

1.1 Senator moves to amend S.F. No. 4699 as follows:

1.2 Delete everything after the enacting clause and insert:

1.3 "ARTICLE 1

1.4 DEPARTMENT OF HUMAN SERVICES HEALTH CARE FINANCE

1.5 Section 1. Minnesota Statutes 2023 Supplement, section 256.9631, is amended to read:

1.6 **256.9631 ~~DIRECT PAYMENT SYSTEM~~ ALTERNATIVE CARE DELIVERY**
1.7 **MODELS FOR MEDICAL ASSISTANCE AND MINNESOTACARE.**

1.8 Subdivision 1. **Direction to the commissioner.** (a) The commissioner, in order to deliver
1.9 services to eligible individuals, achieve better health outcomes, and reduce the cost of health
1.10 care for the state, shall develop an implementation plan plans for a direct payment system
1.11 to deliver services to eligible individuals in order to achieve better health outcomes and
1.12 reduce the cost of health care for the state. Under this system, at least three care delivery
1.13 models that:

1.14 (1) are alternatives to the use of commercial managed care plans to deliver health care
1.15 to Minnesota health care program enrollees; and

1.16 (2) do not shift financial risk to nongovernmental entities.

1.17 (b) One of the alternative models must be a direct payment system under which eligible
1.18 individuals must receive services through the medical assistance fee-for-service system,
1.19 county-based purchasing plans, or and county-owned health maintenance organizations. At
1.20 least one additional model must include county-based purchasing plans and county-owned
1.21 health maintenance organizations in their design, and must allow these entities to deliver
1.22 care in geographic areas on a single plan basis, if:

1.23 (1) these entities contract with all providers that agree to contract terms for network
1.24 participation; and

1.25 (2) the commissioner of human services determines that an entity's provider network is
1.26 adequate to ensure enrollee access and choice.

1.27 (c) Before determining the alternative models for which implementation plans will be
1.28 developed, the commissioner shall consult with the chairs and ranking minority members
1.29 of the legislative committees with jurisdiction over health care finance and policy.

1.30 (d) The commissioner shall present an implementation plan plans for the direct payment
1.31 system selected models to the chairs and ranking minority members of the legislative
1.32 committees with jurisdiction over health care finance and policy by January 15, 2026. The

2.1 commissioner may contract for technical assistance in developing the implementation ~~plan~~
 2.2 plans and conducting related studies and analyses.

2.3 ~~(b) For the purposes of the direct payment system, the commissioner shall make the~~
 2.4 ~~following assumptions:~~

2.5 ~~(1) health care providers are reimbursed directly for all medical assistance covered~~
 2.6 ~~services provided to eligible individuals, using the fee-for-service payment methods specified~~
 2.7 ~~in chapters 256, 256B, 256R, and 256S;~~

2.8 ~~(2) payments to a qualified hospital provider are equivalent to the payments that would~~
 2.9 ~~have been received based on managed care direct payment arrangements. If necessary, a~~
 2.10 ~~qualified hospital provider may use a county-owned health maintenance organization to~~
 2.11 ~~receive direct payments as described in section 256B.1973; and~~

2.12 ~~(3) county-based purchasing plans and county-owned health maintenance organizations~~
 2.13 ~~must be reimbursed at the capitation rate determined under sections 256B.69 and 256B.692.~~

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

2.16 (b) "Eligible individuals" means ~~qualified~~ all medical assistance enrollees, ~~defined as~~
 2.17 ~~persons eligible for medical assistance as families and children and adults without children~~
 2.18 ~~and MinnesotaCare enrollees.~~

2.19 (c) "Minnesota health care programs" means the medical assistance and MinnesotaCare
 2.20 programs.

2.21 ~~(e)~~ (d) "Qualified hospital provider" means a nonstate government teaching hospital
 2.22 with high medical assistance utilization and a level 1 trauma center, and all of the hospital's
 2.23 owned or affiliated health care professionals, ambulance services, sites, and clinics.

2.24 Subd. 3. **Implementation ~~plan~~ plans.** (a) ~~The~~ Each implementation plan must include:

2.25 (1) a timeline for the development and recommended implementation date of the ~~direct~~
 2.26 ~~payment system~~ alternative model. In recommending a timeline, the commissioner must
 2.27 consider:

2.28 (i) timelines required by the existing contracts with managed care plans and county-based
 2.29 purchasing plans to sunset existing delivery models;

2.30 (ii) in counties that choose to operate a county-based purchasing plan under section
 2.31 256B.692, timelines for any new procurements required for those counties to establish a

3.1 new county-based purchasing plan or participate in an existing county-based purchasing
3.2 plan;

3.3 (iii) in counties that choose to operate a county-owned health maintenance organization
3.4 under section 256B.69, timelines for any new procurements required for those counties to
3.5 establish a new county-owned health maintenance organization or to continue serving
3.6 enrollees through an existing county-owned health maintenance organization; and

3.7 (iv) a recommendation on whether the commissioner should contract with a third-party
3.8 administrator to administer the ~~direct payment system~~ alternative model, and the timeline
3.9 needed for procuring an administrator;

3.10 (2) the procedures to be used to ensure continuity of care for enrollees who transition
3.11 from managed care to fee-for-service and any administrative resources needed to carry out
3.12 these procedures;

3.13 (3) recommended quality measures for health care service delivery;

3.14 (4) any changes to fee-for-service payment rates that the commissioner determines are
3.15 necessary to ensure provider access and high-quality care and to reduce health disparities;

3.16 (5) recommendations on ensuring effective care coordination under the ~~direct payment~~
3.17 ~~system~~ alternative model, especially for enrollees who:

3.18 (i) are age 65 or older, blind, or have disabilities;

3.19 (ii) have complex medical conditions, ~~who~~;

3.20 (iii) face socioeconomic barriers to receiving care, ~~or who~~; or

3.21 (iv) are from underserved populations that experience health disparities;

3.22 (6) recommendations on ~~whether the direct payment system should provide supplemental~~
3.23 ~~payments~~ payment arrangements for care coordination, including:

3.24 (i) the provider types eligible for ~~supplemental~~ care coordination payments;

3.25 (ii) procedures to coordinate ~~supplemental~~ care coordination payments with existing
3.26 supplemental or cost-based payment methods or to replace these existing methods; and

3.27 (iii) procedures to align care coordination initiatives funded ~~through supplemental~~
3.28 ~~payments~~ under this section the alternative model with existing care coordination initiatives;

3.29 (7) recommendations on whether the ~~direct payment system~~ alternative model should
3.30 include funding to providers for outreach initiatives to patients who, because of mental

4.1 illness, homelessness, or other circumstances, are unlikely to obtain needed care and
4.2 treatment;

4.3 (8) recommendations for a supplemental payment to qualified hospital providers to offset
4.4 any potential revenue losses resulting from the shift from managed care payments; and

4.5 ~~(9) recommendations on whether and how the direct payment system should be expanded~~
4.6 ~~to deliver services and care coordination to medical assistance enrollees who are age 65 or~~
4.7 ~~older, are blind, or have a disability and to persons enrolled in MinnesotaCare; and~~

4.8 ~~(10)~~ (9) recommendations for statutory changes necessary to implement the ~~direct~~
4.9 ~~payment system~~ alternative model.

4.10 (b) In developing ~~the~~ each implementation plan, the commissioner shall:

4.11 (1) calculate the projected cost of ~~a direct payment system~~ the alternative model relative
4.12 to the cost of the current system;

4.13 (2) assess gaps in care coordination under the current medical assistance and
4.14 MinnesotaCare programs;

4.15 (3) evaluate the effectiveness of approaches other states have taken to coordinate care
4.16 under a fee-for-service system, including the coordination of care provided to persons who
4.17 are age 65 or older, are blind, or have disabilities;

4.18 (4) estimate the loss of revenue and cost savings from other payment enhancements
4.19 based on managed care plan directed payments and pass-throughs;

4.20 (5) estimate cost trends under ~~a direct payment system~~ the alternative model for managed
4.21 care payments to county-based purchasing plans and county-owned health maintenance
4.22 organizations;

4.23 (6) estimate the impact of ~~a direct payment system~~ the alternative model on other revenue,
4.24 including taxes, surcharges, or other federally approved in lieu of services and on other
4.25 arrangements allowed under managed care;

4.26 (7) consider allowing eligible individuals to opt out of managed care as an alternative
4.27 approach;

4.28 ~~(8) assess the feasibility of a medical assistance outpatient prescription drug benefit~~
4.29 ~~carve-out under section 256B.69, subdivision 6d, and in consultation with the commissioners~~
4.30 ~~of commerce and health, assess the feasibility of including MinnesotaCare enrollees and~~
4.31 ~~private sector enrollees of health plan companies in the drug benefit carve-out. The~~
4.32 ~~assessment of feasibility must address and include recommendations related to the process~~

5.1 ~~and terms by which the commissioner would contract with health plan companies to~~
 5.2 ~~administer prescription drug benefits and develop and manage a drug formulary, and the~~
 5.3 ~~impact of the drug benefit carve-out on health care providers, including small pharmacies;~~

5.4 ~~(9)~~ (8) consult with the commissioners of health and commerce and the contractor or
 5.5 contractors analyzing the Minnesota Health Plan ~~under section 19~~ and other health reform
 5.6 models on plan design and assumptions; and

5.7 ~~(10)~~ (9) conduct other analyses necessary to develop the implementation plan.

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

5.9 Sec. 2. Minnesota Statutes 2022, section 256.9657, is amended by adding a subdivision
 5.10 to read:

5.11 Subd. 2a. **Teaching hospital surcharge.** (a) Each teaching hospital shall pay to the
 5.12 medical assistance account a surcharge equal to 1.41 percent of its fiscal year 2021 net
 5.13 patient revenue for inpatient services. The initial surcharge must not be collected more than
 5.14 30 days before the commissioner makes the first of the payments required under section
 5.15 256.969, subdivision 2g. Subsequent surcharge payments must be paid annually in the form
 5.16 and manner specified by the commissioner. The surcharge must comply with all applicable
 5.17 federal requirements and federal laws, including but not limited to Code of Federal
 5.18 Regulations, title 42, section 433.68.

5.19 (b) Revenue from the surcharge must be used by the commissioner only to pay the
 5.20 nonfederal share of the medical assistance supplemental payments described in section
 5.21 256.969, subdivision 2g, and must be used to supplement, and not supplant, medical
 5.22 assistance reimbursement to teaching hospitals.

5.23 (c) For purposes of this subdivision, "teaching hospital" means any Minnesota hospital
 5.24 with a Centers for Medicare and Medicaid Services designation of "teaching hospital" as
 5.25 reported on form CMS-2552-10, worksheet S-2, line 56, that is eligible for reimbursement
 5.26 under section 256.969, subdivision 2g.

5.27 (d) Notwithstanding paragraph (c), the following hospitals are exempt from paying the
 5.28 surcharge under this section:

5.29 (1) all hospitals in Minnesota designated as a children's hospital under Medicare, including
 5.30 Children's Health Care, doing business as Children's Minnesota, and Gillette Children's
 5.31 Specialty Healthcare, doing business as Gillette Children's;

6.1 (2) teaching hospitals with three or fewer full-time equivalent trainees, based on a
6.2 Medicare cost report filed for the fiscal year ending in 2022;

6.3 (3) federal Indian Health Service facilities; and

6.4 (4) regional treatment centers.

6.5 (e) The teaching hospital surcharge established under this subdivision must only be
6.6 assessed if the annual inpatient supplemental payments under section 256.969, subdivision
6.7 2g, are approved by the Centers for Medicare and Medicaid Services.

6.8 (f) The commissioner must reduce the surcharge percentage in paragraph (a) such that
6.9 the aggregate amount collected from hospitals under this subdivision does not exceed the
6.10 total amount needed for the nonfederal share of the annual inpatient supplemental payments
6.11 authorized by section 256.969, subdivision 2g.

6.12 (g) For purposes of this subdivision, net patient revenue for inpatient services must be
6.13 calculated by:

6.14 (1) determining gross inpatient hospital facility charges from the hospital's audited
6.15 statements or, if not contained or segregated within the hospital's audited financial statements,
6.16 using detailed internal financial income statements or schedules; and

6.17 (2) subtracting from gross inpatient hospital facility charges:

6.18 (i) all professional fee charges, home health charges, skilled nursing facility charges,
6.19 hospice charges, end-stage renal disease charges, and other nonhospital charges; and

6.20 (ii) applicable contractual allowances.

6.21 (h) Teaching hospitals subject to the surcharge under this subdivision shall submit to
6.22 the commissioner, in the form and manner specified by the commissioner, all documentation
6.23 necessary to provide reconciliation of the net patient revenue calculation under paragraph
6.24 (b).

6.25 (i) This subdivision is effective on the later of July 1, 2025, or 60 days after the end of
6.26 the first legislative regular session that begins following federal approval for all of the
6.27 following: (1) the amendment in this act adding section 256.9657, subdivision 2a; (2) the
6.28 amendment in this act to section 256.969, subdivision 2b; and (3) the amendment in this
6.29 act adding section 256.969, subdivision 2g. The commissioner of human services shall
6.30 notify the revisor of statutes when federal approval is obtained.

6.31 (j) This subdivision is subject to the implementation requirements in section 9.

7.1 (k) This subdivision expires June 30, 2030, or five years after federal approval is obtained,
7.2 whichever is later.

7.3 Sec. 3. Minnesota Statutes 2023 Supplement, section 256.969, subdivision 2b, is amended
7.4 to read:

7.5 Subd. 2b. **Hospital payment rates.** (a) For discharges occurring on or after November
7.6 1, 2014, hospital inpatient services for hospitals located in Minnesota shall be paid according
7.7 to the following:

7.8 (1) critical access hospitals as defined by Medicare shall be paid using a cost-based
7.9 methodology;

7.10 (2) long-term hospitals as defined by Medicare shall be paid on a per diem methodology
7.11 under subdivision 25;

7.12 (3) rehabilitation hospitals or units of hospitals that are recognized as rehabilitation
7.13 distinct parts as defined by Medicare shall be paid according to the methodology under
7.14 subdivision 12; and

7.15 (4) all other hospitals shall be paid on a diagnosis-related group (DRG) methodology.

7.16 (b) For the period beginning January 1, 2011, through October 31, 2014, rates shall not
7.17 be rebased, except that a Minnesota long-term hospital shall be rebased effective January
7.18 1, 2011, based on its most recent Medicare cost report ending on or before September 1,
7.19 2008, with the provisions under subdivisions 9 and 23, based on the rates in effect on
7.20 December 31, 2010. For rate setting periods after November 1, 2014, in which the base
7.21 years are updated, a Minnesota long-term hospital's base year shall remain within the same
7.22 period as other hospitals.

7.23 (c) Effective for discharges occurring on and after November 1, 2014, payment rates
7.24 for hospital inpatient services provided by hospitals located in Minnesota or the local trade
7.25 area, except for the hospitals paid under the methodologies described in paragraph (a),
7.26 clauses (2) and (3), shall be rebased, incorporating cost and payment methodologies in a
7.27 manner similar to Medicare. The base year or years for the rates effective November 1,
7.28 2014, shall be calendar year 2012. The rebasing under this paragraph shall be budget neutral,
7.29 ensuring that the total aggregate payments under the rebased system are equal to the total
7.30 aggregate payments that were made for the same number and types of services in the base
7.31 year. Separate budget neutrality calculations shall be determined for payments made to
7.32 critical access hospitals and payments made to hospitals paid under the DRG system. Only
7.33 the rate increases or decreases under subdivision 3a or 3c that applied to the hospitals being

8.1 rebased during the entire base period shall be incorporated into the budget neutrality
8.2 calculation.

8.3 (d) For discharges occurring on or after November 1, 2014, through the next rebasing
8.4 that occurs, the rebased rates under paragraph (c) that apply to hospitals under paragraph
8.5 (a), clause (4), shall include adjustments to the projected rates that result in no greater than
8.6 a five percent increase or decrease from the base year payments for any hospital. Any
8.7 adjustments to the rates made by the commissioner under this paragraph and paragraph (e)
8.8 shall maintain budget neutrality as described in paragraph (c).

8.9 (e) For discharges occurring on or after November 1, 2014, the commissioner may make
8.10 additional adjustments to the rebased rates, and when evaluating whether additional
8.11 adjustments should be made, the commissioner shall consider the impact of the rates on the
8.12 following:

8.13 (1) pediatric services;

8.14 (2) behavioral health services;

8.15 (3) trauma services as defined by the National Uniform Billing Committee;

8.16 (4) transplant services;

8.17 (5) obstetric services, newborn services, and behavioral health services provided by
8.18 hospitals outside the seven-county metropolitan area;

8.19 (6) outlier admissions;

8.20 (7) low-volume providers; and

8.21 (8) services provided by small rural hospitals that are not critical access hospitals.

8.22 (f) Hospital payment rates established under paragraph (c) must incorporate the following:

8.23 (1) for hospitals paid under the DRG methodology, the base year payment rate per
8.24 admission is standardized by the applicable Medicare wage index and adjusted by the
8.25 hospital's disproportionate population adjustment;

8.26 (2) for critical access hospitals, payment rates for discharges between November 1, 2014,
8.27 and June 30, 2015, shall be set to the same rate of payment that applied for discharges on
8.28 October 31, 2014;

8.29 (3) the cost and charge data used to establish hospital payment rates must only reflect
8.30 inpatient services covered by medical assistance; and

9.1 (4) in determining hospital payment rates for discharges occurring on or after the rate
9.2 year beginning January 1, 2011, through December 31, 2012, the hospital payment rate per
9.3 discharge shall be based on the cost-finding methods and allowable costs of the Medicare
9.4 program in effect during the base year or years. In determining hospital payment rates for
9.5 discharges in subsequent base years, the per discharge rates shall be based on the cost-finding
9.6 methods and allowable costs of the Medicare program in effect during the base year or
9.7 years.

9.8 (g) The commissioner shall validate the rates effective November 1, 2014, by applying
9.9 the rates established under paragraph (c), and any adjustments made to the rates under
9.10 paragraph (d) or (e), to hospital claims paid in calendar year 2013 to determine whether the
9.11 total aggregate payments for the same number and types of services under the rebased rates
9.12 are equal to the total aggregate payments made during calendar year 2013.

9.13 (h) Effective for discharges occurring on or after July 1, 2017, and every two years
9.14 thereafter, payment rates under this section shall be rebased to reflect only those changes
9.15 in hospital costs between the existing base year or years and the next base year or years. In
9.16 any year that inpatient claims volume falls below the threshold required to ensure a
9.17 statistically valid sample of claims, the commissioner may combine claims data from two
9.18 consecutive years to serve as the base year. Years in which inpatient claims volume is
9.19 reduced or altered due to a pandemic or other public health emergency shall not be used as
9.20 a base year or part of a base year if the base year includes more than one year. Changes in
9.21 costs between base years shall be measured using the lower of the hospital cost index defined
9.22 in subdivision 1, paragraph (a), or the percentage change in the case mix adjusted cost per
9.23 claim. The commissioner shall establish the base year for each rebasing period considering
9.24 the most recent year or years for which filed Medicare cost reports are available, except
9.25 that the base years for the rebasing effective July 1, 2023, are calendar years 2018 and 2019.
9.26 The estimated change in the average payment per hospital discharge resulting from a
9.27 scheduled rebasing must be calculated and made available to the legislature by January 15
9.28 of each year in which rebasing is scheduled to occur, and must include by hospital the
9.29 differential in payment rates compared to the individual hospital's costs.

9.30 (i) Effective for discharges occurring on or after July 1, 2015, inpatient payment rates
9.31 for critical access hospitals located in Minnesota or the local trade area shall be determined
9.32 using a new cost-based methodology. The commissioner shall establish within the
9.33 methodology tiers of payment designed to promote efficiency and cost-effectiveness.
9.34 Payment rates for hospitals under this paragraph shall be set at a level that does not exceed
9.35 the total cost for critical access hospitals as reflected in base year cost reports. Until the

10.1 next rebasing that occurs, the new methodology shall result in no greater than a five percent
10.2 decrease from the base year payments for any hospital, except a hospital that had payments
10.3 that were greater than 100 percent of the hospital's costs in the base year shall have their
10.4 rate set equal to 100 percent of costs in the base year. The rates paid for discharges on and
10.5 after July 1, 2016, covered under this paragraph shall be increased by the inflation factor
10.6 in subdivision 1, paragraph (a). The new cost-based rate shall be the final rate and shall not
10.7 be settled to actual incurred costs. Hospitals shall be assigned a payment tier based on the
10.8 following criteria:

10.9 (1) hospitals that had payments at or below 80 percent of their costs in the base year
10.10 shall have a rate set that equals 85 percent of their base year costs;

10.11 (2) hospitals that had payments that were above 80 percent, up to and including 90
10.12 percent of their costs in the base year shall have a rate set that equals 95 percent of their
10.13 base year costs; and

10.14 (3) hospitals that had payments that were above 90 percent of their costs in the base year
10.15 shall have a rate set that equals 100 percent of their base year costs.

10.16 (j) The commissioner may refine the payment tiers and criteria for critical access hospitals
10.17 to coincide with the next rebasing under paragraph (h). The factors used to develop the new
10.18 methodology may include, but are not limited to:

10.19 (1) the ratio between the hospital's costs for treating medical assistance patients and the
10.20 hospital's charges to the medical assistance program;

10.21 (2) the ratio between the hospital's costs for treating medical assistance patients and the
10.22 hospital's payments received from the medical assistance program for the care of medical
10.23 assistance patients;

10.24 (3) the ratio between the hospital's charges to the medical assistance program and the
10.25 hospital's payments received from the medical assistance program for the care of medical
10.26 assistance patients;

10.27 (4) the statewide average increases in the ratios identified in clauses (1), (2), and (3);

10.28 (5) the proportion of that hospital's costs that are administrative and trends in
10.29 administrative costs; and

10.30 (6) geographic location.

10.31 (k) Subject to subdivision 2g, effective for discharges occurring on or after January 1,
10.32 2024, the rates paid to hospitals described in paragraph (a), clauses (2) to (4), must include

11.1 a rate factor specific to each hospital that qualifies for a medical education and research
11.2 cost distribution under section 62J.692, subdivision 4, paragraph (a).

11.3 **EFFECTIVE DATE.** (a) This section is effective the later of July 1, 2025, or 60 days
11.4 after the end of the first legislative session that begins following federal approval of all of
11.5 the following:

11.6 (1) the amendment in this act to add Minnesota Statutes, section 256.9657, subdivision
11.7 2a;

11.8 (2) the amendments in this act to Minnesota Statutes, section 256.969, subdivision 2b;
11.9 and

11.10 (3) the amendment in this act to add Minnesota Statutes, section 256.969, subdivision
11.11 2g.

11.12 (b) The commissioner of human services shall notify the revisor of statutes when federal
11.13 approval is obtained.

11.14 Sec. 4. Minnesota Statutes 2022, section 256.969, is amended by adding a subdivision to
11.15 read:

11.16 Subd. 2g. **Annual supplemental payment for graduate medical education.** (a) The
11.17 commissioner and contracted managed care organizations shall annually pay an inpatient
11.18 supplemental payment to all eligible hospitals for graduate medical education. A hospital
11.19 must be an eligible hospital to receive an annual supplemental payment under this
11.20 subdivision. Payments under this subdivision must comply with all applicable federal
11.21 requirements and federal laws and meet the requirements of Code of Federal Regulations,
11.22 title 42, section 438.60.

11.23 (b) For purposes of this subdivision, "eligible hospital" means a hospital that:

11.24 (1) is located in Minnesota;

11.25 (2) participates in Minnesota's medical assistance program;

11.26 (3) has received fee-for-service medical assistance payments in the payment year; and

11.27 (4) is either:

11.28 (i) eligible to receive graduate medical education payments from the Medicare program
11.29 under Code of Federal Regulations, title 42, section 413.75; or

12.1 (ii) a hospital in Minnesota designated as a children's hospital under Medicare, including
12.2 Children's Health Care, doing business as Children's Minnesota, and Gillette Children's
12.3 Specialty Healthcare, doing business as Gillette Children's.

12.4 (c) The annual inpatient supplemental payment must be calculated as follows:

12.5 (1) \$425,000 per full-time equivalent trained for each of the first ten full-time equivalents
12.6 at a hospital;

12.7 (2) \$350,000 per full-time equivalent trained for each full-time equivalent between 11
12.8 and 20 full-time equivalents at a hospital;

12.9 (3) \$95,000 per full-time equivalent trained for each full-time equivalent between 21
12.10 and 30 full-time equivalents at a hospital;

12.11 (4) \$70,000 per full-time equivalent trained for each full-time equivalent between 31
12.12 and 400 full-time equivalents at a hospital; and

12.13 (5) \$50,000 per full-time equivalent trained for each full-time equivalent above 401
12.14 full-time equivalents at a hospital.

12.15 (d) The data source for the full-time equivalent trained under paragraph (c) must be the
12.16 Medicare cost report for the fiscal year ending in calendar year 2022. The full-time equivalent
12.17 is calculated by adding the two values populated on lines 10 and 11 on worksheet E, part
12.18 A, of the Medicare cost report for that year, except that for eligible hospitals that are children's
12.19 hospitals, the full-time equivalent is calculated based on interns and residents, as determined
12.20 by adding form CMS-2552-10, worksheet E-4, lines 6, 10.01, and 15.01, or its equivalent,
12.21 for that year.

12.22 (e) An eligible hospital must not accept any reimbursement under section 62J.692 if it
12.23 would result in payments in excess of eligible expenditures. The surcharge paid under section
12.24 256.9657, subdivision 2a, and the payment received under this section must be reported in
12.25 the application under section 62J.692.

12.26 (f) The supplemental payments under this subdivision:

12.27 (1) must not be included as public program revenue under section 62J.692; and

12.28 (2) must be deemed permissible pass-through payments for graduate medical education
12.29 under Code of Federal Regulations, title 42, section 438.6(d), or when the state makes
12.30 payments directly to teaching hospitals for graduate medical education costs approved under
12.31 the state plan under Code of Federal Regulations, title 42, section 438.60.

13.1 (g) The total aggregate state and federal supplemental payments for hospitals under this
13.2 subdivision must not exceed \$203,000,000 per year. The commissioner may reduce the
13.3 amount paid for each full-time equivalent, as described in paragraph (c), on an equal basis
13.4 to limit the total cost of all supplemental payments to the total dollar amounts available.

13.5 (h) This subdivision is effective the later of July 1, 2025, or 60 days after the end of the
13.6 first legislative regular session that begins following federal approval for all of the following:
13.7 (1) the amendment in this act adding section 256.9657, subdivision 2a; (2) the amendment
13.8 in this act to section 256.969, subdivision 2b; and (3) the amendment in this act to add
13.9 section 256.969, subdivision 2g. The commissioner of human services shall notify the revisor
13.10 of statutes when federal approval is obtained.

13.11 (i) This subdivision is subject to the implementation requirements in section 9.

13.12 (j) This subdivision expires June 30, 2030, or five years after federal approval is obtained,
13.13 whichever is later.

13.14 Sec. 5. Minnesota Statutes 2022, section 256.969, is amended by adding a subdivision to
13.15 read:

13.16 Subd. 32. **Biological products for cell and gene therapy.** (a) Effective July 1, 2025,
13.17 and upon necessary federal approval of documentation required to enter into a value-based
13.18 arrangement under section 256B.0625, subdivision 13k, the commissioner may provide
13.19 separate reimbursement to hospitals for biological products provided in the inpatient hospital
13.20 setting as part of cell or gene therapy to treat rare diseases, as defined in United States Code,
13.21 title 21, section 360bb, if the drug manufacturer enters into a value-based arrangement with
13.22 the commissioner.

13.23 (b) The commissioner shall establish the separate reimbursement rate for biological
13.24 products provided under paragraph (a) based on the methodology used for drugs administered
13.25 in an outpatient setting under section 256B.0625, subdivision 13e, paragraph (e).

13.26 **EFFECTIVE DATE.** This section is effective July 1, 2025.

