inpatient portion of the assessment rate;

(3) Gillette Children's Hospital, with a discount of 90 percent off the inpatient portion of the assessment rate;

(4) each hospital not included in another discount category, and with greater than $200,000,000 in total medical assistance inpatient and outpatient revenue in fee-for-service and managed care, as reported in the state fiscal year 2022 Medicare cost report, with a discount of five percent off the inpatient portion of the assessment rate; and

(5) the commissioner must provide a discount off the inpatient portion of the assessment rate, as is necessary, in order to ensure that no single hospital is responsible for greater than 12 percent of the total assessment annually collected statewide.

(n) The commissioner must make the following discounts from the outpatient portion of the assessment under paragraph (b), clause (2), in the stated amount or as necessary to achieve federal approval of the assessment in this section:

(1) each critical access hospital or independent hospital located outside a city of the first class and paid under the Medicare prospective payment system, with a discount of 40 percent off the outpatient portion of the assessment rate;

(2) Gillette Children's Hospital, with a discount of 90 percent off the outpatient portion of the assessment rate;

(3) Hennepin Healthcare, with a discount of 60 percent off the outpatient portion of the assessment rate;

(4) Mayo Rochester, with a discount of 20 percent off the outpatient portion of the assessment rate; and

(5) each hospital not included in another discount category, and with greater than $200,000,000 in total medical assistance inpatient and outpatient revenue in fee-for-service and managed care, as reported in the state fiscal year 2022 Medicare cost report, with a discount of ten percent off the outpatient portion of the assessment rate.

(o) The commissioner must fully exempt the following from the assessment in this section:

(1) federal Indian Health Service facilities;

(2) state-owned or state-operated regional treatment centers and all state-operated services;

(3) federal Veterans Administration Medical Centers; and

(4) long-term acute care hospitals.

(p) If the federal share of the hospital directed payment program under section 256B.1974 is increased as the result of an increase to the federal medical assistance percentage, then the commissioner must reduce the assessment on a uniform percentage basis across eligible hospitals on which the assessment is imposed, such that the aggregate amount collected from hospitals under this subdivision does not exceed the total amount needed to maintain the same aggregate state and federal funding level for the directed payments authorized by section 256B.1974.

(q) Hospitals subject to the assessment under this subdivision must submit to the commissioner on an annual basis, in the form and manner specified by the commissioner in consultation with the Minnesota Hospital Association, all documentation necessary to determine the assessment amounts under this subdivision.

EFFECTIVE DATE. (a) This section is effective the later of January 1, 2026, or federal approval of all of the following:

(1) the waiver for the assessment required under this section; and

(2) the amendments in this act to Minnesota Statutes, sections 256B.1973 and 256B.1974.

(b) The commissioner of human services shall notify the revisor of statutes when federal approval for all amendments set forth in paragraph (a) is obtained.

Sec. 5. Minnesota Statutes 2024, section 256.969, subdivision 2f, is amended to read:

Subd. 2f. **Alternate inpatient payment rate.** (a) Effective January 1, 2022, for a hospital eligible to receive disproportionate share hospital payments under subdivision 9, paragraph (d), clause (6), the commissioner shall reduce the amount calculated under subdivision 9, paragraph (d), clause (6), by 99 percent and compute an alternate inpatient payment rate. The alternate payment rate shall be structured to target a total aggregate reimbursement amount equal to what the hospital would have received for providing fee-for-service inpatient services under this section to patients enrolled in medical assistance had the hospital received the entire amount calculated under subdivision 9, paragraph (d), clause (6). This paragraph expires when paragraph (b) becomes effective.

(b) For hospitals eligible to receive payment under section 256B.1973 or 256B.1974 and meeting the criteria in subdivision 9, paragraph (d), the commissioner shall reduce the amount calculated under subdivision 9, paragraph (d), by one percent and compute an alternate inpatient payment rate. The alternate payment rate shall be structured to target a total aggregate reimbursement amount equal to what the hospital would have received for providing fee-for-service inpatient services under this section to patients enrolled in medical

assistance had the hospital received 99 percent of the entire amount calculated under subdivision 9, paragraph (d). Hospitals that do not meet federal requirements for Medicaid disproportionate share hospitals are not eligible for this alternate payment.

EFFECTIVE DATE. (a) Paragraph (b) of this section is effective the later of January 1, 2026, or federal approval of all of the following:

(1) this section; and

(2) the amendments in this act to Minnesota Statutes, sections 256B.1973 and 256B.1974.

(b) The commissioner of human services shall notify the revisor of statutes when federal approval for all amendments set forth in paragraph (a) is obtained.

Sec. 6. Minnesota Statutes 2024, section 256B.0371, subdivision 3, is amended to read:

Subd. 3. **Contingent contract with dental administrator.** (a) The commissioner shall determine the extent to which managed care ~~and county-based purchasing~~ plans in the aggregate meet the performance benchmark specified in subdivision 1 for coverage year 2024. If managed care ~~and county-based purchasing~~ plans in the aggregate fail to meet the performance benchmark, the commissioner, after issuing a request for information followed by a request for proposals, shall contract with a dental administrator to administer dental services beginning January 1, ~~2026~~ 2028, for ~~all~~ recipients of medical assistance and MinnesotaCare~~, including persons~~ who are served under fee-for-service and persons receiving services through managed care ~~and county-based purchasing~~ plans.

(b) The dental administrator must provide administrative services, including but not limited to:

(1) provider recruitment, contracting, and assistance;

(2) recipient outreach and assistance;

(3) utilization management and reviews of medical necessity for dental services;

(4) dental claims processing;

(5) coordination of dental care with other services;

(6) management of fraud and abuse;

(7) monitoring access to dental services statewide;

(8) performance measurement;

(9) quality improvement and evaluation; ~~and~~

(10) management of third-party liability requirements.; and

(11) establishment of grievance and appeals processes for providers and enrollees that the commissioner can monitor.

(c) Dental administrator payments to contracted dental providers must be ~~at the~~ based on rates ~~established under sections 256B.76 and 256L.11~~ recommended by the dental access working group. If the recommended rates are not established in law prior to July 1, 2027, then dental administrator payments to contracted dental providers must be at the rates established under sections 256B.76 and 256L.11.

(d) Recipients must be given a choice of dental provider, including any provider who agrees to provider participation requirements and payment rates established by the commissioner and dental administrator. The dental administrator must comply with the network adequacy and geographic access requirements that apply to managed care ~~and county-based purchasing~~ plans for dental services under section 62K.14.

(e) The contract with the dental administrator must include ~~a provision that states that if the dental administrator fails to meet, by calendar year 2029, a performance benchmark under which at least 55 percent of children and adults who were continuously enrolled for at least 11 months in either medical assistance or MinnesotaCare received at least one dental visit during the calendar year, the contract must be terminated and the commissioner must enter into a contract with a new dental administrator as soon as practicable~~ performance benchmarks, accountability measures, and progress rewards based on the recommendations from the dental access working group.

~~(f) The commissioner shall implement this subdivision in consultation with representatives of providers who provide dental services to patients enrolled in medical assistance or MinnesotaCare, including but not limited to providers serving primarily low-income and socioeconomically complex populations, and with representatives of managed care plans and county-based purchasing plans.~~

Sec. 7. Minnesota Statutes 2024, section 256B.04, subdivision 12, is amended to read:

Subd. 12. **Limitation on services.** (a) The commissioner shall place limits on the types of services covered by medical assistance, the frequency with which the same or similar services may be covered by medical assistance for an individual recipient, and the amount paid for each covered service. The state agency shall promulgate rules establishing maximum reimbursement rates for emergency and nonemergency transportation.

The rules shall provide:

(1) an opportunity for all recognized transportation providers to be reimbursed for nonemergency transportation consistent with the maximum rates established by the agency; and

(2) reimbursement of public and private nonprofit providers serving the population with a disability generally at reasonable maximum rates that reflect the cost of providing the service regardless of the fare that might be charged by the provider for similar services to individuals other than those receiving medical assistance or medical care under this chapter. This paragraph expires July 1, 2026, for medical assistance fee-for-service and January 1, 2027, for prepaid medical assistance.

(b) The commissioner shall encourage providers reimbursed under this chapter to coordinate their operation with similar services that are operating in the same community. To the extent practicable, the commissioner shall encourage eligible individuals to utilize less expensive providers capable of serving their needs. This paragraph expires July 1, 2026, for medical assistance fee-for-service and January 1, 2027, for prepaid medical assistance.

(c) For the purpose of this subdivision and section 256B.02, subdivision 8, and effective on January 1, 1981, "recognized provider of transportation services" means an operator of special transportation service as defined in section 174.29 that has been issued a current certificate of compliance with operating standards of the commissioner of transportation or, if those standards do not apply to the operator, that the agency finds is able to provide the required transportation in a safe and reliable manner. Until January 1, 1981, "recognized transportation provider" includes an operator of special transportation service that the agency finds is able to provide the required transportation in a safe and reliable manner. This paragraph expires July 1, 2026, for medical assistance fee-for-service and January 1, 2027, for prepaid medical assistance.

(d) Effective July 1, 2026, for medical assistance fee-for-service and January 1, 2027, for prepaid medical assistance, the commissioner shall place limits on the types of services covered by medical assistance, the frequency with which the same or similar services may be covered by medical assistance for an individual recipient, and the amount paid for each covered service.

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

Sec. 8. Minnesota Statutes 2024, 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;

(6) drugs; and

(7) quitline services as described in section 256B.0625, subdivision 68, paragraph (c).

This paragraph expires July 1, 2026, for medical assistance fee-for-service and January 1, 2027, for prepaid medical assistance.

(b) Effective July 1, 2026, for medical assistance fee-for-service and January 1, 2027, for prepaid medical assistance, 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; and

(viii) electronic diagnostic, therapeutic, and life-support systems;

(5) nonemergency medical transportation; and

(6) drugs.

~~(b)~~ (c) Rate changes and recipient cost-sharing under this chapter and chapter 256L do not affect contract payments under this subdivision unless specifically identified.

~~(c)~~ (d) 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. This paragraph expires July 1, 2026, for medical assistance fee-for-service and January 1, 2027, for prepaid medical assistance.

(e) Effective July 1, 2026, for medical assistance fee-for-service and January 1, 2027, for prepaid medical assistance, the commissioner may not utilize volume purchase through competitive bidding and negotiation under the provisions of chapter 16C for incontinence products and related supplies.

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

Sec. 9. Minnesota Statutes 2024, 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 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.

(e) For purposes of this subdivision, unless otherwise covered under this chapter:

(1) "telehealth" means the delivery of health care services or consultations using real-time two-way interactive audio and visual communication or accessible telehealth 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, email, or facsimile transmission or as specified by law, except that between July 1, 2025, and July 1, 2028, telehealth includes communication between a health care provider and a patient that solely consists of audio-only communication;

(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 245I.04, subdivision 10; a mental health certified family peer specialist under section 245I.04, subdivision 12; a mental health rehabilitation worker under section 245I.04, subdivision 14; a mental health behavioral aide under section 245I.04, subdivision 16; a treatment coordinator under section 245G.11, subdivision 7; an alcohol and drug counselor under section 245G.11, subdivision 5; or 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, 2025.

