4.2 **ARTICLE 1**

4.3 **DEPARTMENT OF HEALTH FINANCE**

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

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

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

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

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

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

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

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

5.4 (f) If, after reviewing any information described in paragraph (e) and the results of any
5.5 investigation, the commissioner determines that the provider or facility has not violated this

5.6 section, the commissioner shall notify the provider or facility as well as any relevant
5.7 complainant.

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

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

5.15 (2) if, after taking the action in clause (1) compliance has not been achieved, the
5.16 commissioner of health shall notify the provider or facility that the provider or facility is in
5.17 violation of this section and that the commissioner is imposing a civil monetary penalty. If
5.18 the commissioner determines that more than one health care provider or facility was
5.19 responsible for a violation, the commissioner may impose a civil money penalty against
5.20 each health care provider or facility. The amount of a civil money penalty shall be up to
5.21 $100 for each violation, but shall not exceed $25,000 for identical violations during a
5.22 calendar year; and

5.23 (3) no civil money penalty shall be imposed under this section for violations that occur
5.24 prior to January 1, 2023. Warnings must be issued and any compliance issues must be
5.25 referred to the federal government for enforcement pursuant to the federal No Surprises Act
5.26 or other applicable federal laws and regulations.

5.27 (h) A health care provider or facility may contest whether the finding of facts constitute
5.28 a violation of this section according to the contested case proceeding in sections 14.57 to
5.29 14.62, subject to appeal according to sections 14.63 to 14.68.

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

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

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

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

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

6.9 Subd. 3. **Compliance with 2021 federal law.** Each health plan company, health provider,
6.10 and health facility shall comply with Division BB, Title I of the Consolidated Appropriations

6.11 Act, 2021, also known as the "No Surprises Act," including any federal regulations adopted
6.12 under that act, to the extent that it imposes requirements that apply in this state but are not
6.13 required under the laws of this state. This section does not require compliance with any
6.14 provision of the No Surprises Act before the effective date provided for that provision in
6.15 the Consolidated Appropriations Act. The commissioner shall enforce this subdivision.

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

6.17 Subd. 5. **Coverage restrictions or limitations.** If emergency services are provided by
6.18 a nonparticipating provider, with or without prior authorization, the health plan company
6.19 shall not impose coverage restrictions or limitations that are more restrictive than apply to
6.20 emergency services received from a participating provider. Cost-sharing requirements that
6.21 apply to emergency services received out-of-network must be the same as the cost-sharing
6.22 requirements that apply to services received in-network and shall count toward the in-network
6.23 deductible. All coverage and charges for emergency services must comply with all
6.24 requirements of Division BB, Title I of the Consolidated Appropriations Act, 2021, including
6.25 any federal regulations adopted under that act.

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

6.27 **62Q.556 ~~UNAUTHORIZED PROVIDER SERVICES~~ CONSUMER**
6.28 **PROTECTIONS AGAINST BALANCE BILLING.**

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

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

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

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

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

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

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

7.14 (3) from a nonparticipating provider or facility providing emergency services as defined
7.15 in section 62Q.55, subdivision 3, and other services as described in the requirements of

7.16 Division BB, Title I of the Consolidated Appropriations Act, 2021, including any federal
7.17 regulations adopted under that act.

7.18 (c) (b) The services described in paragraph (a), clause clauses (1) and (2), as defined in
7.19 Division BB, Title I of the Consolidated Appropriations Act, 2021, and any federal
7.20 regulations adopted under that act, are not unauthorized provider services subject to balance
7.21 billing if the enrollee gives advance written informed consent to the prior to receiving
7.22 services from the nonparticipating provider acknowledging that the use of a provider, or
7.23 the services to be rendered, may result in costs not covered by the health plan. The informed
7.24 consent must comply with all requirements of Division BB, Title I of the Consolidated
7.25 Appropriations Act, 2021, including any federal regulations adopted under that act.

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

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

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

8.20 (d) The arbitrator must consider relevant information, including the health plan company's
8.21 payments to other nonparticipating providers for the same services, the circumstances and
8.22 complexity of the particular case, and the usual and customary rate for the service based on
8.23 information available in a database in a national, independent, not-for-profit corporation,

8.24 ~~and similar fees received by the provider for the same services from other health plans in~~
8.25 ~~which the provider is nonparticipating, in reaching a decision.~~

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

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

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

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

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

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

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

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

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

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

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

9.21 (i) an acute condition;

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

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

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

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

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

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

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

10.7 (1) is receiving culturally appropriate services and the health plan company does not
10.8 have a provider in its preferred provider network with special expertise in the delivery of
10.9 those culturally appropriate services within the time and distance requirements of section
10.10 62D.124, subdivision 1; or

10.11 (2) does not speak English and the health plan company does not have a provider in its
10.12 preferred provider network who can communicate with the enrollee, either directly or through
10.13 an interpreter, within the time and distance requirements of section 62D.124, subdivision
10.14 1.

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

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

10.19 Sec. 6. Minnesota Statutes 2020, section 62Q.73, subdivision 7, is amended to read:

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

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

10.28 (c) For an external review of any issue in an adverse determination by a health plan
10.29 company, other than a health plan company licensed under chapter 62D, that requires a
10.30 medical necessity determination, the external review must determine whether the adverse

10.31 determination was consistent with the definition of medically necessary care in section
10.32 62Q.53, subdivision 2.

11.1 (d) For an external review of an adverse determination involving experimental or
11.2 investigational treatment, the external review entity must base its decision on all documents
11.3 submitted by the health plan company and enrollee, including medical records, the attending
11.4 physician, advanced practice registered nurse, or health care professional's recommendation,
11.5 consulting reports from health care professionals, the terms of coverage, federal Food and
11.6 Drug Administration approval, and medical or scientific evidence or evidence-based
11.7 standards.

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

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

11.22 (b) Data collected under this subdivision are nonpublic data as defined in section 13.02.
11.23 Notwithstanding the definition of summary data in section 13.02, subdivision 19, summary
11.24 data prepared under this subdivision may be derived from nonpublic data. The commissioner
11.25 shall establish procedures and safeguards to protect the integrity and confidentiality of any
11.26 data maintained by the commissioner.

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

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

11.31 Subd. 11. **Restricted uses of the all-payer claims data.** (a) Notwithstanding subdivision
11.32 4, paragraph (b), and subdivision 5, paragraph (b), the commissioner or the commissioner's
12.1 designee shall only use the data submitted under subdivisions 4 ~~and~~, 5, and 5b for the
12.2 following purposes:

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

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

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

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

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

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

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

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

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

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

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

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

12.29 ~~(d) The commissioner or the commissioner's designee may use the data submitted under~~
12.30 ~~subdivisions 4 and 5 for the purpose described in paragraph (a), clause (3), until July 1,~~
12.31 ~~2023.~~

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

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

13.5 Subd. 7. **Outcomes reporting; savings determination.** (a) ~~Beginning November 1,~~
13.6 ~~2016, and~~ Each November 1 ~~thereafter~~, the commissioner of health shall determine the
13.7 actual total private and public health care and long-term care spending for Minnesota
13.8 residents related to each health indicator projected in subdivision 6 for the most recent

13.9 calendar year available. The commissioner shall determine the difference between the
13.10 projected and actual spending for each health indicator and for each year, and determine
13.11 the savings attributable to changes in these health indicators. The assumptions and research
13.12 methods used to calculate actual spending must be determined to be appropriate by an
13.13 independent actuarial consultant. If the actual spending is less than the projected spending,
13.14 the commissioner, in consultation with the commissioners of human services and management
13.15 and budget, shall use the proportion of spending for state-administered health care programs
13.16 to total private and public health care spending for each health indicator for the calendar
13.17 year two years before the current calendar year to determine the percentage of the calculated
13.18 aggregate savings amount accruing to state-administered health care programs.

13.19 (b) The commissioner may use the data submitted under section 62U.04, subdivisions
13.20 4 ~~and~~, 5, and 5b, to complete the activities required under this section, but may only report
13.21 publicly on regional data aggregated to granularity of 25,000 lives or greater for this purpose.

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317.25 Section 1. Minnesota Statutes 2020, section 103I.005, subdivision 17a, is amended to
317.26 read:

317.27 Subd. 17a. **~~Temporary boring~~ Submerged closed loop heat exchanger.** ~~"Temporary~~
317.28 ~~boring"~~ "Submerged closed loop heat exchanger" means ~~an excavation that is 15 feet or~~
317.29 ~~more in depth, is sealed within 72 hours of the time of construction, and is drilled, cored,~~
317.30 ~~washed, driven, dug, jetted, or otherwise constructed to~~ a heating and cooling system that:

317.31 (1) ~~conduct physical, chemical, or biological testing of groundwater, including~~
317.32 ~~groundwater quality monitoring~~ is installed in a water supply well;

318.1 (2) ~~monitor or measure physical, chemical, radiological, or biological parameters of~~
318.2 ~~earth materials or earth fluids, including hydraulic conductivity, bearing capacity, or~~
318.3 ~~resistance~~ utilizes the convective flow of groundwater as the primary medium of heat
318.4 exchange;

318.5 (3) ~~measure groundwater levels, including use of a piezometer~~ contains potable water
318.6 as the heat transfer fluid; and

318.7 (4) ~~determine groundwater flow direction or velocity~~ operates using nonconsumptive
318.8 recirculation.

318.9 A submerged closed loop heat exchanger also includes submersible pumps, a heat exchanger
318.10 device, piping, and other necessary appurtenances.

318.11 Sec. 2. Minnesota Statutes 2020, section 103I.005, is amended by adding a subdivision
318.12 to read:

318.13 Subd. 17b. **Temporary boring.** "Temporary boring" means an excavation that is 15
318.14 feet or more in depth, is sealed within 72 hours of the time of construction, and is drilled,
318.15 cored, washed, driven, dug, jetted, or otherwise constructed to:

318.16 (1) conduct physical, chemical, or biological testing of groundwater, including
318.17 groundwater quality monitoring;

318.18 (2) monitor or measure physical, chemical, radiological, or biological parameters of
318.19 earth materials or earth fluids, including hydraulic conductivity, bearing capacity, or
318.20 resistance;

318.21 (3) measure groundwater levels, including use of a piezometer; and

318.22 (4) determine groundwater flow direction or velocity.

318.23 Sec. 3. Minnesota Statutes 2020, section 103I.005, subdivision 20a, is amended to read:

318.24 Subd. 20a. **Water supply well.** "Water supply well" means a well that is not a dewatering
318.25 well or environmental well and includes wells used:

318.26 (1) for potable water supply;

318.27 (2) for irrigation;

318.28 (3) for agricultural, commercial, or industrial water supply;

318.29 (4) for heating or cooling; ~~and~~

318.30 (5) for containing a submerged closed loop heat exchanger; and

319.1 (6) for testing water yield for irrigation, commercial or industrial uses, residential supply,
319.2 or public water supply.

319.3 Sec. 4. **[103I.631] INSTALLATION OF A SUBMERGED CLOSED LOOP HEAT**
319.4 **EXCHANGER.**

319.5 Subdivision 1. **Installation.** Notwithstanding any other provision of law, the
319.6 commissioner must allow the installation of a submerged closed loop heat exchanger in a
319.7 water supply well. A project may consist of more than one water supply well on a particular
319.8 site.

319.9 Subd. 2. **Setbacks.** Water supply wells used only for the nonpotable purpose of providing
319.10 heating and cooling using a submerged closed loop heat exchanger are exempt from isolation
319.11 distance requirements greater than ten feet.

319.12 Subd. 3. **Construction.** The screened interval of a water supply well constructed to
319.13 contain a submerged closed loop heat exchanger completed within a single aquifer may be

319.14 designed and constructed using any combination of screen, casing, leader, riser, sump, or
319.15 other piping combinations, so long as the screen configuration does not interconnect aquifers.

319.16 Subd. 4. **Permits.** A submerged closed loop heat exchanger is not subject to the permit
319.17 requirements in this chapter.

319.18 Subd. 5. **Variances.** A variance is not required to install or operate a submerged closed
319.19 loop heat exchanger.