13.27 Sec. 6. Minnesota Statutes 2023 Supplement, section 256B.0625, subdivision 13e, as
13.28 amended by Laws 2024, chapter 85, section 66, is amended to read:

13.29 Subd. 13e. **Payment rates.** (a) The basis for determining the amount of payment shall
13.30 be the lower of the ingredient costs of the drugs plus the professional dispensing fee; or the
13.31 usual and customary price charged to the public. The usual and customary price means the
13.32 lowest price charged by the provider to a patient who pays for the prescription by cash,

14.1 check, or charge account and includes prices the pharmacy charges to a patient enrolled in
14.2 a prescription savings club or prescription discount club administered by the pharmacy or
14.3 pharmacy chain. The amount of payment basis must be reduced to reflect all discount
14.4 amounts applied to the charge by any third-party provider/insurer agreement or contract for
14.5 submitted charges to medical assistance programs. The net submitted charge may not be
14.6 greater than the patient liability for the service. The professional dispensing fee shall be
14.7 ~~\$10.77~~ \$11.55 for prescriptions filled with legend drugs meeting the definition of "covered
14.8 outpatient drugs" according to United States Code, title 42, section 1396r-8(k)(2). The
14.9 dispensing fee for intravenous solutions that must be compounded by the pharmacist shall
14.10 be ~~\$10.77~~ \$11.55 per claim. The professional dispensing fee for prescriptions filled with
14.11 over-the-counter drugs meeting the definition of covered outpatient drugs shall be ~~\$10.77~~
14.12 \$11.55 for dispensed quantities equal to or greater than the number of units contained in
14.13 the manufacturer's original package. The professional dispensing fee shall be prorated based
14.14 on the percentage of the package dispensed when the pharmacy dispenses a quantity less
14.15 than the number of units contained in the manufacturer's original package. The pharmacy
14.16 dispensing fee for prescribed over-the-counter drugs not meeting the definition of covered
14.17 outpatient drugs shall be \$3.65 for quantities equal to or greater than the number of units
14.18 contained in the manufacturer's original package and shall be prorated based on the
14.19 percentage of the package dispensed when the pharmacy dispenses a quantity less than the
14.20 number of units contained in the manufacturer's original package. The National Average
14.21 Drug Acquisition Cost (NADAC) shall be used to determine the ingredient cost of a drug.
14.22 For drugs for which a NADAC is not reported, the commissioner shall estimate the ingredient
14.23 cost at the wholesale acquisition cost minus two percent. The ingredient cost of a drug for
14.24 a provider participating in the federal 340B Drug Pricing Program shall be either the 340B
14.25 Drug Pricing Program ceiling price established by the Health Resources and Services
14.26 Administration or NADAC, whichever is lower. Wholesale acquisition cost is defined as
14.27 the manufacturer's list price for a drug or biological to wholesalers or direct purchasers in
14.28 the United States, not including prompt pay or other discounts, rebates, or reductions in
14.29 price, for the most recent month for which information is available, as reported in wholesale
14.30 price guides or other publications of drug or biological pricing data. The maximum allowable
14.31 cost of a multisource drug may be set by the commissioner and it shall be comparable to
14.32 the actual acquisition cost of the drug product and no higher than the NADAC of the generic
14.33 product. Establishment of the amount of payment for drugs shall not be subject to the
14.34 requirements of the Administrative Procedure Act.

14.35 (b) Pharmacies dispensing prescriptions to residents of long-term care facilities using
14.36 an automated drug distribution system meeting the requirements of section 151.58, or a

15.1 packaging system meeting the packaging standards set forth in Minnesota Rules, part
15.2 6800.2700, that govern the return of unused drugs to the pharmacy for reuse, may employ
15.3 retrospective billing for prescription drugs dispensed to long-term care facility residents. A
15.4 retrospectively billing pharmacy must submit a claim only for the quantity of medication
15.5 used by the enrolled recipient during the defined billing period. A retrospectively billing
15.6 pharmacy must use a billing period not less than one calendar month or 30 days.

15.7 (c) A pharmacy provider using packaging that meets the standards set forth in Minnesota
15.8 Rules, part 6800.2700, is required to credit the department for the actual acquisition cost
15.9 of all unused drugs that are eligible for reuse, unless the pharmacy is using retrospective
15.10 billing. The commissioner may permit the drug clozapine to be dispensed in a quantity that
15.11 is less than a 30-day supply.

15.12 (d) If a pharmacy dispenses a multisource drug, the ingredient cost shall be the NADAC
15.13 of the generic product or the maximum allowable cost established by the commissioner
15.14 unless prior authorization for the brand name product has been granted according to the
15.15 criteria established by the Drug Formulary Committee as required by subdivision 13f,
15.16 paragraph (a), and the prescriber has indicated "dispense as written" on the prescription in
15.17 a manner consistent with section 151.21, subdivision 2.

15.18 (e) The basis for determining the amount of payment for drugs administered in an
15.19 outpatient setting shall be the lower of the usual and customary cost submitted by the
15.20 provider, 106 percent of the average sales price as determined by the United States
15.21 Department of Health and Human Services pursuant to title XVIII, section 1847a of the
15.22 federal Social Security Act, the specialty pharmacy rate, or the maximum allowable cost
15.23 set by the commissioner. If average sales price is unavailable, the amount of payment must
15.24 be lower of the usual and customary cost submitted by the provider, the wholesale acquisition
15.25 cost, the specialty pharmacy rate, or the maximum allowable cost set by the commissioner.
15.26 The commissioner shall discount the payment rate for drugs obtained through the federal
15.27 340B Drug Pricing Program by 28.6 percent. The payment for drugs administered in an
15.28 outpatient setting shall be made to the administering facility or practitioner. A retail or
15.29 specialty pharmacy dispensing a drug for administration in an outpatient setting is not
15.30 eligible for direct reimbursement.

15.31 (f) The commissioner may establish maximum allowable cost rates for specialty pharmacy
15.32 products that are lower than the ingredient cost formulas specified in paragraph (a). The
15.33 commissioner may require individuals enrolled in the health care programs administered
15.34 by the department to obtain specialty pharmacy products from providers with whom the
15.35 commissioner has negotiated lower reimbursement rates. Specialty pharmacy products are

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

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

16.16 (h) The commissioner shall contract with a vendor to conduct a cost of dispensing survey
16.17 for all pharmacies that are physically located in the state of Minnesota that dispense outpatient
16.18 drugs under medical assistance. The commissioner shall ensure that the vendor has prior
16.19 experience in conducting cost of dispensing surveys. Each pharmacy enrolled with the
16.20 department to dispense outpatient prescription drugs to fee-for-service members must
16.21 respond to the cost of dispensing survey. The commissioner may sanction a pharmacy under
16.22 section 256B.064 for failure to respond. The commissioner shall require the vendor to
16.23 measure a single statewide cost of dispensing for specialty prescription drugs and a single
16.24 statewide cost of dispensing for nonspecialty prescription drugs for all responding pharmacies
16.25 to measure the mean, mean weighted by total prescription volume, mean weighted by
16.26 medical assistance prescription volume, median, median weighted by total prescription
16.27 volume, and median weighted by total medical assistance prescription volume. The
16.28 commissioner shall post a copy of the final cost of dispensing survey report on the
16.29 department's website. The initial survey must be completed no later than January 1, 2021,
16.30 and repeated every three years. The commissioner shall provide a summary of the results
16.31 of each cost of dispensing survey and provide recommendations for any changes to the
16.32 dispensing fee to the chairs and ranking minority members of the legislative committees
16.33 with jurisdiction over medical assistance pharmacy reimbursement. Notwithstanding section
16.34 256.01, subdivision 42, this paragraph does not expire.

17.1 (i) The commissioner shall increase the ingredient cost reimbursement calculated in
17.2 paragraphs (a) and (f) by 1.8 percent for prescription and nonprescription drugs subject to
17.3 the wholesale drug distributor tax under section 295.52.

17.4 **EFFECTIVE DATE.** This section is effective October 1, 2024.

17.5 Sec. 7. Minnesota Statutes 2023 Supplement, section 256B.0625, subdivision 13k, is
17.6 amended to read:

17.7 Subd. 13k. **Value-based purchasing arrangements.** (a) The commissioner may enter
17.8 into a value-based purchasing arrangement under medical assistance or MinnesotaCare, by
17.9 written arrangement with a drug manufacturer based on agreed-upon metrics. The
17.10 commissioner may contract with a vendor to implement and administer the value-based
17.11 purchasing arrangement. A value-based purchasing arrangement may include but is not
17.12 limited to rebates, discounts, price reductions, risk sharing, reimbursements, guarantees,
17.13 shared savings payments, withholds, or bonuses. A value-based purchasing arrangement
17.14 must provide at least the same value or discount in the aggregate as would claiming the
17.15 mandatory federal drug rebate under the Federal Social Security Act, section 1927.

17.16 (b) Nothing in this section shall be interpreted as requiring a drug manufacturer or the
17.17 commissioner to enter into an arrangement as described in paragraph (a).

17.18 (c) Nothing in this section shall be interpreted as altering or modifying medical assistance
17.19 coverage requirements under the federal Social Security Act, section 1927.

17.20 (d) If the commissioner determines that a state plan amendment is necessary before
17.21 implementing a value-based purchasing arrangement, the commissioner shall request the
17.22 amendment and may delay implementing this provision until the amendment is approved.

17.23 (e) The commissioner may provide separate reimbursement to hospitals for drugs provided
17.24 in the inpatient hospital setting as part of a value-based purchasing arrangement. This
17.25 payment must be separate from the diagnostic related group reimbursement for the inpatient
17.26 admission or discharge associated with a stay during which the patient received a drug under
17.27 this section. For payments made under this section, the hospital must not be reimbursed for
17.28 the drug under the payment methodology in section 256.969. The commissioner shall
17.29 establish the separate reimbursement rate for drugs provided under this section based on
17.30 the methodology used for drugs administered in an outpatient setting under section
17.31 256B.0625, subdivision 13e, paragraph (e).

17.32 **EFFECTIVE DATE.** This section is effective upon federal approval. The commissioner
17.33 of human services shall notify the revisor of statutes when federal approval is obtained.

18.1 Sec. 8. Minnesota Statutes 2023 Supplement, section 256L.04, subdivision 10, is amended
18.2 to read:

18.3 Subd. 10. **Citizenship requirements.** (a) Eligibility for MinnesotaCare is available to
18.4 citizens or nationals of the United States; lawfully present noncitizens as defined in Code
18.5 of Federal Regulations, ~~title 8, section 103.12~~ title 45, section 155.20; and undocumented
18.6 noncitizens. For purposes of this subdivision, an undocumented noncitizen is an individual
18.7 who resides in the United States without the approval or acquiescence of the United States
18.8 Citizenship and Immigration Services. Families with children who are citizens or nationals
18.9 of the United States must cooperate in obtaining satisfactory documentary evidence of
18.10 citizenship or nationality according to the requirements of the federal Deficit Reduction
18.11 Act of 2005, Public Law 109-171.

18.12 (b) Notwithstanding subdivisions 1 and 7, eligible persons include families and
18.13 individuals who are ineligible for medical assistance by reason of immigration status and
18.14 who have incomes equal to or less than 200 percent of federal poverty guidelines, except
18.15 that these persons may be eligible for emergency medical assistance under section 256B.06,
18.16 subdivision 4.

18.17 **EFFECTIVE DATE.** This section is effective November 1, 2024.

18.18 Sec. 9. **IMPLEMENTATION OF TEACHING HOSPITAL SURCHARGE AND**
18.19 **GRADUATE MEDICAL EDUCATION SUPPLEMENTAL PAYMENT.**

18.20 (a) The commissioner of human services shall submit to the Centers for Medicare and
18.21 Medicaid Services a request for federal approval to implement the teaching hospital surcharge
18.22 under Minnesota Statutes, section 256.9657, subdivision 2a, and the graduate medical
18.23 education supplemental payments under Minnesota Statutes, section 256.969, subdivisions
18.24 2b and 2g. At least 60 days before submitting the request for approval, the commissioner
18.25 of human services shall make available to the public the draft surcharge requirements, draft
18.26 supplemental payment rates, and an estimate of each nonexempt hospital's surcharge amount.
18.27 The commissioner shall provide at least 60 days for public comment.

18.28 (b) During the design, and prior to submission, of the request for approval described in
18.29 paragraph (a), the commissioner must consult with representatives of eligible hospitals, as
18.30 defined in Minnesota Statutes, section 256.969, subdivision 2g.

18.31 (c) If federal approval is received under paragraph (a), the commissioner shall provide
18.32 a 30-day public comment period on the federally approved terms and conditions for the
18.33 surcharge and supplemental payments. If, during the 30-day comment period, the

19.1 commissioner receives a documented, written statement of opposition from representatives
19.2 of one or more eligible hospitals, as defined in Minnesota Statutes, section 256.9657,
19.3 subdivision 2a, the commissioner shall publish the written statement and indefinitely suspend
19.4 implementation of both the teaching hospital surcharge under Minnesota Statutes, section
19.5 256.9657, subdivision 2a, and the supplemental payments under Minnesota Statutes, section
19.6 256.969, subdivisions 2b and 2g.

19.7 (d) By December 15, 2024, the commissioner of health may make recommendations to
19.8 the legislature for program modifications and conforming amendments to Minnesota Statutes,
19.9 section 62J.692, that are necessary as a result of the amendments to Minnesota Statutes,
19.10 section 256.969, subdivisions 2b and 2g. In developing the recommendations under this
19.11 paragraph, the commissioner of health must consult with eligible hospitals, as defined in
19.12 Minnesota Statutes, section 256.969, subdivision 2g.

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

19.14 **Sec. 10. COUNTY-ADMINISTERED RURAL MEDICAL ASSISTANCE MODEL.**

19.15 Subdivision 1. **Model development.** (a) The commissioner of human services, in
19.16 collaboration with the Association of Minnesota Counties and county-based purchasing
19.17 plans, shall develop a county-administered rural medical assistance (CARMA) model and
19.18 a detailed plan for implementing the CARMA model.

19.19 (b) The CARMA model must be designed to achieve the following objectives:

19.20 (1) provide a distinct county owned and administered alternative to the prepaid medical
19.21 assistance program;

19.22 (2) facilitate greater integration of health care and social services to address social
19.23 determinants of health in rural communities, with the degree of integration of social services
19.24 varying with each county's needs and resources;

19.25 (3) account for the smaller number of medical assistance enrollees and locally available
19.26 providers of behavioral health, oral health, specialty and tertiary care, nonemergency medical
19.27 transportation, and other health care services in rural communities; and

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

19.30 Subd. 2. **County participation.** The CARMA model must give each rural county the
19.31 option of applying to participate in the CARMA model as an alternative to participation in

20.1 the prepaid medical assistance program. The CARMA model must include a process for
 20.2 the commissioner to determine whether and how a rural county can participate.

20.3 Subd. 3. **Report to the legislature.** (a) The commissioner shall report recommendations
 20.4 and an implementation plan for the CARMA model to the chairs and ranking minority
 20.5 members of the legislative committees with jurisdiction over health care policy and finance
 20.6 by January 15, 2025. The CARMA model and implementation plan must address the issues
 20.7 and consider the recommendations identified in the document titled "Recommendations
 20.8 Not Contingent on Outcome(s) of Current Litigation," attached to the September 13, 2022,
 20.9 e-filing to the Second Judicial District Court (Correspondence for Judicial Approval Index
 20.10 #102), that relates to the final contract decisions of the commissioner of human services
 20.11 regarding *South Country Health Alliance v. Minnesota Department of Human Services*, No.
 20.12 62-CV-22-907 (Ramsey Cnty. Dist. Ct. 2022).

20.13 (b) The report must also identify the clarifications, approvals, and waivers that are needed
 20.14 from the Centers for Medicare and Medicaid Services and include any draft legislation
 20.15 necessary to implement the CARMA model.

20.16 **ARTICLE 2**

20.17 **DEPARTMENT OF HUMAN SERVICES HEALTH CARE POLICY**

20.18 Section 1. Minnesota Statutes 2022, section 62M.01, subdivision 3, is amended to read:

20.19 Subd. 3. **Scope.** (a) Nothing in this chapter applies to review of claims after submission
 20.20 to determine eligibility for benefits under a health benefit plan. The appeal procedure
 20.21 described in section 62M.06 applies to any complaint as defined under section 62Q.68,
 20.22 subdivision 2, that requires a medical determination in its resolution.

20.23 (b) Effective January 1, 2026, this chapter ~~does not apply~~ applies to managed care plans
 20.24 or county-based purchasing plans when the plan is providing coverage to state public health
 20.25 care program enrollees under chapter 256B or 256L.

20.26 (c) Effective January 1, 2026, the following sections of this chapter apply to services
 20.27 delivered under chapters 256B and 256L: 62M.02, subdivisions 1 to 5, 7 to 12, 13, 14 to
 20.28 18, and 21; 62M.04; 62M.05, subdivisions 1 to 4; 62M.06, subdivisions 1 to 3; 62M.07;
 20.29 62M.072; 62M.09; 62M.10; 62M.12; 62M.17, subdivision 2; and 62M.18.

21.1 Sec. 2. Minnesota Statutes 2023 Supplement, section 256.0471, subdivision 1, as amended
 21.2 by Laws 2024, chapter 80, article 1, section 76, is amended to read:

21.3 Subdivision 1. **Qualifying overpayment.** Any overpayment for state-funded medical
 21.4 assistance under chapter 256B and state-funded MinnesotaCare under chapter 256L granted
 21.5 pursuant to section 256.045, subdivision 10; ~~chapter 256B for state-funded medical~~
 21.6 ~~assistance;~~ and for assistance granted under chapters 256D, 256I, and 256K, and 256L for
 21.7 ~~state-funded MinnesotaCare~~ except agency error claims, become a judgment by operation
 21.8 of law 90 days after the notice of overpayment is personally served upon the recipient in a
 21.9 manner that is sufficient under rule 4.03(a) of the Rules of Civil Procedure for district courts,
 21.10 or by certified mail, return receipt requested. This judgment shall be entitled to full faith
 21.11 and credit in this and any other state.

21.12 **EFFECTIVE DATE.** This section is effective July 1, 2024.

21.13 Sec. 3. Minnesota Statutes 2022, section 256.9657, subdivision 8, is amended to read:

21.14 Subd. 8. **Commissioner's duties.** ~~(a) Beginning October 1, 2023, the commissioner of~~
 21.15 ~~human services shall annually report to the chairs and ranking minority members of the~~
 21.16 ~~legislative committees with jurisdiction over health care policy and finance regarding the~~
 21.17 ~~provider surcharge program. The report shall include information on total billings, total~~
 21.18 ~~collections, and administrative expenditures for the previous fiscal year. This paragraph~~
 21.19 ~~expires January 1, 2032.~~

21.20 ~~(b)~~ (a) The surcharge shall be adjusted by inflationary and caseload changes in future
 21.21 bienniums to maintain reimbursement of health care providers in accordance with the
 21.22 requirements of the state and federal laws governing the medical assistance program,
 21.23 including the requirements of the Medicaid moratorium amendments of 1991 found in
 21.24 Public Law No. 102-234.

21.25 ~~(c)~~ (b) The commissioner shall request the Minnesota congressional delegation to support
 21.26 a change in federal law that would prohibit federal disallowances for any state that makes
 21.27 a good faith effort to comply with Public Law 102-234 by enacting conforming legislation
 21.28 prior to the issuance of federal implementing regulations.

21.29 Sec. 4. Minnesota Statutes 2022, section 256.969, is amended by adding a subdivision to
 21.30 read:

21.31 Subd. 2h. **Alternate inpatient payment rate for a discharge.** (a) Effective retroactively
 21.32 from January 1, 2024, in any rate year in which a children's hospital discharge is included

22.1 in the federally required disproportionate share hospital payment audit, where the patient
 22.2 discharged had resided in a children's hospital for over 20 years, the commissioner shall
 22.3 compute an alternate inpatient rate for the children's hospital. The alternate payment rate
 22.4 must be the rate computed under this section excluding the disproportionate share hospital
 22.5 payment under subdivision 9, paragraph (d), clause (1), increased by an amount equal to
 22.6 99 percent of what the disproportionate share hospital payment would have been under
 22.7 subdivision 9, paragraph (d), clause (1), had the discharge been excluded.

22.8 (b) In any rate year in which payment to a children's hospital is made using this alternate
 22.9 payment rate, payments must not be made to the hospital under subdivisions 2e, 2f, and 9.

22.10 **EFFECTIVE DATE.** This section is effective upon federal approval. The commissioner
 22.11 of human services shall notify the revisor of statutes when federal approval is obtained.

22.12 Sec. 5. Minnesota Statutes 2022, section 256B.056, subdivision 1a, is amended to read:

22.13 Subd. 1a. **Income and assets generally.** (a)(1) Unless specifically required by state law
 22.14 or rule or federal law or regulation, the methodologies used in counting income and assets
 22.15 to determine eligibility for medical assistance for persons whose eligibility category is based
 22.16 on blindness, disability, or age of 65 or more years, the methodologies for the Supplemental
 22.17 Security Income program shall be used, except as provided ~~under~~ in clause (2) and
 22.18 subdivision 3, paragraph (a), clause (6).

22.19 (2) State tax credits, rebates, and refunds must not be counted as income. State tax credits,
 22.20 rebates, and refunds must not be counted as assets for a period of 12 months after the month
 22.21 of receipt.

22.22 ~~(2)~~ (3) Increases in benefits under title II of the Social Security Act shall not be counted
 22.23 as income for purposes of this subdivision until July 1 of each year. Effective upon federal
 22.24 approval, for children eligible under section 256B.055, subdivision 12, or for home and
 22.25 community-based waiver services whose eligibility for medical assistance is determined
 22.26 without regard to parental income, child support payments, including any payments made
 22.27 by an obligor in satisfaction of or in addition to a temporary or permanent order for child
 22.28 support, and Social Security payments are not counted as income.

22.29 (b)(1) The modified adjusted gross income methodology as defined in United States
 22.30 Code, title 42, section 1396a(e)(14), shall be used for eligibility categories based on:

22.31 (i) children under age 19 and their parents and relative caretakers as defined in section
 22.32 256B.055, subdivision 3a;

22.33 (ii) children ages 19 to 20 as defined in section 256B.055, subdivision 16;

23.1 (iii) pregnant women as defined in section 256B.055, subdivision 6;

23.2 (iv) infants as defined in sections 256B.055, subdivision 10, and 256B.057, subdivision
23.3 1; and

23.4 (v) adults without children as defined in section 256B.055, subdivision 15.

23.5 For these purposes, a "methodology" does not include an asset or income standard, or
23.6 accounting method, or method of determining effective dates.

23.7 (2) For individuals whose income eligibility is determined using the modified adjusted
23.8 gross income methodology in clause (1):

23.9 (i) the commissioner shall subtract from the individual's modified adjusted gross income
23.10 an amount equivalent to five percent of the federal poverty guidelines; and

23.11 (ii) the individual's current monthly income and household size is used to determine
23.12 eligibility for the 12-month eligibility period. If an individual's income is expected to vary
23.13 month to month, eligibility is determined based on the income predicted for the 12-month
23.14 eligibility period.

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

23.16 Sec. 6. Minnesota Statutes 2022, section 256B.056, subdivision 10, is amended to read:

23.17 Subd. 10. **Eligibility verification.** (a) The commissioner shall require women who are
23.18 applying for the continuation of medical assistance coverage following the end of the
23.19 12-month postpartum period to update their income and asset information and to submit
23.20 any required income or asset verification.

23.21 (b) The commissioner shall determine the eligibility of private-sector health care coverage
23.22 for infants less than one year of age eligible under section 256B.055, subdivision 10, or
23.23 256B.057, subdivision 1, paragraph (c), and shall pay for private-sector coverage if this is
23.24 determined to be cost-effective.

23.25 (c) The commissioner shall verify assets and income for all applicants, and for all
23.26 recipients upon renewal.

23.27 (d) The commissioner shall utilize information obtained through the electronic service
23.28 established by the secretary of the United States Department of Health and Human Services
23.29 and other available electronic data sources in Code of Federal Regulations, title 42, sections
23.30 435.940 to 435.956, to verify eligibility requirements. The commissioner shall establish
23.31 standards to define when information obtained electronically is reasonably compatible with

24.1 information provided by applicants and enrollees, including use of self-attestation, to
24.2 accomplish real-time eligibility determinations and maintain program integrity.

24.3 (e) Each person applying for or receiving medical assistance under section 256B.055,
24.4 subdivision 7, and any other person whose resources are required by law to be disclosed to
24.5 determine the applicant's or recipient's eligibility must authorize the commissioner to obtain
24.6 information from financial institutions to ~~identify unreported accounts~~ verify assets as
24.7 required in section 256.01, subdivision 18f. If a person refuses or revokes the authorization,
24.8 the commissioner may determine that the applicant or recipient is ineligible for medical
24.9 assistance. For purposes of this paragraph, an authorization to ~~identify unreported accounts~~
24.10 verify assets meets the requirements of the Right to Financial Privacy Act, United States
24.11 Code, title 12, chapter 35, and need not be furnished to the financial institution.

24.12 (f) County and tribal agencies shall comply with the standards established by the
24.13 commissioner for appropriate use of the asset verification system specified in section 256.01,
24.14 subdivision 18f.

24.15 Sec. 7. Minnesota Statutes 2023 Supplement, section 256B.0622, subdivision 8, is amended
24.16 to read:

24.17 Subd. 8. **Medical assistance payment for assertive community treatment and**
24.18 **intensive residential treatment services.** (a) Payment for intensive residential treatment
24.19 services and assertive community treatment in this section shall be based on one daily rate
24.20 per provider inclusive of the following services received by an eligible client in a given
24.21 calendar day: all rehabilitative services under this section, staff travel time to provide
24.22 rehabilitative services under this section, and nonresidential crisis stabilization services
24.23 under section 256B.0624.

24.24 (b) Except as indicated in paragraph (c), payment will not be made to more than one
24.25 entity for each client for services provided under this section on a given day. If services
24.26 under this section are provided by a team that includes staff from more than one entity, the
24.27 team must determine how to distribute the payment among the members.

24.28 (c) The commissioner shall determine one rate for each provider that will bill medical
24.29 assistance for residential services under this section and one rate for each assertive community
24.30 treatment provider. If a single entity provides both services, one rate is established for the
24.31 entity's residential services and another rate for the entity's nonresidential services under
24.32 this section. A provider is not eligible for payment under this section without authorization
24.33 from the commissioner. The commissioner shall develop rates using the following criteria:

25.1 (1) the provider's cost for services shall include direct services costs, other program
25.2 costs, and other costs determined as follows:

25.3 (i) the direct services costs must be determined using actual costs of salaries, benefits,
25.4 payroll taxes, and training of direct service staff and service-related transportation;

25.5 (ii) other program costs not included in item (i) must be determined as a specified
25.6 percentage of the direct services costs as determined by item (i). The percentage used shall
25.7 be determined by the commissioner based upon the average of percentages that represent
25.8 the relationship of other program costs to direct services costs among the entities that provide
25.9 similar services;

25.10 (iii) physical plant costs calculated based on the percentage of space within the program
25.11 that is entirely devoted to treatment and programming. This does not include administrative
25.12 or residential space;

25.13 (iv) assertive community treatment physical plant costs must be reimbursed as part of
25.14 the costs described in item (ii); and

25.15 (v) subject to federal approval, up to an additional five percent of the total rate may be
25.16 added to the program rate as a quality incentive based upon the entity meeting performance
25.17 criteria specified by the commissioner;

25.18 (2) actual cost is defined as costs which are allowable, allocable, and reasonable, and
25.19 consistent with federal reimbursement requirements under Code of Federal Regulations,
25.20 title 48, chapter 1, part 31, relating to for-profit entities, and Office of Management and
25.21 Budget Circular Number A-122, relating to nonprofit entities;

25.22 (3) the number of service units;

25.23 (4) the degree to which clients will receive services other than services under this section;
25.24 and

25.25 (5) the costs of other services that will be separately reimbursed.

25.26 (d) The rate for intensive residential treatment services and assertive community treatment
25.27 must exclude the medical assistance room and board rate, as defined in section 256B.056,
25.28 subdivision 5d, and services not covered under this section, such as partial hospitalization,
25.29 home care, and inpatient services.