Sec. 10. Minnesota Statutes 2024, 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) 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. This paragraph expires July 1, 2026, for medical assistance fee-for-service and January 1, 2027, for prepaid medical assistance.

(c) 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 transportation, within the meaning of "public transportation" 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 (p).

(d) 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.

(e) 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.

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

(1) adhere to the policies defined by the commissioner;

(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. This paragraph expires July 1, 2026, for medical assistance fee-for-service and January 1, 2027, for prepaid medical assistance.

(g) Effective July 1, 2026, for medical fee-for-service and January 1, 2027, for prepaid medical assistance, the administrative agency of nonemergency medical transportation must:

(1) adhere to the policies defined by the commissioner;

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

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

~~(g)~~ (h) 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 ~~(l)~~ (n), clauses (4), (5), (6), and (7). This paragraph expires July 1, 2026, for medical assistance fee-for-service and January 1, 2027, for prepaid medical assistance.

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

~~(i)~~ (j) 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. This paragraph expires July 1, 2026, for medical assistance fee-for-service and January 1, 2027, for prepaid medical assistance.

(k) Effective July 1, 2026, for medical assistance fee-for-service and January 1, 2027, for prepaid medical assistance, 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 administrator.

~~(j)~~ (l) 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.

~~(k)~~ (m) The administrative agency shall use the level of service process established by the commissioner 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.

~~(l)~~ (n) 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.

~~(m)~~ (o) The local agency shall be the single administrative agency and shall administer and reimburse for modes defined in paragraph ~~(l)~~ (n) according to paragraphs ~~(p) and (q)~~ (r) to (t) 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. This paragraph expires July 1, 2026, for medical assistance fee-for-service and January 1, 2027, for prepaid medical assistance.

~~(n)~~ (p) The commissioner shall:

(1) 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.

~~(o)~~ (q) 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. This paragraph expires July 1, 2026, for medical assistance fee-for-service and January 1, 2027, for prepaid medical assistance.

~~(p)~~ (r) Payments for nonemergency medical transportation must be paid based on the client's assessed mode under paragraph ~~(k)~~ (m), 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 $12.10 for the base rate and $1.43 per mile when provided by a nonemergency medical transportation provider;

(4) $14.30 for the base rate and $1.43 per mile for assisted transport;

(5) $19.80 for the base rate and $1.70 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. This paragraph expires July 1, 2026, for medical assistance fee-for-service and January 1, 2027, for prepaid medical assistance.

(s) Effective July 1, 2026, for medical assistance fee-for-service and January 1, 2027, for prepaid medical assistance, payments for nonemergency medical transportation must be paid based on the client's assessed mode under paragraph (m), not the type of vehicle used to provide the service.

~~(q)~~ (t) 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 ~~(p)~~ (r), 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 ~~(p)~~ (r), 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 ~~(p)~~ (r), clauses (1) to (7). This paragraph expires July 1, 2026, for medical assistance fee-for-service and January 1, 2027, for prepaid medical assistance.

~~(r)~~ (u) For purposes of reimbursement rates for nonemergency medical transportation services under paragraphs ~~(p) and (q)~~ (r) to (t), the zip code of the recipient's place of residence shall determine whether the urban, rural, or super rural reimbursement rate applies. This paragraph expires July 1, 2026, for medical assistance fee-for-service and January 1, 2027, for prepaid medical assistance.

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

~~(t)~~ (w) 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 ~~(p)~~ (r) 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. This paragraph expires July 1, 2026, for medical assistance fee-for-service and January 1, 2027, for prepaid medical assistance.

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

Sec. 11. Minnesota Statutes 2024, 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 services provided statewide on or after January 1, 2026, medical assistance payment rates for ambulance services are increased by 13.68 percent. Capitation payments made to managed care plans and county-based purchasing plans for ambulance services provided on or after January 1, 2026, must be increased to reflect this rate increase.

~~(c)~~ (d) 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 (a) 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.

~~(d)~~ (e) Managed care plans and county-based purchasing plans must provide a fuel adjustment for ambulance services rates when fuel exceeds $3 per gallon. 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 paragraph. This paragraph expires if federal approval is not received for this paragraph at any time.

Sec. 12. Minnesota Statutes 2024, section 256B.0625, is amended by adding a subdivision to read:

Subd. 18i. **Administration of nonemergency medical transportation.** Effective July 1, 2026, for medical assistance fee-for-service and January 1, 2027, for prepaid medical assistance, the commissioner must contract either statewide or regionally for the administration of the nonemergency medical transportation program in compliance with the provisions of this chapter. The contract must include the administration of the nonemergency medical transportation benefit for those enrolled in managed care as described in section 256B.69.

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

Sec. 13. Minnesota Statutes 2024, 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), or, upon federal approval, for FQHCs that are also urban Indian organizations under Title V of the federal Indian Health Improvement Act, as provided under paragraph (k).

(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 establish an encounter payment rate that is equivalent to the all inclusive rate (AIR) payment established by the Indian Health Service and published in the Federal Register. The encounter rate must be updated annually and must reflect the changes in the AIR established by the Indian Health Service each calendar year. FQHCs that are also urban Indian organizations under Title V of the federal Indian Health Improvement Act may elect to be paid: (1) at the encounter rate established under this paragraph; (2) under the alternative payment methodology described in paragraph (l); or (3) under the federally required prospective payment system described in paragraph (f). FQHCs that elect to be paid at the encounter rate established under this paragraph must

continue to meet all state and federal requirements related to FQHCs and urban Indian organizations, and must maintain their statuses as FQHCs and urban Indian organizations.

(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) fundraising, 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, when establishing organization encounter rates under this section for FQHCs and rural health clinics resulting from a merger of existing clinics or the acquisition of an existing clinic by another existing clinic, must use the combined costs and caseloads from the clinics participating in the merger or acquisition to set the encounter rate for the new clinic organization resulting from the merger or acquisition. The scope of services for the newly formed clinic must be inclusive of the scope of services of the clinics participating in the merger or acquisition;

~~(13)~~ (14) 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)~~ (15) 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, 2023, 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. Requirements that otherwise apply to an FQHC covered in this subdivision do not apply to a Tribal FQHC enrolled under this paragraph, except that any requirements necessary to comply with federal regulations do apply to a Tribal FQHC. The commissioner shall establish an alternative payment method for a Tribal FQHC 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.

(n) FQHC reimbursement for mental health targeted case management services is limited to:

(1) only those services described under subdivision 20 and provided in accordance with contracts executed with counties authorized to subcontract for mental health targeted case management services; and

(2) an FQHC's actual incurred costs as separately reported on the cost report submitted to the Centers for Medicare and Medicaid Services and further identified in reports submitted to the commissioner.

(o) Counties contracting with FQHCs for mental health targeted case management remain responsible for the nonfederal share of the cost of the provided mental health targeted case management services. The commissioner must bill each county for the nonfederal share of the mental health targeted case management costs as reported by the FQHC.

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

Sec. 14. Minnesota Statutes 2024, section 256B.1973, subdivision 5, is amended to read:

Subd. 5. **Commissioner's duties; state-directed fee schedule requirement.** (a) For each federally approved directed payment arrangement that is a state-directed fee schedule requirement, the commissioner shall determine a uniform adjustment factor to be applied to each claim submitted by an eligible provider to a health plan. The uniform adjustment factor shall be determined using the average commercial payer rate or using another method acceptable to the Centers for Medicare and Medicaid Services if the average commercial payer rate is not approved, minus the amount necessary for the plan to satisfy tax liabilities under sections 256.9657 and 297I.05 attributable to the directed payment arrangement. The commissioner shall ensure that the application of the uniform adjustment factor maximizes the allowable directed payments and does not result in payments exceeding federal limits, and may use an annual settle-up process. The directed payment ~~shall~~ may be specific to each health plan and prospectively incorporated into capitation payments for that plan.

(b) For each federally approved directed payment arrangement that is a state-directed fee schedule requirement, the commissioner shall develop a plan for the initial implementation of the state-directed fee schedule requirement to ensure that the eligible provider receives the entire permissible value of the federally approved directed payment arrangement. If federal approval of a directed payment arrangement under this subdivision is retroactive, the commissioner shall make a onetime pro rata increase to the uniform adjustment factor and the initial payments in order to include claims submitted between the retroactive federal approval date and the period captured by the initial payments.

Sec. 15. Minnesota Statutes 2024, section 256B.1973, is amended by adding a subdivision to read:

Subd. 9. **Interaction with other directed payments.** An eligible provider under subdivision 3 may participate in the hospital directed payment program under section 256B.1974 for inpatient hospital services, outpatient hospital services, or both. A provider participating in the hospital directed payment program must not receive a directed payment under this section for any provider classes paid via the hospital directed payment program.

A hospital subject to this section must notify the commissioner in writing no later than 30 days after enactment of this subdivision of its intention to participate in the hospital directed payment program under section 256B.1974 for inpatient hospital services, outpatient hospital services, or both. The election under this subdivision is a onetime election, except that if an eligible provider elects to participate in the hospital directed payment program, and the hospital directed payment program expires, then the eligible provider may thereafter elect to participate in the directed payment under this section.

EFFECTIVE DATE. (a) This section is effective on the later of January 1, 2026, or federal approval of all of the following:

(1) the waiver for the assessment required under Minnesota Statutes, section 256.9657, subdivision 2b; and

(2) the amendments in this act to Minnesota Statutes, section 256B.1974.

(b) The commissioner of human services shall notify the revisor of statutes when federal approval for all amendments set forth in paragraph (a) is obtained.

Sec. 16. **[256B.1974] HOSPITAL DIRECTED PAYMENT PROGRAM.**

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

(b) "Health plan" means a managed care plan or county-based purchasing plan that is under contract with the commissioner to deliver services to medical assistance enrollees under section 256B.69.

(c) "Eligible hospital" has the meaning given in section 256.9657, subdivision 2b, paragraph (a), clause (1).

Subd. 2. **Required conditions for program.** The hospital directed payment program is contingent on the satisfaction of all requirements necessary for the collection of an assessment under section 256.9657, and must conform with the requirements for permissible directed managed care organization expenditures under section 256B.6928, subdivision 5.

Subd. 3. **Commissioner's duties; state-directed fee schedule requirement.** (a) For each federally approved directed payment program that is a state-directed fee schedule requirement that includes a quarterly payment amount to be submitted by each health plan to each eligible hospital, the commissioner must determine the quarterly payment amount using the statewide average commercial payer rate, or using another method acceptable to the Centers for Medicare and Medicaid Services if the statewide average commercial payer

rate is not approved. The commissioner must ensure that the application of the quarterly payment amounts maximizes the amount generated by the hospital assessment in section 256.9657, subdivision 2b, for allowable directed payments and does not result in payments exceeding federal limits.