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

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

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

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

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

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

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

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

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

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

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

319.20 Sec. 5. Minnesota Statutes 2020, section 144.057, subdivision 1, is amended to read:

319.21 Subdivision 1. **Background studies required.** (a) Except as specified in paragraph (b),
319.22 the commissioner of health shall contract with the commissioner of human services to
319.23 conduct background studies of:

319.24 (1) individuals providing services that have direct contact, as defined under section
319.25 245C.02, subdivision 11, with patients and residents in hospitals, boarding care homes,
319.26 outpatient surgical centers licensed under sections 144.50 to 144.58; nursing homes and
319.27 home care agencies licensed under chapter 144A; assisted living facilities and assisted living
319.28 facilities with dementia care licensed under chapter 144G; and board and lodging
319.29 establishments that are registered to provide supportive or health supervision services under
319.30 section 157.17;

319.31 (2) individuals specified in section 245C.03, subdivision 1, who perform direct contact
319.32 services in a nursing home or a home care agency licensed under chapter 144A; an assisted
320.1 living facility or assisted living facility with dementia care licensed under chapter 144G;
320.2 or a boarding care home licensed under sections 144.50 to 144.58. If the individual under
320.3 study resides outside Minnesota, the study must include a check for substantiated findings
320.4 of maltreatment of adults and children in the individual's state of residence when the
320.5 information is made available by that state, and must include a check of the National Crime
320.6 Information Center database;

320.7 (3) all other employees in assisted living facilities or assisted living facilities with
320.8 dementia care licensed under chapter 144G, nursing homes licensed under chapter 144A,
320.9 and boarding care homes licensed under sections 144.50 to 144.58. A disqualification of
320.10 an individual in this section shall disqualify the individual from positions allowing direct
320.11 contact or access to patients or residents receiving services. "Access" means physical access
320.12 to a client or the client's personal property without continuous, direct supervision as defined
320.13 in section 245C.02, subdivision 8, when the employee's employment responsibilities do not
320.14 include providing direct contact services;

320.15 (4) individuals employed by a supplemental nursing services agency, as defined under
320.16 section 144A.70, who are providing services in health care facilities; ~~and~~

320.17 (5) controlling persons of a supplemental nursing services agency, as defined under
320.18 section 144A.70~~.~~; and

320.19 (6) license applicants, owners, managerial officials, and controlling individuals who are
320.20 required under section 144A.476, subdivision 1, or 144G.13, subdivision 1, to undergo a
320.21 background study under chapter 245C, regardless of the licensure status of the license
320.22 applicant, owner, managerial official, or controlling individual.

320.23 (b) The commissioner of human services shall not conduct a background study on any
320.24 individual identified in paragraph (a), clauses (1) to (5), if the individual has a valid license
320.25 issued by a health-related licensing board as defined in section 214.01, subdivision 2, and
320.26 has completed the criminal background check as required in section 214.075. An entity that
320.27 is affiliated with individuals who meet the requirements of this paragraph must separate
320.28 those individuals from the entity's roster for NETStudy 2.0.

320.29 (c) If a facility or program is licensed by the Department of Human Services and subject
320.30 to the background study provisions of chapter 245C and is also licensed by the Department
320.31 of Health, the Department of Human Services is solely responsible for the background
320.32 studies of individuals in the jointly licensed programs.

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

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

14.26 **144.122 LICENSE, PERMIT, AND SURVEY FEES.**

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

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

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

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

15.22 15.23 15.24 15.25	Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and American Osteopathic Association (AOA) hospitals	$7,655 plus $16 per bed
15.26	Non-JCAHO and non-AOA hospitals	$5,280 plus $250 per bed
15.27 15.28 15.29 15.30	Nursing home	$183 plus $91 per bed until June 30, 2018. $183 plus $100 per bed between July 1, 2018, and June 30, 2020. $183 plus $105 per bed beginning July 1, 2020.

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

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

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

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

16.9	Prospective payment surveys for hospitals	$	900
16.10	Swing bed surveys for nursing homes	$	1,200

16.11	Psychiatric hospitals	$	1,400
16.12	Rural health facilities	$	1,100
16.13	Portable x-ray providers	$	500
16.14	Home health agencies	$	1,800
16.15	Outpatient therapy agencies	$	800
16.16	End stage renal dialysis providers	$	2,100
16.17	Independent therapists	$	800
16.18	Comprehensive rehabilitation outpatient facilities	$	1,200
16.19	Hospice providers	$	1,700
16.20	Ambulatory surgical providers	$	1,800
16.21	Hospitals	$	4,200
16.22 16.23 16.24	Other provider categories or additional resurveys required to complete initial certification	Actual surveyor costs: average surveyor cost x number of hours for the survey process.	

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

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

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

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

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

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

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

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

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

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

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

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

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

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

18.1 ~~(f)~~ (h) "Designated rural area" means a statutory and home rule charter city or township
18.2 that is outside the seven-county metropolitan area as defined in section 473.121, subdivision
18.3 2, excluding the cities of Duluth, Mankato, Moorhead, Rochester, and St. Cloud.

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

18.7 ~~(h)~~ (j) "Mental health professional" means an individual providing clinical services in
18.8 the treatment of mental illness who is qualified in at least one of the ways specified in section
18.9 245.462, subdivision 18.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

19.19 (2) for midlevel practitioners advanced practice providers agreeing to practice in
19.20 designated rural areas or to teach at least 12 credit hours, or 720 hours per year in the nursing
19.21 field in a postsecondary program at the undergraduate level or the equivalent at the graduate
19.22 level;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

21.10 Subd. 4. **Loan forgiveness.** (a) The commissioner of health may select applicants each
21.11 year for participation in the loan forgiveness program, within the limits of available funding.
21.12 In considering applications from applicants who are mental health professionals, the
21.13 commissioner shall give preference to applicants who work in rural or culturally specific
21.14 organizations. In considering applications from all other applicants, the commissioner shall
21.15 give preference to applicants who document diverse cultural competencies. Except as
21.16 provided in paragraph (b), the commissioner shall distribute available funds for loan
21.17 forgiveness proportionally among the eligible professions according to the vacancy rate for
21.18 each profession in the required geographic area, facility type, teaching area, patient group,
21.19 or specialty type specified in subdivision 2. The commissioner shall allocate funds for
21.20 physician loan forgiveness so that 75 percent of the funds available are used for rural
21.21 physician loan forgiveness and 25 percent of the funds available are used for underserved
21.22 urban communities, physicians agreeing to provide at least 25 percent of the physician's
21.23 yearly patient encounters to patients in an underserved patient population, and pediatric
21.24 psychiatry loan forgiveness. If the commissioner does not receive enough qualified applicants
21.25 each year to use the entire allocation of funds for any eligible profession, the remaining

21.26 funds may be allocated proportionally among the other eligible professions according to
21.27 the vacancy rate for each profession in the required geographic area, patient group, or facility
21.28 type specified in subdivision 2. Applicants are responsible for securing their own qualified
21.29 educational loans. The commissioner shall select participants based on their suitability for
21.30 practice serving the required geographic area or facility type specified in subdivision 2, as
21.31 indicated by experience or training. The commissioner shall give preference to applicants
21.32 closest to completing their training. Except as specified in paragraph (c), for each year that
21.33 a participant meets the service obligation required under subdivision 3, up to a maximum
21.34 of four years, the commissioner shall make annual disbursements directly to the participant
21.35 equivalent to 15 percent of the average educational debt for indebted graduates in their
22.1 profession in the year closest to the applicant's selection for which information is available,
22.2 not to exceed the balance of the participant's qualifying educational loans. Before receiving
22.3 loan repayment disbursements and as requested, the participant must complete and return
22.4 to the commissioner a confirmation of practice form provided by the commissioner verifying
22.5 that the participant is practicing as required under subdivisions 2 and 3. The participant
22.6 must provide the commissioner with verification that the full amount of loan repayment
22.7 disbursement received by the participant has been applied toward the designated loans.
22.8 After each disbursement, verification must be received by the commissioner and approved
22.9 before the next loan repayment disbursement is made. Participants who move their practice
22.10 remain eligible for loan repayment as long as they practice as required under subdivision
22.11 2.

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

22.14 (c) For each year that a participant who is a nurse and who has agreed to teach according
22.15 to subdivision 2 meets the teaching obligation required in subdivision 3, the commissioner
22.16 shall make annual disbursements directly to the participant equivalent to 15 percent of the
22.17 average annual educational debt for indebted graduates in the nursing profession in the year
22.18 closest to the participant's selection for which information is available, not to exceed the
22.19 balance of the participant's qualifying educational loans.

22.20 Sec. 16. Minnesota Statutes 2020, section 144.1501, subdivision 5, is amended to read:

22.21 Subd. 5. **Penalty for nonfulfillment.** If a participant does not fulfill the required
22.22 minimum commitment of service according to subdivision 3, the commissioner of health
22.23 shall collect from the participant the total amount paid to the participant under the loan
22.24 forgiveness program plus interest at a rate established according to section 270C.40. The
22.25 commissioner shall deposit the money collected in ~~the health care access fund to be credited~~
22.26 ~~to the health professional education loan forgiveness program account established in~~
22.27 ~~subdivision 2~~ an account in the special revenue fund. The balance of the account does not
22.28 expire and is appropriated to the commissioner of health for health professional education
22.29 loan forgiveness awards under this section. The commissioner shall allow waivers of all or
22.30 part of the money owed the commissioner as a result of a nonfulfillment penalty if emergency
22.31 circumstances prevented fulfillment of the minimum service commitment.

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

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

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

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

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

23.10 (1) enrolled in the PSLF program;

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

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

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

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

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

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

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

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

23.26 (b) For each year that a participant meets the eligibility requirements described in
23.27 subdivision 2, the commissioner shall make an annual disbursement directly to the participant
23.28 in an amount equal to the minimum loan payments required to be paid by the participant
23.29 under the participant's repayment plan under the PSLF program for the previous loan year.
23.30 Before receiving the annual loan repayment disbursement, the participant must complete
23.31 and return to the commissioner a confirmation of practice form provided by the
24.1 commissioner, verifying that the participant continues to meet the eligibility requirements
24.2 under subdivision 2.

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

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

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

24.19 **144.1505 HEALTH PROFESSIONALS CLINICAL TRAINING EXPANSION**
24.20 **AND RURAL AND UNDERSERVED CLINICAL ROTATIONS GRANT ~~PROGRAM~~**
24.21 **PROGRAMS.**

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

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

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

24.31 ~~(2)~~ (3) "eligible dental therapy program" means a dental therapy education program or
24.32 advanced dental therapy education program that is located in Minnesota and is either:

24.33 (i) approved by the Board of Dentistry; or

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

25.2 ~~(3)~~ (4) "eligible mental health professional program" means a program that is located
25.3 in Minnesota and is listed as a mental health professional program by the appropriate
25.4 accrediting body for clinical social work, psychology, marriage and family therapy, or
25.5 licensed professional clinical counseling, or is a candidate for accreditation;

25.6 ~~(4)~~ (5) "eligible pharmacy program" means a program that is located in Minnesota and
25.7 is currently accredited as a doctor of pharmacy program by the Accreditation Council on
25.8 Pharmacy Education;

25.9 ~~(5)~~ (6) "eligible physician assistant program" means a program that is located in
25.10 Minnesota and is currently accredited as a physician assistant program by the Accreditation
25.11 Review Commission on Education for the Physician Assistant, or is a candidate for
25.12 accreditation;

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

25.16 ~~(6)~~ (8) "mental health professional" means an individual providing clinical services in
25.17 the treatment of mental illness who meets one of the qualifications under section 245.462,
25.18 subdivision 18; and

25.19 ~~(7)~~ (9) "project" means a project to establish or expand clinical training for physician
25.20 assistants, advanced practice registered nurses, pharmacists, physicians, dentists, dental
25.21 therapists, advanced dental therapists, or mental health professionals in Minnesota.

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

25.28 (b) Funds may be used for:

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

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

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

26.3 (4) travel and lodging for students;

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

26.5 (6) development and implementation of cultural competency training;

26.6 (7) evaluations;

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

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

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

26.20 (b) Funds may be used for:

26.21 (1) establishing or expanding rotations and clinical trainings;

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

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

26.25 (4) travel and lodging for students;

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

26.27 (6) development and implementation of cultural competency training;

26.28 (7) evaluations;

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

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

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

27.13 about the length of training and training site settings, the geographic locations of rural sites,
27.14 and rural populations expected to be served.

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

27.26 Subd. 5. **Program oversight.** The commissioner shall determine the amount of a grant
27.27 to be given to an eligible program based on the relative score of each eligible program's
27.28 application and rural locations if applicable under subdivision 2b, other relevant factors
27.29 discussed during the review, and the funds available to the commissioner. Appropriations
27.30 made to the program do not cancel and are available until expended. During the grant period,
27.31 the commissioner may require and collect from programs receiving grants any information
27.32 necessary to evaluate the program.

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

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

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

28.6 (1) is located in Minnesota;

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

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

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

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

28.17 Subd. 2. **Rural residency training program.** (a) The commissioner of health shall
28.18 award rural residency training program grants to eligible programs to plan and implement
28.19 rural residency training programs. A rural residency training program grant shall not exceed
28.20 $250,000 per resident per year for the first year of planning and development, and $225,000
28.21 for each of the following years.