25.30 (e) Physician services that are not separately billed may be included in the rate to the
25.31 extent that a psychiatrist, or other health care professional providing physician services
25.32 within their scope of practice, is a member of the intensive residential treatment services

26.1 treatment team. Physician services, whether billed separately or included in the rate, may
26.2 be delivered by telehealth. For purposes of this paragraph, "telehealth" has the meaning
26.3 given to "mental health telehealth" in section 256B.0625, subdivision 46, when telehealth
26.4 is used to provide intensive residential treatment services.

26.5 (f) When services under this section are provided by an assertive community treatment
26.6 provider, case management functions must be an integral part of the team.

26.7 (g) The rate for a provider must not exceed the rate charged by that provider for the
26.8 same service to other payors.

26.9 (h) The rates for existing programs must be established prospectively based upon the
26.10 expenditures and utilization over a prior 12-month period using the criteria established in
26.11 paragraph (c). The rates for new programs must be established based upon estimated
26.12 expenditures and estimated utilization using the criteria established in paragraph (c).

26.13 (i) Effective for the rate years beginning on and after January 1, 2024, rates for assertive
26.14 community treatment, adult residential crisis stabilization services, and intensive residential
26.15 treatment services must be annually adjusted for inflation using the Centers for Medicare
26.16 and Medicaid Services Medicare Economic Index, as forecasted in the ~~fourth~~ third quarter
26.17 of the calendar year before the rate year. The inflation adjustment must be based on the
26.18 12-month period from the midpoint of the previous rate year to the midpoint of the rate year
26.19 for which the rate is being determined.

26.20 (j) Entities who discontinue providing services must be subject to a settle-up process
26.21 whereby actual costs and reimbursement for the previous 12 months are compared. In the
26.22 event that the entity was paid more than the entity's actual costs plus any applicable
26.23 performance-related funding due the provider, the excess payment must be reimbursed to
26.24 the department. If a provider's revenue is less than actual allowed costs due to lower
26.25 utilization than projected, the commissioner may reimburse the provider to recover its actual
26.26 allowable costs. The resulting adjustments by the commissioner must be proportional to the
26.27 percent of total units of service reimbursed by the commissioner and must reflect a difference
26.28 of greater than five percent.

26.29 (k) A provider may request of the commissioner a review of any rate-setting decision
26.30 made under this subdivision.

27.1 Sec. 8. Minnesota Statutes 2023 Supplement, section 256B.0625, subdivision 9, is amended
27.2 to read:

27.3 Subd. 9. **Dental services.** (a) Medical assistance covers medically necessary dental
27.4 services.

27.5 (b) The following guidelines apply to dental services:

27.6 (1) posterior fillings are paid at the amalgam rate;

27.7 (2) application of sealants are covered once every five years per permanent molar; and

27.8 (3) application of fluoride varnish is covered once every six months.

27.9 (c) In addition to the services specified in paragraph ~~(b)~~ (a), medical assistance covers
27.10 the following services:

27.11 (1) house calls or extended care facility calls for on-site delivery of covered services;

27.12 (2) behavioral management when additional staff time is required to accommodate
27.13 behavioral challenges and sedation is not used;

27.14 (3) oral or IV sedation, if the covered dental service cannot be performed safely without
27.15 it or would otherwise require the service to be performed under general anesthesia in a
27.16 hospital or surgical center; and

27.17 (4) prophylaxis, in accordance with an appropriate individualized treatment plan, but
27.18 no more than four times per year.

27.19 (d) The commissioner shall not require prior authorization for the services included in
27.20 paragraph (c), clauses (1) to (3), and shall prohibit managed care and county-based purchasing
27.21 plans from requiring prior authorization for the services included in paragraph (c), clauses
27.22 (1) to (3), when provided under sections 256B.69, 256B.692, and 256L.12.

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

27.24 Sec. 9. Minnesota Statutes 2023 Supplement, section 256B.0625, subdivision 13e, as
27.25 amended by Laws 2024, chapter 85, section 66, is amended to read:

27.26 Subd. 13e. **Payment rates.** (a) The basis for determining the amount of payment shall
27.27 be the lower of the ingredient costs of the drugs plus the professional dispensing fee; or the
27.28 usual and customary price charged to the public. The usual and customary price means the
27.29 lowest price charged by the provider to a patient who pays for the prescription by cash,
27.30 check, or charge account and includes prices the pharmacy charges to a patient enrolled in
27.31 a prescription savings club or prescription discount club administered by the pharmacy or

28.1 pharmacy chain, unless the prescription savings club or prescription discount club is one
28.2 in which an individual pays a recurring monthly access fee for unlimited access to a defined
28.3 list of drugs for which the pharmacy does not bill the member or a payer on a
28.4 per-standard-transaction basis. The amount of payment basis must be reduced to reflect all
28.5 discount amounts applied to the charge by any third-party provider/insurer agreement or
28.6 contract for submitted charges to medical assistance programs. The net submitted charge
28.7 may not be greater than the patient liability for the service. The professional dispensing fee
28.8 shall be \$10.77 for prescriptions filled with legend drugs meeting the definition of "covered
28.9 outpatient drugs" according to United States Code, title 42, section 1396r-8(k)(2). The
28.10 dispensing fee for intravenous solutions that must be compounded by the pharmacist shall
28.11 be \$10.77 per claim. The professional dispensing fee for prescriptions filled with
28.12 over-the-counter drugs meeting the definition of covered outpatient drugs shall be \$10.77
28.13 for dispensed quantities equal to or greater than the number of units contained in the
28.14 manufacturer's original package. The professional dispensing fee shall be prorated based
28.15 on the percentage of the package dispensed when the pharmacy dispenses a quantity less
28.16 than the number of units contained in the manufacturer's original package. The pharmacy
28.17 dispensing fee for prescribed over-the-counter drugs not meeting the definition of covered
28.18 outpatient drugs shall be \$3.65 for quantities equal to or greater than the number of units
28.19 contained in the manufacturer's original package and shall be prorated based on the
28.20 percentage of the package dispensed when the pharmacy dispenses a quantity less than the
28.21 number of units contained in the manufacturer's original package. The National Average
28.22 Drug Acquisition Cost (NADAC) shall be used to determine the ingredient cost of a drug.
28.23 For drugs for which a NADAC is not reported, the commissioner shall estimate the ingredient
28.24 cost at the wholesale acquisition cost minus two percent. The ingredient cost of a drug for
28.25 a provider participating in the federal 340B Drug Pricing Program shall be either the 340B
28.26 Drug Pricing Program ceiling price established by the Health Resources and Services
28.27 Administration or NADAC, whichever is lower. Wholesale acquisition cost is defined as
28.28 the manufacturer's list price for a drug or biological to wholesalers or direct purchasers in
28.29 the United States, not including prompt pay or other discounts, rebates, or reductions in
28.30 price, for the most recent month for which information is available, as reported in wholesale
28.31 price guides or other publications of drug or biological pricing data. The maximum allowable
28.32 cost of a multisource drug may be set by the commissioner and it shall be comparable to
28.33 the actual acquisition cost of the drug product and no higher than the NADAC of the generic
28.34 product. Establishment of the amount of payment for drugs shall not be subject to the
28.35 requirements of the Administrative Procedure Act.

29.1 (b) Pharmacies dispensing prescriptions to residents of long-term care facilities using
29.2 an automated drug distribution system meeting the requirements of section 151.58, or a
29.3 packaging system meeting the packaging standards set forth in Minnesota Rules, part
29.4 6800.2700, that govern the return of unused drugs to the pharmacy for reuse, may employ
29.5 retrospective billing for prescription drugs dispensed to long-term care facility residents. A
29.6 retrospectively billing pharmacy must submit a claim only for the quantity of medication
29.7 used by the enrolled recipient during the defined billing period. A retrospectively billing
29.8 pharmacy must use a billing period not less than one calendar month or 30 days.

29.9 (c) A pharmacy provider using packaging that meets the standards set forth in Minnesota
29.10 Rules, part 6800.2700, is required to credit the department for the actual acquisition cost
29.11 of all unused drugs that are eligible for reuse, unless the pharmacy is using retrospective
29.12 billing. The commissioner may permit the drug clozapine to be dispensed in a quantity that
29.13 is less than a 30-day supply.

29.14 (d) If a pharmacy dispenses a multisource drug, the ingredient cost shall be the NADAC
29.15 of the generic product or the maximum allowable cost established by the commissioner
29.16 unless prior authorization for the brand name product has been granted according to the
29.17 criteria established by the Drug Formulary Committee as required by subdivision 13f,
29.18 paragraph (a), and the prescriber has indicated "dispense as written" on the prescription in
29.19 a manner consistent with section 151.21, subdivision 2.

29.20 (e) The basis for determining the amount of payment for drugs administered in an
29.21 outpatient setting shall be the lower of the usual and customary cost submitted by the
29.22 provider, 106 percent of the average sales price as determined by the United States
29.23 Department of Health and Human Services pursuant to title XVIII, section 1847a of the
29.24 federal Social Security Act, the specialty pharmacy rate, or the maximum allowable cost
29.25 set by the commissioner. If average sales price is unavailable, the amount of payment must
29.26 be lower of the usual and customary cost submitted by the provider, the wholesale acquisition
29.27 cost, the specialty pharmacy rate, or the maximum allowable cost set by the commissioner.
29.28 The commissioner shall discount the payment rate for drugs obtained through the federal
29.29 340B Drug Pricing Program by 28.6 percent. The payment for drugs administered in an
29.30 outpatient setting shall be made to the administering facility or practitioner. A retail or
29.31 specialty pharmacy dispensing a drug for administration in an outpatient setting is not
29.32 eligible for direct reimbursement.

29.33 (f) The commissioner may establish maximum allowable cost rates for specialty pharmacy
29.34 products that are lower than the ingredient cost formulas specified in paragraph (a). The
29.35 commissioner may require individuals enrolled in the health care programs administered

30.1 by the department to obtain specialty pharmacy products from providers with whom the
30.2 commissioner has negotiated lower reimbursement rates. Specialty pharmacy products are
30.3 defined as those used by a small number of recipients or recipients with complex and chronic
30.4 diseases that require expensive and challenging drug regimens. Examples of these conditions
30.5 include, but are not limited to: multiple sclerosis, HIV/AIDS, transplantation, hepatitis C,
30.6 growth hormone deficiency, Crohn's Disease, rheumatoid arthritis, and certain forms of
30.7 cancer. Specialty pharmaceutical products include injectable and infusion therapies,
30.8 biotechnology drugs, antihemophilic factor products, high-cost therapies, and therapies that
30.9 require complex care. The commissioner shall consult with the Formulary Committee to
30.10 develop a list of specialty pharmacy products subject to maximum allowable cost
30.11 reimbursement. In consulting with the Formulary Committee in developing this list, the
30.12 commissioner shall take into consideration the population served by specialty pharmacy
30.13 products, the current delivery system and standard of care in the state, and access to care
30.14 issues. The commissioner shall have the discretion to adjust the maximum allowable cost
30.15 to prevent access to care issues.

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

30.18 (h) The commissioner shall contract with a vendor to conduct a cost of dispensing survey
30.19 for all pharmacies that are physically located in the state of Minnesota that dispense outpatient
30.20 drugs under medical assistance. The commissioner shall ensure that the vendor has prior
30.21 experience in conducting cost of dispensing surveys. Each pharmacy enrolled with the
30.22 department to dispense outpatient prescription drugs to fee-for-service members must
30.23 respond to the cost of dispensing survey. The commissioner may sanction a pharmacy under
30.24 section 256B.064 for failure to respond. The commissioner shall require the vendor to
30.25 measure a single statewide cost of dispensing for specialty prescription drugs and a single
30.26 statewide cost of dispensing for nonspecialty prescription drugs for all responding pharmacies
30.27 to measure the mean, mean weighted by total prescription volume, mean weighted by
30.28 medical assistance prescription volume, median, median weighted by total prescription
30.29 volume, and median weighted by total medical assistance prescription volume. The
30.30 commissioner shall post a copy of the final cost of dispensing survey report on the
30.31 department's website. The initial survey must be completed no later than January 1, 2021,
30.32 and repeated every three years. The commissioner shall provide a summary of the results
30.33 of each cost of dispensing survey and provide recommendations for any changes to the
30.34 dispensing fee to the chairs and ranking minority members of the legislative committees

31.1 with jurisdiction over medical assistance pharmacy reimbursement. Notwithstanding section
31.2 256.01, subdivision 42, this paragraph does not expire.

31.3 (i) The commissioner shall increase the ingredient cost reimbursement calculated in
31.4 paragraphs (a) and (f) by 1.8 percent for prescription and nonprescription drugs subject to
31.5 the wholesale drug distributor tax under section 295.52.

31.6 Sec. 10. Minnesota Statutes 2022, section 256B.0625, is amended by adding a subdivision
31.7 to read:

31.8 Subd. 25c. Applicability of utilization review provisions. Effective January 1, 2026,
31.9 the following provisions of chapter 62M apply to the commissioner when delivering services
31.10 under chapters 256B and 256L: 62M.02, subdivisions 1 to 5, 7 to 12, 13, 14 to 18, and 21;
31.11 62M.04; 62M.05, subdivisions 1 to 4; 62M.06, subdivisions 1 to 3; 62M.07; 62M.072;
31.12 62M.09; 62M.10; 62M.12; 62M.17, subdivision 2; and 62M.18.

31.13 Sec. 11. Minnesota Statutes 2023 Supplement, section 256B.0701, subdivision 6, is
31.14 amended to read:

31.15 Subd. 6. **Recuperative care facility rate.** (a) The recuperative care facility rate is for
31.16 facility costs and must be paid from state money in an amount equal to the ~~medical assistance~~
31.17 ~~room and board~~ MSA equivalent rate as defined in section 256I.03, subdivision 11a, at the
31.18 time the recuperative care services were provided. The eligibility standards in chapter 256I
31.19 do not apply to the recuperative care facility rate. The recuperative care facility rate is only
31.20 paid when the recuperative care services rate is paid to a provider. Providers may opt to
31.21 only receive the recuperative care services rate.

31.22 (b) Before a recipient is discharged from a recuperative care setting, the provider must
31.23 ensure that the recipient's medical condition is stabilized or that the recipient is being
31.24 discharged to a setting that is able to meet that recipient's needs.

31.25 Sec. 12. Minnesota Statutes 2023 Supplement, section 256B.0947, subdivision 7, is
31.26 amended to read:

31.27 Subd. 7. **Medical assistance payment and rate setting.** (a) Payment for services in this
31.28 section must be based on one daily encounter rate per provider inclusive of the following
31.29 services received by an eligible client in a given calendar day: all rehabilitative services,
31.30 supports, and ancillary activities under this section, staff travel time to provide rehabilitative
31.31 services under this section, and crisis response services under section 256B.0624.

32.1 (b) Payment must not be made to more than one entity for each client for services
 32.2 provided under this section on a given day. If services under this section are provided by a
 32.3 team that includes staff from more than one entity, the team shall determine how to distribute
 32.4 the payment among the members.

32.5 (c) The commissioner shall establish regional cost-based rates for entities that will bill
 32.6 medical assistance for nonresidential intensive rehabilitative mental health services. In
 32.7 developing these rates, the commissioner shall consider:

32.8 (1) the cost for similar services in the health care trade area;

32.9 (2) actual costs incurred by entities providing the services;

32.10 (3) the intensity and frequency of services to be provided to each client;

32.11 (4) the degree to which clients will receive services other than services under this section;

32.12 and

32.13 (5) the costs of other services that will be separately reimbursed.

32.14 (d) The rate for a provider must not exceed the rate charged by that provider for the
 32.15 same service to other payers.

32.16 (e) Effective for the rate years beginning on and after January 1, 2024, rates must be
 32.17 annually adjusted for inflation using the Centers for Medicare and Medicaid Services
 32.18 Medicare Economic Index, as forecasted in the ~~fourth~~ third quarter of the calendar year
 32.19 before the rate year. The inflation adjustment must be based on the 12-month period from
 32.20 the midpoint of the previous rate year to the midpoint of the rate year for which the rate is
 32.21 being determined.

32.22 Sec. 13. Minnesota Statutes 2023 Supplement, section 256B.764, is amended to read:

32.23 **256B.764 REIMBURSEMENT FOR FAMILY PLANNING SERVICES.**

32.24 (a) Effective for services rendered on or after July 1, 2007, payment rates for family
 32.25 planning services shall be increased by 25 percent over the rates in effect June 30, 2007,
 32.26 when these services are provided by a community clinic as defined in section 145.9268,
 32.27 subdivision 1.

32.28 (b) Effective for services rendered on or after July 1, 2013, payment rates for family
 32.29 planning services shall be increased by 20 percent over the rates in effect June 30, 2013,
 32.30 when these services are provided by a community clinic as defined in section 145.9268,
 32.31 subdivision 1. The commissioner shall adjust capitation rates to managed care and
 32.32 county-based purchasing plans to reflect this increase, and shall require plans to pass on the

33.1 full amount of the rate increase to eligible community clinics, in the form of higher payment
33.2 rates for family planning services.

33.3 (c) Effective for services provided on or after January 1, 2024, payment rates for family
33.4 planning, when such services are provided by an eligible community clinic as defined in
33.5 section 145.9268, subdivision 1, and abortion services shall be increased by 20 percent.
33.6 This increase does not apply to federally qualified health centers, rural health centers, or
33.7 Indian health services.

33.8 Sec. 14. Minnesota Statutes 2023 Supplement, section 256L.03, subdivision 1, is amended
33.9 to read:

33.10 Subdivision 1. **Covered health services.** (a) "Covered health services" means the health
33.11 services reimbursed under chapter 256B, with the exception of special education services,
33.12 home care nursing services, ~~adult dental care services other than services covered under~~
33.13 ~~section 256B.0625, subdivision 9, orthodontic services~~, nonemergency medical transportation
33.14 services, personal care assistance and case management services, community first services
33.15 and supports under section 256B.85, behavioral health home services under section
33.16 256B.0757, housing stabilization services under section 256B.051, and nursing home or
33.17 intermediate care facilities services.

33.18 (b) Covered health services shall be expanded as provided in this section.

33.19 (c) For the purposes of covered health services under this section, "child" means an
33.20 individual younger than 19 years of age.

33.21 Sec. 15. Minnesota Statutes 2022, section 524.3-801, as amended by Laws 2024, chapter
33.22 79, article 9, section 20, is amended to read:

33.23 **524.3-801 NOTICE TO CREDITORS.**

33.24 (a) Unless notice has already been given under this section, upon appointment of a
33.25 general personal representative in informal proceedings or upon the filing of a petition for
33.26 formal appointment of a general personal representative, notice thereof, in the form prescribed
33.27 by court rule, shall be given under the direction of the court administrator by publication
33.28 once a week for two successive weeks in a legal newspaper in the county wherein the
33.29 proceedings are pending giving the name and address of the general personal representative
33.30 and notifying creditors of the estate to present their claims within four months after the date
33.31 of the court administrator's notice which is subsequently published or be forever barred,
33.32 unless they are entitled to further service of notice under paragraph (b) or (c).

34.1 (b) The personal representative shall, within three months after the date of the first
34.2 publication of the notice, serve a copy of the notice upon each then known and identified
34.3 creditor in the manner provided in paragraph (c). If the decedent or a predeceased spouse
34.4 of the decedent received assistance for which a claim could be filed under section 246.53,
34.5 256B.15, 256D.16, or 261.04, notice to the commissioner of human services or direct care
34.6 and treatment executive board, as applicable, must be given under paragraph (d) instead of
34.7 under this paragraph or paragraph (c). A creditor is "known" if: (i) the personal representative
34.8 knows that the creditor has asserted a claim that arose during the decedent's life against
34.9 either the decedent or the decedent's estate; (ii) the creditor has asserted a claim that arose
34.10 during the decedent's life and the fact is clearly disclosed in accessible financial records
34.11 known and available to the personal representative; or (iii) the claim of the creditor would
34.12 be revealed by a reasonably diligent search for creditors of the decedent in accessible
34.13 financial records known and available to the personal representative. Under this section, a
34.14 creditor is "identified" if the personal representative's knowledge of the name and address
34.15 of the creditor will permit service of notice to be made under paragraph (c).

34.16 (c) Unless the claim has already been presented to the personal representative or paid,
34.17 the personal representative shall serve a copy of the notice required by paragraph (b) upon
34.18 each creditor of the decedent who is then known to the personal representative and identified
34.19 either by delivery of a copy of the required notice to the creditor, or by mailing a copy of
34.20 the notice to the creditor by certified, registered, or ordinary first class mail addressed to
34.21 the creditor at the creditor's office or place of residence.

34.22 (d)(1) Effective for decedents dying on or after July 1, 1997, if the decedent or a
34.23 predeceased spouse of the decedent received assistance for which a claim could be filed
34.24 under section 246.53, 256B.15, 256D.16, or 261.04, the personal representative or the
34.25 attorney for the personal representative shall serve the commissioner or executive board,
34.26 as applicable, with notice in the manner prescribed in paragraph (c), or electronically in a
34.27 manner prescribed by the commissioner or executive board, as soon as practicable after the
34.28 appointment of the personal representative. The notice must state the decedent's full name,
34.29 date of birth, and Social Security number and, to the extent then known after making a
34.30 reasonably diligent inquiry, the full name, date of birth, and Social Security number for
34.31 each of the decedent's predeceased spouses. The notice may also contain a statement that,
34.32 after making a reasonably diligent inquiry, the personal representative has determined that
34.33 the decedent did not have any predeceased spouses or that the personal representative has
34.34 been unable to determine one or more of the previous items of information for a predeceased

35.1 spouse of the decedent. A copy of the notice to creditors must be attached to and be a part
35.2 of the notice to the commissioner or executive board.

35.3 (2) Notwithstanding a will or other instrument or law to the contrary, except as allowed
35.4 in this paragraph, no property subject to administration by the estate may be distributed by
35.5 the estate or the personal representative until 70 days after the date the notice is served on
35.6 the commissioner or executive board as provided in paragraph (c), unless the local agency
35.7 consents as provided for in clause (6). This restriction on distribution does not apply to the
35.8 personal representative's sale of real or personal property, but does apply to the net proceeds
35.9 the estate receives from these sales. The personal representative, or any person with personal
35.10 knowledge of the facts, may provide an affidavit containing the description of any real or
35.11 personal property affected by this paragraph and stating facts showing compliance with this
35.12 paragraph. If the affidavit describes real property, it may be filed or recorded in the office
35.13 of the county recorder or registrar of titles for the county where the real property is located.
35.14 This paragraph does not apply to proceedings under sections 524.3-1203 and 525.31, or
35.15 when a duly authorized agent of a county is acting as the personal representative of the
35.16 estate.

35.17 (3) At any time before an order or decree is entered under section 524.3-1001 or
35.18 524.3-1002, or a closing statement is filed under section 524.3-1003, the personal
35.19 representative or the attorney for the personal representative may serve an amended notice
35.20 on the commissioner or executive board to add variations or other names of the decedent
35.21 or a predeceased spouse named in the notice, the name of a predeceased spouse omitted
35.22 from the notice, to add or correct the date of birth or Social Security number of a decedent
35.23 or predeceased spouse named in the notice, or to correct any other deficiency in a prior
35.24 notice. The amended notice must state the decedent's name, date of birth, and Social Security
35.25 number, the case name, case number, and district court in which the estate is pending, and
35.26 the date the notice being amended was served on the commissioner or executive board. If
35.27 the amendment adds the name of a predeceased spouse omitted from the notice, it must also
35.28 state that spouse's full name, date of birth, and Social Security number. The amended notice
35.29 must be served on the commissioner or executive board in the same manner as the original
35.30 notice. Upon service, the amended notice relates back to and is effective from the date the
35.31 notice it amends was served, and the time for filing claims arising under section 246.53,
35.32 256B.15, 256D.16 or 261.04 is extended by 60 days from the date of service of the amended
35.33 notice. Claims filed during the 60-day period are undischarged and unbarred claims, may
35.34 be prosecuted by the entities entitled to file those claims in accordance with section
35.35 524.3-1004, and the limitations in section 524.3-1006 do not apply. The personal

36.1 representative or any person with personal knowledge of the facts may provide and file or
36.2 record an affidavit in the same manner as provided for in clause (1).

36.3 (4) Within one year after the date an order or decree is entered under section 524.3-1001
36.4 or 524.3-1002 or a closing statement is filed under section 524.3-1003, any person who has
36.5 an interest in property that was subject to administration by the estate may serve an amended
36.6 notice on the commissioner or executive board to add variations or other names of the
36.7 decedent or a predeceased spouse named in the notice, the name of a predeceased spouse
36.8 omitted from the notice, to add or correct the date of birth or Social Security number of a
36.9 decedent or predeceased spouse named in the notice, or to correct any other deficiency in
36.10 a prior notice. The amended notice must be served on the commissioner or executive board
36.11 in the same manner as the original notice and must contain the information required for
36.12 amendments under clause (3). If the amendment adds the name of a predeceased spouse
36.13 omitted from the notice, it must also state that spouse's full name, date of birth, and Social
36.14 Security number. Upon service, the amended notice relates back to and is effective from
36.15 the date the notice it amends was served. If the amended notice adds the name of an omitted
36.16 predeceased spouse or adds or corrects the Social Security number or date of birth of the
36.17 decedent or a predeceased spouse already named in the notice, then, notwithstanding any
36.18 other laws to the contrary, claims against the decedent's estate on account of those persons
36.19 resulting from the amendment and arising under section 246.53, 256B.15, 256D.16, or
36.20 261.04 are undischarged and unbarred claims, may be prosecuted by the entities entitled to
36.21 file those claims in accordance with section 524.3-1004, and the limitations in section
36.22 524.3-1006 do not apply. The person filing the amendment or any other person with personal
36.23 knowledge of the facts may provide and file or record an affidavit describing affected real
36.24 or personal property in the same manner as clause (1).

36.25 (5) After one year from the date an order or decree is entered under section 524.3-1001
36.26 or 524.3-1002, or a closing statement is filed under section 524.3-1003, no error, omission,
36.27 or defect of any kind in the notice to the commissioner or executive board required under
36.28 this paragraph or in the process of service of the notice on the commissioner or executive
36.29 board, or the failure to serve the commissioner or executive board with notice as required
36.30 by this paragraph, makes any distribution of property by a personal representative void or
36.31 voidable. The distributee's title to the distributed property shall be free of any claims based
36.32 upon a failure to comply with this paragraph.

36.33 (6) The local agency may consent to a personal representative's request to distribute
36.34 property subject to administration by the estate to distributees during the 70-day period after
36.35 service of notice on the commissioner or executive board. The local agency may grant or

37.1 deny the request in whole or in part and may attach conditions to its consent as it deems
37.2 appropriate. When the local agency consents to a distribution, it shall give the estate a written
37.3 certificate evidencing its consent to the early distribution of assets at no cost. The certificate
37.4 must include the name, case number, and district court in which the estate is pending, the
37.5 name of the local agency, describe the specific real or personal property to which the consent
37.6 applies, state that the local agency consents to the distribution of the specific property
37.7 described in the consent during the 70-day period following service of the notice on the
37.8 commissioner or executive board, state that the consent is unconditional or list all of the
37.9 terms and conditions of the consent, be dated, and may include other contents as may be
37.10 appropriate. The certificate must be signed by the director of the local agency or the director's
37.11 designees and is effective as of the date it is dated unless it provides otherwise. The signature
37.12 of the director or the director's designee does not require any acknowledgment. The certificate
37.13 shall be prima facie evidence of the facts it states, may be attached to or combined with a
37.14 deed or any other instrument of conveyance and, when so attached or combined, shall
37.15 constitute a single instrument. If the certificate describes real property, it shall be accepted
37.16 for recording or filing by the county recorder or registrar of titles in the county in which the
37.17 property is located. If the certificate describes real property and is not attached to or combined
37.18 with a deed or other instrument of conveyance, it shall be accepted for recording or filing
37.19 by the county recorder or registrar of titles in the county in which the property is located.
37.20 The certificate constitutes a waiver of the 70-day period provided for in clause (2) with
37.21 respect to the property it describes and is prima facie evidence of service of notice on the
37.22 commissioner or executive board. The certificate is not a waiver or relinquishment of any
37.23 claims arising under section 246.53, 256B.15, 256D.16, or 261.04, and does not otherwise
37.24 constitute a waiver of any of the personal representative's duties under this paragraph.
37.25 Distributees who receive property pursuant to a consent to an early distribution shall remain
37.26 liable to creditors of the estate as provided for by law.