(b) The commissioner must use an annual settle-up process that occurs within the time period allowed for medical assistance managed care claims adjustments.

(c) On and after January 1, 2028, if the federal regulations set forth in Code of Federal Regulations, title 42, parts 430, 438, and 457, remain effective, the hospital directed payment program may be specific to each health plan and prospectively incorporated into capitation payments for that plan.

(d) For each federally approved directed payment program that is a state-directed fee schedule requirement, the commissioner must develop a plan for the initial implementation of the state-directed fee schedule requirement to ensure that eligible hospitals receive the entire permissible value of the federally approved directed payment.

(e) Directed payments under this section must only be used to supplement, and not supplant, medical assistance reimbursement to eligible hospitals. The directed payment program must not modify, reduce, or offset the medical assistance payment rates determined for each eligible hospital as required by section 256.969.

(f) The commissioner must require health plans to make quarterly directed payments according to this section.

(g) Health plans must make quarterly directed payments using electronic funds transfers, if the eligible hospital provides the information necessary to process such transfers, and in accordance with directions provided by the commissioner. Health plans must make quarterly directed payments:

(1) for the first two quarters for which such payments are due, within 30 calendar days of the date the commissioner issued sufficient payments to the health plan to make the directed payments according to this section; and

(2) for all subsequent quarters, within ten calendar days of the date the commissioner issued sufficient payments to the health plan to make the directed payments according to this section.

The commissioner of human services must publish on the Department of Human Services website, on a quarterly basis, the dates that the health plans completed their required quarterly payments under this section.

(h) Payments to health plans that would be paid consistent with actuarial certification and enrollment in the absence of the increased capitation payments under this section must not be reduced as a result of this section.

(i) The commissioner must publish all directed payments resulting from this section owed to each eligible hospital from each health plan on the Department of Human Services website for at least two years. All calculations and reports must be posted no later than the first day of the quarter for which the payments are to be issued.

(j) By December 1 each year, the commissioner must notify each eligible hospital of any changes to the payment methodologies in this section, including but not limited to changes in the directed payment rates, the aggregate directed payment amount for all eligible hospitals, and the eligible hospital's directed payment amount for the upcoming calendar year.

(k) The commissioner must distribute payments required under this section for each eligible hospital within 30 days of a quarterly assessment under section 256.9657, subdivision 2b, being received. The commissioner must pay the directed payments to health plans under contract no later than January 1, April 1, July 1, and October 1 each year.

(l) A hospital is not entitled to payments under this section until it is an eligible hospital. An eligible hospital that has merged with another hospital must have its payments under this section revised at the start of the first full fiscal year after the merger is complete. A closed eligible hospital is entitled to the payments under this section for services provided through the final date of operations.

Subd. 4. **Health plan duties; submission of claims.** Each health plan must submit to the commissioner, in accordance with its contract with the commissioner to serve as a managed care organization in medical assistance, payment information for each claim paid to an eligible hospital for services provided to a medical assistance enrollee. Health plans must allow each eligible hospital to review the health plan's own paid claims detail to enable proper validation that the medical assistance managed care claims volume and content is consistent with the eligible hospital's internal records. To support the validation process for the directed payment program, health plans must permit the commissioner to share inpatient and outpatient claims-level details with eligible hospitals identifying only those claims where the prepaid medical assistance program under section 256B.69 is the payer source. Eligible hospitals must provide notice of discrepancies in claims paid to the commissioner in a form determined by the commissioner. The commissioner is authorized to determine the final disposition of the validation process for disputed claims.

Subd. 5. **Health plan duties; directed payment add-on.** (a) Each health plan must make, in accordance with its contract with the commissioner to serve as a managed care organization in medical assistance, a directed payment to each eligible hospital. The amount of the directed payment to the eligible hospital must be equal to the payment amounts the plan received from the commissioner for such hospital.

(b) Health plans are prohibited from:

(1) setting, establishing, or negotiating reimbursement rates with an eligible hospital in a manner that directly or indirectly takes into account a directed payment that a hospital receives under this section;

(2) unnecessarily delaying a directed payment to an eligible hospital; or

(3) recouping or offsetting a directed payment for any reason, except as expressly authorized by the commissioner.

Subd. 6. **Hospital duties; quarterly supplemental directed payment add-on.** (a) An eligible hospital receiving a directed payment under this section is prohibited from:

(1) setting, establishing, or negotiating reimbursement rates with a managed care organization in a manner that directly or indirectly takes into account a directed payment that an eligible hospital receives under this section; or

(2) directly passing on the cost of an assessment to patients or nonmedical assistance payers, including as a fee or rate increase.

(b) An eligible hospital that violates this subdivision is prohibited from receiving a directed payment under this section for the remainder of the calendar year. This subdivision does not prohibit an eligible hospital from negotiating with a payer for a rate increase.

(c) Any eligible hospital receiving a directed payment under this section must meet the commissioner's standards for directed payments as described in subdivision 7.

Subd. 7. **State minimum policy goals established.** (a) The effect of the directed payments under this section must align with the state's policy goals for medical assistance enrollees. The directed payments must be used to maintain quality and access to a full range of health care delivery mechanisms for medical assistance enrollees, and specifically provide improvement for one of the following quality measures:

(1) overall well child visit rates;

(2) maternal depression screening rates; or

(3) colon cancer screening rates.

(b) The commissioner, in consultation with the Minnesota Hospital Association, must submit to the Centers for Medicare and Medicaid Services a quality measures performance evaluation criteria and methodology to regularly measure access to care and the achievement of state policy goals described in this subdivision.

(c) The quality measures evaluation data, as determined by paragraph (b), must be reported to the Centers for Medicare and Medicaid Services after at least 12 months of directed payments to hospitals.

Subd. 8. **Administrative review.** Before making the payments required under this section, and on at least an annual basis, the commissioner must consult with and provide for review of the payment amounts by a permanent select committee established by the Minnesota Hospital Association. Any data or information reviewed by members of the committee are data not on individuals, as defined in section 13.02. The committee's members may not include any current employee or paid consultant of any hospital.

EFFECTIVE DATE. (a) This section is effective the later of January 1, 2026, or federal approval for all of the following:

(1) the amendments in this act to add Minnesota Statutes, section 256.9657, subdivision 2b; and

(2) the amendments in this act to this section.

(b) The commissioner of human services shall notify the revisor of statutes when federal approval for all amendments set forth in paragraph (a) is obtained.

Sec. 17. **[256B.1975] HOSPITAL DIRECTED PAYMENT PROGRAM ACCOUNT.**

Subdivision 1. **Account established; appropriation.** (a) The hospital directed payment program account is created in the special revenue fund in the state treasury.

(b) Money in the account, including interest earned, is annually appropriated to the commissioner for the purposes specified in section 256B.1974.

(c) Transfers from this account to another fund are prohibited, except as necessary to make the payments required under section 256B.1974.

Subd. 2. **Reports to the legislature.** By January 15, 2027, and each January 15 thereafter, the commissioner must submit a report to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services policy and finance that details the activities and uses of money in the hospital directed payment program

account, including the metrics and outcomes of the policy goals established by section 256B.1974, subdivision 7.

EFFECTIVE DATE. This section is effective on the later of January 1, 2026, or federal approval of the amendments in this act to add Minnesota Statutes, section 256.9657, subdivision 2b. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 18. Minnesota Statutes 2024, section 256B.69, subdivision 3a, is amended to read:

Subd. 3a. **County authority.** (a) The commissioner, when implementing the medical assistance prepayment program within a county, must include the county board in the process of development, approval, and issuance of the request for proposals to provide services to eligible individuals within the proposed county. County boards must be given reasonable opportunity to make recommendations regarding the development, issuance, review of responses, and changes needed in the request for proposals. The commissioner must provide county boards the opportunity to review each proposal based on the identification of community needs under chapters 142F and 145A and county advocacy activities. If a county board finds that a proposal does not address certain community needs, the county board and commissioner shall continue efforts for improving the proposal and network prior to the approval of the contract. The county board shall make recommendations regarding the approval of local networks and their operations to ensure adequate availability and access to covered services. The provider or health plan must respond directly to county advocates and the state prepaid medical assistance ombudsperson regarding service delivery and must be accountable to the state regarding contracts with medical assistance funds. The county board may recommend a maximum number of participating health plans after considering the size of the enrolling population; ensuring adequate access and capacity; considering the client and county administrative complexity; and considering the need to promote the viability of locally developed health plans. The county board or a single entity representing a group of county boards and the commissioner shall mutually select health plans for participation at the time of initial implementation of the prepaid medical assistance program in that county or group of counties and at the time of contract renewal. The commissioner shall also seek input for contract requirements from the county or single entity representing a group of county boards at each contract renewal and incorporate those recommendations into the contract negotiation process.

(b) At the option of the county board, the board may develop contract requirements related to the achievement of local public health goals to meet the health needs of medical

assistance enrollees. These requirements must be reasonably related to the performance of health plan functions and within the scope of the medical assistance benefit set. If the county board and the commissioner mutually agree to such requirements, the department shall include such requirements in all health plan contracts governing the prepaid medical assistance program in that county at initial implementation of the program in that county and at the time of contract renewal. The county board may participate in the enforcement of the contract provisions related to local public health goals.

(c) For counties in which a prepaid medical assistance program has not been established, the commissioner shall not implement that program if a county board submits an acceptable and timely preliminary and final proposal under section 256B.692, until county-based purchasing is no longer operational in that county. For counties in which a prepaid medical assistance program is in existence on or after September 1, 1997, the commissioner must terminate contracts with health plans according to section 256B.692, subdivision 5, if the county board submits and the commissioner accepts a preliminary and final proposal according to that subdivision. The commissioner is not required to terminate contracts that begin on or after September 1, 1997, according to section 256B.692 until two years have elapsed from the date of initial enrollment. This paragraph expires upon the effective date of paragraph (d).

(d) For counties in which a prepaid medical assistance program is in existence on or after September 1, 1997, the commissioner must terminate contracts with health plans according to section 256B.692, subdivision 5, if the county board submits and the commissioner accepts a preliminary and final proposal according to that subdivision. This paragraph is effective January 1, 2027, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

~~(d)~~ (e) In the event that a county board or a single entity representing a group of county boards and the commissioner cannot reach agreement regarding: (i) the selection of participating health plans in that county; (ii) contract requirements; or (iii) implementation and enforcement of county requirements including provisions regarding local public health goals, the commissioner shall resolve all disputes after taking into account the recommendations of a three-person mediation panel. The panel shall be composed of one designee of the president of the association of Minnesota counties, one designee of the commissioner of human services, and one person selected jointly by the designee of the commissioner of human services and the designee of the Association of Minnesota Counties. Within a reasonable period of time before the hearing, the panelists must be provided all

documents and information relevant to the mediation. The parties to the mediation must be given 30 days' notice of a hearing before the mediation panel.