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

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

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

28.26 (3) establishing new rural residency training programs;

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

28.28 (5) travel and lodging for new residents;

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

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

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

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

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

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

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

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

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

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

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

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

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

30.6 (1) provide at least 25 percent of the provider's yearly patient encounters to state public
30.7 program enrollees or patients receiving sliding fee schedule discounts through a formal
30.8 sliding fee schedule meeting the standards established by the United States Department of
30.9 Health and Human Services under Code of Federal Regulations, title 42, section 51c.303;
30.10 or

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

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

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

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

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

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

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

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

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

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

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

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

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

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

31.20 (2) a mental health certified family peer specialist who meets the qualifications in section
31.21 245I.04, subdivision 12;

31.22 (3) a mental health certified peer specialist who meets the qualifications in section
31.23 245I.04, subdivision 10;

31.24 (4) a mental health practitioner who meets a qualification in section 245I.04, subdivision
31.25 4;

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

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

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

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

32.3 (1) primarily provide at least 25 percent of the provider's yearly patient encounters to
32.4 state public program enrollees or patients receiving sliding fee schedule discounts through
32.5 a formal sliding fee schedule meeting the standards established by the United States
32.6 Department of Health and Human Services under Code of Federal Regulations, title 42,
32.7 section 51c.303; or

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

35.30 Sec. 23. Minnesota Statutes 2020, section 144.383, is amended to read:

35.31 **144.383 AUTHORITY OF COMMISSIONER; SAFE DRINKING WATER.**

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

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

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

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

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

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

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

36.20 Sec. 24. Minnesota Statutes 2020, section 144.554, is amended to read:

36.21 **144.554 HEALTH FACILITIES CONSTRUCTION PLAN SUBMITTAL AND**
36.22 **FEES.**

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

	Construction project total estimated cost	Fee
36.32		
36.33	$0 - $10,000	~~$30~~ $45
37.1	$10,001 - $50,000	~~$150~~ $225
37.2	$50,001 - $100,000	~~$300~~ $450
37.3	$100,001 - $150,000	~~$450~~ $675
37.4	$150,001 - $200,000	~~$600~~ $900
37.5	$200,001 - $250,000	~~$750~~ $1,125
37.6	$250,001 - $300,000	~~$900~~ $1,350
37.7	$300,001 - $350,000	~~$1,050~~ $1,575
37.8	$350,001 - $400,000	~~$1,200~~ $1,800

37.9	$400,001 - $450,000	~~$1,350~~ $2,025
37.10	$450,001 - $500,000	~~$1,500~~ $2,250
37.11	$500,001 - $550,000	~~$1,650~~ $2,475
37.12	$550,001 - $600,000	~~$1,800~~ $2,700
37.13	$600,001 - $650,000	~~$1,950~~ $2,925
37.14	$650,001 - $700,000	~~$2,100~~ $3,150
37.15	$700,001 - $750,000	~~$2,250~~ $3,375
37.16	$750,001 - $800,000	~~$2,400~~ $3,600
37.17	$800,001 - $850,000	~~$2,550~~ $3,825
37.18	$850,001 - $900,000	~~$2,700~~ $4,050
37.19	$900,001 - $950,000	~~$2,850~~ $4,275
37.20	$950,001 - $1,000,000	~~$3,000~~ $4,500
37.21	$1,000,001 - $1,050,000	~~$3,150~~ $4,725
37.22	$1,050,001 - $1,100,000	~~$3,300~~ $4,950
37.23	$1,100,001 - $1,150,000	~~$3,450~~ $5,175
37.24	$1,150,001 - $1,200,000	~~$3,600~~ $5,400
37.25	$1,200,001 - $1,250,000	~~$3,750~~ $5,625
37.26	$1,250,001 - $1,300,000	~~$3,900~~ $5,850
37.27	$1,300,001 - $1,350,000	~~$4,050~~ $6,075
37.28	$1,350,001 - $1,400,000	~~$4,200~~ $6,300
37.29	$1,400,001 - $1,450,000	~~$4,350~~ $6,525
37.30	$1,450,001 - $1,500,000	~~$4,500~~ $6,750
37.31	$1,500,001 and over	~~$4,800~~ $7,200

37.32 Sec. 25. **[144.7051] DEFINITIONS.**

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

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

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

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

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

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

38.12 Sec. 26. **[144.7053] HOSPITAL NURSE STAFFING COMMITTEES.**

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

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

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

38.29 Subd. 3. **Compensation.** A hospital must treat participation in committee meetings by
38.30 any hospital employee as scheduled work time and compensate each committee member at
38.31 the employee's existing rate of pay. A hospital must relieve all direct care registered nurse

38.32 members of the hospital nurse staffing committee of other work duties during the times at
38.33 which the committee meets.

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

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

39.7 (b) Each hospital nurse staffing committee must:

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

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

39.11 (3) review the documentation of compliance maintained by the hospital under section
39.12 144.7056, subdivision 5;

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

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

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

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

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

39.21 Sec. 27. Minnesota Statutes 2020, section 144.7055, is amended to read:

39.22 **144.7055 HOSPITAL CORE STAFFING PLAN ~~REPORTS~~.**

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

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

39.28 ~~(c)~~ (b) "Nonmanagerial care staff" means registered nurses, licensed practical nurses,
39.29 and other health care workers, which may include but is not limited to nursing assistants,
39.30 nursing aides, patient care technicians, and patient care assistants, who perform
40.1 nonmanagerial direct patient care functions for more than 50 percent of their scheduled
40.2 hours on a given patient care unit.

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

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

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

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

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

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

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

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

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

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

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

41.3 (c) Core staffing plans must ensure that:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

42.19 Subd. 3. **Standard electronic reporting ~~developed~~ of core staffing plans.** ~~(a) Hospitals~~
42.20 Each hospital must submit the core staffing plans approved by the hospital's nurse staffing
42.21 committee to the Minnesota Hospital Association ~~by January 1, 2014~~. The Minnesota
42.22 Hospital Association shall include each ~~reporting~~ hospital's core staffing ~~plan~~ plans on the
42.23 Minnesota Hospital Association's Minnesota Hospital Quality Report website ~~by April 1,~~
42.24 ~~2014~~ by June 1, 2024. Hospitals shall submit to the Minnesota Hospital Association any
42.25 substantial ~~changes~~ updates to ~~the~~ a core staffing plan ~~shall be updated~~ within 30 days of
42.26 the approval of the updates by the hospital's nurse staffing committee or of amendment
42.27 through arbitration. The Minnesota Hospital Association shall update the Minnesota Hospital
42.28 Quality Report website with the updated core staffing plans within 30 days of receipt of the
42.29 updated plan.

42.30 Subd. 4. **Standard electronic reporting of direct patient care report.** ~~(b)~~ The Minnesota
42.31 Hospital Association shall include on its website for each reporting hospital on a quarterly
42.32 basis the actual direct patient care hours per patient and per unit. Hospitals must submit the
43.1 direct patient care report to the Minnesota Hospital Association ~~by July 1, 2014, and~~ quarterly
43.2 ~~thereafter~~.

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

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

43.7 Sec. 28. **[144.7056] IMPLEMENTATION OF HOSPITAL CORE STAFFING PLANS.**

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

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

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

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

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

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

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

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

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

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

44.9 Sec. 29. **[144.7059] RETALIATION PROHIBITED.**

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

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

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

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

44.19 (4) submitting a report of unsafe staffing conditions.

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

44.21 Sec. 30. **[144.8611] DRUG OVERDOSE AND SUBSTANCE ABUSE PREVENTION.**

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

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

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

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

45.19 Subd. 5. **Eligible grantees.** (a) Organizations eligible to receive grant funding under
45.20 subdivision 4 include not-for-profit agencies or organizations with existing organizational
45.21 structure, capacity, trainers, facilities, and infrastructure designed to deliver model workplace
45.22 policies and practices; that have training and education for employees, supervisors, and

45.23 executive leadership of companies, businesses, and industry; and that have the ability to
45.24 evaluate the three goals of the workplace initiative specified in subdivision 4.

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

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

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

46.1 Sec. 31. Minnesota Statutes 2020, section 144.9501, subdivision 9, is amended to read:

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

46.6 Sec. 32. **[144.9981] CLIMATE RESILIENCY.**

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

46.9 (1) increase awareness of climate change;

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

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

46.14 (4) coordinate with the commissioners of the Pollution Control Agency, natural resources,
46.15 agriculture, and other state agencies in climate resiliency related planning and
46.16 implementation.

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

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

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

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

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

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

332.11 Sec. 15. **[145.267] FETAL ALCOHOL SPECTRUM DISORDERS PREVENTION**
332.12 **GRANTS.**

332.13 (a) The commissioner of health shall award a grant to a statewide organization that
332.14 focuses solely on prevention of and intervention with fetal alcohol spectrum disorders. The
332.15 grant recipient must make subgrants to eligible regional collaboratives in rural and urban
332.16 areas of the state for the purposes specified in paragraph (c).

332.17 (b) "Eligible regional collaboratives" means a partnership between at least one local
332.18 government or Tribal government and at least one community-based organization and,
332.19 where available, a family home visiting program. For purposes of this paragraph, a local
332.20 government includes a county or a multicounty organization, a county-based purchasing
332.21 entity, or a community health board.

332.22 (c) Eligible regional collaboratives must use subgrant funds to reduce the incidence of
332.23 fetal alcohol spectrum disorders and other prenatal drug-related effects in children in
332.24 Minnesota by identifying and serving pregnant women suspected of or known to use or
332.25 abuse alcohol or other drugs. Eligible regional collaboratives must provide intensive services
332.26 to chemically dependent women to increase positive birth outcomes.

332.27 (d) An eligible regional collaborative that receives a subgrant under this section must
332.28 report to the grant recipient by January 15 of each year on the services and programs funded
332.29 by the subgrant. The report must include measurable outcomes for the previous year,
332.30 including the number of pregnant women served and the number of toxin-free babies born.
332.31 The grant recipient must compile the information in the subgrant reports and submit a
332.32 summary report to the commissioner of health by February 15 of each year.

332.33 **EFFECTIVE DATE.** This section is effective July 1, 2023.

47.1 Sec. 33. **[145.361] LONG COVID; SUPPORTING SURVIVORS AND MONITORING**
47.2 **IMPACT.**

47.3 Subdivision 1. **Definition.** For the purpose of this section, "long COVID" means health
47.4 problems that people experience four or more weeks after being infected with SARS-CoV-2,

47.5 the virus that causes COVID-19. Long COVID is also called post COVID, long-haul COVID,
47.6 chronic COVID, post-acute COVID, or post-acute sequelae of COVID-19 (PASC).

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

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

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

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

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

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

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

47.29 Subd. 5. **Grant recipient and contractor eligibility.** The commissioner of health shall
47.30 award contracts and competitive grants to organizations that serve communities
47.31 disproportionately impacted by COVID-19 and long COVID including but not limited to
47.32 rural and low-income areas, Black and African Americans, African immigrants, American
48.1 Indians, Asian American-Pacific Islanders, Latino, LGBTQ+, and persons with disabilities.
48.2 Organizations may also address intersectionality within such groups.

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

48.8 Sec. 34. Minnesota Statutes 2020, section 145.56, is amended by adding a subdivision to
48.9 read:

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

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

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

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

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

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

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

48.25 (f) "988 Hotline" or "Lifeline Center" means a state-identified center that is a member
48.26 of the National Suicide Prevention Lifeline network that responds to statewide or regional
48.27 988 contacts.

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

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

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

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

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

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

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

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

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

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

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

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

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

49.28 Sec. 37. **[145.871] UNIVERSAL, VOLUNTARY HOME VISITING PROGRAM.**

49.29 Subdivision 1. **Grant program.** (a) The commissioner of health shall award grants to
49.30 eligible individuals and entities to establish voluntary home visiting services to families
49.31 expecting or caring for an infant, including families adopting an infant. The following
50.1 individuals and entities are eligible for a grant under this section: community health boards;
50.2 nonprofit organizations; Tribal Nations; and health care providers, including doulas,
50.3 community health workers, perinatal health educators, early childhood family education
50.4 home visiting providers, nurses, community health technicians, and local public health
50.5 nurses.

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

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

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

50.11 (i) maternal and newborn health;

50.12 (ii) school readiness and achievement;

50.13 (iii) family economic self-sufficiency;

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

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

50.16 (vi) reduction in crime or domestic violence.

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

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

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

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

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

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

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

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

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

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

51.18 Sec. 38. Minnesota Statutes 2020, section 145.924, is amended to read:

51.19 **145.924 AIDS PREVENTION GRANTS.**

51.20 (a) The commissioner may award grants to community health boards as defined in section
51.21 145A.02, subdivision 5, state agencies, state councils, or nonprofit corporations to provide
51.22 evaluation and counseling services to populations at risk for acquiring human
51.23 immunodeficiency virus infection, including, but not limited to, minorities, adolescents,
51.24 intravenous drug users, and homosexual men.

51.25 (b) The commissioner may award grants to agencies experienced in providing services
51.26 to communities of color, for the design of innovative outreach and education programs for
51.27 targeted groups within the community who may be at risk of acquiring the human
51.28 immunodeficiency virus infection, including intravenous drug users and their partners,
51.29 adolescents, gay and bisexual individuals and women. Grants shall be awarded on a request
51.30 for proposal basis and shall include funds for administrative costs. Priority for grants shall
51.31 be given to agencies or organizations that have experience in providing service to the
51.32 particular community which the grantee proposes to serve; that have policy makers
51.33 representative of the targeted population; that have experience in dealing with issues relating
52.1 to HIV/AIDS; and that have the capacity to deal effectively with persons of differing sexual
52.2 orientations. For purposes of this paragraph, the "communities of color" are: the
52.3 American-Indian community; the Hispanic community; the African-American community;
52.4 and the Asian-Pacific community.

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

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

52.11 Sec. 39. **[145.9271] COMMUNITY SOLUTIONS FOR HEALTHY CHILD**
52.12 **DEVELOPMENT GRANT PROGRAM.**

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

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

52.22 (2) reduce racial disparities in children's health and development from prenatal to grade
52.23 3; and

52.24 (3) promote racial and geographic equity.