37.27 (7) All affidavits provided for under this paragraph:

37.28 (i) shall be provided by persons who have personal knowledge of the facts stated in the
37.29 affidavit;

37.30 (ii) may be filed or recorded in the office of the county recorder or registrar of titles in
37.31 the county in which the real property they describe is located for the purpose of establishing
37.32 compliance with the requirements of this paragraph; and

37.33 (iii) are prima facie evidence of the facts stated in the affidavit.

38.1 (8) This paragraph applies to the estates of decedents dying on or after July 1, 1997.
 38.2 Clause (5) also applies with respect to all notices served on the commissioner of human
 38.3 services before July 1, 1997, under Laws 1996, chapter 451, article 2, section 55. All notices
 38.4 served on the commissioner before July 1, 1997, pursuant to Laws 1996, chapter 451, article
 38.5 2, section 55, shall be deemed to be legally sufficient for the purposes for which they were
 38.6 intended, notwithstanding any errors, omissions or other defects.

38.7 **Sec. 16. DIRECTION TO COMMISSIONER; REIMBURSEMENT FOR**
 38.8 **EXTRACORPOREAL MEMBRANE OXYGENATION CANNULATION AS AN**
 38.9 **OUTPATIENT SERVICE.**

38.10 The commissioner of human services, in consultation with providers and hospitals, shall
 38.11 determine the feasibility of an outpatient reimbursement mechanism for medical assistance
 38.12 coverage of extracorporeal membrane oxygenation (ECMO) cannulation performed outside
 38.13 an inpatient hospital setting or in a self-contained mobile ECMO unit. If an outpatient
 38.14 reimbursement mechanism is feasible, then the commissioner of human services shall
 38.15 develop a recommended payment mechanism. By January 15, 2025, the commissioner of
 38.16 human services shall submit a recommendation and the required legislative language to the
 38.17 chairs and ranking minority members of the legislative committees with jurisdiction over
 38.18 health care finance. If such a payment mechanism is infeasible, the commissioner of human
 38.19 services shall submit an explanation as to why it is infeasible.

38.20 **ARTICLE 3**

38.21 **HEALTH CARE**

38.22 Section 1. Minnesota Statutes 2022, section 62V.05, subdivision 12, is amended to read:

38.23 **Subd. 12. Reports on interagency agreements and intra-agency transfers.** The
 38.24 MNsure Board shall provide ~~quarterly reports to the chairs and ranking minority members~~
 38.25 ~~of the legislative committees with jurisdiction over health and human services policy and~~
 38.26 ~~finance on:~~ legislative reports on interagency agreements and intra-agency transfers according
 38.27 to section 15.0395.

38.28 ~~(1) interagency agreements or service-level agreements and any renewals or extensions~~
 38.29 ~~of existing interagency or service-level agreements with a state department under section~~
 38.30 ~~15.01, state agency under section 15.012, or the Department of Information Technology~~
 38.31 ~~Services, with a value of more than \$100,000, or related agreements with the same department~~
 38.32 ~~or agency with a cumulative value of more than \$100,000; and~~

39.1 ~~(2) transfers of appropriations of more than \$100,000 between accounts within or between~~
 39.2 ~~agencies.~~

39.3 ~~The report must include the statutory citation authorizing the agreement, transfer or dollar~~
 39.4 ~~amount, purpose, and effective date of the agreement, the duration of the agreement, and a~~
 39.5 ~~copy of the agreement.~~

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

39.7 Sec. 2. Minnesota Statutes 2022, section 62V.08, is amended to read:

39.8 **62V.08 REPORTS.**

39.9 (a) MNsure shall submit a report to the legislature by ~~January 15, 2015~~ March 31, 2025,
 39.10 and each ~~January 15~~ March 31 thereafter, on: (1) the performance of MNsure operations;
 39.11 (2) meeting MNsure responsibilities; (3) an accounting of MNsure budget activities; (4)
 39.12 practices and procedures that have been implemented to ensure compliance with data
 39.13 practices laws, and a description of any violations of data practices laws or procedures; and
 39.14 (5) the effectiveness of the outreach and implementation activities of MNsure in reducing
 39.15 the rate of uninsurance.

39.16 (b) MNsure must publish its administrative and operational costs on a website to educate
 39.17 consumers on those costs. The information published must include: (1) the amount of
 39.18 premiums and federal premium subsidies collected; (2) the amount and source of revenue
 39.19 received under section 62V.05, subdivision 1, paragraph (b), clause (3); (3) the amount and
 39.20 source of any other fees collected for purposes of supporting operations; and (4) any misuse
 39.21 of funds as identified in accordance with section 3.975. The website must be updated at
 39.22 least annually.

39.23 Sec. 3. Minnesota Statutes 2022, section 62V.11, subdivision 4, is amended to read:

39.24 Subd. 4. **Review of costs.** The board shall submit for review the annual budget of MNsure
 39.25 for the next fiscal year by ~~March 15~~ 31 of each year, beginning ~~March 15, 2014~~ 31, 2025.

39.26 Sec. 4. Minnesota Statutes 2023 Supplement, section 151.74, subdivision 3, is amended
 39.27 to read:

39.28 Subd. 3. **Access to urgent-need insulin.** (a) MNsure shall develop an application form
 39.29 to be used by an individual who is in urgent need of insulin. The application must ask the
 39.30 individual to attest to the eligibility requirements described in subdivision 2. The form shall
 39.31 be accessible through MNsure's website. MNsure shall also make the form available to

40.1 pharmacies and health care providers who prescribe or dispense insulin, hospital emergency
40.2 departments, urgent care clinics, and community health clinics. By submitting a completed,
40.3 signed, and dated application to a pharmacy, the individual attests that the information
40.4 contained in the application is correct.

40.5 (b) If the individual is in urgent need of insulin, the individual may present a completed,
40.6 signed, and dated application form to a pharmacy. The individual must also:

40.7 (1) have a valid insulin prescription; and

40.8 (2) present the pharmacist with identification indicating Minnesota residency in the form
40.9 of a valid Minnesota identification card, driver's license or permit, individual taxpayer
40.10 identification number, or Tribal identification card as defined in section 171.072, paragraph

40.11 (b). If the individual in urgent need of insulin is under the age of 18, the individual's parent
40.12 or legal guardian must provide the pharmacist with proof of residency.

40.13 (c) Upon receipt of a completed and signed application, the pharmacist shall dispense
40.14 the prescribed insulin in an amount that will provide the individual with a 30-day supply.
40.15 The pharmacy must notify the health care practitioner who issued the prescription order no
40.16 later than 72 hours after the insulin is dispensed.

40.17 (d) The pharmacy may submit to the manufacturer of the dispensed insulin product or
40.18 to the manufacturer's vendor a claim for payment that is in accordance with the National
40.19 Council for Prescription Drug Program standards for electronic claims processing, unless
40.20 the manufacturer agrees to send to the pharmacy a replacement supply of the same insulin
40.21 as dispensed in the amount dispensed. If the pharmacy submits an electronic claim to the
40.22 manufacturer or the manufacturer's vendor, the manufacturer or vendor shall reimburse the
40.23 pharmacy in an amount that covers the pharmacy's acquisition cost.

40.24 (e) The pharmacy may collect an insulin co-payment from the individual to cover the
40.25 pharmacy's costs of processing and dispensing in an amount not to exceed \$35 for the 30-day
40.26 supply of insulin dispensed.

40.27 (f) The pharmacy shall also provide each eligible individual with the information sheet
40.28 described in subdivision 7 and a list of trained navigators provided by the Board of Pharmacy
40.29 for the individual to contact if the individual ~~is in need of accessing~~ needs to access ongoing
40.30 insulin coverage options, including assistance in:

40.31 (1) applying for medical assistance or MinnesotaCare;

40.32 (2) applying for a qualified health plan offered through MNsure, subject to open and
40.33 special enrollment periods;

41.1 (3) accessing information on providers who participate in prescription drug discount
41.2 programs, including providers who are authorized to participate in the 340B program under
41.3 section 340b of the federal Public Health Services Act, United States Code, title 42, section
41.4 256b; and

41.5 (4) accessing insulin manufacturers' patient assistance programs, co-payment assistance
41.6 programs, and other foundation-based programs.

41.7 (g) The pharmacist shall retain a copy of the application form submitted by the individual
41.8 to the pharmacy for reporting and auditing purposes.

41.9 (h) A manufacturer may submit to the commissioner of administration a request for
41.10 reimbursement in an amount not to exceed \$35 for each 30-day supply of insulin the
41.11 manufacturer provides under paragraph (d). The commissioner of administration shall
41.12 determine the manner and format for submitting and processing requests for reimbursement.
41.13 After receiving a reimbursement request, the commissioner of administration shall reimburse
41.14 the manufacturer in an amount not to exceed \$35 for each 30-day supply of insulin the
41.15 manufacturer provided under paragraph (d).

41.16 **EFFECTIVE DATE.** This section is effective December 1, 2024.

41.17 Sec. 5. Minnesota Statutes 2022, section 151.74, subdivision 6, is amended to read:

41.18 Subd. 6. **Continuing safety net program; process.** (a) The individual shall submit to
41.19 a pharmacy the statement of eligibility provided by the manufacturer under subdivision 5,
41.20 paragraph (b). Upon receipt of an individual's eligibility status, the pharmacy shall submit
41.21 an order containing the name of the insulin product and the daily dosage amount as contained
41.22 in a valid prescription to the product's manufacturer.

41.23 (b) The pharmacy must include with the order to the manufacturer the following
41.24 information:

41.25 (1) the pharmacy's name and shipping address;

41.26 (2) the pharmacy's office telephone number, fax number, email address, and contact
41.27 name; and

41.28 (3) any specific days or times when deliveries are not accepted by the pharmacy.

41.29 (c) Upon receipt of an order from a pharmacy and the information described in paragraph
41.30 (b), the manufacturer shall send to the pharmacy a 90-day supply of insulin as ordered,
41.31 unless a lesser amount is requested in the order, at no charge to the individual or pharmacy.

42.1 (d) Except as authorized under paragraph (e), the pharmacy shall provide the insulin to
42.2 the individual at no charge to the individual. The pharmacy shall not provide insulin received
42.3 from the manufacturer to any individual other than the individual associated with the specific
42.4 order. The pharmacy shall not seek reimbursement for the insulin received from the
42.5 manufacturer or from any third-party payer.

42.6 (e) The pharmacy may collect a co-payment from the individual to cover the pharmacy's
42.7 costs for processing and dispensing in an amount not to exceed \$50 for each 90-day supply
42.8 if the insulin is sent to the pharmacy.

42.9 (f) The pharmacy may submit to a manufacturer a reorder for an individual if the
42.10 individual's eligibility statement has not expired. Upon receipt of a reorder from a pharmacy,
42.11 the manufacturer must send to the pharmacy an additional 90-day supply of the product,
42.12 unless a lesser amount is requested, at no charge to the individual or pharmacy if the
42.13 individual's eligibility statement has not expired.

42.14 (g) Notwithstanding paragraph (c), a manufacturer may send the insulin as ordered
42.15 directly to the individual if the manufacturer provides a mail order service option.

42.16 (h) A manufacturer may submit to the commissioner of administration a request for
42.17 reimbursement in an amount not to exceed \$105 for each 90-day supply of insulin the
42.18 manufacturer provides under paragraphs (c) and (f). The commissioner of administration
42.19 shall determine the manner and format for submitting and processing requests for
42.20 reimbursement. After receiving a reimbursement request, the commissioner of administration
42.21 shall reimburse the manufacturer in an amount not to exceed \$105 for each 90-day supply
42.22 of insulin the manufacturer provided under paragraphs (c) and (f). If the manufacturer
42.23 provides less than a 90-day supply of insulin under paragraphs (c) and (f), the manufacturer
42.24 may submit a request for reimbursement not to exceed \$35 for each 30-day supply of insulin
42.25 provided.

42.26 **EFFECTIVE DATE.** This section is effective December 1, 2024.

42.27 **Sec. 6. [151.741] INSULIN MANUFACTURER REGISTRATION FEE.**

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

42.30 (b) "Board" means the Minnesota Board of Pharmacy under section 151.02.

42.31 (c) "Manufacturer" means a manufacturer licensed under section 151.252 and engaged
42.32 in the manufacturing of prescription insulin.

43.1 Subd. 2. **Assessment of registration fee.** (a) The board shall assess each manufacturer
43.2 an annual registration fee of \$100,000, except as provided in paragraph (b). The board shall
43.3 notify each manufacturer of this requirement beginning November 1, 2024, and each
43.4 November 1 thereafter.

43.5 (b) A manufacturer may request an exemption from the annual registration fee. The
43.6 board shall exempt a manufacturer from the annual registration fee if the manufacturer can
43.7 demonstrate to the board, in the form and manner specified by the board, that gross revenue
43.8 from sales of prescription insulin produced by that manufacturer and sold or delivered within
43.9 or into Minnesota was less than five percent of the total gross revenue from sales of
43.10 prescription insulin produced by all manufacturers and sold or delivered within or into
43.11 Minnesota in the previous calendar year.

43.12 Subd. 3. **Payment of the registration fee; deposit of fee.** (a) Each manufacturer must
43.13 pay the registration fee by March 1, 2025, and by each March 1 thereafter. In the event of
43.14 a change in ownership of the manufacturer, the new owner must pay the registration fee
43.15 that the original owner would have been assessed had the original owner retained ownership.
43.16 The board may assess a late fee of ten percent per month or any portion of a month that the
43.17 registration fee is paid after the due date.

43.18 (b) The registration fee, including any late fees, must be deposited in the insulin safety
43.19 net program account.

43.20 Subd. 4. **Insulin safety net program account.** The insulin safety net program account
43.21 is established in the special revenue fund in the state treasury. Money in the account is
43.22 appropriated each fiscal year to:

43.23 (1) the MNsure board in an amount sufficient to carry out assigned duties under section
43.24 151.74, subdivision 7; and

43.25 (2) the Board of Pharmacy in an amount sufficient to cover costs incurred by the board
43.26 in assessing and collecting the registration fee under this section and in administering the
43.27 insulin safety net program under section 151.74.

43.28 Subd. 5. **Insulin repayment account; annual transfer from health care access fund.** (a)
43.29 The insulin repayment account is established in the special revenue fund in the state treasury.
43.30 Money in the account is appropriated each fiscal year to the commissioner of administration
43.31 to reimburse manufacturers for insulin dispensed under the insulin safety net program in
43.32 section 151.74, in accordance with section 151.74, subdivisions 3, paragraph (h), and 6,
43.33 paragraph (h), and to cover costs incurred by the commissioner in providing these
43.34 reimbursement payments.

44.1 (b) By June 30, 2025, and each June 30 thereafter, the commissioner of administration
 44.2 shall certify to the commissioner of management and budget the total amount expended in
 44.3 the prior fiscal year for:

44.4 (1) reimbursement to manufacturers for insulin dispensed under the insulin safety net
 44.5 program in section 151.74, in accordance with section 151.74, subdivisions 3, paragraph
 44.6 (h), and 6, paragraph (h); and

44.7 (2) costs incurred by the commissioner of administration in providing the reimbursement
 44.8 payments described in clause (1).

44.9 (c) The commissioner of management and budget shall transfer from the health care
 44.10 access fund to the special revenue fund, beginning July 1, 2025, and each July 1 thereafter,
 44.11 an amount equal to the amount to which the commissioner of administration certified
 44.12 pursuant to paragraph (b).

44.13 Subd. 6. **Contingent transfer by commissioner.** If subdivisions 2 and 3, or the
 44.14 application of subdivisions 2 and 3 to any person or circumstance, are held invalid for any
 44.15 reason in a court of competent jurisdiction, the invalidity of subdivisions 2 and 3 does not
 44.16 affect other provisions of this act, and the commissioner of management and budget shall
 44.17 annually transfer from the health care access fund to the insulin safety net program account
 44.18 an amount sufficient to implement subdivision 4.

44.19 **EFFECTIVE DATE.** This section is effective July 1, 2024.

44.20 Sec. 7. Laws 2020, chapter 73, section 8, is amended to read:

44.21 Sec. 8. **APPROPRIATIONS.**

44.22 (a) \$297,000 is appropriated in fiscal year 2020 from the health care access fund to the
 44.23 Board of Directors of MNsure ~~to train navigators to assist individuals and provide~~
 44.24 ~~compensation as required~~ for the insulin safety net program under Minnesota Statutes,
 44.25 section 151.74, ~~subdivision 7. Of this appropriation, \$108,000 is for implementing the~~
 44.26 ~~training requirements for navigators and \$189,000 is for application assistance bonus~~
 44.27 ~~payments.~~ This is a onetime appropriation and is available until ~~December 31, 2024~~ June
 44.28 30, 2027.

44.29 (b) \$250,000 is appropriated in fiscal year 2020 from the health care access fund to the
 44.30 Board of Directors of MNsure for a public awareness campaign for the insulin safety net
 44.31 program established under Minnesota Statutes, section 151.74. This is a onetime appropriation
 44.32 and is available until December 31, 2024.

45.1 (c) \$76,000 is appropriated in fiscal year 2021 from the health care access fund to the
 45.2 Board of Pharmacy to implement Minnesota Statutes, section 151.74. The base for this
 45.3 appropriation is \$76,000 in fiscal year 2022; \$76,000 in fiscal year 2023; \$76,000 in fiscal
 45.4 year 2024; \$38,000 in fiscal year 2025; and \$0 in fiscal year 2026.

45.5 (d) \$136,000 in fiscal year 2021 is appropriated from the health care access fund to the
 45.6 commissioner of health to implement the survey to assess program satisfaction in Minnesota
 45.7 Statutes, section 151.74, subdivision 12. The base for this appropriation is \$80,000 in fiscal
 45.8 year 2022 and \$0 in fiscal year 2023. This is a onetime appropriation.

45.9 **Sec. 8. REPEALER; SUNSET FOR THE LONG-TERM SAFETY NET INSULIN**
 45.10 **PROGRAM.**

45.11 Minnesota Statutes 2022, section 151.74, subdivision 16, is repealed.

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

45.13 **ARTICLE 4**

45.14 **HEALTH INSURANCE**

45.15 Section 1. Minnesota Statutes 2022, section 43A.24, is amended by adding a subdivision
 45.16 to read:

45.17 **Subd. 4. For-profit health maintenance organizations prohibited.** The commissioner
 45.18 must ensure that state paid hospital, medical, and dental benefits are not provided to eligible
 45.19 employees by a health maintenance organization which is not a nonprofit corporation
 45.20 organized under chapter 317A or a local governmental unit, as defined in section 62D.02.

45.21 **EFFECTIVE DATE.** This section is effective January 1, 2025.

45.22 Sec. 2. Minnesota Statutes 2022, section 62A.0411, is amended to read:

45.23 **62A.0411 MATERNITY CARE.**

45.24 **Subdivision 1. Minimum inpatient care.** Every health plan as defined in section 62Q.01,
 45.25 subdivision 3, that provides maternity benefits must, consistent with other coinsurance,
 45.26 co-payment, deductible, and related contract terms, provide coverage of a minimum of 48
 45.27 hours of inpatient care following a vaginal delivery and a minimum of 96 hours of inpatient
 45.28 care following a caesarean section for a mother and her newborn. The health plan shall not
 45.29 provide any compensation or other nonmedical remuneration to encourage a mother and
 45.30 newborn to leave inpatient care before the duration minimums specified in this section.

46.1 Subd. 1a. **Medical facility transfer.** (a) If a health care provider acting within the
46.2 provider's scope of practice recommends that either the mother or newborn be transferred
46.3 to a different medical facility, every health plan must provide the coverage required under
46.4 subdivision 1 for the mother, newborn, and newborn siblings at both medical facilities. The
46.5 coverage required under this subdivision includes but is not limited to expenses related to
46.6 transferring all individuals from one medical facility to a different medical facility.

46.7 (b) The coverage required under this subdivision must be provided without cost sharing,
46.8 including but not limited to deductible, co-pay, or coinsurance. The coverage required under
46.9 this paragraph must be provided without any limitation that is not generally applicable to
46.10 other coverages under the plan.

46.11 (c) Notwithstanding paragraph (b), a health plan that is a high-deductible health plan in
46.12 conjunction with a health savings account must include cost-sharing for the coverage required
46.13 under this subdivision at the minimum level necessary to preserve the enrollee's ability to
46.14 make tax-exempt contributions and withdrawals from the health savings account as provided
46.15 in section 223 of the Internal Revenue Code of 1986.

46.16 Subd. 2. **Minimum postdelivery outpatient care.** (a) The health plan must also provide
46.17 coverage for postdelivery outpatient care to a mother and her newborn if the duration of
46.18 inpatient care is less than the minimums provided in this section.

46.19 (b) Postdelivery care consists of a minimum of one home visit by a registered nurse.
46.20 Services provided by the registered nurse include, but are not limited to, parent education,
46.21 assistance and training in breast and bottle feeding, and conducting any necessary and
46.22 appropriate clinical tests. The home visit must be conducted within four days following the
46.23 discharge of the mother and her child.

46.24 Subd. 3. **Health plan defined.** For purposes of this section, "health plan" has the meaning
46.25 given in section 62Q.01, subdivision 3, and county-based purchasing plans.

46.26 **EFFECTIVE DATE.** This section is effective January 1, 2025, and applies to all policies,
46.27 plans, certificates, and contracts offered, issued, or renewed on or after that date.

46.28 Sec. 3. Minnesota Statutes 2022, section 62A.15, is amended by adding a subdivision to
46.29 read:

46.30 Subd. 3d. **Pharmacist.** All benefits provided by a policy or contract referred to in
46.31 subdivision 1 relating to expenses incurred for medical treatment or services provided by
46.32 a licensed physician must include services provided by a licensed pharmacist, according to

47.1 the requirements of section 151.01, to the extent a licensed pharmacist's services are within
47.2 the pharmacist's scope of practice.

47.3 **EFFECTIVE DATE.** This section is effective January 1, 2025, and applies to policies
47.4 or contracts offered, issued, or renewed on or after that date.

47.5 Sec. 4. Minnesota Statutes 2022, section 62A.15, subdivision 4, is amended to read:

47.6 Subd. 4. **Denial of benefits.** (a) No carrier referred to in subdivision 1 may, in the
47.7 payment of claims to employees in this state, deny benefits payable for services covered by
47.8 the policy or contract if the services are lawfully performed by a licensed chiropractor, a
47.9 licensed optometrist, a registered nurse meeting the requirements of subdivision 3a, a licensed
47.10 physician assistant, ~~or~~ a licensed acupuncture practitioner, or a licensed pharmacist.

47.11 (b) When carriers referred to in subdivision 1 make claim determinations concerning
47.12 the appropriateness, quality, or utilization of chiropractic health care for Minnesotans, any
47.13 of these determinations that are made by health care professionals must be made by, or
47.14 under the direction of, or subject to the review of licensed doctors of chiropractic.

47.15 (c) When a carrier referred to in subdivision 1 makes a denial of payment claim
47.16 determination concerning the appropriateness, quality, or utilization of acupuncture services
47.17 for individuals in this state performed by a licensed acupuncture practitioner, a denial of
47.18 payment claim determination that is made by a health professional must be made by, under
47.19 the direction of, or subject to the review of a licensed acupuncture practitioner.

47.20 **EFFECTIVE DATE.** This section is effective January 1, 2025, and applies to policies
47.21 or contracts offered, issued, or renewed on or after that date.

47.22 Sec. 5. Minnesota Statutes 2022, section 62A.28, subdivision 2, is amended to read:

47.23 Subd. 2. **Required coverage.** (a) Every policy, plan, certificate, or contract referred to
47.24 in subdivision 1 ~~issued or renewed after August 1, 1987,~~ must provide coverage for scalp
47.25 hair prostheses, including all equipment and accessories necessary for regular use of scalp
47.26 hair prostheses, worn for hair loss suffered as a result of a health condition, including but
47.27 not limited to alopecia areata or the treatment for cancer, unless there is a clinical basis for
47.28 limitation.

47.29 (b) The coverage required by this section is subject to the co-payment, coinsurance,
47.30 deductible, and other enrollee cost-sharing requirements that apply to similar types of items
47.31 under the policy, plan, certificate, or contract and may be limited to one prosthesis per
47.32 benefit year.

48.1 (c) The coverage required by this section for scalp hair prostheses is limited to \$1,000
48.2 per benefit year.

48.3 (d) A scalp hair prosthesis must be prescribed by a doctor to be covered under this
48.4 section.

48.5 **EFFECTIVE DATE.** This section is effective January 1, 2025, and applies to all policies,
48.6 plans, certificates, and contracts offered, issued, or renewed on or after that date.

48.7 Sec. 6. **[62A.3098] RAPID WHOLE GENOME SEQUENCING; COVERAGE.**

48.8 Subdivision 1. **Definition.** For purposes of this section, "rapid whole genome sequencing"
48.9 or "rWGS" means an investigation of the entire human genome, including coding and
48.10 noncoding regions and mitochondrial deoxyribonucleic acid, to identify disease-causing
48.11 genetic changes that returns the final results in 14 days. Rapid whole genome sequencing
48.12 includes patient-only whole genome sequencing and duo and trio whole genome sequencing
48.13 of the patient and the patient's biological parent or parents.

48.14 Subd. 2. **Required coverage.** A health plan that provides coverage to Minnesota residents
48.15 must cover rWGS testing if the enrollee:

48.16 (1) is 21 years of age or younger;

48.17 (2) has a complex or acute illness of unknown etiology that is not confirmed to have
48.18 been caused by an environmental exposure, toxic ingestion, an infection with a normal
48.19 response to therapy, or trauma; and

48.20 (3) is receiving inpatient hospital services in an intensive care unit or a neonatal or high
48.21 acuity pediatric care unit.

48.22 Subd. 3. **Coverage criteria.** Coverage may be based on the following medical necessity
48.23 criteria:

48.24 (1) the enrollee has symptoms that suggest a broad differential diagnosis that would
48.25 require an evaluation by multiple genetic tests if rWGS testing is not performed;

48.26 (2) timely identification of a molecular diagnosis is necessary in order to guide clinical
48.27 decision making, and the rWGS testing may aid in guiding the treatment or management
48.28 of the enrollee's condition; and

48.29 (3) the enrollee's complex or acute illness of unknown etiology includes at least one of
48.30 the following conditions:

- 49.1 (i) congenital anomalies involving at least two organ systems, or complex or multiple
49.2 congenital anomalies in one organ system;
- 49.3 (ii) specific organ malformations that are highly suggestive of a genetic etiology;
- 49.4 (iii) abnormal laboratory tests or abnormal chemistry profiles suggesting the presence
49.5 of a genetic disease, complex metabolic disorder, or inborn error of metabolism;
- 49.6 (iv) refractory or severe hypoglycemia or hyperglycemia;
- 49.7 (v) abnormal response to therapy related to an underlying medical condition affecting
49.8 vital organs or bodily systems;
- 49.9 (vi) severe muscle weakness, rigidity, or spasticity;
- 49.10 (vii) refractory seizures;
- 49.11 (viii) a high-risk stratification on evaluation for a brief resolved unexplained event with
49.12 any of the following features:
- 49.13 (A) a recurrent event without respiratory infection;
- 49.14 (B) a recurrent seizure-like event; or
- 49.15 (C) a recurrent cardiopulmonary resuscitation;
- 49.16 (ix) abnormal cardiac diagnostic testing results that are suggestive of possible
49.17 channelopathies, arrhythmias, cardiomyopathies, myocarditis, or structural heart disease;
- 49.18 (x) abnormal diagnostic imaging studies that are suggestive of underlying genetic
49.19 condition;
- 49.20 (xi) abnormal physiologic function studies that are suggestive of an underlying genetic
49.21 etiology; or
- 49.22 (xii) family genetic history related to the patient's condition.
- 49.23 Subd. 4. **Cost sharing.** Coverage provided in this section is subject to the enrollee's
49.24 health plan cost-sharing requirements, including any deductibles, co-payments, or coinsurance
49.25 requirements that apply to diagnostic testing services.
- 49.26 Subd. 5. **Payment for services provided.** If the enrollee's health plan uses a capitated
49.27 or bundled payment arrangement to reimburse a provider for services provided in an inpatient
49.28 setting, reimbursement for services covered under this section must be paid separately and
49.29 in addition to any reimbursement otherwise payable to the provider under the capitated or
49.30 bundled payment arrangement, unless the health carrier and the provider have negotiated

50.1 an increased capitated or bundled payment rate that includes the services covered under this
50.2 section.