~~(e)~~ (f) If a county which elects to implement county-based purchasing ceases to implement county-based purchasing, it is prohibited from assuming the responsibility of county-based purchasing for a period of five years from the date it discontinues purchasing.

~~(f)~~ (g) The commissioner shall not require that contractual disputes between county-based purchasing entities and the commissioner be mediated by a panel that includes a representative of the Minnesota Council of Health Plans.

~~(g)~~ (h) At the request of a county-purchasing entity, the commissioner shall adopt a contract reprocurement or renewal schedule under which all counties included in the entity's service area are reprocured or renewed at the same time.

~~(h)~~ (i) The commissioner shall provide a written report under section 3.195 to the chairs of the legislative committees having jurisdiction over human services in the senate and the house of representatives describing in detail the activities undertaken by the commissioner to ensure full compliance with this section. The report must also provide an explanation for any decisions of the commissioner not to accept the recommendations of a county or group of counties required to be consulted under this section. The report must be provided at least 30 days prior to the effective date of a new or renewed prepaid or managed care contract in a county.

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

Sec. 19. **[256B.695] COUNTY-ADMINISTERED RURAL MEDICAL ASSISTANCE PROGRAM.**

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

(b) "CARMA" means the county-administered rural medical assistance program established under this section.

(c) "Commissioner" means the commissioner of human services.

(d) "Eligible individual" means an individual who is:

(1) residing in a county administering CARMA; and

(2) eligible for medical assistance, MinnesotaCare, Minnesota Senior Health Options (MSHO), Minnesota Senior Care Plus (MSC+), or Special Needs Basic Care (SNBC).

(e) "Enrollee" means an individual enrolled in CARMA.

(f) "PMAP" means the prepaid medical assistance program under section 256B.69.

(g) "Rural county" has the meaning given to "rural area" in Code of Federal Regulations, title 42, section 438.52.

Subd. 2. **Program established.** A CARMA is established to:

(1) provide a county-owned and county-administered alternative to PMAP;

(2) facilitate integration of health care, public health, and social services to address health-related social needs in rural communities;

(3) account for the fewer enrollees and local providers of health care and community services in rural communities; and

(4) promote accountability for health outcomes, health equity, customer service, community outreach, and cost of care.

Subd. 3. **County participation.** Each county or group of counties authorized under section 256B.692 may administer CARMA for any or all eligible individuals as an alternative to PMAP, MinnesotaCare, MSHO, MSC+, or SNBC programs. Counties choosing and authorized to administer CARMA are exempt from the procurement process as required under section 256B.69.

Subd. 4. **Oversight and regulation.** CARMA is governed by sections 256B.69 and 256B.692, unless otherwise provided for under this section. The commissioner must develop and implement a procurement process requiring applications from county-based purchasing plans interested in offering CARMA. The procurement process must require county-based purchasing plans to demonstrate compliance with federal and state regulatory requirements and the ability to meet the goals of the program set forth in subdivision 2. The commissioner must review and approve or disapprove applications.

Subd. 5. **CARMA enrollment.** (a) Subject to paragraphs (d) and (e), eligible individuals must be automatically enrolled in CARMA, but may decline enrollment. Eligible individuals may enroll in fee-for-service medical assistance. Eligible individuals may change their CARMA elections on an annual basis.

(b) Eligible individuals must be able to enroll in CARMA through the selection process in accordance with the election period established in section 256B.69, subdivision 4, paragraph (e).

(c) Enrollees who were not previously enrolled in the medical assistance program or MinnesotaCare can change their selection once within the first year after enrollment in CARMA. Enrollees who were not previously in CARMA have 90 days to make a change and changes are allowed for additional special circumstances.

(d) The commissioner may offer a second health plan other than, and in addition to, CARMA to eligible individuals when another health plan is required by federal law or rule. The commissioner may offer a replacement plan to eligible individuals, as determined by the commissioner, when counties administering CARMA have their contract terminated for cause.

(e) The commissioner may, on a county-by-county basis, offer a health plan other than, and in addition to, CARMA to individuals who are eligible for both Medicare and medical assistance due to age or disability if the commissioner deems it necessary for enrollees to have another choice of health plan. Factors the commissioner must consider when determining if the other health plan is necessary include the number of available Medicare Advantage Plan options that are not special needs plans in the county, the size of the enrolling population, the additional administrative burden placed on providers and counties by multiple health plan options in a county, the need to ensure the viability and success of the CARMA program, and the impact to the medical assistance program.

(f) In counties where the commissioner is required by federal law or elects to offer a second health plan other than CARMA pursuant to paragraphs (d) and (e), eligible enrollees who do not select a health plan at the time of enrollment must automatically be enrolled in CARMA.

(g) This subdivision supersedes section 256B.694.

Subd. 6. **Benefits and services.** (a) Counties or groups of counties administering CARMA must cover all benefits and services required to be covered by medical assistance under section 256B.0625.

(b) Counties or groups of counties administering CARMA may include health-related social needs (HRSN) benefits as covered services under medical assistance as of January 1, 2030. Coverage for HRSN must be based on the assessed needs of housing, food, transportation, utilities, and interpersonal safety.

(c) Counties or groups of counties administering CARMA may reimburse enrollees directly for out-of-pocket costs incurred obtaining assessed HRSN services provided by nontraditional providers who are unable to accept payment via traditional health insurance

methods. Enrollees must not be reimbursed for out-of-pocket costs paid to providers eligible to enroll.

Subd. 7. **Payment.** (a) The commissioner, in consultation with counties and groups of counties administering CARMA, must develop a mechanism for making payments to counties and groups of counties that administer CARMA. The payment mechanism must:

(1) be governed by contracts with terms, including but not limited to payment rates, amended on an as-needed basis;

(2) pay a full-risk monthly capitation payment for services included in CARMA, including the cost for administering CARMA benefits and services;

(3) include risk corridors based on minimum loss ratio, total cost of care, or other metrics;

(4) include a settle-up process tied to the risk corridor arrangement allowing a county or group of counties administering CARMA to retain savings for reinvestment in health care activities and operations to protect against significant losses that a county or group of counties administering CARMA or the state might realize, beginning no sooner than after a county's third year of CARMA operations;

(5) include a collaborative rate-setting process accounting for CARMA experience, regional experience, and the Department of Human Services fee-for-service experience; and

(6) be exempt from section 256B.69, subdivisions 5a, paragraphs (c) and (f), and 5d, and payment for Medicaid services provided under section 256B.69, subdivision 28, paragraph (b), no sooner than three years after CARMA implementation.

(b) Payments for benefits and services under subdivision 6, paragraph (a), must not exceed payments that otherwise would have been paid to health plans under medical assistance for that county or region. Payments for HRSN benefits under subdivision 6, paragraph (b), must be in addition to payments for benefits and services under subdivision 6, paragraph (a).

Subd. 8. **Quality measures.** (a) The commissioner and counties and groups of counties administering CARMA must collaborate to establish quality measures for CARMA not to exceed the extent of quality measures required under sections 256B.69 and 256B.692. The measures must include:

(1) enrollee experience and outcomes;

(2) population health;

(3) health equity; and

(4) the value of health care spending.

(b) The commissioner and counties and groups of counties administering CARMA must collaborate to define a quality improvement model for CARMA. The model must include a focus on locally specified measures based on counties' unique needs. The locally specified measures for the county or group of counties administering CARMA must be determined before the commissioner enters into any contract with a county or group of counties.

Subd. 9. **Data and systems integration.** The commissioner and counties and groups of counties administering CARMA must collaborate to:

(1) identify and address barriers that prevent counties and groups of counties administering CARMA from reviewing individual enrollee eligibility information to identify eligibility and to help enrollees apply for other appropriate programs and resources;

(2) identify and address barriers preventing counties and groups of counties administering CARMA from more readily communicating with and educating potential and current enrollees regarding other program opportunities, including helping enrollees apply for those programs and navigate transitions between programs;

(3) develop and test, in counties participating in CARMA, a universal public assistance application form to reduce the administrative barriers associated with applying for and participating in various public programs;

(4) identify and address regulatory and system barriers that may prohibit counties and groups of counties administering CARMA, agencies, and other partners from working together to identify and address an individual's needs;

(5) facilitate greater interoperability between counties and groups of counties administering CARMA, agencies, and other partners to send and receive the data necessary to support CARMA, counties, and local health system efforts to improve the health and welfare of prospective and enrolled populations;

(6) support efforts of counties and groups of counties administering CARMA to incorporate the necessary automation and interoperability to eliminate manual processes when related to the data exchanged; and

(7) support the creation and maintenance by counties and groups of counties administering CARMA of an updated electronic inventory of community resources available to assist the enrollee in the enrollee's HRSN, including an electronic closed-loop referral system.

EFFECTIVE DATE. This section is effective January 1, 2027, 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. **IMPLEMENTATION OF HOSPITAL ASSESSMENT AND DIRECTED PAYMENT PROGRAM.**

(a) The commissioner of human services must immediately begin all necessary claims analysis to calculate the assessment and payments required under Minnesota Statutes, section 256.9657, subdivision 2b, and the hospital directed payment program described in Minnesota Statutes, section 256B.1974.

(b) The commissioner of human services, in consultation with the Minnesota Hospital Association, must submit to the Centers for Medicare and Medicaid Services a request for federal approval to implement the hospital assessment described in Minnesota Statutes, section 256.9657, subdivision 2b, and the hospital directed payment program under Minnesota Statutes, section 256B.1974. At least 15 days before submitting the request for approval, the commissioner must make available to the public the draft assessment requirements, draft directed payment details, and an estimate of each assessment amount for each eligible hospital without an exemption from the assessment pursuant to Minnesota Statutes, section 256.9657, subdivision 2b, paragraph (k).

(c) During the design and prior to submission of the request for approval under paragraph (b), the commissioner of human services must consult with the Minnesota Hospital Association and any eligible hospitals without an exemption from the assessment pursuant to Minnesota Statutes, section 256.9657, subdivision 2b, paragraph (k), and that are not members of the Minnesota Hospital Association.

(d) If federal approval is received for the request under paragraph (b), the commissioner of human services must provide at least 15 days of public posting and review of the federally approved terms and conditions for the assessment and the directed payment program prior to any assessment under Minnesota Statutes, section 256.9657, subdivision 2b, becoming due from an eligible hospital.

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

Sec. 21. **REQUEST FOR FEDERAL WAIVER.**

The commissioner of human services must seek all federal waivers and authority necessary to implement the county-assisted rural medical assistance (CARMA) program

under Minnesota Statutes, section 256B.695. Any part of the CARMA program that does not require federal approval shall have an effective date as specified in state law. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

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

Sec. 22. **IMPLEMENTATION OF HOSPITAL ASSESSMENT AND DIRECTED PAYMENT PROGRAM.**

(a) The commissioner of human services must immediately begin all necessary claims analysis to calculate the assessment and payments required under Minnesota Statutes, section 256.9657, subdivision 2b, and the hospital directed payment program described in Minnesota Statutes, section 256B.1974.