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

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

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

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

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

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

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

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

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

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

53.17 (1) two members representing the African Heritage community;

53.18 (2) two members representing the Latino community;

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

53.20 (4) two members representing the American Indian community;

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

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

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

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

53.29 (c) The community solutions advisory council shall:

53.30 (1) advise the commissioner on the development of the request for proposals for
53.31 community solutions healthy child development grants. In advising the commissioner, the
54.1 council must consider how to build on the capacity of communities to promote child and
54.2 family well-being and address social determinants of healthy child development;

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

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

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

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

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

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

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

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

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

54.19 Subd. 5. **Strategic consideration and priority of proposals; eligible populations;**
54.20 **grant awards.** (a) The commissioner, in consultation with the community solutions advisory
54.21 council, shall develop a request for proposals for healthy child development grants. In
54.22 developing the proposals and awarding the grants, the commissioner shall consider building
54.23 on the capacity of communities to promote child and family well-being and address social
54.24 determinants of healthy child development. Proposals must focus on increasing racial equity
54.25 and healthy child development and reducing health disparities experienced by children of

54.26 Black, nonwhite people of color, and American Indian communities from prenatal to grade
54.27 3 and their families.

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

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

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

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

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

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

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

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

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

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

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

55.20 Sec. 40. **[145.9272] LEAD TESTING AND REMEDIATION GRANT PROGRAM;**
55.21 **SCHOOLS, CHILD CARE CENTERS, FAMILY CHILD CARE PROVIDERS.**

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

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

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

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

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

56.6 Subd. 3. **Uses of grant funds.** Licensed child care centers and licensed family child care
56.7 providers must use grant funds under this section to test their drinking water for lead;
56.8 remediate sources of lead contamination within the building, including lead service lines
56.9 and premises plumbing; and implement best practices for water management within the
56.10 building. Schools must use grant funds under this section to remediate sources of lead
56.11 contamination within the building and implement best practices for water management
56.12 within the building.

56.13 Sec. 41. **[145.9274] REPORTS; SCHOOL TEST RESULTS AND REMEDIATION**
56.14 **EFFORTS FOR LEAD IN DRINKING WATER.**

56.15 (a) School districts and charter schools must report to the commissioner of health in a
56.16 form and manner determined by the commissioner:

56.17 (1) test results regarding the presence of lead in drinking water in the school district's
56.18 or charter school's buildings; and

56.19 (2) information on remediation efforts to address lead in drinking water, if a test reveals
56.20 lead in drinking water in an amount above 15 parts per billion.

56.21 (b) The commissioner must post on the department website and annually update the test
56.22 results and information on remediation efforts reported under paragraph (a). The
56.23 commissioner must post test results and remediation efforts by school site.

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

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

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

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

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

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

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

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

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

57.23 Subdivision 1. **Establishment.** The commissioner of health shall support collaboration
57.24 and coordination between state and community partners to develop, refine, and expand the
57.25 community health workers profession across the state equipping them to address health
57.26 needs and to improve health outcomes by addressing the social conditions that impact health
57.27 status. Community health professionals' work expands beyond health care to bring health
57.28 and racial equity into public safety, social services, youth and family services, schools,
57.29 neighborhood associations, and more.

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

58.1 Subd. 3. **Evaluation.** The commissioner of health shall design, conduct, and evaluate
58.2 the CHW initiative using measures of workforce capacity, employment opportunity, reach
58.3 of services, and return on investment, as well as descriptive measures of the extant CHW
58.4 models as they compare with the national community health workers' landscape. These
58.5 more proximal measures are collected and analyzed as foundational to longer-term change

58.6 in social determinants of health and rates of death and injury by suicide, overdose, firearms,
58.7 alcohol, and chronic disease.

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

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

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

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

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

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

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

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

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

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

59.7 Subdivision 1. **Purposes.** The purposes of the Healthy Beginnings, Healthy Families
59.8 Act are to: (1) address the significant disparities in early childhood outcomes and increase
59.9 the number of children who are school ready through establishing the Minnesota collaborative
59.10 to prevent infant mortality; (2) sustain the Help Me Connect online navigator; (3) improve
59.11 universal access to developmental and social-emotional screening and follow-up; and (4)

59.12 sustain and expand the model jail practices for children of incarcerated parents in Minnesota
59.13 jails.

59.14 Subd. 2. **Minnesota collaborative to prevent infant mortality.** (a) The Minnesota
59.15 collaborative to prevent infant mortality is established. The goals of the Minnesota
59.16 collaborative to prevent infant mortality program are to:

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

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

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

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

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

60.9 (b) Grantee activities shall:

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

60.11 (2) be based on community input;

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

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

60.16 (c) The commissioner shall review each application to determine whether the application
60.17 is complete and whether the applicant and the project are eligible for a grant. In evaluating
60.18 applications under this subdivision, the commissioner shall establish criteria including but
60.19 not limited to: (1) the eligibility of the project; (2) the applicant's thoroughness and clarity
60.20 in describing the infant health issues grant funds are intended to address; (3) a description
60.21 of the applicant's proposed project; (4) a description of the population demographics and
60.22 service area of the proposed project; and (5) evidence of efficiencies and effectiveness
60.23 gained through collaborative efforts.

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

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

60.28 (b) For the purposes of carrying out the grant program under subdivision 3, including
60.29 for administrative purposes, the commissioner shall award contracts to appropriate entities
60.30 to assist in training and to provide technical assistance to grantees.

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

61.1 (1) partnership development and capacity building;

61.2 (2) Tribal support;

61.3 (3) implementation support for specific infant health strategies;

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

61.5 (5) health equity.

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

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

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

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

61.18 (b) Help Me Connect shall provide community outreach that includes support for and
61.19 participation in the help me connect system, including disseminating information and
61.20 compiling and maintaining a current resource directory that includes but is not limited to
61.21 primary and specialty medical care providers, early childhood education and child care
61.22 programs, developmental disabilities assessment and intervention programs, mental health
61.23 services, family and social support programs, child advocacy and legal services, public
61.24 health and human services and resources, and other appropriate early childhood information.

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

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

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

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

62.9 (b) The commissioner shall:

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

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

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

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

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

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

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

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

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

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

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

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

63.14 (1) parenting classes or groups;

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

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

63.17 (4) correctional staff training;

63.18 (5) policies and practices for family visits; and

63.19 (6) family-focused reentry planning.

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

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

63.25 (b) For the purposes of carrying out the grant program under subdivision 10, including
63.26 for administrative purposes, the commissioner shall award contracts to appropriate entities
63.27 to assist in training and provide technical assistance to grantees.

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

63.30 (1) evidence-based training for incarcerated parents;

63.31 (2) partnership building and community engagement;

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

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

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

64.5 Subdivision 1. **Purpose.** (a) The purpose of the Minnesota School Health Initiative is
64.6 to implement evidence-based practices to strengthen and expand health promotion and
64.7 health care delivery activities in schools to improve the holistic health of students. To better
64.8 serve students, the Minnesota School Health Initiative shall unify the best practices of the
64.9 school-based health center and Whole School, Whole Community, Whole Child models.

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

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

64.15 (b) "School-based health center" or "comprehensive school-based health center" means
64.16 a safety net health care delivery model that is located in or near a school facility and that
64.17 offers comprehensive health care, including preventive and behavioral health services, by
64.18 licensed and qualified health professionals in accordance with federal, state, and local law.
64.19 When not located on school property, the school-based health center must have an established
64.20 relationship with one or more schools in the community and operate primarily to serve those
64.21 student groups.

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

64.24 (1) health care providers;

64.25 (2) community clinics;

64.26 (3) hospitals;

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

64.28 (5) health care foundations or nonprofit organizations;

64.29 (6) higher education institutions; or

64.30 (7) local health departments.

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

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

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

65.9 (2) provide health services through a sponsoring organization; and

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

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

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

65.17 (1) preventative health care;

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

65.19 (3) mental health care and crisis management;

65.20 (4) acute care for illness and injury;

65.21 (5) oral health care;

65.22 (6) vision care;

65.23 (7) nutritional counseling;

65.24 (8) substance abuse counseling;

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

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

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

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

66.7 Subd. 6. **Oral health in school settings.** (a) The commissioner of health shall administer
66.8 a program to provide competitive grants to schools, oral health providers, and other
66.9 community groups to build capacity and infrastructure to establish, expand, link, or strengthen
66.10 oral health services in school settings.

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

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

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

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

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

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

66.21 Subd. 7. **Whole School, Whole Community, Whole Child grants.** (a) The commissioner
66.22 of health shall administer a program to provide competitive grants to local public health
66.23 organizations, schools, and community organizations using the evidence-based Whole
66.24 School, Whole Community, Whole Child (WSCC) model to increase alignment, integration,
66.25 and collaboration between public health and education sectors to improve each child's
66.26 cognitive, physical, oral, social, and emotional development.

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

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

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

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

67.3 (4) promote and establish lifelong healthy behaviors.

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

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

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

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

67.14 (1) needs assessment;

67.15 (2) community engagement and capacity building;

67.16 (3) community asset building and risk behavior reduction;

67.17 (4) dental provider training in calibration;

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

67.19 (6) communications;

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

67.21 (8) health equity;

67.22 (9) data collection and analysis; and

67.23 (10) evaluation.

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

67.25 Subdivision 1. **Funding formula for community health boards.** (a) Base funding for
67.26 each community health board eligible for a local public health grant under section 145A.03,
67.27 subdivision 7, shall be determined by each community health board's fiscal year 2003
67.28 allocations, prior to unallotment, for the following grant programs: community health

67.29 services subsidy; state and federal maternal and child health special projects grants; family
67.30 home visiting grants; TANF MN ENABL grants; TANF youth risk behavior grants; and
68.1 available women, infants, and children grant funds in fiscal year 2003, prior to unallotment,
68.2 distributed based on the proportion of WIC participants served in fiscal year 2003 within
68.3 the CHS service area.

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

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

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

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

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

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

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

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

69.1 (c) Notwithstanding paragraph (b), if a community health board can demonstrate that
69.2 foundational public health responsibilities are fulfilled, the community health board may
69.3 use funding for foundational public health responsibilities for local priorities developed

69.4 through the community health assessment and community health improvement planning
69.5 process.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(e) Notwithstanding this subdivision, nothing in this section shall be construed to prohibit an institution or entity from establishing, implementing, or enforcing a policy that permits only persons licensed by the commissioner to remove or cause to be removed a dead body or body part from the institution or entity.

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

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

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

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

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

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

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

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

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

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

71.21 **149A.03 DUTIES OF COMMISSIONER.**

71.22 The commissioner shall:

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

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

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

71.28 (iii) licensing and operation of a funeral establishment;

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

71.30 (v) licensing and operation of a crematory;

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

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

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

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

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

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

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

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

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

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

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

72.24 **149A.09 DENIAL; REFUSAL TO REISSUE; REVOCATION; SUSPENSION;**
72.25 **LIMITATION OF LICENSE, REGISTRATION, OR PERMIT.**

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

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

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

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

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

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

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

73.21 (7) has a conservator or guardian appointed;

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

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

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

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

73.31 Subd. 2. **Hearings related to refusal to renew, suspension, or revocation of license,**
73.32 **registration, or permit.** If the regulatory agency proposes to deny renewal, suspend, or
73.33 revoke a license, registration, or permit issued under this chapter, the regulatory agency
74.1 must first notify, in writing, the person against whom the action is proposed to be taken and
74.2 provide an opportunity to request a hearing under the contested case provisions of sections
74.3 14.57 to 14.62. If the subject of the proposed action does not request a hearing by notifying
74.4 the regulatory agency, by mail, within 20 calendar days after the receipt of the notice of
74.5 proposed action, the regulatory agency may proceed with the action without a hearing and
74.6 the action will be the final order of the regulatory agency.

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

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

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

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

74.19 **149A.11 PUBLICATION OF DISCIPLINARY ACTIONS.**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

75.29 (b) To renew a registration, the transfer care specialist must submit a completed renewal
75.30 application as provided by the commissioner and the appropriate fees specified in section
75.31 149A.65. Every five years, the renewal application must include proof of completion of a
75.32 training program that meets the requirements in subdivision 4.

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

76.2 **149A.60 PROHIBITED CONDUCT.**

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

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

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

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

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

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

76.24 **149A.62 IMMUNITY; REPORTING.**

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

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

149A.63 PROFESSIONAL COOPERATION.

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

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

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

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

(2) $125 for the mortuary science examination;

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

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

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

(6) $687 for the initial and renewal registration of a transfer care specialist.

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

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

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

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

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

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

Any advertising or other printed material that contains the names or pictures of persons affiliated with a funeral establishment, alkaline hydrolysis facility, or crematory shall state

78.6 the position held by the persons and shall identify each person who is licensed or unlicensed
78.7 under this chapter.