50.3 Subd. 6. **Genetic data.** Genetic data generated as a result of performing rWGS and
50.4 covered under this section: (1) must be used for the primary purpose of assisting the ordering
50.5 provider and treating care team to diagnose and treat the patient; (2) is protected health
50.6 information as set forth under the Health Insurance Portability and Accountability Act
50.7 (HIPAA), the Health Information Technology for Economic and Clinical Health Act, and
50.8 any promulgated regulations, including but not limited to Code of Federal Regulations, title
50.9 45, parts 160 and 164, subparts A and E; and (3) is a protected health record under sections
50.10 144.291 to 144.298.

50.11 Subd. 7. **Reimbursement.** (a) The commissioner of commerce must reimburse health
50.12 carriers for coverage under this section. Reimbursement is available only for coverage that
50.13 would not have been provided by the health plan without the requirements of this section.
50.14 Treatments and services covered by the health plan as of January 1, 2024, are ineligible for
50.15 payments under this subdivision by the commissioner of commerce.

50.16 (b) Health carriers must report to the commissioner of commerce quantified costs
50.17 attributable to the additional benefit under this section in a format developed by the
50.18 commissioner. A health plan's coverage as of January 1, 2024, must be used by the health
50.19 carrier as the basis for determining whether coverage would not have been provided by the
50.20 health plan for purposes of this subdivision.

50.21 (c) The commissioner of commerce must evaluate submissions and make payments to
50.22 health carriers as provided in Code of Federal Regulations, title 45, section 155.170.

50.23 Subd. 8. **Appropriation.** Each fiscal year, an amount necessary to make payments to
50.24 health carriers to defray the cost of providing coverage under this section is appropriated
50.25 to the commissioner of commerce.

50.26 **EFFECTIVE DATE.** This section is effective January 1, 2025, and applies to a health
50.27 plan offered, issued, or sold on or after that date.

50.28 Sec. 7. **[62A.59] COVERAGE OF SERVICE; PRIOR AUTHORIZATION.**

50.29 Subdivision 1. **Service for which prior authorization not required.** A health carrier
50.30 must not retrospectively deny or limit coverage of a health care service for which prior
50.31 authorization was not required by the health carrier, unless there is evidence that the health
50.32 care service was provided based on fraud or misinformation.

51.1 Subd. 2. Service for which prior authorization required but not obtained. A health
 51.2 carrier must not deny or limit coverage of a health care service which the enrollee has already
 51.3 received solely on the basis of lack of prior authorization if the service would otherwise
 51.4 have been covered had the prior authorization been obtained.

51.5 EFFECTIVE DATE. This section is effective January 1, 2026, and applies to health
 51.6 plans offered, sold, issued, or renewed on or after that date.

51.7 Sec. 8. [62C.045] APPLICATION OF OTHER LAW.

51.8 Sections 145D.30 to 145D.37 apply to service plan corporations operating under this
 51.9 chapter.

51.10 EFFECTIVE DATE. This section is effective July 1, 2025.

51.11 Sec. 9. Minnesota Statutes 2022, section 62D.02, subdivision 7, is amended to read:

51.12 Subd. 7. **Comprehensive health maintenance services.** "Comprehensive health
 51.13 maintenance services" means a set of comprehensive health services which the enrollees
 51.14 might reasonably require to be maintained in good health including as a minimum, but not
 51.15 limited to, emergency care, emergency ground ambulance transportation services, inpatient
 51.16 hospital and physician care, outpatient health services and preventive health services.
 51.17 ~~Elective, induced abortion, except as medically necessary to prevent the death of the mother,~~
 51.18 ~~whether performed in a hospital, other abortion facility or the office of a physician, shall~~
 51.19 ~~not be mandatory for any health maintenance organization.~~

51.20 EFFECTIVE DATE. This section is effective January 1, 2025, and applies to health
 51.21 plans offered, sold, issued, or renewed on or after that date.

51.22 Sec. 10. Minnesota Statutes 2022, section 62D.04, subdivision 5, is amended to read:

51.23 Subd. 5. **Participation; government programs.** Health maintenance organizations that
 51.24 are a nonprofit corporation organized under chapter 317A or a local governmental unit shall,
 51.25 as a condition of receiving and retaining a certificate of authority, participate in the medical
 51.26 assistance and MinnesotaCare programs. A health maintenance organization governed by
 51.27 this subdivision is required to submit proposals in good faith that meet the requirements of
 51.28 the request for proposal provided that the requirements can be reasonably met by a health
 51.29 maintenance organization to serve individuals eligible for the above programs in a geographic
 51.30 region of the state if, at the time of publication of a request for proposal, the percentage of
 51.31 recipients in the public programs in the region who are enrolled in the health maintenance
 51.32 organization is less than the health maintenance organization's percentage of the total number

52.1 of individuals enrolled in health maintenance organizations in the same region. Geographic
52.2 regions shall be defined by the commissioner of human services in the request for proposals.

52.3 **EFFECTIVE DATE.** This section is effective January 1, 2025.

52.4 Sec. 11. **[62D.1071] COVERAGE OF LICENSED PHARMACIST SERVICES.**

52.5 Subdivision 1. **Pharmacist.** All benefits provided by a health maintenance contract
52.6 relating to expenses incurred for medical treatment or services provided by a licensed
52.7 physician must include services provided by a licensed pharmacist to the extent a licensed
52.8 pharmacist's services are within the pharmacist's scope of practice.

52.9 Subd. 2. **Denial of benefits.** When paying claims for enrollees in Minnesota, a health
52.10 maintenance organization must not deny payment for medical services covered by an
52.11 enrollee's health maintenance contract if the services are lawfully performed by a licensed
52.12 pharmacist.

52.13 Subd. 3. **Exemptions.** (a) This section does not apply to or affect the coverage or
52.14 reimbursement for medication therapy management services under section 62Q.676 or
52.15 256B.0625, subdivisions 5, 13h, and 28a.

52.16 (b) This section does not apply to managed care organizations or county-based purchasing
52.17 plans when the plan provides coverage to public health care program enrollees under chapter
52.18 256B or 256L.

52.19 **EFFECTIVE DATE.** This section is effective January 1, 2025, and applies to health
52.20 plans offered, issued, or renewed on or after that date.

52.21 Sec. 12. Minnesota Statutes 2022, section 62D.12, subdivision 19, is amended to read:

52.22 Subd. 19. **Coverage of service.** A health maintenance organization may not deny or
52.23 limit coverage of a service which the enrollee has already received solely on the basis of
52.24 lack of prior authorization or second opinion, to the extent that the service would otherwise
52.25 have been covered under the member's contract by the health maintenance organization had
52.26 prior authorization or second opinion been obtained. This subdivision expires December
52.27 31, 2025, for health plans offered, sold, issued, or renewed on or after that date.

52.28 Sec. 13. Minnesota Statutes 2022, section 62D.20, subdivision 1, is amended to read:

52.29 Subdivision 1. **Rulemaking.** The commissioner of health may, pursuant to chapter 14,
52.30 promulgate such reasonable rules as are necessary or proper to carry out the provisions of
52.31 sections 62D.01 to 62D.30. Included among such rules shall be those which provide minimum

53.1 requirements for the provision of comprehensive health maintenance services, as defined
 53.2 in section 62D.02, subdivision 7, and reasonable exclusions therefrom. ~~Nothing in such~~
 53.3 ~~rules shall force or require a health maintenance organization to provide elective, induced~~
 53.4 ~~abortions, except as medically necessary to prevent the death of the mother, whether~~
 53.5 ~~performed in a hospital, other abortion facility, or the office of a physician; the rules shall~~
 53.6 ~~provide every health maintenance organization the option of excluding or including elective,~~
 53.7 ~~induced abortions, except as medically necessary to prevent the death of the mother, as part~~
 53.8 ~~of its comprehensive health maintenance services.~~

53.9 **EFFECTIVE DATE.** This section is effective January 1, 2025, and applies to health
 53.10 plans offered, sold, issued, or renewed on or after that date.

53.11 Sec. 14. Minnesota Statutes 2022, section 62D.22, subdivision 5, is amended to read:

53.12 Subd. 5. **Other state law.** Except as otherwise provided in sections 62A.01 to 62A.42
 53.13 and 62D.01 to 62D.30, ~~and except as they eliminate elective, induced abortions, wherever~~
 53.14 ~~performed, from health or maternity benefits,~~ provisions of the insurance laws and provisions
 53.15 of nonprofit health service plan corporation laws shall not be applicable to any health
 53.16 maintenance organization granted a certificate of authority under sections 62D.01 to 62D.30.

53.17 **EFFECTIVE DATE.** This section is effective January 1, 2025, and applies to health
 53.18 plans offered, sold, issued, or renewed on or after that date.

53.19 Sec. 15. Minnesota Statutes 2022, section 62D.22, is amended by adding a subdivision to
 53.20 read:

53.21 Subd. 5a. **Application of other law.** Effective July 1, 2025, sections 145D.30 to 145D.37
 53.22 apply to nonprofit health maintenance organizations operating under this chapter.

53.23 Sec. 16. **[62D.221] OVERSIGHT OF TRANSACTIONS.**

53.24 Subdivision 1. **Insurance provisions applicable to health maintenance**
 53.25 **organizations.** Health maintenance organizations are subject to sections 60A.135, 60A.136,
 53.26 60A.137, 60A.16, 60A.161, 60D.17, 60D.18, and 60D.20 and must comply with the
 53.27 provisions of these sections applicable to insurers. In applying these sections to health
 53.28 maintenance organizations, "commissioner" means the commissioner of health. Health
 53.29 maintenance organizations are subject to Minnesota Rules, chapter 2720, as applicable to
 53.30 sections 60D.17, 60D.18, and 60D.20, and must comply with the provisions of chapter 2720
 53.31 applicable to insurers, unless the commissioner of health adopts rules to implement this
 53.32 subdivision.

54.1 Subd. 2. **Statement.** In addition to the conditions in section 60D.17, subdivision 1,
 54.2 subjecting a health maintenance organization to filing requirements, no person other than
 54.3 the issuer shall acquire all or substantially all of the assets of a domestic nonprofit health
 54.4 maintenance organization through any means unless at the time the offer, request, or
 54.5 invitation is made or the agreement is entered into the person has filed with the commissioner
 54.6 and has sent to the health maintenance organization a statement containing the information
 54.7 required in section 60D.17 and the offer, request, invitation, agreement, or acquisition has
 54.8 been approved by the commissioner of health in the manner prescribed in section 60D.17.

54.9 Sec. 17. Minnesota Statutes 2022, section 62M.02, subdivision 1a, is amended to read:

54.10 Subd. 1a. **Adverse determination.** "Adverse determination" means a decision by a
 54.11 utilization review organization relating to an admission, extension of stay, or health care
 54.12 service that is partially or wholly adverse to the enrollee, including:

54.13 (1) a decision to deny an admission, extension of stay, or health care service on the basis
 54.14 that it is not medically necessary; or

54.15 (2) an authorization for a health care service that is less intensive than the health care
 54.16 service specified in the original request for authorization.

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

54.18 Sec. 18. Minnesota Statutes 2022, section 62M.02, subdivision 5, is amended to read:

54.19 Subd. 5. **Authorization.** "Authorization" means a determination by a utilization review
 54.20 organization that an admission, extension of stay, or other health care service has been
 54.21 reviewed and that, based on the information provided, it satisfies the utilization review
 54.22 requirements of the applicable health benefit plan and the health plan company or
 54.23 commissioner will then pay for the covered benefit, provided the preexisting limitation
 54.24 provisions, the general exclusion provisions, and any deductible, co-payment, coinsurance,
 54.25 or other policy requirements have been met.

54.26 Sec. 19. Minnesota Statutes 2022, section 62M.02, is amended by adding a subdivision
 54.27 to read:

54.28 Subd. 8a. **Commissioner.** "Commissioner" means, effective January 1, 2026, for the
 54.29 sections specified in section 62M.01, subdivision 3, paragraph (c), the commissioner of
 54.30 human services, unless otherwise specified.

55.1 Sec. 20. Minnesota Statutes 2022, section 62M.02, subdivision 11, is amended to read:

55.2 Subd. 11. **Enrollee.** "Enrollee" means:

55.3 (1) an individual covered by a health benefit plan and includes an insured policyholder,
55.4 subscriber, contract holder, member, covered person, or certificate holder; or

55.5 (2) effective January 1, 2026, for the sections specified in section 62M.01, subdivision
55.6 3, paragraph (c), a recipient receiving coverage through fee-for-service under chapters 256B
55.7 and 256L.

55.8 Sec. 21. Minnesota Statutes 2022, section 62M.02, subdivision 12, is amended to read:

55.9 Subd. 12. **Health benefit plan.** (a) "Health benefit plan" means:

55.10 (1) a policy, contract, or certificate issued by a health plan company for the coverage of
55.11 medical, dental, or hospital benefits; or

55.12 (2) effective January 1, 2026, for the sections specified in section 62M.01, subdivision
55.13 3, paragraph (c), coverage of medical, dental, or hospital benefits through fee-for-service
55.14 under chapters 256B and 256L, as specified by the commissioner on the agency's public
55.15 website or through other forms of recipient and provider guidance.

55.16 (b) A health benefit plan does not include coverage that is:

55.17 (1) limited to disability or income protection coverage;

55.18 (2) automobile medical payment coverage;

55.19 (3) supplemental to liability insurance;

55.20 (4) designed solely to provide payments on a per diem, fixed indemnity, or nonexpense
55.21 incurred basis;

55.22 (5) credit accident and health insurance issued under chapter 62B;

55.23 (6) blanket accident and sickness insurance as defined in section 62A.11;

55.24 (7) accident only coverage issued by a licensed and tested insurance agent; or

55.25 (8) workers' compensation.

55.26 Sec. 22. Minnesota Statutes 2022, section 62M.02, subdivision 21, is amended to read:

55.27 Subd. 21. **Utilization review organization.** "Utilization review organization" means an
55.28 entity including but not limited to an insurance company licensed under chapter 60A to
55.29 offer, sell, or issue a policy of accident and sickness insurance as defined in section 62A.01;

56.1 a prepaid limited health service organization issued a certificate of authority and operating
56.2 under sections 62A.451 to 62A.4528; a health service plan licensed under chapter 62C; a
56.3 health maintenance organization licensed under chapter 62D; a community integrated service
56.4 network licensed under chapter 62N; an accountable provider network operating under
56.5 chapter 62T; a fraternal benefit society operating under chapter 64B; a joint self-insurance
56.6 employee health plan operating under chapter 62H; a multiple employer welfare arrangement,
56.7 as defined in section 3 of the Employee Retirement Income Security Act of 1974 (ERISA),
56.8 United States Code, title 29, section 1103, as amended; a third-party administrator licensed
56.9 under section 60A.23, subdivision 8, which conducts utilization review and authorizes or
56.10 makes adverse determinations regarding an admission, extension of stay, or other health
56.11 care services for a Minnesota resident; effective January 1, 2026, for the sections specified
56.12 in section 62M.01, subdivision 3, paragraph (c), the commissioner of human services for
56.13 purposes of delivering services through fee-for-service under chapters 256B and 256L; any
56.14 other entity that provides, offers, or administers hospital, outpatient, medical, prescription
56.15 drug, or other health benefits to individuals treated by a health professional under a policy,
56.16 plan, or contract; or any entity performing utilization review that is affiliated with, under
56.17 contract with, or conducting utilization review on behalf of, a business entity in this state.
56.18 Utilization review organization does not include a clinic or health care system acting pursuant
56.19 to a written delegation agreement with an otherwise regulated utilization review organization
56.20 that contracts with the clinic or health care system. The regulated utilization review
56.21 organization is accountable for the delegated utilization review activities of the clinic or
56.22 health care system.

56.23 Sec. 23. Minnesota Statutes 2022, section 62M.04, subdivision 1, is amended to read:

56.24 Subdivision 1. **Responsibility for obtaining authorization.** A health benefit plan that
56.25 includes utilization review requirements must specify the process for notifying the utilization
56.26 review organization in a timely manner and obtaining authorization for health care services.
56.27 Each health plan company must provide a clear and concise description of this process to
56.28 an enrollee as part of the policy, subscriber contract, or certificate of coverage. Effective
56.29 January 1, 2026, the commissioner must provide a clear and concise description of this
56.30 process to fee-for-service recipients receiving services under chapters 256B and 256L,
56.31 through the agency's public website or through other forms of recipient guidance. In addition
56.32 to the enrollee, the utilization review organization must allow any provider or provider's
56.33 designee, or responsible patient representative, including a family member, to fulfill the
56.34 obligations under the health benefit plan.

57.1 A claims administrator that contracts directly with providers for the provision of health
57.2 care services to enrollees may, through contract, require the provider to notify the review
57.3 organization in a timely manner and obtain authorization for health care services.

57.4 Sec. 24. Minnesota Statutes 2022, section 62M.05, subdivision 3a, is amended to read:

57.5 Subd. 3a. **Standard review determination.** (a) ~~Notwithstanding subdivision 3b, a~~
57.6 ~~standard review determination on all requests for utilization review must be communicated~~
57.7 ~~to the provider and enrollee in accordance with this subdivision within five business days~~
57.8 ~~after receiving the request if the request is received electronically, or within six business~~
57.9 ~~days if received through nonelectronic means, provided that all information reasonably~~
57.10 ~~necessary to make a determination on the request has been made available to the utilization~~
57.11 ~~review organization. Effective January 1, 2022, A standard review determination on all~~
57.12 requests for utilization review must be communicated to the provider and enrollee in
57.13 accordance with this subdivision within five business days after receiving the request,
57.14 regardless of how the request was received, provided that all information reasonably
57.15 necessary to make a determination on the request has been made available to the utilization
57.16 review organization.

57.17 (b) When a determination is made to authorize, notification must be provided promptly
57.18 by telephone to the provider. The utilization review organization shall send written
57.19 notification to the provider or shall maintain an audit trail of the determination and telephone
57.20 notification. For purposes of this subdivision, "audit trail" includes documentation of the
57.21 telephone notification, including the date; the name of the person spoken to; the enrollee;
57.22 the service, procedure, or admission authorized; and the date of the service, procedure, or
57.23 admission. If the utilization review organization indicates authorization by use of a number,
57.24 the number must be called the "authorization number." For purposes of this subdivision,
57.25 notification may also be made by facsimile to a verified number or by electronic mail to a
57.26 secure electronic mailbox. These electronic forms of notification satisfy the "audit trail"
57.27 requirement of this paragraph.

57.28 (c) When an adverse determination is made, notification must be provided within the
57.29 time periods specified in paragraph (a) by telephone, by facsimile to a verified number, or
57.30 by electronic mail to a secure electronic mailbox to the attending health care professional
57.31 and hospital or physician office as applicable. Written notification must also be sent to the
57.32 hospital or physician office as applicable and attending health care professional if notification
57.33 occurred by telephone. For purposes of this subdivision, notification may be made by
57.34 facsimile to a verified number or by electronic mail to a secure electronic mailbox. Written

58.1 notification must be sent to the enrollee and may be sent by United States mail, facsimile
 58.2 to a verified number, or by electronic mail to a secure mailbox. The written notification
 58.3 must include all reasons relied on by the utilization review organization for the determination
 58.4 and the process for initiating an appeal of the determination. Upon request, the utilization
 58.5 review organization shall provide the provider or enrollee with the criteria used to determine
 58.6 the necessity, appropriateness, and efficacy of the health care service and identify the
 58.7 database, professional treatment parameter, or other basis for the criteria. Reasons for an
 58.8 adverse determination may include, among other things, the lack of adequate information
 58.9 to authorize after a reasonable attempt has been made to contact the provider or enrollee.

58.10 (d) When an adverse determination is made, the written notification must inform the
 58.11 enrollee and the attending health care professional of the right to submit an appeal to the
 58.12 internal appeal process described in section 62M.06 and the procedure for initiating the
 58.13 internal appeal. The written notice shall be provided in a culturally and linguistically
 58.14 appropriate manner consistent with the provisions of the Affordable Care Act as defined
 58.15 under section 62A.011, subdivision 1a.

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

58.17 Sec. 25. Minnesota Statutes 2022, section 62M.07, subdivision 2, is amended to read:

58.18 Subd. 2. **Prior authorization of emergency certain services prohibited.** No utilization
 58.19 review organization, health plan company, or claims administrator may conduct or require
 58.20 prior authorization of:

58.21 (1) emergency confinement or an emergency service. The enrollee or the enrollee's
 58.22 authorized representative may be required to notify the health plan company, claims
 58.23 administrator, or utilization review organization as soon as reasonably possible after the
 58.24 beginning of the emergency confinement or emergency service;

58.25 (2) outpatient mental health treatment or outpatient substance use disorder treatment,
 58.26 except for treatment which is a medication. Prior authorizations required for medications
 58.27 used for outpatient mental health treatment or outpatient substance use disorder treatment
 58.28 must be processed according to section 62M.05, subdivision 3b, for initial determinations,
 58.29 and according to section 62M.06, subdivision 2, for appeals;

58.30 (3) antineoplastic cancer treatment that is consistent with guidelines of the National
 58.31 Comprehensive Cancer Network, except for treatment which is a medication. Prior
 58.32 authorizations required for medications used for antineoplastic cancer treatment must be

59.1 processed according to section 62M.05, subdivision 3b, for initial determinations, and
59.2 according to section 62M.06, subdivision 2, for appeals;

59.3 (4) services that currently have a rating of A or B from the United States Preventive
59.4 Services Task Force, immunizations recommended by the Advisory Committee on
59.5 Immunization Practices of the Centers for Disease Control and Prevention, or preventive
59.6 services and screenings provided to women as described in Code of Federal Regulations,
59.7 title 45, section 147.130;

59.8 (5) pediatric hospice services provided by a hospice provider licensed under sections
59.9 144A.75 to 144A.755; and

59.10 (6) treatment delivered through a neonatal abstinence program operated by pediatric
59.11 pain or palliative care subspecialists.

59.12 Clauses (2) to (6) are effective January 1, 2026, and apply to health benefit plans offered,
59.13 sold, issued, or renewed on or after that date.

59.14 Sec. 26. Minnesota Statutes 2022, section 62M.07, subdivision 4, is amended to read:

59.15 Subd. 4. **Submission of prior authorization requests.** (a) If prior authorization for a
59.16 health care service is required, the utilization review organization, health plan company, or
59.17 claim administrator must allow providers to submit requests for prior authorization of the
59.18 health care services without unreasonable delay by telephone, facsimile, or voice mail or
59.19 through an electronic mechanism 24 hours a day, seven days a week. This subdivision does
59.20 not apply to dental service covered under MinnesotaCare or medical assistance.

59.21 (b) Effective January 1, 2027, for health benefit plans offered, sold, issued, or renewed
59.22 on or after that date, utilization review organizations, health plan companies, and claims
59.23 administrators must have and maintain a prior authorization application programming
59.24 interface (API) that automates the prior authorization process for health care services,
59.25 excluding prescription drugs and medications. The API must allow providers to determine
59.26 whether a prior authorization is required for health care services, identify prior authorization
59.27 information and documentation requirements, and facilitate the exchange of prior
59.28 authorization requests and determinations from provider electronic health records or practice
59.29 management systems. The API must use the Health Level Seven (HL7) Fast Healthcare
59.30 Interoperability Resources (FHIR) standard in accordance with Code of Federal Regulations,
59.31 title 45, section 170.215(a)(1), and the most recent standards and guidance adopted by the
59.32 United States Department of Health and Human Services to implement that section. Prior

60.1 authorization submission requests for prescription drugs and medications must comply with
60.2 the requirements of section 62J.497.

60.3 Sec. 27. Minnesota Statutes 2022, section 62M.07, is amended by adding a subdivision
60.4 to read:

60.5 Subd. 5. **Treatment of a chronic condition.** This subdivision is effective January 1,
60.6 2026, and applies to health benefit plans offered, sold, issued, or renewed on or after that
60.7 date. An authorization for treatment of a chronic health condition does not expire unless
60.8 the standard of treatment for that health condition changes. A chronic health condition is a
60.9 condition that is expected to last one year or more and:

60.10 (1) requires ongoing medical attention to effectively manage the condition or prevent
60.11 an adverse health event; or

60.12 (2) limits one or more activities of daily living.

60.13 Sec. 28. Minnesota Statutes 2022, section 62M.10, subdivision 7, is amended to read:

60.14 Subd. 7. **Availability of criteria.** (a) For utilization review determinations other than
60.15 prior authorization, a utilization review organization shall, upon request, provide to an
60.16 enrollee, a provider, and the commissioner of commerce the criteria used to determine the
60.17 medical necessity, appropriateness, and efficacy of a procedure or service and identify the
60.18 database, professional treatment guideline, or other basis for the criteria.

60.19 (b) For prior authorization determinations, a utilization review organization must submit
60.20 the organization's current prior authorization requirements and restrictions, including written,
60.21 evidence-based, clinical criteria used to make an authorization or adverse determination, to
60.22 all health plan companies for which the organization performs utilization review. A health
60.23 plan company must post on its public website the prior authorization requirements and
60.24 restrictions of any utilization review organization that performs utilization review for the
60.25 health plan company. These prior authorization requirements and restrictions must be detailed
60.26 and written in language that is easily understandable to providers. This paragraph does not
60.27 apply to the commissioner of human services when delivering services through fee-for-service
60.28 under chapters 256B and 256L.

60.29 (c) Effective January 1, 2026, the commissioner of human services must post on the
60.30 department's public website the prior authorization requirements and restrictions, including
60.31 written, evidence-based, clinical criteria used to make an authorization or adverse
60.32 determination, that apply to prior authorization determinations for fee-for-service under

61.1 chapters 256B and 256L. These prior authorization requirements and restrictions must be
61.2 detailed and written in language that is easily understandable to providers.

61.3 Sec. 29. Minnesota Statutes 2022, section 62M.10, subdivision 8, is amended to read:

61.4 Subd. 8. **Notice; new prior authorization requirements or restrictions; change to**
61.5 **existing requirement or restriction.** (a) Before a utilization review organization may
61.6 implement a new prior authorization requirement or restriction or amend an existing prior
61.7 authorization requirement or restriction, the utilization review organization must submit the
61.8 new or amended requirement or restriction to all health plan companies for which the
61.9 organization performs utilization review. A health plan company must post on its website
61.10 the new or amended requirement or restriction. This paragraph does not apply to the
61.11 commissioner of human services when delivering services through fee-for-service under
61.12 chapters 256B and 256L.

61.13 (b) At least 45 days before a new prior authorization requirement or restriction or an
61.14 amended existing prior authorization requirement or restriction is implemented, the utilization
61.15 review organization, health plan company, or claims administrator must provide written or
61.16 electronic notice of the new or amended requirement or restriction to all Minnesota-based,
61.17 in-network attending health care professionals who are subject to the prior authorization
61.18 requirements and restrictions. This paragraph does not apply to the commissioner of human
61.19 services when delivering services through fee-for-service under chapters 256B and 256L.

61.20 (c) Effective January 1, 2026, before the commissioner of human services may implement
61.21 a new prior authorization requirement or restriction or amend an existing prior authorization
61.22 requirement or restriction, the commissioner, at least 45 days before the new or amended
61.23 requirement or restriction takes effect, must provide written or electronic notice of the new
61.24 or amended requirement or restriction, to all health care professionals participating as
61.25 fee-for-service providers under chapters 256B and 256L who are subject to the prior
61.26 authorization requirements and restrictions.