(b) The commissioner of human services, in consultation with the Minnesota Hospital Association, must submit to the Centers for Medicare and Medicaid Services a request for federal approval to implement the hospital assessment described in Minnesota Statutes, section 256.9657, subdivision 2b, and the hospital directed payment program under Minnesota Statutes, section 256B.1974. At least 15 days before submitting the request for approval, the commissioner must make available to the public the draft assessment requirements, draft directed payment details, and an estimate of each assessment amount for each eligible hospital without an exemption from the assessment pursuant to Minnesota Statutes, section 256.9657, subdivision 2b, paragraph (k).

(c) During the design and prior to submission of the request for approval under paragraph (b), the commissioner of human services must consult with the Minnesota Hospital Association and any eligible hospitals without an exemption from the assessment pursuant to Minnesota Statutes, section 256.9657, subdivision 2b, paragraph (k), and that are not members of the Minnesota Hospital Association.

(d) If federal approval is received for the request under paragraph (b), the commissioner of human services must provide at least 15 days of public posting and review of the federally approved terms and conditions for the assessment and the directed payment program prior to any assessment under Minnesota Statutes, section 256.9657, subdivision 2b, becoming due from an eligible hospital.

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

Sec. 23. **COUNTY-ADMINISTERED RURAL MEDICAL ASSISTANCE PROGRAM IMPLEMENTATION COSTS.**

Up to $500,000 of the nonfederal share of the costs to the Department of Human Services for implementation of the requirements under the county-assisted rural medical assistance (CARMA) program under Minnesota Statutes, section 256B.695, must be paid via an intergovernmental funds transfer to the commissioner of human services, by each county or group of counties authorized under Minnesota Statutes, section 256B.692, seeking to administer a CARMA program. The costs must be paid in a manner that is in compliance with the requirements of Code of Federal Regulations, title 42, section 433.51. Within one year of receiving payment under this section, the commissioner must provide a settle-up process for any county or group of counties authorized under Minnesota Statutes, section 256B.692, administering a CARMA program and making payment under this section, to document and adjust payments owed to account for the commissioner's actual implementation costs for Minnesota Statutes, section 256B.695.

Sec. 24. **MEDICAL ASSISTANCE COVERAGE OF TRADITIONAL HEALTH CARE PRACTICES.**

Subdivision 1. **Waiver request.** By October 1, 2025, the commissioner of human services, in consultation with Tribes, Tribal organizations, and urban Indian organizations, shall apply to the Centers for Medicare and Medicaid Services for a waiver to allow the state's medical assistance program to provide coverage for traditional health care practices received through Indian health service facilities, facilities operated by Tribes or Tribal organizations under the Indian Self-Determination and Education Assistance Act, or facilities operated by urban Indian organizations under Title V of the Indian Health Care Improvement Act.

Subd. 2. **Requirements.** (a) A qualified provider must determine whether a medical assistance enrollee is eligible to receive traditional health care practices under this section.

(b) Traditional health care practices are covered under this section if they are received from a qualified provider.

(c) For purposes of this section, a "qualified provider" is a practitioner or provider who is employed by or under contract with the Indian Health Service, a 638 Tribal clinic, or a Title V urban Indian organization. Each facility is responsible for ensuring that a qualified provider has the necessary experience and appropriate training to provide traditional health care practices.

Subd. 3. **Payments for traditional health care practices.** Reimbursement for traditional health care practices under this section is set at the outpatient, per visit rate established by the Indian Health Service under sections 321(a) and 322(b) of the Public Health Service Act. Reimbursement is limited to one payment per day per medical assistance enrollee receiving traditional health care practices.

EFFECTIVE DATE. This section is effective January 1, 2026, or upon federal approval, whichever is later, except that subdivision 1, is effective the day following final enactment. The commissioner of human services must notify the revisor of statutes when federal approval is obtained.

Sec. 25. **DIRECTION TO COMMISSIONER OF HUMAN SERVICES; ENHANCED FEDERAL REIMBURSEMENT FOR FAMILY PLANNING SERVICES IN MEDICAL ASSISTANCE.**

The commissioner of human services must make the systems modification necessary to claim enhanced federal reimbursement for all family planning services under the medical assistance program.

Sec. 26. **DENTAL ACCESS WORKING GROUP.**

Subdivision 1. **Establishment.** (a) The commissioner of human services must establish a working group as part of the Dental Services Advisory Committee to identify and make recommendations on the state's goals, priorities, and processes for contracting with a dental administrator under Minnesota Statutes, section 256B.0371.

(b) The working group must include members of the Dental Services Advisory Committee, and at least one representative from each of the following:

(1) critical access dental providers;

(2) dental providers serving primarily low-income and socioeconomically complex populations;

(3) dental providers that serve private-pay patients as well as medical assistance and MinnesotaCare enrollees;

(4) rural critical access dental providers that do not have clinics in the seven-county metropolitan area as defined in Minnesota Statutes, section 473.121, subdivision 2; and

(5) managed care plans.

Subd. 2. **Recommendations.** (a) The working group must provide recommendations to the commissioner on:

(1) establishing and implementing a dental payment rate structure for medical assistance and MinnesotaCare that:

(i) is based on the most recent cost data available;

(ii) promotes accountability while considering geographic differences in access to and cost of dental services, critical access dental status, patient characteristics, transportation needs, and medical and dental benefit coordination; and

(iii) can be updated regularly;

(2) performance benchmarks that focus on improving oral health for medical assistance and MinnesotaCare enrollees, including consideration of Dental Quality Alliance and Oral Health Impact Profile measures for broader assessment of a full range of services, and the feasibility, cost, and value of providing the services;

(3) methods for measuring progress toward the performance benchmarks and holding the dental administrator accountable for progress, including providing rewards for progress;

(4) establishing goals and processes to ensure coordination of care among medical assistance and MinnesotaCare providers, including dental, medical, and other care providers, particularly for patients with complex cases engaged in active treatment plans at the time of transition to the dental administrator under Minnesota Statutes, section 256B.0371;

(5) developing and implementing an infrastructure and workforce development strategy that invests in the medical assistance and MinnesotaCare dental system through grants and loans at a level that enables continued development of dental capacity commensurate with that obtained through the managed care delivery system and from philanthropic sources; and

(6) developing and implementing a workforce development strategy to support the pipeline of dental providers and oral health practitioners at all levels.

(b) The working group must provide the recommendations required under this subdivision to the commissioner by .....

Subd. 3. **Reporting requirements.** (a) By ....., the commissioner, in consultation with its contracted dental administrator, must develop an implementation plan and timeline to effectuate the recommendations from the working group under this section.

(b) By ....., the commissioner must submit a report with the working group recommendations, implementation plan, timeline, and any draft legislation required to implement the implementation plan to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services policy and finance.

Sec. 27. **REPEALER.**

(a) Laws 2023, chapter 70, article 16, section 22, is repealed.

(b) Minnesota Statutes 2024, section 256B.0625, subdivisions 18b, 18e, and 18h, are repealed.

EFFECTIVE DATE. Paragraph (b) is effective July 1, 2026, for medical assistance fee-for-service and January 1, 2027, for prepaid medical assistance.

ARTICLE 6
OFFICE OF EMERGENCY MEDICAL SERVICES

Section 1. **[144E.54] AMBULANCE OPERATING DEFICIT GRANT PROGRAM.**

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

(b) "Capital expenses" means expenses incurred by a licensee for the purchase, improvement, or maintenance of assets with an expected useful life of greater than five years that improve the efficiency of provided ambulance services or the capabilities of the licensee.

(c) "Eligible applicant" or "eligible licensee" means any licensee who possessed a license not excluded under subdivision 4 or 5 in the last completed state fiscal year for which data was provided to the director, as provided in section 62J.49; who continues to operate that same nonexcluded license at the time of application; and who provides verifiable evidence of an operating deficit in the state fiscal year prior to submitting an application.

(d) "Government licensee" means any government entity, as defined in section 118A.01, subdivision 2, including a Tribe, that is a licensee.

(e) "Insurance revenue" means revenue from Medicare, medical assistance, private health insurance, third-party liability insurance, and payments from individuals.

(f) "Operating deficit" means the sum of insurance revenue and other revenue is less than the sum of operational expenses and capital expenses.

(g) "Operational expenses" means costs related to the day-to-day operations of an ambulance service, including but not limited to costs related to personnel, supplies and equipment, fuel, vehicle maintenance, travel, education, and fundraising.

(h) "Other revenue" means revenue from any revenue that is not insurance revenue, including but not limited to grants, tax revenue, donations, fundraisers, or standby fees.

Subd. 2. **Program establishment.** An ambulance operating deficit grant program is established to award grants to applicants to address revenue shortfalls creating operating deficits among eligible applicants.

Subd. 3. **Licensee providing specialized life support services excluded.** Licensees providing specialized life support services as described in section 144E.101, subdivision 9, are not eligible for grants under this section.

Subd. 4. **Other licensees excluded.** Licensees whose individual primary service areas are located mostly within a metropolitan county listed in section 473.121, subdivision 4, or within the cities of Duluth, Mankato, St. Cloud, or Rochester are not eligible for grants under this section.

Subd. 5. **Application process.** (a) An eligible licensee may apply to the director, in the form and manner determined by the director, for a grant under this section.

(b) A grant application made by a government licensee must be accompanied by a resolution of support from the governing body.

Subd. 6. **Director calculations.** The director shall award grants only to applicants who provide verifiable evidence of an operating deficit in the last completed state fiscal year for which data were provided to the director. The director may audit the financial data provided to the director by applicants, as provided in section 62J.49. A grant awarded must not be more than five percent more than any previous grant without special permission from the director.

Subd. 7. **Grant awards; limitations.** (a) Grants awarded under this section to eligible applicants may be proportionally distributed based on money available. Total amounts awarded must not exceed the amount in the ambulance operating deficit account.

(b) The director shall award grants annually.

(c) The director must not award individual grants that exceed the amount of the grantee's most recent verified operating deficit as reported to the director.

Subd. 8. **Eligible expenditures.** A grantee must spend grant money received under this section on operational expenses and capital expenses incurred to provide ambulance services.

Subd. 9. **Report.** By February 15, 2026, and annually thereafter, the director must submit a report to the chairs and ranking minority members of the legislative committees with jurisdiction over health finance and policy. The report must describe the number and amount of grants awarded under this section and the uses made of grant money by grantees.

Sec. 2. **[144E.55] RURAL EMS UNCOMPENSATED CARE POOL PAYMENT PROGRAM.**

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

(b) "Eligible licensee" means a licensee that primarily provides ambulance services outside the metropolitan counties listed in section 473.121, subdivision 4.

(c) "Public safety answering point" has the meaning given in section 403.02, subdivision 19.

Subd. 2. **Payment program established.** The director must establish and administer a rural EMS uncompensated care pool payment program. Under the program, the director must make payments to eligible licensees according to this section.