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

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

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

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

78.15 Subd. 5. **Reimbursement prohibited.** No licensee, clinical student, practicum student,
78.16 or intern, or transfer care specialist shall offer, solicit, or accept a commission, fee, bonus,
78.17 rebate, or other reimbursement in consideration for recommending or causing a dead human
78.18 body to be disposed of by a specific body donation program, funeral establishment, alkaline
78.19 hydrolysis facility, crematory, mausoleum, or cemetery.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

79.27 (2) the date and time of removal;

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

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

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

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

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

80.7 Subd. 5. **Retention of certificate of removal.** A copy of the certificate of removal shall
80.8 be given, where possible, to the person or representative of the legal entity having physical
80.9 or legal custody of the body at the death site. The original certificate of removal shall be
80.10 retained by the individual making the removal and shall be kept on file, at the funeral
80.11 establishment to which the body was taken, for a period of three calendar years following
80.12 the date of the removal. If the removal was performed by a transfer care specialist not
80.13 employed by the funeral establishment to which the body was taken, the transfer care
80.14 specialist shall retain a copy of the certificate on file at the transfer care specialist's business
80.15 address as registered with the commissioner for a period of three calendar years following
80.16 the date of removal. Following this period, and subject to any other laws requiring retention

80.17 of records, the funeral establishment may then place the records in storage or reduce them
80.18 to microfilm, microfiche, laser disc, or any other method that can produce an accurate
80.19 reproduction of the original record, for retention for a period of ten calendar years from the
80.20 date of the removal of the body. At the end of this period and subject to any other laws
80.21 requiring retention of records, the funeral establishment may destroy the records by shredding,
80.22 incineration, or any other manner that protects the privacy of the individuals identified in
80.23 the records.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

83.4 Subdivision 1. **Medical cannabis manufacturer registration and renewal.** (a) The
83.5 commissioner shall register ~~two~~ at least four and up to ten in-state manufacturers for the
83.6 production of all medical cannabis within the state. ~~A~~ The registration ~~agreement between~~
83.7 ~~the commissioner and a manufacturer~~ is valid for two years, unless revoked under subdivision
83.8 1a, and is nontransferable. ~~The commissioner shall register new manufacturers or reregister~~
83.9 ~~the existing manufacturers by December 1 every two years, using the factors described in~~
83.10 ~~this subdivision. The commissioner shall accept applications after December 1, 2014, if one~~
83.11 ~~of the manufacturers registered before December 1, 2014, ceases to be registered as a~~
83.12 ~~manufacturer. The commissioner's determination that no manufacturer exists to fulfill the~~
83.13 ~~duties under sections 152.22 to 152.37 is subject to judicial review in Ramsey County~~
83.14 ~~District Court.~~ Once the commissioner has registered more than two manufacturers,
83.15 registration renewal for at least one manufacturer must occur each year. The commissioner
83.16 shall begin registering additional manufacturers by December 1, 2022. The commissioner
83.17 shall renew a registration if the manufacturer meets the factors described in this subdivision
83.18 and submits the registration renewal fee under section 152.35.

83.19 (b) An individual or entity seeking registration or registration renewal under this
83.20 subdivision must apply to the commissioner in a form and manner established by the
83.21 commissioner. As part of the application, the applicant must submit an attestation signed
83.22 by a bona fide labor organization stating that the applicant has entered into a labor peace
83.23 agreement. Before accepting applications for registration or registration renewal, the
83.24 commissioner must publish on the Office of Medical Cannabis website the application
83.25 scoring criteria established by the commissioner to determine whether the applicant meets
83.26 requirements for registration or registration renewal. Data submitted during the application
83.27 process are private data on individuals or nonpublic data as defined in section 13.02 until
83.28 the manufacturer is registered under this section. Data on a manufacturer that is registered
83.29 are public data, unless the data are trade secret or security information under section 13.37.

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

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

83.33 ~~(2)~~ (1) a manufacturer must comply with all requirements under sections 152.22 to
83.34 152.37~~.~~;

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

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

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

84.7 (1) the technical expertise of the manufacturer in cultivating medical cannabis and
84.8 converting the medical cannabis into an acceptable delivery method under section 152.22,
84.9 subdivision 6;

84.10 (2) the qualifications of the manufacturer's employees;

84.11 (3) the long-term financial stability of the manufacturer;

84.12 (4) the ability to provide appropriate security measures on the premises of the
84.13 manufacturer;

84.14 (5) whether the manufacturer has demonstrated an ability to meet the medical cannabis
84.15 production needs required by sections 152.22 to 152.37; ~~and~~

84.16 (6) the manufacturer's projection and ongoing assessment of fees on patients with a
84.17 qualifying medical condition~~.~~;

84.18 (7) the manufacturer's inclusion of leadership or beneficial ownership, as defined in
84.19 section 302A.011, subdivision 41, by:

84.20 (i) minority persons as defined in section 116M.14, subdivision 6;

84.21 (ii) women;

84.22 (iii) individuals with disabilities as defined in section 363A.03, subdivision 12; or

84.23 (iv) military veterans who satisfy the requirements of section 197.447;

84.24 (8) the extent to which registering the manufacturer or renewing the registration will
84.25 expand service to a currently underserved market;

84.26 (9) the extent to which registering the manufacturer or renewing the registration will
84.27 promote development in a low-income area as defined in section 116J.982, subdivision 1,
84.28 paragraph (e);

84.29 (10) beneficial ownership as defined in section 302A.011, subdivision 41, of the
84.30 manufacturer by Minnesota residents; and

85.1 (11) other factors the commissioner determines are necessary to protect patient health
85.2 and ensure public safety.

85.3 (e) Commitments made by an applicant in the application for registration or registration
85.4 renewal, including but not limited to maintenance of a labor peace agreement, shall be an
85.5 ongoing material condition of maintaining a manufacturer registration.

85.6 ~~(d)~~ (f) If an officer, director, or controlling person of the manufacturer pleads or is found
85.7 guilty of intentionally diverting medical cannabis to a person other than allowed by law
85.8 under section 152.33, subdivision 1, the commissioner may decide not to renew the
85.9 registration of the manufacturer, provided the violation occurred while the person was an
85.10 officer, director, or controlling person of the manufacturer.

85.11 ~~(e) The commissioner shall require each medical cannabis manufacturer to contract with~~
85.12 ~~an independent laboratory to test medical cannabis produced by the manufacturer. The~~
85.13 ~~commissioner shall approve the laboratory chosen by each manufacturer and require that~~
85.14 ~~the laboratory report testing results to the manufacturer in a manner determined by the~~
85.15 ~~commissioner.~~

85.16 Sec. 82. Minnesota Statutes 2020, section 152.25, is amended by adding a subdivision to
85.17 read:

85.18 Subd. 1d. **Background study.** (a) Before the commissioner registers a manufacturer or
85.19 renews a registration, each officer, director, and controlling person of the manufacturer
85.20 must consent to a background study and must submit to the commissioner a completed
85.21 criminal history records check consent form, a full set of classifiable fingerprints, and the
85.22 required fees. The commissioner must submit these materials to the Bureau of Criminal
85.23 Apprehension. The bureau must conduct a Minnesota criminal history records check, and
85.24 the superintendent is authorized to exchange fingerprints with the Federal Bureau of
85.25 Investigation to obtain national criminal history record information. The bureau must return
85.26 the results of the Minnesota and federal criminal history records checks to the commissioner.

85.27 (b) The commissioner must not register a manufacturer or renew a registration if an
85.28 officer, director, or controlling person of the manufacturer has been convicted of, pled guilty
85.29 to, or received a stay of adjudication for:

85.30 (1) a violation of state or federal law related to theft, fraud, embezzlement, breach of
85.31 fiduciary duty, or other financial misconduct that is a felony under Minnesota law or would
85.32 be a felony if committed in Minnesota; or

86.1 (2) a violation of state or federal law relating to unlawful manufacture, distribution,
86.2 prescription, or dispensing of a controlled substance that is a felony under Minnesota law
86.3 or would be a felony if committed in Minnesota.

86.4 Sec. 83. Minnesota Statutes 2020, section 152.29, subdivision 4, is amended to read:

86.5 Subd. 4. **Report.** (a) Each manufacturer shall report to the commissioner on a monthly
86.6 basis the following information on each individual patient for the month prior to the report:

86.7 (1) the amount and dosages of medical cannabis distributed;

86.8 (2) the chemical composition of the medical cannabis; and

86.9 (3) the tracking number assigned to any medical cannabis distributed.

86.10 (b) For transactions involving Tribal medical cannabis program patients, each
86.11 manufacturer shall report to the commissioner on a weekly basis the following information
86.12 on each individual Tribal medical cannabis program patient for the week prior to the report:

86.13 (1) the name of the Tribal medical cannabis program in which the Tribal medical cannabis
86.14 program patient is enrolled;

86.15 (2) the amount and dosages of medical cannabis distributed;

86.16 (3) the chemical composition of the medical cannabis; and

86.17 (4) the tracking number assigned to the medical cannabis distributed.

86.18 Sec. 84. Minnesota Statutes 2020, section 152.29, is amended by adding a subdivision to
86.19 read:

86.20 Subd. 5. **Distribution to Tribal medical cannabis program patient.** (a) A manufacturer
86.21 may distribute medical cannabis in accordance with subdivisions 1 to 4 to a Tribal medical
86.22 cannabis program patient.

86.23 (b) Prior to distribution, the Tribal medical cannabis program patient must provide to
86.24 the manufacturer:

86.25 (1) a valid medical cannabis registration verification card or equivalent document issued
86.26 by a Tribal medical cannabis program that indicates that the Tribal medical cannabis program
86.27 patient is authorized to use medical cannabis on Indian lands over which the Tribe has
86.28 jurisdiction; and

86.29 (2) a valid photographic identification card issued by the Tribal medical cannabis
86.30 program, valid driver's license, or valid state identification card.

87.1 (c) A manufacturer shall distribute medical cannabis to a Tribal medical cannabis program
87.2 patient only in a form allowed under section 152.22, subdivision 6.

87.3 Sec. 85. **[152.291] TRIBAL MEDICAL CANNABIS PROGRAM;**
87.4 **MANUFACTURERS.**

87.5 Subdivision 1. **Manufacturer.** Notwithstanding the requirements and limitations in
87.6 section 152.29, subdivision 1, paragraph (a), a Tribal medical cannabis program operated
87.7 by a federally recognized Indian Tribe located in Minnesota shall be recognized as a medical
87.8 cannabis manufacturer.

87.9 Subd. 2. **Manufacturer transportation.** (a) A manufacturer registered with a Tribal
87.10 medical cannabis program may transport medical cannabis to testing laboratories and to
87.11 other Indian lands in the state.

87.12 (b) A manufacturer registered with a Tribal medical cannabis program must staff a motor
87.13 vehicle used to transport medical cannabis with at least two employees of the manufacturer.
87.14 Each employee in the transport vehicle must carry identification specifying that the employee
87.15 is an employee of the manufacturer, and one employee in the transport vehicle must carry
87.16 a detailed transportation manifest that includes the place and time of departure, the address
87.17 of the destination, and a description and count of the medical cannabis being transported.

87.18 Sec. 86. Minnesota Statutes 2020, section 152.30, is amended to read:

87.19 **152.30 PATIENT DUTIES.**

87.20 (a) A patient shall apply to the commissioner for enrollment in the registry program by
87.21 submitting an application as required in section 152.27 and an annual registration fee as
87.22 determined under section 152.35.

87.23 (b) As a condition of continued enrollment, patients shall agree to:

87.24 (1) continue to receive regularly scheduled treatment for their qualifying medical
87.25 condition from their health care practitioner; and

87.26 (2) report changes in their qualifying medical condition to their health care practitioner.

87.27 (c) A patient shall only receive medical cannabis from a registered manufacturer or
87.28 Tribal medical cannabis program but is not required to receive medical cannabis products
87.29 from only a registered manufacturer or Tribal medical cannabis program.

88.1 Sec. 87. Minnesota Statutes 2020, section 152.32, is amended to read:

88.2 **152.32 PROTECTIONS FOR REGISTRY PROGRAM PARTICIPATION OR**
88.3 **PARTICIPATION IN A TRIBAL MEDICAL CANNABIS PROGRAM.**

88.4 Subdivision 1. **Presumption.** (a) There is a presumption that a patient enrolled in the
88.5 registry program under sections 152.22 to 152.37 or a Tribal medical cannabis program
88.6 patient enrolled in a Tribal medical cannabis program is engaged in the authorized use of
88.7 medical cannabis.

88.8 (b) The presumption may be rebutted:

88.9 (1) by evidence that a patient's conduct related to use of medical cannabis was not for
88.10 the purpose of treating or alleviating the patient's qualifying medical condition or symptoms
88.11 associated with the patient's qualifying medical condition; or

88.12 (2) by evidence that a Tribal medical cannabis program patient's use of medical cannabis
88.13 was not for a purpose authorized by the Tribal medical cannabis program.

88.14 Subd. 2. **Criminal and civil protections.** (a) Subject to section 152.23, the following
88.15 are not violations under this chapter:

88.16 (1) use or possession of medical cannabis or medical cannabis products by a patient
88.17 enrolled in the registry program, or; possession by a registered designated caregiver or the
88.18 parent, legal guardian, or spouse of a patient if the parent, legal guardian, or spouse is listed
88.19 on the registry verification; or use or possession of medical cannabis or medical cannabis
88.20 products by a Tribal medical cannabis program patient;

88.21 (2) possession, dosage determination, or sale of medical cannabis or medical cannabis
88.22 products by a medical cannabis manufacturer, employees of a manufacturer, a laboratory
88.23 conducting testing on medical cannabis, or employees of the laboratory; and

88.24 (3) possession of medical cannabis or medical cannabis products by any person while
88.25 carrying out the duties required under sections 152.22 to 152.37.