61.27 Sec. 30. Minnesota Statutes 2022, section 62M.17, subdivision 2, is amended to read:

61.28 Subd. 2. **Effect of change in prior authorization clinical criteria.** (a) If, during a plan
61.29 year, a utilization review organization changes coverage terms for a health care service or
61.30 the clinical criteria used to conduct prior authorizations for a health care service, the change
61.31 in coverage terms or change in clinical criteria shall not apply until the next plan year for
61.32 any enrollee who received prior authorization for a health care service using the coverage
61.33 terms or clinical criteria in effect before the effective date of the change.

62.1 (b) Paragraph (a) does not apply if a utilization review organization changes coverage
 62.2 terms for a drug or device that has been deemed unsafe by the United States Food and Drug
 62.3 Administration (FDA); that has been withdrawn by either the FDA or the product
 62.4 manufacturer; or when an independent source of research, clinical guidelines, or
 62.5 evidence-based standards has issued drug- or device-specific warnings or recommended
 62.6 changes in drug or device usage.

62.7 (c) Paragraph (a) does not apply if a utilization review organization changes coverage
 62.8 terms for a service or the clinical criteria used to conduct prior authorizations for a service
 62.9 when an independent source of research, clinical guidelines, or evidence-based standards
 62.10 has recommended changes in usage of the service for reasons related to patient harm. This
 62.11 paragraph expires December 31, 2025, for health benefit plans offered, sold, issued, or
 62.12 renewed on or after that date.

62.13 (d) Effective January 1, 2026, and applicable to health benefit plans offered, sold, issued,
 62.14 or renewed on or after that date, paragraph (a) does not apply if a utilization review
 62.15 organization changes coverage terms for a service or the clinical criteria used to conduct
 62.16 prior authorizations for a service when an independent source of research, clinical guidelines,
 62.17 or evidence-based standards has recommended changes in usage of the service for reasons
 62.18 related to previously unknown and imminent patient harm.

62.19 ~~(d)~~ (e) Paragraph (a) does not apply if a utilization review organization removes a brand
 62.20 name drug from its formulary or places a brand name drug in a benefit category that increases
 62.21 the enrollee's cost, provided the utilization review organization (1) adds to its formulary a
 62.22 generic or multisource brand name drug rated as therapeutically equivalent according to
 62.23 the FDA Orange Book, or a biologic drug rated as interchangeable according to the FDA
 62.24 Purple Book, at a lower cost to the enrollee, and (2) provides at least a 60-day notice to
 62.25 prescribers, pharmacists, and affected enrollees.

62.26 Sec. 31. **[62M.19] ANNUAL REPORT TO COMMISSIONER OF HEALTH; PRIOR**
 62.27 **AUTHORIZATIONS.**

62.28 On or before September 1 each year, each utilization review organization must report
 62.29 to the commissioner of health, in a form and manner specified by the commissioner,
 62.30 information on prior authorization requests for the previous calendar year. The report
 62.31 submitted under this subdivision must include the following data:

62.32 (1) the total number of prior authorization requests received;

62.33 (2) the number of prior authorization requests for which an authorization was issued;

63.1 (3) the number of prior authorization requests for which an adverse determination was
 63.2 issued;

63.3 (4) the number of adverse determinations reversed on appeal;

63.4 (5) the 25 codes with the highest number of prior authorization requests and the
 63.5 percentage of authorizations for each of these codes;

63.6 (6) the 25 codes with the highest percentage of prior authorization requests for which
 63.7 an authorization was issued and the total number of the requests;

63.8 (7) the 25 codes with the highest percentage of prior authorization requests for which
 63.9 an adverse determination was issued but which was reversed on appeal and the total number
 63.10 of the requests;

63.11 (8) the 25 codes with the highest percentage of prior authorization requests for which
 63.12 an adverse determination was issued and the total number of the requests; and

63.13 (9) the reasons an adverse determination to a prior authorization request was issued,
 63.14 expressed as a percentage of all adverse determinations. The reasons listed may include but
 63.15 are not limited to:

63.16 (i) the patient did not meet prior authorization criteria;

63.17 (ii) incomplete information was submitted by the provider to the utilization review
 63.18 organization;

63.19 (iii) the treatment program changed; and

63.20 (iv) the patient is no longer covered by the health benefit plan.

63.21 Sec. 32. Minnesota Statutes 2022, section 62Q.097, is amended by adding a subdivision
 63.22 to read:

63.23 Subd. 3. **Prohibited application questions.** An application for provider credentialing
 63.24 must not:

63.25 (1) require the provider to disclose past health conditions;

63.26 (2) require the provider to disclose current health conditions, if the provider is being
 63.27 treated so that the condition does not affect the provider's ability to practice medicine; or

63.28 (3) require the disclosure of any health conditions that would not affect the provider's
 63.29 ability to practice medicine in a competent, safe, and ethical manner.

64.1 **EFFECTIVE DATE.** This section applies to applications for provider credentialing
 64.2 submitted to a health plan company on or after January 1, 2025.

64.3 Sec. 33. Minnesota Statutes 2022, section 62Q.14, is amended to read:

64.4 **62Q.14 RESTRICTIONS ON ENROLLEE SERVICES.**

64.5 No health plan company may restrict the choice of an enrollee as to where the enrollee
 64.6 receives services related to:

64.7 (1) the voluntary planning of the conception and bearing of children, ~~provided that this~~
 64.8 ~~clause does not refer to abortion services;~~

64.9 (2) the diagnosis of infertility;

64.10 (3) the testing and treatment of a sexually transmitted disease; and

64.11 (4) the testing for AIDS or other HIV-related conditions.

64.12 **EFFECTIVE DATE.** This section is effective January 1, 2025, and applies to health
 64.13 plans offered, sold, issued, or renewed on or after that date.

64.14 Sec. 34. Minnesota Statutes 2022, section 62Q.19, subdivision 3, is amended to read:

64.15 Subd. 3. **Health plan company affiliation.** A health plan company must offer a provider
 64.16 contract to ~~any~~ all designated essential community ~~provider~~ providers located within the
 64.17 area served by the health plan company. A health plan company must include all essential
 64.18 community providers that have accepted a contract in each of the company's provider
 64.19 networks. A health plan company shall not restrict enrollee access to services designated
 64.20 to be provided by the essential community provider for the population that the essential
 64.21 community provider is certified to serve. A health plan company may also make other
 64.22 providers available for these services. A health plan company may require an essential
 64.23 community provider to meet all data requirements, utilization review, and quality assurance
 64.24 requirements on the same basis as other health plan providers.

64.25 **EFFECTIVE DATE.** This section is effective January 1, 2025, and applies to health
 64.26 plans offered, issued, or renewed on or after that date.

64.27 Sec. 35. Minnesota Statutes 2022, section 62Q.19, is amended by adding a subdivision to
 64.28 read:

64.29 Subd. 4a. **Contract payment rates; private.** An essential community provider and a
 64.30 health plan company may negotiate the payment rate for covered services provided by the

65.1 essential community provider. This rate must be at least the same rate per unit of service
65.2 as is paid by the health plan company to the essential community provider under the provider
65.3 contract between the two with the highest number of enrollees receiving health care services
65.4 from the provider or, if there is no provider contract between the health plan company and
65.5 the essential community provider, the rate must be at least the same rate per unit of service
65.6 as is paid to other plan providers for the same or similar services. The provider contract
65.7 used to set the rate under this subdivision must be in relation to an individual, small group,
65.8 or large group health plan. This subdivision applies only to provider contracts in relation
65.9 to individual, small employer, and large group health plans.

65.10 Sec. 36. Minnesota Statutes 2022, section 62Q.19, subdivision 5, is amended to read:

65.11 Subd. 5. **Contract payment rates; public.** An essential community provider and a
65.12 health plan company may negotiate the payment rate for covered services provided by the
65.13 essential community provider. This rate must be at least the same rate per unit of service
65.14 as is paid to other health plan providers for the same or similar services. This subdivision
65.15 applies only to provider contracts in relation to health plans offered through the State
65.16 Employee Group Insurance Program, medical assistance, and MinnesotaCare.

65.17 Sec. 37. Minnesota Statutes 2023 Supplement, section 62Q.473, is amended by adding a
65.18 subdivision to read:

65.19 Subd. 3. **Reimbursement.** (a) The commissioner of commerce must reimburse health
65.20 plan companies for coverage under this section. Reimbursement is available only for coverage
65.21 that would not have been provided by the health plan without the requirements of this
65.22 section. Treatments and services covered by the health plan as of January 1, 2023, are
65.23 ineligible for payment under this subdivision by the commissioner of commerce.

65.24 (b) Health plan companies must report to the commissioner of commerce quantified
65.25 costs attributable to the additional benefit under this section in a format developed by the
65.26 commissioner. A health plan's coverage as of January 1, 2023, must be used by the health
65.27 plan company as the basis for determining whether coverage would not have been provided
65.28 by the health plan for purposes of this subdivision.

65.29 (c) The commissioner of commerce must evaluate submissions and make payments to
65.30 health plan companies as provided in Code of Federal Regulations, title 45, section 155.170.

65.31 **EFFECTIVE DATE.** This section is effective January 1, 2025, and applies to health
65.32 plans offered, issued, or renewed on or after that date.

66.1 Sec. 38. Minnesota Statutes 2023 Supplement, section 62Q.473, is amended by adding a
66.2 subdivision to read:

66.3 Subd. 4. **Appropriation.** Each fiscal year, an amount necessary to make payments to
66.4 health plan companies to defray the cost of providing coverage under this section is
66.5 appropriated to the commissioner of commerce.

66.6 **EFFECTIVE DATE.** This section is effective January 1, 2025, and applies to health
66.7 plans offered, issued, or renewed on or after that date.

66.8 Sec. 39. **[62Q.524] COVERAGE OF ABORTIONS AND ABORTION-RELATED**
66.9 **SERVICES.**

66.10 Subdivision 1. **Definition.** For purposes of this section, "abortion" means any medical
66.11 treatment intended to induce the termination of a pregnancy with a purpose other than
66.12 producing a live birth.

66.13 Subd. 2. **Required coverage.** (a) A health plan must provide coverage for abortions and
66.14 abortion-related services, including preabortion services and follow-up services.

66.15 (b) A health plan must not impose on the coverage under this section any co-payment,
66.16 coinsurance, deductible, or other enrollee cost-sharing that is greater than the cost-sharing
66.17 that applies to similar services covered under the health plan.

66.18 (c) A health plan must not impose any limitation on the coverage under this section,
66.19 including but not limited to any utilization review, prior authorization, referral requirements,
66.20 restrictions, or delays, that is not generally applicable to other coverages under the plan.

66.21 Subd. 3. **Exclusion.** This section does not apply to managed care organizations or
66.22 county-based purchasing plans when the plan provides coverage to public health care
66.23 program enrollees under chapter 256B or 256L.

66.24 Subd. 4. **Reimbursement.** (a) The commissioner of commerce must reimburse health
66.25 plan companies for coverage under this section. Reimbursement is available only for coverage
66.26 that would not have been provided by the health plan without the requirements of this
66.27 section. Treatments and services covered by the health plan as of January 1, 2024, are
66.28 ineligible for payment under this subdivision by the commissioner of commerce.

66.29 (b) Health plan companies must report to the commissioner of commerce quantified
66.30 costs attributable to the additional benefit under this section in a format developed by the
66.31 commissioner. A health plan's coverage as of January 1, 2024, must be used by the health

67.1 plan company as the basis for determining whether coverage would not have been provided
67.2 by the health plan for purposes of this subdivision.

67.3 (c) The commissioner of commerce must evaluate submissions and make payments to
67.4 health plan companies as provided in Code of Federal Regulations, title 45, section 155.170.

67.5 Subd. 5. **Appropriation.** Each fiscal year, an amount necessary to make payments to
67.6 health plan companies to defray the cost of providing coverage under this section is
67.7 appropriated to the commissioner of commerce.

67.8 **EFFECTIVE DATE.** This section is effective January 1, 2025, and applies to health
67.9 plans offered, sold, issued, or renewed on or after that date.

67.10 Sec. 40. **[62Q.531] AMINO ACID-BASED FORMULA COVERAGE.**

67.11 Subdivision 1. **Definition.** (a) For purposes of this section, the following term has the
67.12 meaning given.

67.13 (b) "Formula" means an amino acid-based elemental formula.

67.14 Subd. 2. **Required coverage.** A health plan company must provide coverage for formula
67.15 when formula is medically necessary.

67.16 Subd. 3. **Covered conditions.** Conditions for which formula is medically necessary
67.17 include but are not limited to:

67.18 (1) cystic fibrosis;

67.19 (2) amino acid, organic acid, and fatty acid metabolic and malabsorption disorders;

67.20 (3) IgE mediated allergies to food proteins;

67.21 (4) food protein-induced enterocolitis syndrome;

67.22 (5) eosinophilic esophagitis;

67.23 (6) eosinophilic gastroenteritis;

67.24 (7) eosinophilic colitis; and

67.25 (8) mast cell activation syndrome.

67.26 **EFFECTIVE DATE.** This section is effective January 1, 2025, and applies to health
67.27 plans offered, issued, or sold on or after that date.

68.1 Sec. 41. **[62Q.665] COVERAGE FOR ORTHOTIC AND PROSTHETIC DEVICES.**

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

68.4 (b) "Accredited facility" means any entity that is accredited to provide comprehensive
68.5 orthotic or prosthetic devices or services by a Centers for Medicare and Medicaid Services
68.6 approved accrediting agency.

68.7 (c) "Orthosis" means:

68.8 (1) an external medical device that is:

68.9 (i) custom-fabricated or custom-fitted to a specific patient based on the patient's unique
68.10 physical condition;

68.11 (ii) applied to a part of the body to correct a deformity, provide support and protection,
68.12 restrict motion, improve function, or relieve symptoms of a disease, syndrome, injury, or
68.13 postoperative condition; and

68.14 (iii) deemed medically necessary by a prescribing physician or licensed health care
68.15 provider who has authority in Minnesota to prescribe orthotic and prosthetic devices, supplies,
68.16 and services; and

68.17 (2) any provision, repair, or replacement of a device that is furnished or performed by:

68.18 (i) an accredited facility in comprehensive orthotic services; or

68.19 (ii) a health care provider licensed in Minnesota and operating within the provider's
68.20 scope of practice which allows the provider to provide orthotic or prosthetic devices, supplies,
68.21 or services.

68.22 (d) "Orthotics" means:

68.23 (1) the science and practice of evaluating, measuring, designing, fabricating, assembling,
68.24 fitting, adjusting, or servicing and providing the initial training necessary to accomplish the
68.25 fitting of an orthotic device for the support, correction, or alleviation of a neuromuscular
68.26 or musculoskeletal dysfunction, disease, injury, or deformity;

68.27 (2) evaluation, treatment, and consultation related to an orthotic device;

68.28 (3) basic observation of gait and postural analysis;

68.29 (4) assessing and designing orthosis to maximize function and provide support and
68.30 alignment necessary to prevent or correct a deformity or to improve the safety and efficiency
68.31 of mobility and locomotion;

69.1 (5) continuing patient care to assess the effect of an orthotic device on the patient's
69.2 tissues; and

69.3 (6) proper fit and function of the orthotic device by periodic evaluation.

69.4 (e) "Prosthesis" means:

69.5 (1) an external medical device that is:

69.6 (i) used to replace or restore a missing limb, appendage, or other external human body
69.7 part; and

69.8 (ii) deemed medically necessary by a prescribing physician or licensed health care
69.9 provider who has authority in Minnesota to prescribe orthotic and prosthetic devices, supplies,
69.10 and services; and

69.11 (2) any provision, repair, or replacement of a device that is furnished or performed by:

69.12 (i) an accredited facility in comprehensive prosthetic services; or

69.13 (ii) a health care provider licensed in Minnesota and operating within the provider's
69.14 scope of practice which allows the provider to provide orthotic or prosthetic devices, supplies,
69.15 or services.

69.16 (f) "Prosthetics" means:

69.17 (1) the science and practice of evaluating, measuring, designing, fabricating, assembling,
69.18 fitting, aligning, adjusting, or servicing, as well as providing the initial training necessary
69.19 to accomplish the fitting of, a prosthesis through the replacement of external parts of a
69.20 human body lost due to amputation or congenital deformities or absences;

69.21 (2) the generation of an image, form, or mold that replicates the patient's body segment
69.22 and that requires rectification of dimensions, contours, and volumes for use in the design
69.23 and fabrication of a socket to accept a residual anatomic limb to, in turn, create an artificial
69.24 appendage that is designed either to support body weight or to improve or restore function
69.25 or anatomical appearance, or both;

69.26 (3) observational gait analysis and clinical assessment of the requirements necessary to
69.27 refine and mechanically fix the relative position of various parts of the prosthesis to maximize
69.28 function, stability, and safety of the patient;

69.29 (4) providing and continuing patient care in order to assess the prosthetic device's effect
69.30 on the patient's tissues; and

69.31 (5) assuring proper fit and function of the prosthetic device by periodic evaluation.

70.1 Subd. 2. Coverage. (a) A health plan must provide coverage for orthotic and prosthetic
70.2 devices, supplies, and services, including repair and replacement, at least equal to the
70.3 coverage provided under federal law for health insurance for the aged and disabled under
70.4 sections 1832, 1833, and 1834 of the Social Security Act, United States Code, title 42,
70.5 sections 1395k, 1395l, and 1395m, but only to the extent consistent with this section.

70.6 (b) A health plan must not subject orthotic and prosthetic benefits to separate financial
70.7 requirements that apply only with respect to those benefits. A health plan may impose
70.8 co-payment and coinsurance amounts on those benefits, except that any financial
70.9 requirements that apply to such benefits must not be more restrictive than the financial
70.10 requirements that apply to the health plan's medical and surgical benefits, including those
70.11 for internal restorative devices.

70.12 (c) A health plan may limit the benefits for, or alter the financial requirements for,
70.13 out-of-network coverage of prosthetic and orthotic devices, except that the restrictions and
70.14 requirements that apply to those benefits must not be more restrictive than the financial
70.15 requirements that apply to the out-of-network coverage for the health plan's medical and
70.16 surgical benefits.

70.17 (d) A health plan must cover orthoses and prostheses when furnished under an order by
70.18 a prescribing physician or licensed health care prescriber who has authority in Minnesota
70.19 to prescribe orthoses and prostheses, and that coverage for orthotic and prosthetic devices,
70.20 supplies, accessories, and services must include those devices or device systems, supplies,
70.21 accessories, and services that are customized to the covered individual's needs.

70.22 (e) A health plan must cover orthoses and prostheses determined by the enrollee's provider
70.23 to be the most appropriate model that meets the medical needs of the enrollee for purposes
70.24 of performing physical activities, as applicable, including but not limited to running, biking,
70.25 and swimming, and maximizing the enrollee's limb function.

70.26 (f) A health plan must cover orthoses and prostheses for showering or bathing.

70.27 Subd. 3. Prior authorization. A health plan may require prior authorization for orthotic
70.28 and prosthetic devices, supplies, and services in the same manner and to the same extent as
70.29 prior authorization is required for any other covered benefit.

70.30 Subd. 4. Reimbursement. (a) The commissioner of commerce must reimburse health
70.31 plan companies for coverage under this section. Reimbursement is available only for coverage
70.32 that would not have been provided by the health plan without the requirements of this
70.33 section. Treatments and services covered by the health plan as of January 1, 2024, are
70.34 ineligible for payment under this subdivision by the commissioner of commerce.

71.1 (b) Health plan companies must report to the commissioner of commerce quantified
71.2 costs attributable to the additional benefit under this section in a format developed by the
71.3 commissioner. A health plan's coverage as of January 1, 2024, must be used by the health
71.4 plan company as the basis for determining whether coverage would not have been provided
71.5 by the health plan for purposes of this subdivision.

71.6 (c) The commissioner of commerce must evaluate submissions and make payments to
71.7 health plan companies as provided in Code of Federal Regulations, title 45, section 155.170.

71.8 Subd. 5. **Appropriation.** Each fiscal year, an amount necessary to make payments to
71.9 health plan companies to defray the cost of providing coverage under this section is
71.10 appropriated to the commissioner of commerce.

71.11 **EFFECTIVE DATE.** This section is effective January 1, 2025, and applies to all health
71.12 plans offered, issued, or renewed on or after that date.

71.13 Sec. 42. **[62Q.6651] MEDICAL NECESSITY AND NONDISCRIMINATION**
71.14 **STANDARDS FOR COVERAGE OF PROSTHETICS OR ORTHOTICS.**

71.15 (a) When performing a utilization review for a request for coverage of prosthetic or
71.16 orthotic benefits, a health plan company shall apply the most recent version of evidence-based
71.17 treatment and fit criteria as recognized by relevant clinical specialists.

71.18 (b) A health plan company shall render utilization review determinations in a
71.19 nondiscriminatory manner and shall not deny coverage for habilitative or rehabilitative
71.20 benefits, including prosthetics or orthotics, solely on the basis of an enrollee's actual or
71.21 perceived disability.

71.22 (c) A health plan company shall not deny a prosthetic or orthotic benefit for an individual
71.23 with limb loss or absence that would otherwise be covered for a nondisabled person seeking
71.24 medical or surgical intervention to restore or maintain the ability to perform the same
71.25 physical activity.

71.26 (d) A health plan offered, issued, or renewed in Minnesota that offers coverage for
71.27 prosthetics and custom orthotic devices shall include language describing an enrollee's rights
71.28 pursuant to paragraphs (b) and (c) in its evidence of coverage and any benefit denial letters.

71.29 (e) A health plan that provides coverage for prosthetic or orthotic services shall ensure
71.30 access to medically necessary clinical care and to prosthetic and custom orthotic devices
71.31 and technology from not less than two distinct prosthetic and custom orthotic providers in
71.32 the plan's provider network located in Minnesota. In the event that medically necessary
71.33 covered orthotics and prosthetics are not available from an in-network provider, the health

72.1 plan company shall provide processes to refer a member to an out-of-network provider and
72.2 shall fully reimburse the out-of-network provider at a mutually agreed upon rate less member
72.3 cost sharing determined on an in-network basis.

72.4 (f) If coverage for prosthetic or custom orthotic devices is provided, payment shall be
72.5 made for the replacement of a prosthetic or custom orthotic device or for the replacement
72.6 of any part of the devices, without regard to continuous use or useful lifetime restrictions,
72.7 if an ordering health care provider determines that the provision of a replacement device,
72.8 or a replacement part of a device, is necessary because:

72.9 (1) of a change in the physiological condition of the patient;

72.10 (2) of an irreparable change in the condition of the device or in a part of the device; or

72.11 (3) the condition of the device, or the part of the device, requires repairs and the cost of
72.12 the repairs would be more than 60 percent of the cost of a replacement device or of the part
72.13 being replaced.

72.14 (g) Confirmation from a prescribing health care provider may be required if the prosthetic
72.15 or custom orthotic device or part being replaced is less than three years old.

72.16 **EFFECTIVE DATE.** This section is effective January 1, 2025, and applies to all health
72.17 plans offered, issued, or renewed on or after that date.

72.18 Sec. 43. **[62Q.666] INTERMITTENT CATHETERS.**

72.19 Subdivision 1. **Required coverage.** A health plan must provide coverage for intermittent
72.20 urinary catheters and insertion supplies if intermittent catheterization is recommended by
72.21 the enrollee's health care provider. At least 180 intermittent catheters per month with insertion
72.22 supplies must be covered unless a lesser amount is prescribed by the enrollee's health care
72.23 provider. A health plan providing coverage under the medical assistance program may be
72.24 required to provide coverage for more than 180 intermittent catheters per month with
72.25 insertion supplies.

72.26 Subd. 2. **Cost-sharing requirements.** A health plan is prohibited from imposing a
72.27 deductible, co-payment, coinsurance, or other restriction on intermittent catheters and
72.28 insertion supplies that the health plan does not apply to durable medical equipment in general.

72.29 **EFFECTIVE DATE.** This section is effective for any health plan issued or renewed
72.30 on or after January 1, 2025.

73.1 Sec. 44. [62Q.679] RELIGIOUS OBJECTIONS.

73.2 Subdivision 1. Definitions. (a) The definitions in this subdivision apply to this section.

73.3 (b) "Closely held for-profit entity" means an entity that is not a nonprofit entity, has
73.4 more than 50 percent of the value of its ownership interest owned directly or indirectly by
73.5 five or fewer owners, and has no publicly traded ownership interest. For purposes of this
73.6 paragraph:

73.7 (1) ownership interests owned by a corporation, partnership, limited liability company,
73.8 estate, trust, or similar entity are considered owned by that entity's shareholders, partners,
73.9 members, or beneficiaries in proportion to their interest held in the corporation, partnership,
73.10 limited liability company, estate, trust, or similar entity;

73.11 (2) ownership interests owned by a nonprofit entity are considered owned by a single
73.12 owner;

73.13 (3) ownership interests owned by all individuals in a family are considered held by a
73.14 single owner. For purposes of this clause, "family" means brothers and sisters, including
73.15 half-brothers and half-sisters, a spouse, ancestors, and lineal descendants; and

73.16 (4) if an individual or entity holds an option, warrant, or similar right to purchase an
73.17 ownership interest, the individual or entity is considered to be the owner of those ownership
73.18 interests.

73.19 (c) "Eligible organization" means an organization that opposes covering some or all
73.20 health benefits under section 62Q.522, 62Q.524, or 62Q.585 on account of religious
73.21 objections and that is:

73.22 (1) organized as a nonprofit entity and holds itself out to be religious; or

73.23 (2) organized and operates as a closely held for-profit entity, and the organization's
73.24 owners or highest governing body has adopted, under the organization's applicable rules of
73.25 governance and consistent with state law, a resolution or similar action establishing that the
73.26 organization objects to covering some or all health benefits under section 62Q.522, 62Q.524,
73.27 or 62Q.585 on account of the owners' sincerely held religious beliefs.

73.28 (d) "Exempt organization" means an organization that is organized and operates as a
73.29 nonprofit entity and meets the requirements of section 6033(a)(3)(A)(i) or (iii) of the Internal
73.30 Revenue Code of 1986, as amended.

73.31 Subd. 2. Exemption. (a) An exempt organization is not required to provide coverage
73.32 under section 62Q.522, 62Q.524, or 62Q.585 if the exempt organization has religious

74.1 objections to the coverage. An exempt organization that chooses to not provide coverage
74.2 pursuant to this paragraph must notify employees as part of the hiring process and must
74.3 notify all employees at least 30 days before:

74.4 (1) an employee enrolls in the health plan; or

74.5 (2) the effective date of the health plan, whichever occurs first.

74.6 (b) If the exempt organization provides partial coverage under section 62Q.522, 62Q.524,
74.7 or 62Q.585, the notice required under paragraph (a) must provide a list of the portions of
74.8 such coverage which the organization refuses to cover.

74.9 Subd. 3. **Accommodation for eligible organizations.** (a) A health plan established or
74.10 maintained by an eligible organization complies with the coverage requirements of section
74.11 62Q.522, 62Q.524, or 62Q.585, with respect to the health benefits identified in the notice
74.12 under this paragraph, if the eligible organization provides notice to any health plan company
74.13 with which the eligible organization contracts that it is an eligible organization and that the
74.14 eligible organization has a religious objection to coverage for all or a subset of the health
74.15 benefits under section 62Q.522, 62Q.524, or 62Q.585.

74.16 (b) The notice from an eligible organization to a health plan company under paragraph
74.17 (a) must include: (1) the name of the eligible organization; (2) a statement that it objects to
74.18 coverage for some or all of the health benefits under section 62Q.522, 62Q.524, or 62Q.585,
74.19 including a list of the health benefits to which the eligible organization objects, if applicable;
74.20 and (3) the health plan name. The notice must be executed by a person authorized to provide
74.21 notice on behalf of the eligible organization.