Subd. 3. **Excluded responses.** The director must exclude EMS responses by specialized life support, as described in section 144E.101, subdivision 9, in calculating payments under this section.

Subd. 4. **Application process.** (a) An eligible licensee seeking a payment under this section must apply to the director each year by March 31, in the form and manner determined by the director. In the application, the eligible licensee must specify the number of the eligible licensee's EMS responses that meet the criteria in subdivision 5.

(b) When an eligible licensee, an eligible licensee's parent company, a subsidiary of an eligible licensee, or a subsidiary of an eligible licensee's parent company collectively hold multiple licenses, the director must treat all such related licensees as a single eligible licensee.

Subd. 5. **Eligible EMS responses.** In order for an EMS response to be an eligible EMS response for purposes of subdivision 6, the EMS response must meet the following criteria:

(1) the EMS response was initiated by a request for emergency medical services initially received by a public safety answering point;

(2) an ambulance responded to the scene;

(3) the ambulance was not canceled while en route to the scene;

(4) the ambulance did not transport a person from the scene to a hospital emergency department;

(5) the eligible licensee did not receive any payment for the EMS response from any source; and

(6) the EMS response was initiated between January 1 and December 31 of the year prior to the year the application is submitted.

Subd. 6. **Calculations.** (a) The director must calculate payments as provided in paragraphs (b) and (c) for an eligible licensee that completes an application under subdivision 4.

(b) The director must award points for eligible EMS responses as follows:

(1) for eligible EMS responses one to 25, an eligible licensee is awarded ten points per response;

(2) for eligible EMS responses 26 to 50, an eligible licensee is awarded five points per response;

(3) for eligible EMS responses 51 to 100, an eligible licensee is awarded three points per response;

(4) for eligible EMS responses 101 to 200, an eligible licensee is awarded one point per response; and

(5) for eligible EMS responses exceeding 200, an eligible licensee is awarded zero points.

(c) The director must total the number of all points awarded to all applying eligible licensees under paragraph (b). The director must divide the amount appropriated for purposes of this section by the total number of points awarded to determine a per-point amount. The payment for each eligible licensee shall be calculated by multiplying the eligible licensee's number of awarded points by the established per-point amount.

Subd. 7. **Payment.** The director must certify the payment amount for each eligible licensee and must make the full payment to each eligible licensee by May 30 each year.

ARTICLE 7

MISCELLANEOUS

Section 1. **[135A.1367] OPIATE ANTAGONIST.**

Subdivision 1. **Definition.** For purposes of this section, "opiate antagonist" has the meaning given in section 604A.04, subdivision 1.

Subd. 2. **Minnesota State Colleges and Universities; University of Minnesota.** (a) The Board of Trustees of the Minnesota State Colleges and Universities shall, and the Board of Regents of the University of Minnesota is requested to:

(1) maintain a supply of opiate antagonists at each campus site to be administered in compliance with section 151.37, subdivision 12; and

(2) have at least two doses of a nasal opiate antagonist available on site at each campus residential building.

(b) The commissioner of health shall identify resources, including at least one training video, to help postsecondary institutions implement an opiate antagonist emergency response and make the resources available for institutions.

(c) The Board of Trustees and the Board of Regents may adopt a model plan for use, storage, and administration of opiate antagonists on system campuses.

Subd. 3. **Tribal colleges.** (a) The commissioner of health shall distribute funds to Leech Lake Tribal College, White Earth Tribal College, and Red Lake Nation Tribal College to make opiate antagonists available according to paragraph (b). The commissioner may determine an appropriate method to equitably allocate the amounts appropriated among the colleges.

(b) A Tribal college receiving funds under this section must:

(1) maintain a supply of opiate antagonists at each campus site to be administered in compliance with section 151.37, subdivision 12; and

(2) have at least two doses of a nasal opiate antagonist available on site at each campus residential building.

EFFECTIVE DATE. This section is effective beginning in the 2025-2026 academic year.

Sec. 2. Minnesota Statutes 2024, section 145C.01, is amended by adding a subdivision to read:

Subd. 1c. **Emergency medical services provider.** "Emergency medical services provider" means:

(1) an ambulance service licensed under chapter 144E;

(2) a medical response unit as defined in section 144E.275, subdivision 1;

(3) an emergency medical responder as defined in section 144E.001, subdivision 6; or

(4) ambulance service personnel as defined in section 144E.001, subdivision 3a.

Sec. 3. Minnesota Statutes 2024, section 145C.01, is amended by adding a subdivision to read:

Subd. 7b. **Nonopioid directive.** "Nonopioid directive" means a written instrument that includes one or more instructions that a patient must not be administered an opioid by a health professional or be offered a prescription for an opioid by a prescriber.

Sec. 4. Minnesota Statutes 2024, section 145C.01, is amended by adding a subdivision to read:

Subd. 7c. **Prescriber.** "Prescriber" means an individual who is authorized by section 148.235; 151.01, subdivision 23; or 151.37 to prescribe prescription drugs.

Sec. 5. Minnesota Statutes 2024, section 145C.17, is amended to read:

145C.17 OPIOID INSTRUCTIONS ENTERED INTO HEALTH RECORD.

At the request of the patient or health care agent, a health care provider shall enter into the patient's health care record any instructions relating to administering, dispensing, or prescribing an opioid. A health care provider presented with a nonopioid directive executed by or on behalf of a patient must include the nonopioid directive in the patient's health care record. A health care provider receiving notice of revocation of a patient's nonopioid directive must note the revocation in the patient's health care record.

Sec. 6. **[145C.18] NONOPIOID DIRECTIVE.**

Subdivision 1. **Execution.** A patient with the capacity to do so may execute a nonopioid directive on the patient's own behalf. A patient's health care agent may execute a nonopioid directive on behalf of the patient. A nonopioid directive must include one or more instructions

that the patient must not be administered an opioid by a health professional or be offered a prescription for an opioid by a prescriber.

Subd. 2. **Revocation.** A patient who executed a nonopioid directive on the patient's own behalf may revoke the nonopioid directive at any time and in any manner in which the patient is able to communicate an intent to revoke the nonopioid directive. A patient's health care agent may revoke the nonopioid directive executed on behalf of a patient by executing a written, dated statement of revocation and by providing notice of the revocation to the patient's health care provider.

Subd. 3. **Compliance with nonopioid directive; exception.** (a) Except as specified in paragraph (b), prescribers and health professionals must comply with a nonopioid directive executed under this section.

(b) A prescriber or a health professional acting on the order of a prescriber may administer an opioid to a patient with a nonopioid directive if:

(1) the patient is being treated, in emergency circumstances, in a hospital setting or in a setting outside a hospital;

(2) in the prescriber's professional opinion, it is medically necessary to administer an opioid to the patient in order to treat the patient, including but not limited to during a surgical procedure when one or more complications arise; and

(3) it is not practical or feasible for the prescriber or health professional to access the patient's health care record.

If an opioid is administered according to this paragraph to a patient with a nonopioid directive, the prescriber must ensure that the patient is provided with information on substance use disorder services.

Subd. 4. **Immunities.** Except as otherwise provided by law, the following persons or entities are not subject to criminal prosecution, civil liability, or professional disciplinary action for failing to prescribe, administer, or dispense an opioid to a patient with a nonopioid directive; for the administration of an opioid in the circumstances in subdivision 3, paragraph (b), to a patient with a nonopioid directive; or for the inadvertent administration of an opioid to a patient with a nonopioid directive, if the act or failure to act was performed in good faith and in accordance with the applicable standard of care:

(1) a health professional whose scope of practice includes prescribing, administering, or dispensing a controlled substance;

(2) an employee of a health professional described in clause (1);

(3) a health care facility or an employee of a health care facility; or

(4) an emergency medical services provider.

Subd. 5. **Nonopioid directive form.** The commissioner of health must develop a nonopioid directive form for use by patients and health care agents to communicate to health professionals and prescribers that a patient with a nonopioid directive must not be administered an opioid or offered a prescription for an opioid. The commissioner must include on the nonopioid directive form instructions for how to revoke a nonopioid directive and other information the commissioner deems relevant. The commissioner must post the form on the Department of Health website.

Sec. 7. Minnesota Statutes 2024, section 151.37, subdivision 12, is amended to read:

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

(1) an emergency medical responder registered pursuant to section 144E.27;

(2) a peace officer as defined in section 626.84, subdivision 1, paragraphs (c) and (d);

(3) correctional employees of a state or local political subdivision;

(4) staff of community-based health disease prevention or social service programs;

(5) a volunteer firefighter;

(6) a nurse or any other personnel employed by, or under contract with, a postsecondary institution or a charter, public, or private school; and

(7) transit rider investment program personnel authorized under section 473.4075.

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

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

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

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

(d) Notwithstanding section 148.235, subdivisions 8 and 9, a licensed practical nurse is authorized to possess and administer according to this subdivision an opiate antagonist in a school setting.

Sec. 8. **[325M.335] MENTAL HEALTH WARNING LABEL.**

Subdivision 1. **Warning label required.** (a) A social media platform must ensure that a conspicuous mental health warning label that complies with the requirements under this section:

(1) appears each time a user accesses the social media platform; and

(2) only disappears when the user: (i) exits the social media platform; or (ii) acknowledges the potential for harm and chooses to proceed to the social media platform despite the risk.

(b) A mental health warning label under this section must:

(1) in a manner that conforms with the guidelines established under subdivision 2, warn the user of potential negative mental health impacts of accessing the social media platform; and

(2) provide the user access to resources to address the potential negative mental health impacts described in clause (1) and include the website and telephone number of a national suicide prevention and mental health crisis hotline system, including but not limited to the 988 Suicide and Crisis Lifeline.

(c) A social media platform is prohibited from:

(1) providing the warning label exclusively in the social media platform's terms and conditions;

(2) including extraneous information in the warning label that obscures the visibility or prominence of the warning label; or

(3) allowing a user to disable a warning label, except as provided under paragraph (a).

Subd. 2. **Content of label.** (a) The commissioner of health, in consultation with the commissioner of commerce, must develop guidelines for social media platforms that contain appropriate requirements for the warning labels required under this section. The guidelines must be based on current evidence regarding the negative mental health impacts of social media platforms. The commissioners must review and revise the guidelines as appropriate.

(b) The commissioner of health is exempt from chapter 14, including section 14.386, when implementing this subdivision.

Sec. 9. Minnesota Statutes 2024, section 325M.34, is amended to read:

325M.34 ENFORCEMENT AUTHORITY.

(a) The attorney general may investigate and bring an action against a social media platform for an alleged violation of section 325M.33 or 325M.335.

(b) Nothing in sections 325M.30 to 325M.34 creates a private cause of action in favor of a person injured by a violation of section 325M.33.