88.26 (b) Medical cannabis obtained and distributed pursuant to sections 152.22 to 152.37 and
88.27 associated property is not subject to forfeiture under sections 609.531 to 609.5316.

88.28 (c) The commissioner, members of a Tribal medical cannabis board, the commissioner's
88.29 or Tribal medical cannabis board's staff, the commissioner's or Tribal medical cannabis
88.30 board's agents or contractors, and any health care practitioner are not subject to any civil or
88.31 disciplinary penalties by the Board of Medical Practice, the Board of Nursing, or by any
88.32 business, occupational, or professional licensing board or entity, solely for the participation
89.1 in the registry program under sections 152.22 to 152.37 or in a Tribal medical cannabis
89.2 program. A pharmacist licensed under chapter 151 is not subject to any civil or disciplinary
89.3 penalties by the Board of Pharmacy when acting in accordance with the provisions of
89.4 sections 152.22 to 152.37. Nothing in this section affects a professional licensing board
89.5 from taking action in response to violations of any other section of law.

89.6 (d) Notwithstanding any law to the contrary, the commissioner, the governor of
89.7 Minnesota, or an employee of any state agency may not be held civilly or criminally liable
89.8 for any injury, loss of property, personal injury, or death caused by any act or omission
89.9 while acting within the scope of office or employment under sections 152.22 to 152.37.

89.10 (e) Federal, state, and local law enforcement authorities are prohibited from accessing
89.11 the patient registry under sections 152.22 to 152.37 except when acting pursuant to a valid
89.12 search warrant.

89.13 (f) Notwithstanding any law to the contrary, neither the commissioner nor a public
89.14 employee may release data or information about an individual contained in any report,
89.15 document, or registry created under sections 152.22 to 152.37 or any information obtained
89.16 about a patient participating in the program, except as provided in sections 152.22 to 152.37.

89.17 (g) No information contained in a report, document, or registry or obtained from a patient
89.18 or a Tribal medical cannabis program patient under sections 152.22 to 152.37 may be

89.19 admitted as evidence in a criminal proceeding unless independently obtained or in connection
89.20 with a proceeding involving a violation of sections 152.22 to 152.37.

89.21 (h) Notwithstanding section 13.09, any person who violates paragraph (e) or (f) is guilty
89.22 of a gross misdemeanor.

89.23 (i) An attorney may not be subject to disciplinary action by the Minnesota Supreme
89.24 Court, a Tribal court, or the professional responsibility board for providing legal assistance
89.25 to prospective or registered manufacturers or others related to activity that is no longer
89.26 subject to criminal penalties under state law pursuant to sections 152.22 to 152.37, or for
89.27 providing legal assistance to a Tribal medical cannabis program.

89.28 (j) Possession of a registry verification or application for enrollment in the program by
89.29 a person entitled to possess or apply for enrollment in the registry program, or possession
89.30 of a verification or equivalent issued by a Tribal medical cannabis program by a person
89.31 entitled to possess such verification, does not constitute probable cause or reasonable
89.32 suspicion, nor shall it be used to support a search of the person or property of the person
89.33 possessing or applying for the registry verification or equivalent, or otherwise subject the
89.34 person or property of the person to inspection by any governmental agency.

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

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

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

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

90.21 (2) the person's status as a Tribal medical cannabis program patient enrolled in a Tribal
90.22 medical cannabis program; or

90.23 ~~(2)~~ (3) a patient's positive drug test for cannabis components or metabolites, unless the
90.24 patient used, possessed, or was impaired by medical cannabis on the premises of the place
90.25 of employment or during the hours of employment.

90.26 (d) An employee who is required to undergo employer drug testing pursuant to section
90.27 181.953 may present verification of enrollment in the patient registry or of enrollment in a
90.28 Tribal medical cannabis program as part of the employee's explanation under section 181.953,
90.29 subdivision 6.

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

91.4 Sec. 88. Minnesota Statutes 2020, section 152.33, subdivision 1, is amended to read:

91.5 Subdivision 1. **Intentional diversion; criminal penalty.** In addition to any other
91.6 applicable penalty in law, a manufacturer or an agent of a manufacturer who intentionally
91.7 transfers medical cannabis to a person other than another registered manufacturer, a patient,
91.8 a registered designated caregiver, a Tribal medical cannabis program patient, or, if listed
91.9 on the registry verification, a parent, legal guardian, or spouse of a patient is guilty of a
91.10 felony punishable by imprisonment for not more than two years or by payment of a fine of
91.11 not more than $3,000, or both. A person convicted under this subdivision may not continue
91.12 to be affiliated with the manufacturer and is disqualified from further participation under
91.13 sections 152.22 to 152.37.

91.14 Sec. 89. Minnesota Statutes 2020, section 152.35, is amended to read:

91.15 **152.35 FEES; DEPOSIT OF REVENUE.**

91.16 (a) The commissioner shall collect an enrollment fee of ~~$200~~ $40 from patients enrolled
91.17 under ~~this~~ section 152.27. ~~If the patient provides evidence of receiving Social Security~~
91.18 ~~disability insurance (SSDI), Supplemental Security Income (SSI), veterans disability, or~~
91.19 ~~railroad disability payments, or being enrolled in medical assistance or MinnesotaCare, then~~
91.20 ~~the fee shall be $50. For purposes of this section:~~

91.21 ~~(1) a patient is considered to receive SSDI if the patient was receiving SSDI at the time~~
91.22 ~~the patient was transitioned to retirement benefits by the United States Social Security~~
91.23 ~~Administration; and~~

91.24 ~~(2) veterans disability payments include VA dependency and indemnity compensation.~~

91.25 ~~Unless a patient provides evidence of receiving payments from or participating in one of~~
91.26 ~~the programs specifically listed in this paragraph, the commissioner of health must collect~~

91.27 ~~the $200 enrollment fee from a patient to enroll the patient in the registry program.~~ The fees
91.28 shall be payable annually and are due on the anniversary date of the patient's enrollment.
91.29 The fee amount shall be deposited in the state treasury and credited to the state government
91.30 special revenue fund.

91.31 (b) The commissioner shall collect ~~an~~ a nonrefundable registration application fee of
91.32 ~~$20,000~~ $10,000 from each entity submitting an application for registration as a medical
92.1 cannabis manufacturer. Revenue from the fee shall be deposited in the state treasury and
92.2 credited to the state government special revenue fund.

92.3 (c) The commissioner shall establish and collect an annual registration renewal fee from
92.4 a medical cannabis manufacturer equal to the cost of regulating and inspecting the
92.5 manufacturer ~~in that year~~ for the upcoming registration period. Revenue from the fee amount
92.6 shall be deposited in the state treasury and credited to the state government special revenue
92.7 fund.

92.8 (d) A medical cannabis manufacturer may charge patients enrolled in the registry program
92.9 a reasonable fee for costs associated with the operations of the manufacturer. The
92.10 manufacturer may establish a sliding scale of patient fees based upon a patient's household
92.11 income and may accept private donations to reduce patient fees.

333.8 Sec. 17. Minnesota Statutes 2021 Supplement, section 245C.03, subdivision 5a, is amended
333.9 to read:

333.10 Subd. 5a. **Facilities serving children or adults licensed or regulated by the**
333.11 **Department of Health.** (a) Except as specified in paragraph (b), the commissioner shall
333.12 conduct background studies of:

333.13 (1) individuals providing services who have direct contact, as defined under section
333.14 245C.02, subdivision 11, with patients and residents in hospitals, boarding care homes,
333.15 outpatient surgical centers licensed under sections 144.50 to 144.58; nursing homes and
333.16 home care agencies licensed under chapter 144A; assisted living facilities and assisted living
333.17 facilities with dementia care licensed under chapter 144G; and board and lodging
333.18 establishments that are registered to provide supportive or health supervision services under
333.19 section 157.17;

333.20 (2) individuals specified in subdivision 2 who provide direct contact services in a nursing
333.21 home or a home care agency licensed under chapter 144A; an assisted living facility or
333.22 assisted living facility with dementia care licensed under chapter 144G; or a boarding care
333.23 home licensed under sections 144.50 to 144.58. If the individual undergoing a study resides
333.24 outside of Minnesota, the study must include a check for substantiated findings of
333.25 maltreatment of adults and children in the individual's state of residence when the state
333.26 makes the information available;

333.27 (3) all other employees in assisted living facilities or assisted living facilities with
333.28 dementia care licensed under chapter 144G, nursing homes licensed under chapter 144A,
333.29 and boarding care homes licensed under sections 144.50 to 144.58. A disqualification of
333.30 an individual in this section shall disqualify the individual from positions allowing direct
333.31 contact with or access to patients or residents receiving services. "Access" means physical
333.32 access to a client or the client's personal property without continuous, direct supervision as
333.33 defined in section 245C.02, subdivision 8, when the employee's employment responsibilities
333.34 do not include providing direct contact services;

334.1 (4) individuals employed by a supplemental nursing services agency, as defined under
334.2 section 144A.70, who are providing services in health care facilities; ~~and~~

334.3 (5) controlling persons of a supplemental nursing services agency, as defined by section
334.4 144A.70~~.~~; and

334.5 (6) license applicants, owners, managerial officials, and controlling individuals who are
334.6 required under section 144A.476, subdivision 1, or 144G.13, subdivision 1, to undergo a
334.7 background study under this chapter, regardless of the licensure status of the license applicant,
334.8 owner, managerial official, or controlling individual.

334.9 (b) The commissioner of human services shall not conduct a background study on any
334.10 individual identified in paragraph (a), clauses (1) to (5), if the individual has a valid license
334.11 issued by a health-related licensing board as defined in section 214.01, subdivision 2, and
334.12 has completed the criminal background check as required in section 214.075. An entity that
334.13 is affiliated with individuals who meet the requirements of this paragraph must separate
334.14 those individuals from the entity's roster for NETStudy 2.0.

334.15 (c) If a facility or program is licensed by the Department of Human Services and the
334.16 Department of Health and is subject to the background study provisions of this chapter, the
334.17 Department of Human Services is solely responsible for the background studies of individuals
334.18 in the jointly licensed program.

334.19 ~~(c)~~ (d) The commissioner of health shall review and make decisions regarding
334.20 reconsideration requests, including whether to grant variances, according to the procedures
334.21 and criteria in this chapter. The commissioner of health shall inform the requesting individual
334.22 and the Department of Human Services of the commissioner of health's decision regarding
334.23 the reconsideration. The commissioner of health's decision to grant or deny a reconsideration
334.24 of a disqualification is a final administrative agency action.

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

334.26 Sec. 18. Minnesota Statutes 2020, section 245C.31, subdivision 1, is amended to read:

334.27 Subdivision 1. **Board determines disciplinary or corrective action.** (a) ~~When the~~
334.28 ~~subject of a background study is regulated by a health-related licensing board as defined in~~
334.29 ~~chapter 214, and the commissioner determines that the regulated individual is responsible~~
334.30 ~~for substantiated maltreatment under section 626.557 or chapter 260E, instead of the~~

334.31 ~~commissioner making a decision regarding disqualification, the board shall make a~~
334.32 ~~determination whether to impose disciplinary or corrective action under chapter 214~~ The
334.33 commissioner shall notify a health-related licensing board as defined in section 214.01,
335.1 subdivision 2, if the commissioner determines that an individual who is licensed by the
335.2 health-related licensing board and who is included on the board's roster list provided in
335.3 accordance with subdivision 3a is responsible for substantiated maltreatment under section
335.4 626.557 or chapter 260E, in accordance with subdivision 2. Upon receiving notification,
335.5 the health-related licensing board shall make a determination as to whether to impose
335.6 disciplinary or corrective action under chapter 214.

335.7 (b) This section does not apply to a background study of an individual regulated by a
335.8 health-related licensing board if the individual's study is related to child foster care, adult
335.9 foster care, or family child care licensure.

335.10 **EFFECTIVE DATE.** This section is effective February 1, 2023.

335.11 Sec. 19. Minnesota Statutes 2020, section 245C.31, subdivision 2, is amended to read:

335.12 Subd. 2. **Commissioner's notice to board.** ~~(a)~~ The commissioner shall notify ~~the~~ a
335.13 health-related licensing board:

335.14 (1) ~~upon completion of a background study that produces~~ of a record showing that the
335.15 individual licensed by the board was determined to have been responsible for substantiated
335.16 maltreatment;

335.17 (2) upon the commissioner's completion of an investigation that determined ~~the~~ an
335.18 individual licensed by the board was responsible for substantiated maltreatment; or

335.19 (3) upon receipt from another agency of a finding of substantiated maltreatment for
335.20 which ~~the~~ an individual licensed by the board was responsible.

335.21 ~~(b) The commissioner's notice to the health-related licensing board shall indicate whether~~
335.22 ~~the commissioner would have disqualified the individual for the substantiated maltreatment~~
335.23 ~~if the individual were not regulated by the board.~~

335.24 ~~(c) The commissioner shall concurrently send the notice under this subdivision to the~~
335.25 ~~individual who is the subject of the background study.~~

335.26 **EFFECTIVE DATE.** This section is effective February 1, 2023.