74.22 (c) An eligible organization must provide a copy of the notice under paragraph (a) to
74.23 prospective employees as part of the hiring process and to all employees at least 30 days
74.24 before:

74.25 (1) an employee enrolls in the health plan; or

74.26 (2) the effective date of the health plan, whichever occurs first.

74.27 (d) A health plan company that receives a copy of the notice under paragraph (a) with
74.28 respect to a health plan established or maintained by an eligible organization must, for all
74.29 future enrollments in the health plan:

74.30 (1) expressly exclude coverage for those health benefits identified in the notice under
74.31 paragraph (a) from the health plan; and

75.1 (2) provide separate payments for any health benefits required to be covered under
75.2 section 62Q.522, 62Q.524, or 62Q.585 for enrollees as long as the enrollee remains enrolled
75.3 in the health plan.

75.4 (e) The health plan company must not impose any cost-sharing requirements, including
75.5 co-pays, deductibles, or coinsurance, or directly or indirectly impose any premium, fee, or
75.6 other charge for the health benefits under section 62Q.522 on the enrollee. The health plan
75.7 company must not directly or indirectly impose any premium, fee, or other charge for the
75.8 health benefits under section 62Q.522, 62Q.524, or 62Q.585 on the eligible organization
75.9 or health plan.

75.10 (f) On January 1, 2025, and every year thereafter a health plan company must notify the
75.11 commissioner, in a manner determined by the commissioner, of the number of eligible
75.12 organizations granted an accommodation under this subdivision.

75.13 **EFFECTIVE DATE.** This section is effective January 1, 2025, and applies to health
75.14 plans offered, sold, issued, or renewed on or after that date.

75.15 Sec. 45. Minnesota Statutes 2022, section 62Q.73, subdivision 2, is amended to read:

75.16 Subd. 2. **Exception.** (a) This section does not apply to governmental programs except
75.17 as permitted under paragraph (b). For purposes of this subdivision, "governmental programs"
75.18 means the prepaid medical assistance program; effective January 1, 2026, the medical
75.19 assistance fee-for-service program; the MinnesotaCare program; the demonstration project
75.20 for people with disabilities; and the federal Medicare program.

75.21 (b) In the course of a recipient's appeal of a medical determination to the commissioner
75.22 of human services under section 256.045, the recipient may request an expert medical
75.23 opinion be arranged by the external review entity under contract to provide independent
75.24 external reviews under this section. If such a request is made, the cost of the review shall
75.25 be paid by the commissioner of human services. Any medical opinion obtained under this
75.26 paragraph shall only be used by a state human services judge as evidence in the recipient's
75.27 appeal to the commissioner of human services under section 256.045.

75.28 (c) Nothing in this subdivision shall be construed to limit or restrict the appeal rights
75.29 provided in section 256.045 for governmental program recipients.

76.1 Sec. 46. Minnesota Statutes 2023 Supplement, section 145D.01, subdivision 1, is amended
76.2 to read:

76.3 Subdivision 1. **Definitions.** (a) For purposes of this ~~chapter~~ section and section 145D.02,
76.4 the following terms have the meanings given.

76.5 (b) "Captive professional entity" means a professional corporation, limited liability
76.6 company, or other entity formed to render professional services in which a beneficial owner
76.7 is a health care provider employed by, controlled by, or subject to the direction of a hospital
76.8 or hospital system.

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

76.10 (d) "Control," including the terms "controlling," "controlled by," and "under common
76.11 control with," means the possession, direct or indirect, of the power to direct or cause the
76.12 direction of the management and policies of a health care entity, whether through the
76.13 ownership of voting securities, membership in an entity formed under chapter 317A, by
76.14 contract other than a commercial contract for goods or nonmanagement services, or otherwise,
76.15 unless the power is the result of an official position with, corporate office held by, or court
76.16 appointment of, the person. Control is presumed to exist if any person, directly or indirectly,
76.17 owns, controls, holds with the power to vote, or holds proxies representing 40 percent or
76.18 more of the voting securities of any other person, or if any person, directly or indirectly,
76.19 constitutes 40 percent or more of the membership of an entity formed under chapter 317A.
76.20 The attorney general may determine that control exists in fact, notwithstanding the absence
76.21 of a presumption to that effect.

76.22 (e) "Health care entity" means:

76.23 (1) a hospital;

76.24 (2) a hospital system;

76.25 (3) a captive professional entity;

76.26 (4) a medical foundation;

76.27 (5) a health care provider group practice;

76.28 (6) an entity organized or controlled by an entity listed in clauses (1) to (5); or

76.29 (7) an entity that owns or exercises control over an entity listed in clauses (1) to (5).

76.30 (f) "Health care provider" means a physician licensed under chapter 147, a physician
76.31 assistant licensed under chapter 147A, or an advanced practice registered nurse as defined

77.1 in section 148.171, subdivision 3, who provides health care services, including but not
77.2 limited to medical care, consultation, diagnosis, or treatment.

77.3 (g) "Health care provider group practice" means two or more health care providers legally
77.4 organized in a partnership, professional corporation, limited liability company, medical
77.5 foundation, nonprofit corporation, faculty practice plan, or other similar entity:

77.6 (1) in which each health care provider who is a member of the group provides services
77.7 that a health care provider routinely provides, including but not limited to medical care,
77.8 consultation, diagnosis, and treatment, through the joint use of shared office space, facilities,
77.9 equipment, or personnel;

77.10 (2) for which substantially all services of the health care providers who are group
77.11 members are provided through the group and are billed in the name of the group practice
77.12 and amounts so received are treated as receipts of the group; or

77.13 (3) in which the overhead expenses of, and the income from, the group are distributed
77.14 in accordance with methods previously determined by members of the group.

77.15 An entity that otherwise meets the definition of health care provider group practice in this
77.16 paragraph shall be considered a health care provider group practice even if its shareholders,
77.17 partners, members, or owners include a professional corporation, limited liability company,
77.18 or other entity in which any beneficial owner is a health care provider and that is formed to
77.19 render professional services.

77.20 (h) "Hospital" means a health care facility licensed as a hospital under sections 144.50
77.21 to 144.56.

77.22 (i) "Medical foundation" means a nonprofit legal entity through which health care
77.23 providers perform research or provide medical services.

77.24 (j) "Transaction" means a single action, or a series of actions within a five-year period,
77.25 which occurs in part within the state of Minnesota or involves a health care entity formed
77.26 or licensed in Minnesota, that constitutes:

77.27 (1) a merger or exchange of a health care entity with another entity;

77.28 (2) the sale, lease, or transfer of 40 percent or more of the assets of a health care entity
77.29 to another entity;

77.30 (3) the granting of a security interest of 40 percent or more of the property and assets
77.31 of a health care entity to another entity;

78.1 (4) the transfer of 40 percent or more of the shares or other ownership of a health care
78.2 entity to another entity;

78.3 (5) an addition, removal, withdrawal, substitution, or other modification of one or more
78.4 members of the health care entity's governing body that transfers control, responsibility for,
78.5 or governance of the health care entity to another entity;

78.6 (6) the creation of a new health care entity;

78.7 (7) an agreement or series of agreements that results in the sharing of 40 percent or more
78.8 of the health care entity's revenues with another entity, including affiliates of such other
78.9 entity;

78.10 (8) an addition, removal, withdrawal, substitution, or other modification of the members
78.11 of a health care entity formed under chapter 317A that results in a change of 40 percent or
78.12 more of the membership of the health care entity; or

78.13 (9) any other transfer of control of a health care entity to, or acquisition of control of a
78.14 health care entity by, another entity.

78.15 (k) A transaction as defined in paragraph (j) does not include:

78.16 (1) an action or series of actions that meets one or more of the criteria set forth in
78.17 paragraph (j), clauses (1) to (9), if, immediately prior to all such actions, the health care
78.18 entity directly, or indirectly through one or more intermediaries, controls, is controlled by,
78.19 or is under common control with, all other parties to the action or series of actions;

78.20 (2) a mortgage or other secured loan for business improvement purposes entered into
78.21 by a health care entity that does not directly affect delivery of health care or governance of
78.22 the health care entity;

78.23 (3) a clinical affiliation of health care entities formed solely for the purpose of
78.24 collaborating on clinical trials or providing graduate medical education;

78.25 (4) the mere offer of employment to, or hiring of, a health care provider by a health care
78.26 entity;

78.27 (5) contracts between a health care entity and a health care provider primarily for clinical
78.28 services; or

78.29 (6) a single action or series of actions within a five-year period involving only entities
78.30 that operate solely as a nursing home licensed under chapter 144A; a boarding care home
78.31 licensed under sections 144.50 to 144.56; a supervised living facility licensed under sections
78.32 144.50 to 144.56; an assisted living facility licensed under chapter 144G; a foster care setting

79.1 licensed under Minnesota Rules, parts 9555.5105 to 9555.6265, for a physical location that
79.2 is not the primary residence of the license holder; a community residential setting as defined
79.3 in section 245D.02, subdivision 4a; or a home care provider licensed under sections 144A.471
79.4 to 144A.483.

79.5 **EFFECTIVE DATE.** This section is effective July 1, 2025.

79.6 Sec. 47. **[145D.30] DEFINITIONS.**

79.7 Subdivision 1. **Application.** For purposes of sections 145D.30 to 145D.37, the following
79.8 terms have the meanings given unless the context clearly indicates otherwise.

79.9 Subd. 2. **Commissioner** "Commissioner" means the commissioner of commerce for a
79.10 nonprofit health coverage entity that is a nonprofit health service plan corporation operating
79.11 under chapter 62C or the commissioner of health for a nonprofit health coverage entity that
79.12 is a nonprofit health maintenance organization operating under chapter 62D.

79.13 Subd. 3. **Control.** "Control," including the terms "controlling," "controlled by," and
79.14 "under common control with," means the possession, direct or indirect, of the power to
79.15 direct or cause the direction of the management and policies of a nonprofit health coverage
79.16 entity, whether through the ownership of voting securities, through membership in an entity
79.17 formed under chapter 317A, by contract other than a commercial contract for goods or
79.18 nonmanagement services, or otherwise, unless the power is the result of an official position
79.19 with, corporate office held by, or court appointment of the person. Control is presumed to
79.20 exist if any person, directly or indirectly, owns, controls, holds with the power to vote, or
79.21 holds proxies representing 40 percent or more of the voting securities of any other person
79.22 or if any person, directly or indirectly, constitutes 40 percent or more of the membership
79.23 of an entity formed under chapter 317A. The attorney general may determine that control
79.24 exists in fact, notwithstanding the absence of a presumption to that effect.

79.25 Subd. 4. **Conversion transaction.** "Conversion transaction" means a transaction otherwise
79.26 permitted under applicable law in which a nonprofit health coverage entity:

79.27 (1) merges, consolidates, converts, or transfers all or substantially all of its assets to any
79.28 entity except a corporation that is exempt under United States Code, title 26, section
79.29 501(c)(3);

79.30 (2) makes a series of separate transfers within a 60-month period that in the aggregate
79.31 constitute a transfer of all or substantially all of the nonprofit health coverage entity's assets
79.32 to any entity except a corporation that is exempt under United States Code, title 26, section
79.33 501(c)(3); or

80.1 (3) adds or substitutes one or more directors or officers that effectively transfer the
80.2 control of, responsibility for, or governance of the nonprofit health coverage entity to any
80.3 entity except a corporation that is exempt under United States Code, title 26, section
80.4 501(c)(3).

80.5 Subd. 5. **Corporation.** "Corporation" has the meaning given in section 317A.011,
80.6 subdivision 6, and also includes a nonprofit limited liability company organized under
80.7 section 322C.1101.

80.8 Subd. 6. **Director.** "Director" has the meaning given in section 317A.011, subdivision
80.9 7.

80.10 Subd. 7. **Family member.** "Family member" means a spouse, parent, child, spouse of
80.11 a child, brother, sister, or spouse of a brother or sister.

80.12 Subd. 8. **Full and fair value.** "Full and fair value" means at least the amount that the
80.13 public benefit assets of the nonprofit health coverage entity would be worth if the assets
80.14 were equal to stock in the nonprofit health coverage entity, if the nonprofit health coverage
80.15 entity was a for-profit corporation and if the nonprofit health coverage entity had 100 percent
80.16 of its stock authorized by the corporation and available for purchase without transfer
80.17 restrictions. The valuation shall consider market value, investment or earning value, net
80.18 asset value, goodwill, amount of donations received, and control premium, if any.

80.19 Subd. 9. **Nonprofit health coverage entity.** "Nonprofit health coverage entity" means
80.20 a domestic nonprofit health service plan corporation operating under chapter 62C or a
80.21 domestic nonprofit health maintenance organization operating under chapter 62D.

80.22 Subd. 10. **Officer.** "Officer" has the meaning given in section 317A.011, subdivision
80.23 15.

80.24 Subd. 11. **Public benefit assets.** "Public benefit assets" means the entirety of a nonprofit
80.25 health coverage entity's assets, whether tangible or intangible, including but not limited to
80.26 its goodwill and anticipated future revenue.

80.27 Subd. 12. **Related organization.** "Related organization" has the meaning given in section
80.28 317A.011, subdivision 18.

80.29 **EFFECTIVE DATE.** This section is effective July 1, 2025.

80.30 Sec. 48. **[145D.31] CERTAIN CONVERSION TRANSACTIONS PROHIBITED.**

80.31 A nonprofit health coverage entity must not enter into a conversion transaction if:

81.1 (1) doing so would result in less than the full and fair value of all public benefit assets
 81.2 remaining dedicated to the public benefit; or

81.3 (2) an individual who has been an officer, director, or other executive of the nonprofit
 81.4 health coverage entity or of a related organization, or a family member of such an individual:

81.5 (i) has held or will hold, whether guaranteed or contingent, an ownership stake, stock,
 81.6 securities, investment, or other financial interest in an entity to which the nonprofit health
 81.7 coverage entity transfers public benefit assets in connection with the conversion transaction;

81.8 (ii) has received or will receive any type of compensation or other financial benefit,
 81.9 except for salary or wages paid for employment, from an entity to which the nonprofit health
 81.10 coverage entity transfers public benefit assets in connection with the conversion transaction;

81.11 (iii) has held or will hold, whether guaranteed or contingent, an ownership stake, stock,
 81.12 securities, investment, or other financial interest in an entity that has or will have a business
 81.13 relationship with an entity to which the nonprofit health coverage entity transfers public
 81.14 benefit assets in connection with the conversion transaction; or

81.15 (iv) has received or will receive any type of compensation or other financial benefit,
 81.16 except for salary or wages paid for employment, from an entity that has or will have a
 81.17 business relationship with an entity to which the nonprofit health coverage entity transfers
 81.18 public benefit assets in connection with the conversion transaction.

81.19 **EFFECTIVE DATE.** This section is effective July 1, 2025.

81.20 **Sec. 49. [145D.32] REQUIREMENTS FOR NONPROFIT HEALTH COVERAGE**
 81.21 **ENTITY CONVERSION TRANSACTIONS.**

81.22 Subdivision 1. **Notice.** (a) Before entering into a conversion transaction, a nonprofit
 81.23 health coverage entity must notify the attorney general according to section 317A.811. In
 81.24 addition to the elements listed in section 317A.811, subdivision 1, the notice required by
 81.25 this subdivision must also include: (1) an itemization of the nonprofit health coverage entity's
 81.26 public benefit assets and an independent third-party valuation of the nonprofit health coverage
 81.27 entity's public benefit assets; and (2) other information contained in forms provided by the
 81.28 attorney general.

81.29 (b) When the nonprofit health coverage entity provides the attorney general with the
 81.30 notice and other information required under paragraph (a), the nonprofit health coverage
 81.31 entity must also provide a copy of this notice and other information to the applicable
 81.32 commissioner.

82.1 Subd. 2. **Nonprofit health coverage entity requirements.** Before entering into a
82.2 conversion transaction, a nonprofit health coverage entity must ensure that:

82.3 (1) the proposed conversion transaction complies with chapters 317A and 501B and
82.4 other applicable laws;

82.5 (2) the proposed conversion transaction does not involve or constitute a breach of
82.6 charitable trust;

82.7 (3) the nonprofit health coverage entity shall receive full and fair value for its public
82.8 benefit assets;

82.9 (4) the value of the public benefit assets to be transferred has not been manipulated in
82.10 a manner that causes or caused the value of the assets to decrease;

82.11 (5) the proceeds of the proposed conversion transaction shall be used in a manner
82.12 consistent with the public benefit for which the assets are held by the nonprofit health
82.13 coverage entity; and

82.14 (6) the proposed conversion transaction shall not result in a breach of fiduciary duty.

82.15 Subd. 3. **Listening sessions and public comment.** The attorney general or the
82.16 commissioner may hold public listening sessions or forums and may solicit public comments
82.17 regarding the proposed conversion transaction.

82.18 Subd. 4. **Waiting period.** (a) Subject to paragraphs (b) and (c), a nonprofit health
82.19 coverage entity must not enter into a conversion transaction until 60 days after the nonprofit
82.20 health coverage entity has given written notice as required in subdivision 1.

82.21 (b) The attorney general may waive all or part of the waiting period or may extend the
82.22 waiting period for an additional 60 days by notifying the nonprofit health coverage entity
82.23 of the extension in writing.

82.24 (c) The time periods specified in this subdivision shall be suspended while an
82.25 investigation into the conversion transaction is pending or while a request from the attorney
82.26 general for additional information is outstanding.

82.27 Subd. 5. **Funds restricted for a particular purpose.** Nothing in this section relieves a
82.28 nonprofit health coverage entity from complying with requirements for funds that are
82.29 restricted for a particular purpose. Funds restricted for a particular purpose must continue
82.30 to be used in accordance with the purpose for which they were restricted under sections
82.31 317A.671 and 501B.31. A nonprofit health coverage entity may not convert, transfer, or

83.1 sell assets if the transaction would result in the use of the assets conflicting with their
83.2 restricted purpose.

83.3 **EFFECTIVE DATE.** This section is effective July 1, 2025.

83.4 Sec. 50. **[145D.34] ENFORCEMENT AND REMEDIES.**

83.5 Subdivision 1. **Investigation.** The attorney general has the powers in section 8.31.
83.6 Nothing in this subdivision limits the powers, remedies, or responsibilities of the attorney
83.7 general under this chapter; chapter 8, 309, 317A, or 501B; or any other chapter. For purposes
83.8 of this section, an approval by the commissioner for regulatory purposes does not impair
83.9 or inform the attorney general's authority.

83.10 Subd. 2. **Enforcement and penalties.** (a) The attorney general may bring an action in
83.11 district court to enjoin or unwind a conversion transaction or seek other equitable relief
83.12 necessary to protect the public interest if:

83.13 (1) a nonprofit health coverage entity or conversion transaction violates sections 145D.30
83.14 to 145D.32; or

83.15 (2) the conversion transaction is contrary to the public interest.

83.16 In seeking injunctive relief, the attorney general must not be required to establish irreparable
83.17 harm but must instead establish that a violation of sections 145D.30 to 145D.32 occurred
83.18 or that the requested order promotes the public interest.

83.19 (b) Factors informing whether a conversion transaction is contrary to the public interest
83.20 include but are not limited to whether:

83.21 (1) the conversion transaction shall result in increased health care costs for patients; and

83.22 (2) the conversion transaction shall adversely impact provider cost trends and containment
83.23 of total health care spending.

83.24 (c) The attorney general may enforce sections 145D.30 to 145D.32 under section 8.31.

83.25 (d) Failure of the entities involved in a conversion transaction to provide timely
83.26 information as required by the attorney general or the commissioner shall be an independent
83.27 and sufficient ground for a court to enjoin or unwind the transaction or provide other equitable
83.28 relief, provided the attorney general notifies the entities of the inadequacy of the information
83.29 provided and provides the entities with a reasonable opportunity to remedy the inadequacy.

83.30 (e) An officer, director, or other executive found to have violated sections 145D.30 to
83.31 145D.32 shall be subject to a civil penalty of up to \$100,000 for each violation. A corporation

84.1 or other entity which is a party to or materially participated in a conversion transaction
84.2 found to have violated sections 145D.30 to 145D.32 shall be subject to a civil penalty of
84.3 up to \$1,000,000. A court may also award reasonable attorney fees and costs of investigation
84.4 and litigation.

84.5 Subd. 3. **Commissioner of health; data and research.** The commissioner of health
84.6 must provide the attorney general, upon request, with data and research on broader market
84.7 trends, impacts on prices and outcomes, public health and population health considerations,
84.8 and health care access, for the attorney general to use when evaluating whether a conversion
84.9 transaction is contrary to public interest. The commissioner of health may share with the
84.10 attorney general, according to section 13.05, subdivision 9, any not public data, as defined
84.11 in section 13.02, subdivision 8a, held by the commissioner to aid in the investigation and
84.12 review of the conversion transaction, and the attorney general must maintain this data with
84.13 the same classification according to section 13.03, subdivision 4, paragraph (c).

84.14 Subd. 4. **Failure to take action.** Failure by the attorney general to take action with
84.15 respect to a conversion transaction under this section does not constitute approval of the
84.16 conversion transaction or waiver, nor shall failure prevent the attorney general from taking
84.17 action in the same, similar, or subsequent circumstances.

84.18 **EFFECTIVE DATE.** This section is effective July 1, 2025.

84.19 Sec. 51. **[145D.35] DATA PRACTICES.**

84.20 Data provided by a nonprofit health coverage entity to the commissioner or the attorney
84.21 general under sections 145D.30 to 145D.32 are, for data on individuals, confidential data
84.22 on individuals as defined under section 13.02, subdivision 3, and, for data not on individuals,
84.23 protected nonpublic data as defined under section 13.02, subdivision 13. The provided data
84.24 are not subject to subpoena and shall not be subject to discovery or admissible in evidence
84.25 in any private civil action. The attorney general or the commissioner may provide access
84.26 to any data classified as confidential or protected nonpublic under this section to any law
84.27 enforcement agency if the attorney general or commissioner determines that the access aids
84.28 the law enforcement process. This section shall not be construed to limit the attorney general's
84.29 authority to use the data in furtherance of any legal action brought according to section
84.30 145D.34.

84.31 **EFFECTIVE DATE.** This section is effective July 1, 2025.

85.1 **Sec. 52. [145D.36] COMMISSIONER OF HEALTH; REPORTS AND ANALYSIS.**

85.2 Notwithstanding any law to the contrary, the commissioner of health may use data or
85.3 information submitted under sections 60A.135 to 60A.137, 60A.17, 60D.18, 60D.20,
85.4 62D.221, and 145D.32 to conduct analyses of the aggregate impact of transactions within
85.5 nonprofit health coverage entities and organizations which include nonprofit health coverage
85.6 entities or their affiliates on access to or the cost of health care services, health care market
85.7 consolidation, and health care quality. The commissioner of health must issue periodic
85.8 public reports on the number and types of conversion transactions subject to sections 145D.30
85.9 to 145D.35 and on the aggregate impact of conversion transactions on health care costs,
85.10 quality, and competition in Minnesota.

85.11 **EFFECTIVE DATE.** This section is effective July 1, 2025.

85.12 **Sec. 53. [145D.37] RELATION TO OTHER LAW.**

85.13 (a) Sections 145D.30 to 145D.36 are in addition to and do not affect or limit any power,
85.14 remedy, or responsibility of a health maintenance organization, a service plan corporation,
85.15 the attorney general, the commissioner of health, or the commissioner of commerce under
85.16 this chapter; chapter 8, 62C, 62D, 309, 317A, or 501B; or other law.

85.17 (b) Nothing in sections 145D.03 to 145D.36 authorizes a nonprofit health coverage entity
85.18 to enter into a conversion transaction not otherwise permitted under chapter 317A or 501B
85.19 or other law.

85.20 **EFFECTIVE DATE.** This section is effective July 1, 2025.

85.21 **Sec. 54. [214.41] PHYSICIAN WELLNESS PROGRAM.**

85.22 Subdivision 1. **Definition.** For the purposes of this section, "physician wellness program"
85.23 means a program of evaluation, counseling, or other modality to address an issue related to
85.24 career fatigue or wellness related to work stress for physicians licensed under chapter 147
85.25 that is administered by a statewide association that is exempt from taxation under United
85.26 States Code, title 26, section 501(c)(6), and that primarily represents physicians and
85.27 osteopaths of multiple specialties. Physician wellness program does not include the provision
85.28 of services intended to monitor for impairment under the authority of section 214.31.

85.29 Subd. 2. **Confidentiality.** Any record of a person's participation in a physician wellness
85.30 program is confidential and not subject to discovery, subpoena, or a reporting requirement
85.31 to the applicable board, unless the person voluntarily provides for written release of the

86.1 information or the disclosure is required to meet the licensee's obligation to report according
 86.2 to section 147.111.

86.3 Subd. 3. **Civil liability.** Any person, agency, institution, facility, or organization employed
 86.4 by, contracting with, or operating a physician wellness program is immune from civil liability
 86.5 for any action related to their duties in connection with a physician wellness program when
 86.6 acting in good faith.

86.7 Sec. 55. Minnesota Statutes 2022, section 256B.035, is amended to read:

86.8 **256B.035 MANAGED CARE.**

86.9 The commissioner of human services may contract with public or private entities or
 86.10 operate a preferred provider program to deliver health care services to medical assistance
 86.11 and MinnesotaCare program recipients. The commissioner may enter into risk-based and
 86.12 non-risk-based contracts. The commissioner must not enter into a contract with a health
 86.13 maintenance organization, as defined in section 62D.02, which is not a nonprofit corporation
 86.14 organized under chapter 317A or a local governmental unit, as defined in section 62D.02.
 86.15 Contracts may be for the full range of health services, or a portion thereof, for medical
 86.16 assistance populations to determine the effectiveness of various provider reimbursement
 86.17 and care delivery mechanisms. The commissioner may seek necessary federal waivers and
 86.18 implement projects when approval of the waivers is obtained from the Centers for Medicare
 86.19 and Medicaid Services of the United States Department of Health and Human Services.

86.20 **EFFECTIVE DATE.** This section is effective January 1, 2025, and applies to managed
 86.21 care contracts under medical assistance and MinnesotaCare that take effect on or after that
 86.22 date.

86.23 Sec. 56. Minnesota Statutes 2023 Supplement, section 256B.0625, subdivision 3a, is
 86.24 amended to read:

86.25 Subd. 3a. **Gender-affirming services care.** Medical assistance covers gender-affirming
 86.26 services care, as defined in section 62Q.585.

86.27 **EFFECTIVE DATE.** This section is effective January 1, 2025.

86.28 Sec. 57. Minnesota Statutes 2022, section 256B.0625, subdivision 12, is amended to read:

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

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

87.4 **EFFECTIVE DATE.** This section is effective January 1, 2025, or upon federal approval,
87.5 whichever is later. The commissioner of human services shall notify the revisor of statutes
87.6 when federal approval is obtained.

87.7 Sec. 58. Minnesota Statutes 2023 Supplement, section 256B.0625, subdivision 16, is
87.8 amended to read:

87.9 Subd. 16. **Abortion services.** Medical assistance covers ~~abortion services determined~~
87.10 ~~to be medically necessary by the treating provider and delivered in accordance with all~~
87.11 ~~applicable Minnesota laws~~ abortion and abortion-related services, including preabortion
87.12 services and follow-up services.

87.13 **EFFECTIVE DATE.** This section is effective January 1, 2025, or upon federal approval,
87.14 whichever is later. The commissioner of human services shall notify the revisor of statutes
87.15 when federal approval is obtained.

87.16 Sec. 59. Minnesota Statutes 2022, section 256B.0625, subdivision 32, is amended to read:

87.17 Subd. 32. **Nutritional products.** Medical assistance covers nutritional products needed
87.18 for nutritional supplementation because solid food or nutrients thereof cannot be properly
87.19 absorbed by the body or needed for treatment of phenylketonuria, hyperlysinemia, maple
87.20 syrup urine disease, a combined allergy to human milk, cow's milk, and soy formula, or
87.21 any other childhood or adult diseases, conditions, or disorders identified by the commissioner
87.22 as requiring a similarly necessary nutritional product. Medical assistance covers amino
87.23 acid-based elemental formulas in the same manner as is required under section 62Q.531.
87.24 Nutritional products needed for the treatment of a combined allergy to human milk, cow's
87.25 milk, and soy formula require prior authorization. Separate payment shall not be made for
87.26 nutritional products for residents of long-term care facilities. Payment for dietary
87.27 requirements is a component of the per diem rate paid to these facilities.