ARTICLE 8

DEPARTMENT OF HUMAN SERVICES APPROPRIATIONS

Section 1. **HUMAN SERVICES APPROPRIATIONS.**

The sums shown in the columns marked "Appropriations" are appropriated to the commissioner of human services for the purposes specified in this article. The appropriations are from the general fund, or another named fund, and are available for the fiscal years indicated for each purpose. The figures "2026" and "2027" used in this article mean that the appropriations listed under them are available for the fiscal year ending June 30, 2026, or June 30, 2027, respectively. "The first year" is fiscal year 2026. "The second year" is fiscal year 2027. "The biennium" is fiscal years 2026 and 2027.

	APPROPRIATIONS Available for the Year Ending June 30	
	2026	**2027**
Sec. 2. **COMMISSIONER OF HUMAN SERVICES**	**$ 2,865,274,000**	**$ 2,954,109,000**

Subdivision 1. **Total Appropriation**

Appropriations by Fund	2026	2027
General	1,583,167,000	1,795,471,000
Health Care Access	1,282,107,000	1,158,634,000

The amounts that may be spent for each purpose are specified in this article.

Subd. 2. **Information Technology Appropriations**

(a) **IT appropriations generally.** This appropriation includes money for information technology projects, services, and support. Funding for information technology project costs must be incorporated into the service-level agreement and paid to Minnesota IT Services by the Department of Human Services under the rates and mechanism specified in that agreement.

(b) **Receipts for systems project.** Appropriations and federal receipts for information technology systems projects for MMIS and METS must be deposited in the state systems account authorized in Minnesota Statutes, section 256.014. Money appropriated for information technology projects approved by the commissioner of Minnesota IT Services, funded by the legislature, and approved by the commissioner of management and budget may be transferred from one project to another and from development to operations as the commissioner of human services deems necessary. Any unexpended balance in the appropriation for these projects does not cancel and is available for ongoing development and operations.

Sec. 3. **CENTRAL OFFICE; OPERATIONS**

Subdivision 1. **Total Appropriation**	**$**	**232,000**	**$**	**232,000**

Subd. 2. **Base Level Adjustment**

The base for this section is $75,000 in fiscal year 2028 and $75,000 in fiscal year 2029.

Sec. 4. **CENTRAL OFFICE; HEALTH CARE**

Subdivision 1. **Total Appropriation** **$ 3,964,000 $ 24,131,000**

Subd. 2. **Base Level Adjustment**

The base for this section is $44,158,000 in fiscal year 2028 and $44,158,000 in fiscal year 2029.

Sec. 5. **CENTRAL OFFICE; BEHAVIORAL HEALTH**

Subdivision 1. **Total Appropriation** **$ 0 $ 741,000**

Subd. 2. **Base Level Adjustment**

The base for this section is $768,000 in fiscal year 2028 and $768,000 in fiscal year 2029.

Sec. 6. **FORECASTED PROGRAMS; MEDICAL ASSISTANCE**

Subdivision 1. **Total Appropriation** **$ 2,852,802,000 $ 2,920,843,000**

Appropriations by Fund

General	1,574,160,000	1,765,674,000
Health Care Access	1,278,642,000	1,155,169,000

Subd. 2. **Base Level Adjustment**

The health care access fund base for this section is $1,157,833,000 in fiscal year 2028 and $1,176,922,000 in fiscal year 2029.

Sec. 7. **FORECASTED PROGRAMS; BEHAVIORAL HEALTH FUND** **$ 0 $ 39,000**

Sec. 8. **GRANT PROGRAMS; HEALTH CARE GRANTS** **$ 8,276,000 $ 8,276,000**

Appropriations by Fund

General	4,811,000	4,811,000
Health Care Access	3,465,000	3,465,000

Sec. 9. **TRANSFERS.**

Subdivision 1. **Grants.** The commissioner of human services, with the advance approval of the commissioner of management and budget, may transfer unencumbered appropriation balances for the biennium ending June 30, 2027, within fiscal years among general assistance,

medical assistance, MinnesotaCare, the Minnesota supplemental aid program, the housing support program, and the entitlement portion of the behavioral health fund between fiscal years of the biennium. The commissioner shall report to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services quarterly about transfers made under this subdivision.

Subd. 2. **Administration.** Positions, salary money, and nonsalary administrative money may be transferred within the Department of Human Services as the commissioner deems necessary, with the advance approval of the commissioner of management and budget. The commissioner shall report to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services finance quarterly about transfers made under this section.

Sec. 10. **GRANT ADMINISTRATION COSTS.**

The administrative costs retention requirement under Minnesota Statutes, section 16B.98, subdivision 14, is inapplicable to any appropriation in this article for a grant.

Sec. 11. **APPROPRIATIONS GIVEN EFFECT ONCE.**

If an appropriation, cancellation, or transfer in this article is enacted more than once during the 2025 regular session, the appropriation, cancellation, or transfer must be given effect once.

Sec. 12. **EXPIRATION OF UNCODIFIED LANGUAGE.**

All uncodified language contained in this article expires June 30, 2027, unless a different expiration date is explicit or an appropriation is made available beyond June 30, 2027.

ARTICLE 9
DEPARTMENT OF HEALTH APPROPRIATIONS

Section 1. **HEALTH APPROPRIATIONS.**

The sums shown in the columns marked "Appropriations" are appropriated to the commissioner of health for the purposes specified in this article. The appropriations are from the general fund, or another named fund, and are available for the fiscal years indicated for each purpose. The figures "2026" and "2027" used in this article mean that the appropriations listed under them are available for the fiscal year ending June 30, 2026, or June 30, 2027, respectively. "The first year" is fiscal year 2026. "The second year" is fiscal year 2027. "The biennium" is fiscal years 2026 and 2027.

APPROPRIATIONS

Available for the Year

Ending June 30

	2026	**2027**
Sec. 2. **COMMISSIONER OF HEALTH**	**$ 413,039,000**	**$ 410,410,000**

Appropriations by Fund

	2026	2027
General	265,883,000	264,366,000
State Government Special Revenue	80,678,000	80,512,000
Health Care Access	54,765,000	53,819,000
Federal TANF	11,713,000	11,713,000

The amounts that may be spent for each purpose are specified in this article.

Sec. 3. **HEALTH IMPROVEMENT**

Subdivision 1. **Total Appropriation**	**$ 285,240,000**	**$ 280,679,000**

Appropriations by Fund

General	210,915,000	208,746,000
State Government Special Revenue	9,258,000	9,258,000
Health Care Access	53,354,000	50,962,000
Federal TANF	11,713,000	11,713,000

Subd. 2. **Local and Tribal Public Health Cannabis and Substance Misuse Grant Program**

$6,256,000 in fiscal year 2026 and $6,256,000 in fiscal year 2027 are from the general fund for the local and Tribal public health cannabis and substance misuse grant program under Minnesota Statutes, section 144.197, subdivision 4.

Subd. 3. **Cannabis and Substance Misuse Prevention and Education Programs; Youth Prevention and Education Program**

$4,876,000 in fiscal year 2026 and $4,890,000 in fiscal year 2027 are from the general fund for the cannabis and substance misuse youth prevention and education program under Minnesota Statutes, section 144.197, subdivision 1.

Subd. 4. **Public Health Infrastructure Funds**

$4,000,000 in fiscal year 2026 and $4,000,000 in fiscal year 2027 are from the general fund to distribute to community health boards and Tribal governments to support their ability to meet national public health standards.

Subd. 5. **Sexual and Reproductive Health Services Grant Program**

$11,483,000 in fiscal year 2026 and $11,483,000 in fiscal year 2027 are from the general fund for the sexual and reproductive health services grant program under Minnesota Statutes, section 145.925.

Subd. 6. **Internal Policy to Promote Diversity, Equity, and Inclusion**

The general fund appropriations in this section include reductions of $337,000 in fiscal year 2026 and $337,000 in fiscal year 2027 for an internal Department of Health policy to promote diversity, equity, and inclusion funded under Laws 2023, chapter 70.

Subd. 7. **Partner Engagement and Staffing**

The general fund appropriations in this section include reductions of $110,000 in fiscal year 2026 and $110,000 in fiscal year 2027 for partner engagement and staffing activities

funded under Laws 2023, chapter 70, and Laws 2021, First Special Session chapter 7.

Subd. 8. **Development of Nonopioid Directive Form**

$10,000 in fiscal year 2026 is from the general fund for the development of a nonopioid directive form under Minnesota Statutes, section 145C.18, subdivision 5.

Subd. 9. **Spoken Language Health Care Interpreter Work Group**

$150,000 in fiscal year 2026 is from the general fund for the spoken language health care interpreter work group. This appropriation is available until June 30, 2027.

Subd. 10. **Dementia Services Program**

$500,000 in fiscal year 2026 and $500,000 in fiscal year 2027 are from the general fund for the dementia services program under Minnesota Statutes, section 144.063.

Subd. 11. **Opiate Antagonists at Tribal Colleges**

$75,000 in fiscal year 2026 and $75,000 in fiscal year 2027 are from the general fund to make opiate antagonists available at Tribal colleges under Minnesota Statutes, section 135A.1367, subdivision 3.

Subd. 12. **Materials on Recognizing Signs of Physical Abuse in Infants**

$55,000 in fiscal year 2026 is from the general fund for the development of materials on recognizing the signs of physical abuse in infants under Minnesota Statutes, section 144.124, subdivision 2.

Subd. 13. **Opioid Use Prevention and Education**

$500,000 in fiscal year 2026 and $500,000 in fiscal year 2027 are from the general fund for a grant to Change the Outcome to provide:

(1) data-centered learning opportunities on the dangers of opioid use in middle and high schools and communities in Minnesota;

(2) instruction on prevention strategies, assessing personal risk, and how to recognize an overdose;

(3) information on emerging drug trends including but not limited to fentanyl, xylazine, and pressed pills; and

(4) access to resources, including support for those struggling with substance use disorders.

Subd. 14. **Guidelines for Social Media Mental Health Warning Labels**

$45,000 in fiscal year 2026 is from the general fund to develop and review guidelines for social media mental health warning labels under Minnesota Statutes, section 325M.335, subdivision 2.

Subd. 15. **TANF Appropriations**

TANF funds must be used as follows:

(1) $3,579,000 in fiscal year 2026 and $3,579,000 in fiscal year 2027 are from the TANF fund for home visiting and nutritional services listed under Minnesota Statutes, section 145.882, subdivision 7, clauses (6) and (7). Funds must be distributed to community health boards according to Minnesota Statutes, section 145A.131, subdivision 1;

(2) $2,000,000 in fiscal year 2026 and $2,000,000 in fiscal year 2027 are from the TANF fund for decreasing racial and ethnic disparities in infant mortality rates under Minnesota Statutes, section 145.928, subdivision 7;

(3) $4,978,000 in fiscal year 2026 and $4,978,000 in fiscal year 2027 are from the TANF fund for the family home visiting grant program under Minnesota Statutes, section 145A.17. Of these amounts, $4,000,000 in fiscal year 2026 and $4,000,000 in fiscal year 2027 must be distributed to community health boards under Minnesota Statutes, section 145A.131, subdivision 1; and $978,000 in fiscal year 2026 and $978,000 in fiscal year 2027 must be distributed to Tribal governments under Minnesota Statutes, section 145A.14, subdivision 2a;

(4) $1,156,000 in fiscal year 2026 and $1,156,000 in fiscal year 2027 are from the TANF fund for sexual and reproductive health services grants under Minnesota Statutes, section 145.925; and

(5) the commissioner may use up to 6.23 percent of the funds appropriated from the TANF fund each fiscal year to conduct the ongoing evaluations required under Minnesota Statutes, section 145A.17, subdivision 7, and training and technical assistance required under Minnesota Statutes, section 145A.17, subdivisions 4 and 5.