335.27 Sec. 20. Minnesota Statutes 2020, section 245C.31, is amended by adding a subdivision
335.28 to read:

335.29 Subd. 3a. **Agreements with health-related licensing boards.** The commissioner and
335.30 each health-related licensing board shall enter into an agreement in order for each board to
335.31 provide the commissioner with a daily roster list of individuals who have a license issued
336.1 by the board in active status. The list must include for each licensed individual the individual's

336.2 name, aliases, date of birth, and license number; the date the license was issued; status of
336.3 the license; and the last four digits of the individual's social security number.

336.4 **EFFECTIVE DATE.** This section is effective August 1, 2022.

92.12 Sec. 90. Laws 2021, First Special Session chapter 7, article 3, section 44, is amended to
92.13 read:
92.14 Sec. 44. **MENTAL HEALTH CULTURAL COMMUNITY CONTINUING**
92.15 **EDUCATION GRANT PROGRAM.**

92.16 (a) The commissioner of health shall develop a grant program, in consultation with the
92.17 relevant mental health licensing boards, to:

92.18 (1) provide for the continuing education necessary for social workers, marriage and
92.19 family therapists, psychologists, and professional clinical counselors to become supervisors
92.20 for individuals pursuing licensure in mental health professions;

92.21 (2) cover the costs when supervision is required for professionals becoming supervisors;
92.22 and

92.23 (3) cover the supervisory costs for mental health practitioners pursuing licensure at the
92.24 professional level.

92.25 (b) Social workers, marriage and family therapists, psychologists, and professional
92.26 clinical counselors obtaining continuing education and mental health practitioners needing
92.27 supervised hours to become licensed as professionals under this section must:

92.28 (1) be members of communities of color or underrepresented communities as defined
92.29 in Minnesota Statutes, section 148E.010, subdivision 20, or practice in a mental health
92.30 professional shortage area; and

93.1 (2) ~~work for community mental health providers and~~ agree to deliver at least 25 percent
93.2 of their yearly patient encounters to state public program enrollees or patients receiving
93.3 sliding fee schedule discounts through a formal sliding fee schedule meeting the standards
93.4 established by the United States Department of Health and Human Services under Code of
93.5 Federal Regulations, title 42, section 51, chapter 303.

93.6 Sec. 91. **BENEFIT AND COST ANALYSIS OF A UNIVERSAL HEALTH REFORM**
93.7 **PROPOSAL.**

93.8 Subdivision 1. **Contract for analysis of proposal.** The commissioner of health shall
93.9 contract with the University of Minnesota School of Public Health and the Carlson School
93.10 of Management to conduct an analysis of the benefits and costs of a legislative proposal for
93.11 a universal health care financing system and a similar analysis of the current health care
93.12 financing system to assist the state in comparing the proposal to the current system.

93.13 Subd. 2. **Proposal.** The commissioner of health, with input from the commissioners of
93.14 human services and commerce, shall submit to the University of Minnesota for analysis a

93.15 legislative proposal known as the Minnesota Health Plan that would offer a universal health
93.16 care plan designed to meet the following principles:

93.17 (1) ensure all Minnesotans are covered;

93.18 (2) cover all necessary care, including dental, vision and hearing, mental health, chemical
93.19 dependency treatment, prescription drugs, medical equipment and supplies, long-term care,
93.20 and home care; and

93.21 (3) allow patients to choose their doctors, hospitals, and other providers.

93.22 Subd. 3. **Proposal analysis.** (a) The analysis must measure the performance of both the
93.23 Minnesota Health Plan and the current health care financing system over a ten-year period
93.24 to contrast the impact on:

93.25 (1) the number of people covered versus the number of people who continue to lack
93.26 access to health care because of financial or other barriers, if any;

93.27 (2) the completeness of the coverage and the number of people lacking coverage for
93.28 dental, long-term care, medical equipment or supplies, vision and hearing, or other health
93.29 services that are not covered, if any;

93.30 (3) the adequacy of the coverage, the level of underinsured in the state, and whether
93.31 people with coverage can afford the care they need or whether cost prevents them from
93.32 accessing care;

94.1 (4) the timeliness and appropriateness of the care received and whether people turn to
94.2 inappropriate care such as emergency rooms because of a lack of proper care in accordance
94.3 with clinical guidelines; and

94.4 (5) total public and private health care spending in Minnesota under the current system
94.5 versus under the legislative proposal, including all spending by individuals, businesses, and
94.6 government. "Total public and private health care spending" means spending on all medical
94.7 care including but not limited to dental, vision and hearing, mental health, chemical
94.8 dependency treatment, prescription drugs, medical equipment and supplies, long-term care,
94.9 and home care, whether paid through premiums, co-pays and deductibles, other out-of-pocket
94.10 payments, or other funding from government, employers, or other sources. Total public and
94.11 private health care spending also includes the costs associated with administering, delivering,
94.12 and paying for the care. The costs of administering, delivering, and paying for the care
94.13 includes all expenses by insurers, providers, employers, individuals, and government to
94.14 select, negotiate, purchase, and administer insurance and care including but not limited to
94.15 coverage for health care, dental, long-term care, prescription drugs, medical expense portions
94.16 of workers compensation and automobile insurance, and the cost of administering and
94.17 paying for all health care products and services that are not covered by insurance. The
94.18 analysis of total health care spending shall examine whether there are savings or additional
94.19 costs under the legislative proposal compared to the existing system due to:

94.20 (i) reduced insurance, billing, underwriting, marketing, evaluation, and other
94.21 administrative functions including savings from global budgeting for hospitals and
94.22 institutional care instead of billing for individual services provided;

94.23 (ii) reduced prices on medical services and products including pharmaceuticals due to
94.24 price negotiations, if applicable under the proposal;

94.25 (iii) changes in utilization, better health outcomes, and reduced time away from work
94.26 due to prevention, early intervention, health-promoting activities, and to the extent possible
94.27 given available data and resources;

94.28 (iv) shortages or excess capacity of medical facilities and equipment under either the
94.29 current system or the proposal;

94.30 (v) the impact on state, local, and federal government non-health-care expenditures such
94.31 as reduced crime and out-of-home placement costs due to mental health or chemical
94.32 dependency coverage; and

95.1 (vi) job losses or gains in health care delivery, health billing and insurance administration,
95.2 and elsewhere in the economy under the proposal due to implementation of the reforms and
95.3 the resulting reduction of insurance and administrative burdens on businesses.

95.4 (b) The analysts may consult with authors of the legislative proposal to gain understanding
95.5 or clarification of the specifics of the proposal. The analysis shall assume that the provisions
95.6 in the proposal are not preempted by federal law or that the federal government gives a
95.7 waiver to the preemptions.

95.8 (c) The commissioner shall issue a final report by January 15, 2023, and may provide
95.9 interim reports and status updates to the governor and the chairs and ranking minority
95.10 members of the legislative committees with jurisdiction over health and human services
95.11 policy and finance.

95.12 Sec. 92. **NURSING WORKFORCE REPORT.**

95.13 The commissioner of health shall provide a public report on the following topics:

95.14 (1) Minnesota's supply of active licensed registered nurses;

95.15 (2) trends in Minnesota regarding retention by hospitals of licensed registered nurses;

95.16 (3) reasons licensed registered nurses are leaving direct care positions at hospitals; and

95.17 (4) reasons licensed registered nurses are choosing not to renew their licenses and leaving
95.18 the profession.

95.19 Sec. 93. **EMMETT LOUIS TILL VICTIMS RECOVERY PROGRAM.**

95.20 Subdivision 1. **Short title.** This section shall be known as the Emmett Louis Till Victims
95.21 Recovery Program.

95.22 Subd. 2. **Program established; grants.** (a) The commissioner of health shall establish
95.23 the Emmett Louis Till Victims Recovery Program to address the health and wellness needs
95.24 of:

95.25 (1) victims who experienced trauma, including historical trauma, resulting from events
95.26 such as assault or another violent physical act, intimidation, false accusations, wrongful
95.27 conviction, a hate crime, the violent death of a family member, or experiences of
95.28 discrimination or oppression based on the victim's race, ethnicity, or national origin; and

95.29 (2) the families and heirs of victims described in clause (1), who experienced trauma,
95.30 including historical trauma, because of their proximity or connection to the victim.

96.1 (b) The commissioner, in consultation with victims, families, and heirs who experienced
96.2 trauma and with community-based organizations that provide culturally appropriate services
96.3 to victims experiencing trauma and their families and heirs, shall award competitive grants
96.4 to applicants for projects to provide the following services to victims, families, and heirs
96.5 described in paragraph (a):

96.6 (1) health and wellness services, which may include services and support to address
96.7 physical health, mental health, and cultural needs;

96.8 (2) remembrance and legacy preservation activities;

96.9 (3) cultural awareness services; and

96.10 (4) community resources and services to promote healing for victims, families, and heirs
96.11 described in paragraph (a).

96.12 (c) In awarding grants under this section, the commissioner must prioritize grant awards
96.13 to community-based organizations experienced in providing support and services to victims,
96.14 families, and heirs described in paragraph (a).

96.15 Subd. 3. **Evaluation.** Grant recipients must provide the commissioner with information
96.16 required by the commissioner to evaluate the grant program, in a time and manner specified
96.17 by the commissioner.

96.18 Subd. 4. **Report.** By January 15, 2023, the commissioner must submit a status report
96.19 on the operation and results of the grant program, to the extent possible. The report must
96.20 be submitted to the chairs and ranking minority members of the legislative committees with
96.21 jurisdiction over health care. The report must include information on grant program activities
96.22 to date, services offered by grant recipients, and an assessment of the need to continue to
96.23 offer services to victims, families, and heirs who experienced trauma.

96.24 Sec. 94. **IDENTIFY STRATEGIES FOR REDUCTION OF ADMINISTRATIVE**
96.25 **SPENDING AND LOW-VALUE CARE; REPORT.**

96.26 (a) The commissioner of health shall develop recommendations for strategies to reduce
96.27 the volume and growth of administrative spending by health care organizations and group

96.28 purchasers and the amount of low-value care delivered to Minnesota residents. In support
96.29 of the development of recommendations, the commissioner shall:

96.30 (1) review the availability of data and identify gaps in the data infrastructure to estimate
96.31 aggregated and disaggregated administrative spending and low-value care;

97.1 (2) based on available data, estimate the volume and change over time of administrative
97.2 spending and low-value care in Minnesota;

97.3 (3) conduct an environmental scan and key informant interviews with experts in health
97.4 care finance, health economics, health care management or administration, or the
97.5 administration of health insurance benefits to identify drivers of spending growth for spending
97.6 on administrative services or the provision of low-value care; and

97.7 (4) convene a clinical learning community and an employer task force to review the
97.8 evidence from clauses (1) to (3) and develop a set of actionable strategies to address
97.9 administrative spending volume and growth and the magnitude of the volume of low-value
97.10 care.

97.11 (b) By December 15, 2024, the commissioner shall report the recommendations to the
97.12 chairs and ranking members of the legislative committees with jurisdiction over health and
97.13 human services financing and policy.

97.14 Sec. 95. **INITIAL IMPLEMENTATION OF THE KEEPING NURSES AT THE**
97.15 **BEDSIDE ACT.**

97.16 (a) By April 1, 2024, each hospital must establish and convene a hospital nurse staffing
97.17 committee as described under Minnesota Statutes, section 144.7053.

97.18 (b) By June 1, 2024, each hospital must implement core staffing plans developed by its
97.19 hospital nurse staffing committee and satisfy the plan posting requirements under Minnesota
97.20 Statutes, section 144.7056.

97.21 (c) By June 1, 2024, each hospital must submit to the commissioner of health core
97.22 staffing plans meeting the requirements of Minnesota Statutes, section 144.7055.

97.23 Sec. 96. **LEAD SERVICE LINE INVENTORY GRANT PROGRAM.**

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

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

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

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

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

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

98.4 The commissioner of health shall develop a plan to assess readiness of rural communities
98.5 and rural health care providers to adopt value-based, global budgeting, or alternative payment
98.6 systems and recommend steps needed to implement. The commissioner may use the
98.7 development of case studies and modeling of alternate payment systems to demonstrate
98.8 value-based payment systems that ensure a baseline level of essential community or regional
98.9 health services and address population health needs. The commissioner shall develop
98.10 recommendations for pilot projects by January 1, 2025, with the aim of ensuring financial
98.11 viability of rural health care systems in the context of spending growth targets. The
98.12 commissioner shall share findings with the Health Care Affordability Board.

98.13 Sec. 98. **PROGRAM TO DISTRIBUTE COVID-19 TESTS, MASKS, AND**
98.14 **RESPIRATORS.**

98.15 Subdivision 1. **Definitions.** (a) The terms defined in this subdivision apply to this section.

98.16 (b) "Antigen test" means a lateral flow immunoassay intended for the qualitative detection
98.17 of nucleocapsid protein antigens from the SARS-CoV-2 virus in nasal swabs, that has
98.18 emergency use authorization from the United States Food and Drug Administration and
98.19 that is authorized for nonprescription home use with self-collected nasal swabs.

98.20 (c) "COVID-19 test" means a test authorized by the United States Food and Drug
98.21 Administration to detect the presence of genetic material of the SARS-CoV-2 virus either
98.22 through a molecular method that detects the RNA or nucleic acid component of the virus,
98.23 such as polymerase chain reaction or isothermal amplification, or through a rapid lateral
98.24 flow immunoassay that detects the nucleocapsid protein antigens from the SARS-CoV-2
98.25 virus.