Subd. 16. **TANF Carryforward**

Any unexpended balance of the TANF appropriation in the first year does not cancel but is available in the second year.

Subd. 17. **Base Level Adjustment**

The general fund base for this section is $207,520,000 in fiscal year 2028 and $207,520,000 in fiscal year 2029.

Sec. 4. **HEALTH PROTECTION**

Subdivision 1. **Total Appropriation**		**$ 105,523,000**	**$ 104,982,000**
Appropriations by Fund			
General		34,103,000	33,728,000
State Government Special Revenue		71,420,000	71,254,000

Subd. 2. **Infectious Disease Prevention, Early Detection, and Outbreak Response**

$1,300,000 in fiscal year 2026 and $1,300,000 in fiscal year 2027 are from the general fund for infectious disease prevention, early detection, and outbreak response activities under Minnesota Statutes, section 144.05, subdivision 1.

Subd. 3. **Collaborative Funding for State and Outside Partners**

The general fund appropriations in this section include reductions of $30,000 in fiscal year 2026 and $30,000 in fiscal year 2027 for collaborative funding for state and outside partners funded under Laws 2023, chapter 70.

Subd. 4. **Base Level Adjustments**

The general fund base for this section is $33,683,000 in fiscal year 2028 and $33,683,000 in fiscal year 2029. The state government special revenue fund base for this

section is $71,265,000 in fiscal year 2028 and $71,277,000 in fiscal year 2029.

Sec. 5. **HEALTH OPERATIONS** **$ 22,276,000 $ 24,749,000**

Appropriations by Fund		
General	20,865,000	21,892,000
Health Care Access	1,411,000	2,857,000

Sec. 6. **TRANSFERS.**

Positions, salary money, and nonsalary administrative money may be transferred within the Department of Health as the commissioner deems necessary with the advance approval of the commissioner of management and budget. The commissioner shall report to the chairs and ranking minority members of the legislative committees with jurisdiction over health finance quarterly about transfers made under this section.

Sec. 7. **INDIRECT COSTS NOT TO FUND PROGRAMS.**

The commissioner of health shall not use indirect cost allocations to pay for the operational costs of any program for which the commissioner is responsible.

Sec. 8. **GRANT ADMINISTRATION COSTS.**

The administrative costs retention requirement under Minnesota Statutes, section 16B.98, subdivision 14, is inapplicable to any appropriation in this article for a grant.

Sec. 9. **APPROPRIATIONS GIVEN EFFECT ONCE.**

If an appropriation, cancellation, or transfer in this article is enacted more than once during the 2025 regular session, the appropriation, cancellation, or transfer must be given effect once.

Sec. 10. **EXPIRATION OF UNCODIFIED LANGUAGE.**

All uncodified language contained in this article expires on June 30, 2027, unless a different expiration date is explicit or an appropriation is made available after June 30, 2027.

ARTICLE 10

OTHER AGENCY APPROPRIATIONS

Section 1. **OTHER AGENCY APPROPRIATIONS.**

The sums shown in the columns marked "Appropriations" are appropriated to the agencies and for the purposes specified in this article. The appropriations are from the general fund, or another named fund, and are available for the fiscal years indicated for each purpose. The figures "2026" and "2027" used in this article mean that the appropriations listed under them are available for the fiscal year ending June 30, 2026, or June 30, 2027, respectively. "The first year" is fiscal year 2026. "The second year" is fiscal year 2027. "The biennium" is fiscal years 2026 and 2027.

	APPROPRIATIONS	
	Available for the Year	
	Ending June 30	
	2026	**2027**

Sec. 2. **HEALTH-RELATED BOARDS**

Subdivision 1. **Total Appropriation** **$** **35,241,000** **$** **35,127,000**

Appropriations by Fund

	2026	2027
General	643,000	643,000
State Government Special Revenue	34,598,000	34,484,000

These amounts are appropriated from the state government special revenue fund, unless specified otherwise, for the purposes specified in the following subdivisions.

Subd. 2. **Board of Behavioral Health and Therapy**	1,309,000	1,309,000
Subd. 3. **Board of Chiropractic Examiners**	1,114,000	1,114,000
Subd. 4. **Board of Dentistry**	4,308,000	4,310,000

(a) **Administrative services unit; operating costs.** Of this appropriation, $1,936,000 in fiscal year 2026 and $1,936,000 in fiscal year 2027 are for operating costs of the administrative services unit. The administrative services unit may receive and

expend reimbursements for services it performs for other agencies.

(b) **Administrative services unit; volunteer health care provider program.** Of this appropriation, $150,000 in fiscal year 2026 and $150,000 in fiscal year 2027 are to pay for medical professional liability coverage required under Minnesota Statutes, section 214.40.

(c) **Administrative services unit; retirement costs.** Of this appropriation, $237,000 in fiscal year 2026 and $237,000 in fiscal year 2027 are for the administrative services unit to pay for the retirement costs of health-related board employees. This funding may be transferred to the health board incurring retirement costs. Any board that has an unexpended balance for an amount transferred under this paragraph shall transfer the unexpended amount to the administrative services unit. If the amount appropriated in the first year of the biennium is not sufficient, the amount from the second year of the biennium is available.

(d) **Administrative services unit; contested cases and other legal proceedings.** Of this appropriation, $200,000 in fiscal year 2026 and $200,000 in fiscal year 2027 are for costs of contested case hearings and other unanticipated costs of legal proceedings involving health-related boards under this section. Upon certification by a health-related board to the administrative services unit that unanticipated costs for legal proceedings will be incurred and that available appropriations are insufficient to pay for the unanticipated

costs for that board, the administrative services unit is authorized to transfer money from this appropriation to the board for payment of costs for contested case hearings and other unanticipated costs of legal proceedings with the approval of the commissioner of management and budget. The commissioner of management and budget must require any board that has an unexpended balance or an amount transferred under this paragraph to transfer the unexpended amount to the administrative services unit to be deposited in the state government special revenue fund.

Subd. 5. **Board of Dietetics and Nutrition Practice**	277,000	277,000
Subd. 6. **Board of Executives for Long-term Services and Supports**	835,000	835,000
Subd. 7. **Board of Marriage and Family Therapy**	457,000	457,000
Subd. 8. **Board of Medical Practice**	6,196,000	6,141,000

Base Level Adjustment. The state government special revenue fund base for this subdivision is $6,132,000 in fiscal year 2028 and $6,132,000 in fiscal year 2029.

Subd. 9. **Board of Nursing**	6,275,000	6,275,000
Subd. 10. **Board of Occupational Therapy Practice**	560,000	560,000
Subd. 11. **Board of Optometry**	280,000	280,000

Subd. 12. **Board of Pharmacy**

Appropriations by Fund		
General	643,000	643,000
State Government Special Revenue	6,280,000	6,280,000

(a) **Medication Repository Program.** $175,000 in fiscal year 2026 and $175,000 in

fiscal year 2027 are from the general fund for the medication repository program under Minnesota Statutes, section 151.555. The general fund base for this appropriation is $450,000 in fiscal year 2028 and $450,000 in fiscal year 2029.

(b) **Base Level Adjustments.** The general fund base for this subdivision is $918,000 in fiscal year 2028 and $918,000 in fiscal year 2029.

Subd. 13. **Board of Physical Therapy**	789,000	789,000
Subd. 14. **Board of Podiatric Medicine**	301,000	301,000
Subd. 15. **Board of Psychology**	2,781,000	2,781,000

Health Professionals Services Program. $1,324,000 in fiscal year 2026 and $1,324,000 in fiscal year 2027 are for the health professionals services program.

Subd. 16. **Board of Social Work**	2,073,000	2,012,000

Base Level Adjustments. The state government special revenue fund base for this subdivision is $2,022,000 in fiscal year 2028 and $2,022,000 in fiscal year 2029.

Subd. 17. **Board of Veterinary Medicine**	763,000	763,000

Sec. 3. **OFFICE OF EMERGENCY MEDICAL SERVICES**	**$ 22,168,000**	**$ 20,631,000**

Subdivision 1. **Ambulance Operating Deficit Grant Program**

$9,916,000 in fiscal year 2026 and $9,916,000 in fiscal year 2027 are for the ambulance operating deficit grant program under Minnesota Statutes, section 144E.54. The base for this appropriation is $9,516,000 in fiscal year 2028 and $9,516,000 in fiscal year 2029.

Subd. 2. **Rural EMS Uncompensated Care Pool Payment Program**

$5,239,000 in fiscal year 2026 and $5,267,000 in fiscal year 2027 are for the rural EMS uncompensated care pool payment program under Minnesota Statutes, section 144E.55. The base for this appropriation is $4,978,000 in fiscal year 2028 and $4,978,000 in fiscal year 2029.

Subd. 3. **Base Level Adjustments**

The base for this section is $19,942,000 in fiscal year 2028 and $19,942,000 in fiscal year 2029.

Sec. 4. **RARE DISEASE ADVISORY COUNCIL** **$ 674,000 $ 679,000**

Sec. 5. **BOARD OF DIRECTORS OF MNSURE** **$ 70,000 $ 70,000**

Sec. 6. Laws 2024, chapter 127, article 67, section 4, is amended to read:

Sec. 4. **BOARD OF PHARMACY**

	Appropriations by Fund	
General	1,500,000	-0-
State Government Special Revenue	-0-	27,000

(a) **Legal Costs.** $1,500,000 in fiscal year 2024 is from the general fund for legal costs. This is a onetime appropriation and is available until June 30, 2027.

(b) **Base Level Adjustment.** The state government special revenue fund base is increased by $27,000 in fiscal year 2026 and increased by $27,000 in fiscal year 2027.

EFFECTIVE DATE. This section is effective June 30, 2025.

Sec. 7. **GRANT ADMINISTRATION COSTS.**

The administrative costs retention requirement under Minnesota Statutes, section 16B.98, subdivision 14, is inapplicable to any appropriation in this article for a grant.

Sec. 8. **APPROPRIATIONS GIVEN EFFECT ONCE.**

If an appropriation, cancellation, or transfer in this article is enacted more than once during the 2025 regular session, the appropriation, cancellation, or transfer must be given effect once.

Sec. 9. **EXPIRATION OF UNCODIFIED LANGUAGE.**

All uncodified language contained in this article expires June 30, 2027, unless a different expiration date is explicit or an appropriation is made available after June 30, 2027."

Amend the title accordingly