98.26 (d) "KN95 respirator" means a type of filtering facepiece respirator that is commonly
98.27 made and used in China, is designed and tested to meet an international standard, and does
98.28 not include an exhalation valve.

98.29 (e) "Mask" means a face covering intended to contain droplets and particles in a person's
98.30 breath, cough, or sneeze.

98.31 (f) "Respirator" means a face covering that filters the air and fits closely on the face to
98.32 filter out particles, including the SARS-CoV-2 virus.

99.1 Subd. 2. **Program established.** In order to help reduce the number of cases of COVID-19
99.2 in the state, the commissioner of health must administer a program to distribute to individuals
99.3 in Minnesota, COVID-19 tests, including antigen tests; and masks and respirators, including
99.4 KN95 respirators and similar respirators approved by the Centers for Disease Control and

99.5 Prevention and authorized by the commissioner for distribution under this program. Masks
99.6 and respirators distributed under this program may include child-sized masks and respirators,
99.7 if such masks and respirators are available and the commissioner finds there is a need for
99.8 them. COVID-19 tests, masks, and respirators must be distributed at no cost to the individuals
99.9 receiving them and may be shipped directly to individuals; distributed through local health
99.10 departments, COVID community coordinators, and other community-based organizations;
99.11 and distributed through other means determined by the commissioner. The commissioner
99.12 may prioritize distribution under this section to communities and populations who are
99.13 disproportionately impacted by COVID-19 or who have difficulty accessing COVID-19
99.14 tests, masks, or respirators.

99.15 Subd. 3. **Process to order COVID-19 tests, masks, and respirators.** The commissioner
99.16 may establish a process for individuals to order COVID-19 tests, masks, and respirators to
99.17 be shipped directly to the individual.

99.18 Subd. 4. **Notice.** An entity distributing KN95 respirators or similar respirators under this
99.19 section may include with the respirators a notice that individuals with a medical condition
99.20 that may make it difficult to wear a KN95 respirator or similar respirator should consult
99.21 with a health care provider before use.

99.22 Subd. 5. **Coordination.** The commissioner may coordinate this program with other state
99.23 and federal programs that distribute COVID-19 tests, masks, or respirators to the public.

99.24 Sec. 99. **REPORT ON TRANSPARENCY OF HEALTH CARE PAYMENTS.**

99.25 Subdivision 1. **Definitions.** (a) The terms defined in this subdivision apply to this section.

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

99.27 (c) "Non-claims-based payments" means payments to health care providers designed to
99.28 support and reward value of health care services over volume of health care services and
99.29 includes alternative payment models or incentives, payments for infrastructure expenditures
99.30 or investments, and payments for workforce expenditures or investments.

99.31 (d) "Nonpublic data" has the meaning given in Minnesota Statutes, section 13.02,
99.32 subdivision 9.

100.1 (e) "Primary care services" means integrated, accessible health care services provided
100.2 by clinicians who are accountable for addressing a large majority of personal health care
100.3 needs, developing a sustained partnership with patients, and practicing in the context of
100.4 family and community. Primary care services include but are not limited to preventive
100.5 services, office visits, annual physicals, pre-operative physicals, assessments, care
100.6 coordination, development of treatment plans, management of chronic conditions, and
100.7 diagnostic tests.

100.8 Subd. 2. **Report.** (a) To provide the legislature with information needed to meet the
100.9 evolving health care needs of Minnesotans, the commissioner shall report to the legislature
100.10 by February 15, 2023, on the volume and distribution of health care spending across payment

100.11 models used by health plan companies and third-party administrators, with a particular focus
100.12 on value-based care models and primary care spending.

100.13 (b) The report must include specific health plan and third-party administrator estimates
100.14 of health care spending for claims-based payments and non-claims-based payments for the
100.15 most recent available year, reported separately for Minnesotans enrolled in state health care
100.16 programs, Medicare Advantage, and commercial health insurance. The report must also
100.17 include recommendations on changes needed to gather better data from health plan companies
100.18 and third-party administrators on the use of value-based payments that pay for value of
100.19 health care services provided over volume of services provided, promote the health of all
100.20 Minnesotans, reduce health disparities, and support the provision of primary care services
100.21 and preventive services.

100.22 (c) In preparing the report, the commissioner shall:

100.23 (1) describe the form, manner, and timeline for submission of data by health plan
100.24 companies and third-party administrators to produce estimates as specified in paragraph
100.25 (b);

100.26 (2) collect summary data that permits the computation of:

100.27 (i) the percentage of total payments that are non-claims-based payments; and

100.28 (ii) the percentage of payments in item (i) that are for primary care services;

100.29 (3) where data was not directly derived, specify the methods used to estimate data
100.30 elements;

100.31 (4) notwithstanding Minnesota Statutes, section 62U.04, subdivision 11, conduct analyses
100.32 of the magnitude of primary care payments using data collected by the commissioner under
100.33 Minnesota Statutes, section 62U.04; and

101.1 (5) conduct interviews with health plan companies and third-party administrators to
101.2 better understand the types of non-claims-based payments and models in use, the purposes
101.3 or goals of each, the criteria for health care providers to qualify for these payments, and the
101.4 timing and structure of health plan companies or third-party administrators making these
101.5 payments to health care provider organizations.

101.6 (d) Health plan companies and third-party administrators must comply with data requests
101.7 from the commissioner under this section within 60 days after receiving the request.

101.8 (e) Data collected under this section are nonpublic data. Notwithstanding the definition
101.9 of summary data in Minnesota Statutes, section 13.02, subdivision 19, summary data prepared
101.10 under this section may be derived from nonpublic data. The commissioner shall establish
101.11 procedures and safeguards to protect the integrity and confidentiality of any data maintained
101.12 by the commissioner.

101.13 Sec. 100. **SAFETY IMPROVEMENTS FOR STATE LICENSED LONG-TERM**
101.14 **CARE FACILITIES.**

101.15 Subdivision 1. **Temporary grant program for long-term care safety**
101.16 **improvements.** The commissioner of health shall develop, implement, and manage a
101.17 temporary, competitive grant process for state-licensed long-term care facilities to improve
101.18 their ability to reduce the transmission of COVID-19 or other similar conditions.

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

101.21 (b) "Eligible facility" means:

101.22 (1) an assisted living facility licensed under chapter 144G;

101.23 (2) a supervised living facility licensed under chapter 144;

101.24 (3) a boarding care facility that is not federally certified and is licensed under chapter
101.25 144; and

101.26 (4) a nursing home that is not federally certified and is licensed under chapter 144A.

101.27 (c) "Eligible project" means a modernization project to update, remodel, or replace
101.28 outdated equipment, systems, technology, or physical spaces.

101.29 Subd. 3. **Program.** (a) The commissioner of health shall award improvement grants to
101.30 an eligible facility. An improvement grant shall not exceed $1,250,000.

102.1 (b) Funds may be used to improve the safety, quality of care, and livability of aging
102.2 infrastructure in a Department of Health licensed eligible facility with an emphasis on
102.3 reducing the transmission risk of COVID-19 and other infections. Projects include but are
102.4 not limited to:

102.5 (1) heating, ventilation, and air-conditioning systems improvements to reduce airborne
102.6 exposures;

102.7 (2) physical space changes for infection control; and

102.8 (3) technology improvements to reduce social isolation and improve resident or client
102.9 well-being.

102.10 (c) Notwithstanding any law to the contrary, funds awarded in a grant agreement do not
102.11 lapse until expended by the grantee.

102.12 Subd. 4. **Applications.** An eligible facility seeking a grant shall apply to the
102.13 commissioner. The application must include a description of the resident population
102.14 demographics, the problem the proposed project will address, a description of the project
102.15 including construction and remodeling drawings or specifications, sources of funds for the
102.16 project, including any in-kind resources, uses of funds for the project, the results expected,
102.17 and a plan to maintain or operate any facility or equipment included in the project. The

102.18 applicant must describe achievable objectives, a timetable, and roles and capabilities of
102.19 responsible individuals and organization. An applicant must submit to the commissioner
102.20 evidence that competitive bidding was used to select contractors for the project.

102.21 Subd. 5. **Consideration of applications.** The commissioner shall review each application
102.22 to determine if the application is complete and if the facility and the project are eligible for
102.23 a grant. In evaluating applications, the commissioner shall develop a standardized scoring
102.24 system that assesses: (1) the applicant's understanding of the problem, description of the
102.25 project and the likelihood of a successful outcome of the project; (2) the extent to which
102.26 the project will reduce the transmission of COVID-19; (3) the extent to which the applicant
102.27 has demonstrated that it has made adequate provisions to ensure proper and efficient operation
102.28 of the facility once the project is completed; (4) and other relevant factors as determined
102.29 by the commissioner. During application review, the commissioner may request additional
102.30 information about a proposed project, including information on project cost. Failure to
102.31 provide the information requested disqualifies an applicant.

102.32 Subd. 6. **Program oversight.** The commissioner shall determine the amount of a grant
102.33 to be given to an eligible facility based on the relative score of each eligible facility's
102.34 application, other relevant factors discussed during the review, and the funds available to
103.1 the commissioner. During the grant period and within one year after completion of the grant
103.2 period, the commissioner may collect from an eligible facility receiving a grant, any
103.3 information necessary to evaluate the program.

103.4 Subd. 7. **Expiration.** This section expires June 30, 2025.

103.5 Sec. 101. **STUDY OF THE DEVELOPMENT OF A STATEWIDE REGISTRY FOR**
103.6 **PROVIDER ORDERS FOR LIFE-SUSTAINING TREATMENT.**

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

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

103.10 (c) "Life-sustaining treatment" means any medical procedure, pharmaceutical drug,
103.11 medical device, or medical intervention that maintains life by sustaining, restoring, or
103.12 supplanting a vital function. Life-sustaining treatment does not include routine care necessary
103.13 to sustain patient cleanliness and comfort.

103.14 (d) "POLST" means a provider order for life-sustaining treatment, signed by a physician,
103.15 advanced practice registered nurse, or physician assistant, to ensure that the medical treatment
103.16 preferences of a patient with an advanced serious illness who is nearing the end of life are
103.17 honored.

103.18 (e) "POLST form" means a portable medical form used to communicate a physician's
103.19 order to help ensure that a patient's medical treatment preferences are conveyed to emergency
103.20 medical service personnel and other health care providers.

103.21 Subd. 2. **Study.** (a) The commissioner, in consultation with the advisory committee
103.22 established in paragraph (c), shall study the issues related to creating a statewide registry
103.23 of POLST forms to ensure that a patient's medical treatment preferences are followed by
103.24 all health care providers. The registry must allow for the submission of completed POLST
103.25 forms and for the forms to be accessed by health care providers and emergency medical
103.26 service personnel in a timely manner, for the provision of care or services.

103.27 (b) As a part of the study, the commissioner shall develop recommendations on the
103.28 following:

103.29 (1) electronic capture, storage, and security of information in the registry;

103.30 (2) procedures to protect the accuracy and confidentiality of information submitted to
103.31 the registry;

103.32 (3) limits as to who can access the registry;

104.1 (4) where the registry should be housed;

104.2 (5) ongoing funding models for the registry; and

104.3 (6) any other action needed to ensure that patients' rights are protected and that their
104.4 health care decisions are followed.

104.5 (c) The commissioner shall create an advisory committee with members representing
104.6 physicians, physician assistants, advanced practice registered nurses, nursing homes,
104.7 emergency medical service providers, hospice and palliative care providers, the disability
104.8 community, attorneys, medical ethicists, and the religious community.

104.9 Subd. 3. **Report.** The commissioner shall submit a report on the results of the study,
104.10 including recommendations on establishing a statewide registry of POLST forms, to the
104.11 chairs and ranking minority members of the legislative committees with jurisdiction over
104.12 health and human services policy and finance by February 1, 2023.

104.13 Sec. 102. **REVISOR INSTRUCTION.**

104.14 (a) The revisor of statutes shall codify Laws 2021, First Special Session chapter 7, article
104.15 3, section 44, as Minnesota Statutes, section 144.1512. The revisor of statutes may make
104.16 any necessary cross-reference changes.

104.17 (b) The revisor of statutes shall correct cross-references in Minnesota Statutes to conform
104.18 with the relettering of paragraphs in Minnesota Statutes, section 144.1501, subdivision 1.

104.19 (c) In Minnesota Statutes, section 144.7055, the revisor shall renumber paragraphs (b)
104.20 to (e) alphabetically as individual subdivisions under Minnesota Statutes, section 144.7051.
104.21 The revisor shall make any necessary changes to sentence structure for this renumbering
104.22 while preserving the meaning of the text. The revisor shall also make necessary

104.23 cross-reference changes in Minnesota Statutes and Minnesota Rules consistent with the
104.24 renumbering.

104.25 (d) The revisor of statutes shall renumber Minnesota Statutes, sections 145A.145 and
104.26 145A.17, as new sections following Minnesota Statutes, section 145.871. The revisor shall
104.27 also make necessary cross-reference changes consistent with the renumbering.

337.13 Sec. 23. **REPEALER.**

337.14 Minnesota Statutes 2020, section 254A.21, is repealed effective July 1, 2023.