87.28 **EFFECTIVE DATE.** This section is effective January 1, 2025.

87.29 Sec. 60. Minnesota Statutes 2022, section 256B.0625, is amended by adding a subdivision
87.30 to read:

87.31 Subd. 72. **Orthotic and prosthetic devices.** Medical assistance covers orthotic and
87.32 prosthetic devices, supplies, and services according to section 256B.066.

88.1 **EFFECTIVE DATE.** This section is effective January 1, 2025, or upon federal approval,
88.2 whichever is later. The commissioner of human services shall notify the revisor of statutes
88.3 when federal approval is obtained.

88.4 Sec. 61. Minnesota Statutes 2022, section 256B.0625, is amended by adding a subdivision
88.5 to read:

88.6 Subd. 73. **Rapid whole genome sequencing.** Medical assistance covers rapid whole
88.7 genome sequencing (rWGS) testing. Coverage and eligibility for rWGS testing, and the use
88.8 of genetic data, must meet the requirements specified in section 62A.3098, subdivisions 1
88.9 to 3 and 6.

88.10 **EFFECTIVE DATE.** This section is effective January 1, 2025.

88.11 Sec. 62. Minnesota Statutes 2022, section 256B.0625, is amended by adding a subdivision
88.12 to read:

88.13 Subd. 74. **Intermittent catheters.** Medical assistance covers intermittent urinary catheters
88.14 and insertion supplies if intermittent catheterization is recommended by the enrollee's health
88.15 care provider. Medical assistance must meet the requirements that would otherwise apply
88.16 to a health plan under section 62Q.666.

88.17 Sec. 63. Minnesota Statutes 2022, section 256B.0625, is amended by adding a subdivision
88.18 to read:

88.19 Subd. 75. **Scalp hair prostheses.** Medical assistance covers scalp hair prostheses and
88.20 all equipment and accessories necessary for their regular use under the conditions and in
88.21 compliance with the requirements specified in section 62A.28, except that the limitation on
88.22 coverage required per benefit year set forth in section 62A.28, subdivision 2, paragraph (c),
88.23 does not apply.

88.24 **EFFECTIVE DATE.** This section is effective January 1, 2025.

88.25 Sec. 64. Minnesota Statutes 2022, section 256B.0625, is amended by adding a subdivision
88.26 to read:

88.27 Subd. 76. **Transfer of mothers and newborns.** Medical assistance covers the transfer
88.28 of mothers or newborns between medical facilities. Medical assistance must meet the same
88.29 requirements that would otherwise apply to a health plan under section 62A.0411.

88.30 **EFFECTIVE DATE.** This section is effective January 1, 2025.

89.1 Sec. 65. **[256B.066] ORTHOTIC AND PROSTHETIC DEVICES, SUPPLIES, AND**
89.2 **SERVICES.**

89.3 Subdivision 1. Definitions. All terms used in this section have the meanings given them
89.4 in section 62Q.665, subdivision 1.

89.5 Subd. 2. Coverage requirements. (a) Medical assistance covers orthotic and prosthetic
89.6 devices, supplies, and services:

89.7 (1) furnished under an order by a prescribing physician or licensed health care prescriber
89.8 who has authority in Minnesota to prescribe orthoses and prostheses. Coverage for orthotic
89.9 and prosthetic devices, supplies, accessories, and services under this clause includes those
89.10 devices or device systems, supplies, accessories, and services that are customized to the
89.11 enrollee's needs;

89.12 (2) determined by the enrollee's provider to be the most appropriate model that meets
89.13 the medical needs of the enrollee for purposes of performing physical activities, as applicable,
89.14 including but not limited to running, biking, and swimming, and maximizing the enrollee's
89.15 limb function; or

89.16 (3) for showering or bathing.

89.17 (b) The coverage set forth in paragraph (a) includes the repair and replacement of those
89.18 orthotic and prosthetic devices, supplies, and services described therein.

89.19 (c) Coverage of a prosthetic or orthotic benefit must not be denied for an individual with
89.20 limb loss or absence that would otherwise be covered for a nondisabled person seeking
89.21 medical or surgical intervention to restore or maintain the ability to perform the same
89.22 physical activity.

89.23 (d) If coverage for prosthetic or custom orthotic devices is provided, payment must be
89.24 made for the replacement of a prosthetic or custom orthotic device or for the replacement
89.25 of any part of the devices, without regard to useful lifetime restrictions, if an ordering health
89.26 care provider determines that the provision of a replacement device, or a replacement part
89.27 of a device, is necessary because:

89.28 (1) of a change in the physiological condition of the enrollee;

89.29 (2) of an irreparable change in the condition of the device or in a part of the device; or

89.30 (3) the condition of the device, or the part of the device, requires repairs and the cost of
89.31 the repairs would be more than 60 percent of the cost of a replacement device or of the part
89.32 being replaced.

90.1 Subd. 3. **Restrictions on coverage.** (a) Prior authorization may be required for orthotic
 90.2 and prosthetic devices, supplies, and services.

90.3 (b) A utilization review for a request for coverage of prosthetic or orthotic benefits must
 90.4 apply the most recent version of evidence-based treatment and fit criteria as recognized by
 90.5 relevant clinical specialists.

90.6 (c) Utilization review determinations must be rendered in a nondiscriminatory manner
 90.7 and must not deny coverage for habilitative or rehabilitative benefits, including prosthetics
 90.8 or orthotics, solely on the basis of an enrollee's actual or perceived disability.

90.9 (d) Evidence of coverage and any benefit denial letters must include language describing
 90.10 an enrollee's rights pursuant to paragraphs (b) and (c).

90.11 (e) Confirmation from a prescribing health care provider may be required if the prosthetic
 90.12 or custom orthotic device or part being replaced is less than three years old.

90.13 Subd. 4. **Managed care plan access to care.** (a) Managed care plans and county-based
 90.14 purchasing plans subject to this section must ensure access to medically necessary clinical
 90.15 care and to prosthetic and custom orthotic devices and technology from at least two distinct
 90.16 prosthetic and custom orthotic providers in the plan's provider network located in Minnesota.

90.17 (b) In the event that medically necessary covered orthotics and prosthetics are not
 90.18 available from an in-network provider, the plan must provide processes to refer an enrollee
 90.19 to an out-of-network provider and must fully reimburse the out-of-network provider at a
 90.20 mutually agreed upon rate less enrollee cost sharing determined on an in-network basis.

90.21 **EFFECTIVE DATE.** This section is effective January 1, 2025, or upon federal approval,
 90.22 whichever is later. The commissioner of human services shall notify the revisor of statutes
 90.23 when federal approval is obtained.

90.24 Sec. 66. Minnesota Statutes 2022, section 256B.69, subdivision 2, is amended to read:

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

90.27 (a) "Commissioner" means the commissioner of human services. For the remainder of
 90.28 this section, the commissioner's responsibilities for methods and policies for implementing
 90.29 the project will be proposed by the project advisory committees and approved by the
 90.30 commissioner.

90.31 (b) "Demonstration provider" means a nonprofit health maintenance organization,
 90.32 community integrated service network, or accountable provider network authorized and

91.1 operating under chapter 62D, 62N, or 62T that participates in the demonstration project
 91.2 according to criteria, standards, methods, and other requirements established for the project
 91.3 and approved by the commissioner. For purposes of this section, a county board, or group
 91.4 of county boards operating under a joint powers agreement, is considered a demonstration
 91.5 provider if the county or group of county boards meets the requirements of section 256B.692.

91.6 (c) "Eligible individuals" means those persons eligible for medical assistance benefits
 91.7 as defined in sections 256B.055, 256B.056, and 256B.06.

91.8 (d) "Limitation of choice" means suspending freedom of choice while allowing eligible
 91.9 individuals to choose among the demonstration providers.

91.10 **EFFECTIVE DATE.** This section is effective January 1, 2025.

91.11 Sec. 67. Minnesota Statutes 2022, section 256L.12, subdivision 7, is amended to read:

91.12 Subd. 7. **Managed care plan vendor requirements.** (a) The following requirements
 91.13 apply to all counties or vendors who contract with the Department of Human Services to
 91.14 serve MinnesotaCare recipients. Managed care plan contractors:

91.15 (1) shall authorize and arrange for the provision of the full range of services listed in
 91.16 section 256L.03 in order to ensure appropriate health care is delivered to enrollees;

91.17 (2) shall accept the prospective, per capita payment or other contractually defined payment
 91.18 from the commissioner in return for the provision and coordination of covered health care
 91.19 services for eligible individuals enrolled in the program;

91.20 (3) may contract with other health care and social service practitioners to provide services
 91.21 to enrollees;

91.22 (4) shall provide for an enrollee grievance process as required by the commissioner and
 91.23 set forth in the contract with the department;

91.24 (5) shall retain all revenue from enrollee co-payments;

91.25 (6) shall accept all eligible MinnesotaCare enrollees, without regard to health status or
 91.26 previous utilization of health services;

91.27 (7) shall demonstrate capacity to accept financial risk according to requirements specified
 91.28 in the contract with the department. A health maintenance organization licensed under
 91.29 chapter 62D, or a nonprofit health plan licensed under chapter 62C, is not required to
 91.30 demonstrate financial risk capacity, beyond that which is required to comply with chapters
 91.31 62C and 62D; and

92.1 (8) shall submit information as required by the commissioner, including data required
92.2 for assessing enrollee satisfaction, quality of care, cost, and utilization of services.

92.3 (b) A health maintenance organization must be a nonprofit corporation organized under
92.4 chapter 317A to serve as a managed care contractor under this section and section 256L.121.

92.5 **EFFECTIVE DATE.** This section is effective January 1, 2025.

92.6 Sec. 68. Minnesota Statutes 2022, section 317A.811, subdivision 1, is amended to read:

92.7 Subdivision 1. **When required.** (a) Except as provided in subdivision 6, the following
92.8 corporations shall notify the attorney general of their intent to dissolve, merge, consolidate,
92.9 or convert, or to transfer all or substantially all of their assets:

92.10 (1) a corporation that holds assets for a charitable purpose as defined in section 501B.35,
92.11 subdivision 2; ~~or~~

92.12 (2) a corporation that is exempt under section 501(c)(3) of the Internal Revenue Code
92.13 of 1986, or any successor section; or

92.14 (3) effective July 1, 2025, a nonprofit health coverage entity as defined in section
92.15 145D.30.

92.16 (b) The notice must include:

92.17 (1) the purpose of the corporation that is giving the notice;

92.18 (2) a list of assets owned or held by the corporation for charitable purposes;

92.19 (3) a description of restricted assets and purposes for which the assets were received;

92.20 (4) a description of debts, obligations, and liabilities of the corporation;

92.21 (5) a description of tangible assets being converted to cash and the manner in which
92.22 they will be sold;

92.23 (6) anticipated expenses of the transaction, including attorney fees;

92.24 (7) a list of persons to whom assets will be transferred, if known, or the name of the
92.25 converted organization;

92.26 (8) the purposes of persons receiving the assets or of the converted organization; and

92.27 (9) the terms, conditions, or restrictions, if any, to be imposed on the transferred or
92.28 converted assets.

92.29 The notice must be signed on behalf of the corporation by an authorized person.

93.1 Sec. 69. **SUPERSEDING EFFECT.**

93.2 Minnesota Statutes, section 62Q.679, in this article shall supersede Minnesota Statutes,
 93.3 section 62Q.679, in 2024 S.F. No. 4097, article 1, section 8, if enacted.

93.4 Sec. 70. **INITIAL REPORTS TO COMMISSIONER OF HEALTH; PRIOR**
 93.5 **AUTHORIZATIONS.**

93.6 Utilization review organizations must submit initial reports to the commissioner of health
 93.7 under Minnesota Statutes, section 62M.19, by September 1, 2025.

93.8 Sec. 71. **REPEALER.**

93.9 (a) Minnesota Statutes 2022, section 62A.041, subdivision 3, is repealed.

93.10 (b) Minnesota Statutes 2023 Supplement, section 62Q.522, subdivisions 3 and 4, are
 93.11 repealed.

93.12 **EFFECTIVE DATE.** This section is effective January 1, 2025, and applies to health
 93.13 plans offered, sold, issued, or renewed on or after that date.

93.14 **ARTICLE 5**93.15 **DEPARTMENT OF HEALTH FINANCE**

93.16 Section 1. Minnesota Statutes 2022, section 103I.621, subdivision 1, is amended to read:

93.17 Subdivision 1. **Permit.** (a) Notwithstanding any department or agency rule to the contrary,
 93.18 the commissioner shall issue, on request by the owner of the property and payment of the
 93.19 permit fee, permits for the reinjection of water by a properly constructed well into the same
 93.20 aquifer from which the water was drawn for the operation of a groundwater thermal exchange
 93.21 device.

93.22 (b) As a condition of the permit, an applicant must agree to allow inspection by the
 93.23 commissioner during regular working hours for department inspectors.

93.24 (c) Not more than 200 permits may be issued for small systems having maximum
 93.25 capacities of 20 gallons per minute or less and that are compliant with the natural resource
 93.26 water-use requirements under subdivision 2. ~~The small systems are subject to inspection~~
 93.27 ~~twice a year.~~

93.28 (d) Not more than ~~ten~~ 100 permits may be issued for larger systems having maximum
 93.29 capacities ~~from over 20 to 50~~ over 20 to 50 gallons per minute and that are compliant with the natural

94.1 resource water-use requirements under subdivision 2. The larger systems are subject to
 94.2 inspection four times a year.

94.3 (e) A person issued a permit must comply with this section and permit conditions deemed
 94.4 necessary to protect public health and safety of the groundwater for the permit to be valid.

94.5 The permit conditions may include but are not limited to requirements for:

94.6 (1) notification to the commissioner at intervals specified in the permit conditions;

94.7 (2) system operation and maintenance;

94.8 (3) system location and construction;

94.9 (4) well location and construction;

94.10 (5) signage;

94.11 (6) reports of system construction, performance, operation, and maintenance;

94.12 (7) removal of the system upon termination of its use or system failure;

94.13 (8) disclosure of the system at the time of property transfer;

94.14 (9) obtaining approval from the commissioner prior to deviation from the approval plan

94.15 and conditions;

94.16 (10) groundwater level monitoring; and

94.17 (11) groundwater quality monitoring.

94.18 (f) The property owner or the property owner's agent must submit to the commissioner
 94.19 a permit application on a form provided by the commissioner, or in a format approved by
 94.20 the commissioner, that provides any information necessary to protect public health and
 94.21 safety of the groundwater.

94.22 (g) A permit granted under this section is not valid if a water-use permit is required for
 94.23 the project and is not approved by the commissioner of natural resources.

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

94.25 Sec. 2. Minnesota Statutes 2022, section 103I.621, subdivision 2, is amended to read:

94.26 Subd. 2. **Water-use requirements apply.** Water-use permit requirements and penalties
 94.27 under chapter ~~103F~~ 103G and related rules adopted and enforced by the commissioner of
 94.28 natural resources apply to groundwater thermal exchange permit recipients. A person who
 94.29 violates a provision of this section is subject to enforcement or penalties for the noncomplying
 94.30 activity that are available to the commissioner and the Pollution Control Agency.

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

95.2 Sec. 3. Minnesota Statutes 2023 Supplement, section 144.1501, subdivision 2, is amended
95.3 to read:

95.4 Subd. 2. ~~Creation of account~~ **Availability.** (a) ~~A health professional education loan~~
95.5 ~~forgiveness program account is established.~~ The commissioner of health shall use money
95.6 ~~from the account to establish a~~ appropriated for health professional education loan forgiveness
95.7 program in this section:

95.8 (1) for medical residents, physicians, mental health professionals, and alcohol and drug
95.9 counselors agreeing to practice in designated rural areas or underserved urban communities
95.10 or specializing in the area of pediatric psychiatry;

95.11 (2) for midlevel practitioners agreeing to practice in designated rural areas or to teach
95.12 at least 12 credit hours, or 720 hours per year in the nursing field in a postsecondary program
95.13 at the undergraduate level or the equivalent at the graduate level;

95.14 (3) for nurses who agree to practice in a Minnesota nursing home; in an intermediate
95.15 care facility for persons with developmental disability; in a hospital if the hospital owns
95.16 and operates a Minnesota nursing home and a minimum of 50 percent of the hours worked
95.17 by the nurse is in the nursing home; in an assisted living facility as defined in section
95.18 144G.08, subdivision 7; or for a home care provider as defined in section 144A.43,
95.19 subdivision 4; or agree to teach at least 12 credit hours, or 720 hours per year in the nursing
95.20 field in a postsecondary program at the undergraduate level or the equivalent at the graduate
95.21 level;

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

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

95.30 (6) for dentists agreeing to deliver at least 25 percent of the dentist's yearly patient
95.31 encounters to state public program enrollees or patients receiving sliding fee schedule
95.32 discounts through a formal sliding fee schedule meeting the standards established by the

96.1 United States Department of Health and Human Services under Code of Federal Regulations,
96.2 title 42, section ~~51, chapter 303~~ 51c.303; and

96.3 (7) for nurses employed as a hospital nurse by a nonprofit hospital and providing direct
96.4 care to patients at the nonprofit hospital.

96.5 (b) Appropriations made ~~to the account~~ for health professional education loan forgiveness
96.6 in this section do not cancel and are available until expended, except that at the end of each
96.7 biennium, any remaining balance in the account that is not committed by contract and not
96.8 needed to fulfill existing commitments shall cancel to the fund.

96.9 Sec. 4. Minnesota Statutes 2022, section 144.1501, subdivision 5, is amended to read:

96.10 Subd. 5. **Penalty for nonfulfillment.** If a participant does not fulfill the required
96.11 minimum commitment of service according to subdivision 3, the commissioner of health
96.12 shall collect from the participant the total amount paid to the participant under the loan
96.13 forgiveness program plus interest at a rate established according to section 270C.40. The
96.14 commissioner shall deposit the money collected in ~~the health care access fund to be credited~~
96.15 ~~to a dedicated account in the special revenue fund. The balance of the account is appropriated~~
96.16 annually to the commissioner for the health professional education loan forgiveness program
96.17 ~~account~~ established in subdivision 2. The commissioner shall allow waivers of all or part
96.18 of the money owed the commissioner as a result of a nonfulfillment penalty if emergency
96.19 circumstances prevented fulfillment of the minimum service commitment.

96.20 Sec. 5. Minnesota Statutes 2022, section 144.555, subdivision 1a, is amended to read:

96.21 Subd. 1a. **Notice of closing, curtailing operations, relocating services, or ceasing to**
96.22 **offer certain services; hospitals.** (a) The controlling persons of a hospital licensed under
96.23 sections 144.50 to 144.56 or a hospital campus must notify the commissioner of health ~~and~~
96.24 the public, and others at least ~~120~~ 182 days before the hospital or hospital campus voluntarily
96.25 plans to implement one of the following scheduled actions listed in paragraph (b), unless
96.26 the controlling persons can demonstrate to the commissioner that meeting the advanced
96.27 notice requirement is not feasible and the commissioner approves a shorter advanced notice.

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

96.29 (1) ~~cease~~ ceasing operations;

96.30 (2) ~~curtail~~ curtailing operations to the extent that patients must be relocated;

96.31 (3) ~~relocate~~ relocating the provision of health services to another hospital or another
96.32 hospital campus; or

97.1 (4) ~~cease offering~~ ceasing to offer maternity care and newborn care services, intensive
 97.2 care unit services, inpatient mental health services, or inpatient substance use disorder
 97.3 treatment services.

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

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

97.8 Sec. 6. Minnesota Statutes 2022, section 144.555, subdivision 1b, is amended to read:

97.9 Subd. 1b. **Public hearing.** Within ~~45~~ 30 days after receiving notice under subdivision
 97.10 1a, the commissioner shall conduct a public hearing on the scheduled cessation of operations,
 97.11 curtailment of operations, relocation of health services, or cessation in offering health
 97.12 services. The commissioner must provide adequate public notice of the hearing in a time
 97.13 and manner determined by the commissioner. The controlling persons of the hospital or
 97.14 hospital campus must participate in the public hearing. The public hearing must be held at
 97.15 a location that is within ten miles of the hospital or hospital campus or with the
 97.16 commissioner's approval as close as is practicable, and that is provided or arranged by the
 97.17 hospital or hospital campus. Video conferencing technology must be used to allow members
 97.18 of the public to view and participate in the hearing. The public hearing must include:

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

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

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

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

98.1 Sec. 7. Minnesota Statutes 2022, section 144.555, is amended by adding a subdivision to
98.2 read:

98.3 Subd. 1d. **Methods of providing notice; content of notice.** (a) A notice required under
98.4 subdivision 1a must be provided to patients, hospital personnel, the public, local units of
98.5 government, and the commissioner of health using at least the following methods:

98.6 (1) posting a notice of the proposed cessation of operations, curtailment, relocation of
98.7 health services, or cessation in offering health services at the main public entrance of the
98.8 hospital or hospital campus;

98.9 (2) providing written notice to the commissioner of health, to the city council in the city
98.10 where the hospital or hospital campus is located, and to the county board in the county
98.11 where the hospital or hospital campus is located;

98.12 (3) providing written notice to the local health department as defined in section 145A.02,
98.13 subdivision 8b, for the community where the hospital or hospital campus is located;

98.14 (4) providing notice to the public through a written public announcement which must
98.15 be distributed to local media outlets;

98.16 (5) providing written notice to existing patients of the hospital or hospital campus; and

98.17 (6) notifying all personnel currently employed in the unit, hospital, or hospital campus
98.18 impacted by the proposed cessation, curtailment, or relocation.

98.19 (b) A notice required under subdivision 1a must include:

98.20 (1) a description of the proposed cessation of operations, curtailment, relocation of health
98.21 services, or cessation in offering health services. The description must include:

98.22 (i) the number of beds, if any, that will be eliminated, repurposed, reassigned, or otherwise
98.23 reconfigured to serve populations or patients other than those currently served;

98.24 (ii) the current number of beds in the impacted unit, hospital, or hospital campus, and
98.25 the number of beds in the impacted unit, hospital, or hospital campus after the proposed
98.26 cessation, curtailment, or relocation takes place;

98.27 (iii) the number of existing patients who will be impacted by the proposed cessation,
98.28 curtailment, or relocation;

98.29 (iv) any decrease in personnel, or relocation of personnel to a different unit, hospital, or
98.30 hospital campus, caused by the proposed cessation, curtailment, or relocation;

99.1 (v) a description of the health services provided by the unit, hospital, or hospital campus
 99.2 impacted by the proposed cessation, curtailment, or relocation; and

99.3 (vi) identification of the three nearest available health care facilities where patients may
 99.4 obtain the health services provided by the unit, hospital, or hospital campus impacted by
 99.5 the proposed cessation, curtailment, or relocation, and any potential barriers to seamlessly
 99.6 transition patients to receive services at one of these facilities. If the unit, hospital, or hospital
 99.7 campus impacted by the proposed cessation, curtailment, or relocation serves medical
 99.8 assistance or Medicare enrollees, the information required under this item must specify
 99.9 whether any of the three nearest available facilities serves medical assistance or Medicare
 99.10 enrollees; and

99.11 (2) a telephone number, email address, and address for each of the following, to which
 99.12 interested parties may offer comments on the proposed cessation, curtailment, or relocation:

99.13 (i) the hospital or hospital campus; and

99.14 (ii) the parent entity, if any, or the entity under contract, if any, that acts as the corporate
 99.15 administrator of the hospital or hospital campus.

99.16 Sec. 8. Minnesota Statutes 2022, section 144.555, subdivision 2, is amended to read:

99.17 Subd. 2. **Penalty; facilities other than hospitals.** Failure to notify the commissioner
 99.18 under subdivision 1, ~~1a, or 1c or failure to participate in a public hearing under subdivision~~
 99.19 ~~1b~~ may result in issuance of a correction order under section 144.653, subdivision 5.

99.20 Sec. 9. Minnesota Statutes 2022, section 144.555, is amended by adding a subdivision to
 99.21 read:

99.22 Subd. 3. **Penalties; hospitals.** (a) Failure to participate in a public hearing under
 99.23 subdivision 1b or failure to notify the commissioner under subdivision 1c may result in
 99.24 issuance of a correction order under section 144.653, subdivision 5.

99.25 (b) Notwithstanding any law to the contrary, the commissioner must impose on the
 99.26 controlling persons of a hospital or hospital campus a fine of \$20,000 for each failure to
 99.27 provide notice to an individual or entity or at a location required under subdivision 1d,
 99.28 paragraph (a). The cumulative fines imposed under this paragraph must not exceed \$60,000
 99.29 for any scheduled action requiring notice under subdivision 1a. The commissioner is not
 99.30 required to issue a correction order before imposing a fine under this paragraph. Section
 99.31 144.653, subdivision 8, applies to fines imposed under this paragraph.

100.1 Sec. 10. [144.556] RIGHT OF FIRST REFUSAL; SALE OF HOSPITAL OR
100.2 HOSPITAL CAMPUS.

100.3 (a) The controlling persons of a hospital licensed under sections 144.50 to 144.56 or a
100.4 hospital campus must not sell or convey the hospital or hospital campus, offer to sell or
100.5 convey the hospital or hospital campus to a person other than a local unit of government
100.6 listed in this paragraph, or voluntarily cease operations of the hospital or hospital campus
100.7 unless the controlling persons have first made a good faith offer to sell or convey the hospital
100.8 or hospital campus to the home rule charter or statutory city, county, town, or hospital
100.9 district in which the hospital or hospital campus is located.

100.10 (b) The offer to sell or convey the hospital or hospital campus to a local unit of
100.11 government under paragraph (a) must be at a price that does not exceed the current fair
100.12 market value of the hospital or hospital campus. A party to whom an offer is made under
100.13 paragraph (a) must accept or decline the offer within 60 days of receipt. If the party to whom
100.14 the offer is made fails to respond within 60 days of receipt, the offer is deemed declined.

100.15 Sec. 11. Minnesota Statutes 2022, section 144A.61, subdivision 3a, is amended to read:

100.16 Subd. 3a. **Competency evaluation program.** (a) The commissioner of health shall
100.17 approve the competency evaluation program.

100.18 (b) A competency evaluation must be administered to persons who desire to be listed
100.19 in the nursing assistant registry. The tests may only be administered by technical colleges,
100.20 community colleges, or other organizations approved by the ~~Department of Health~~
100.21 commissioner of health. The commissioner must ensure any written portions of the
100.22 competency evaluation are available in languages other than English that are commonly
100.23 spoken by persons who desire to be listed in the nursing assistant registry. The commissioner
100.24 may consult with the state demographer or the commissioner of employment and economic
100.25 development when identifying languages that are commonly spoken by persons who desire
100.26 to be listed in the nursing assistant registry.

100.27 (c) The commissioner of health shall approve a nursing assistant for the registry without
100.28 requiring a competency evaluation if the nursing assistant is in good standing on a nursing
100.29 assistant registry in another state.

100.30 **EFFECTIVE DATE.** This section is effective January 1, 2025.

101.1 Sec. 12. Minnesota Statutes 2022, section 144A.70, subdivision 3, is amended to read:

101.2 Subd. 3. **Controlling person.** "Controlling person" means a business entity or entities,
101.3 officer, program administrator, or director, whose responsibilities include ~~the direction of~~
101.4 ~~the management or policies of a supplemental nursing services agency~~ the management and
101.5 decision-making authority to establish or control business policy and all other policies of a
101.6 supplemental nursing services agency. Controlling person also means an individual who,
101.7 directly or indirectly, beneficially owns an interest in a corporation, partnership, or other
101.8 business association that is a controlling person.

101.9 Sec. 13. Minnesota Statutes 2022, section 144A.70, subdivision 5, is amended to read:

101.10 Subd. 5. **Person.** "Person" includes an individual, ~~firm,~~ corporation, partnership, limited
101.11 liability company, or association.

101.12 Sec. 14. Minnesota Statutes 2022, section 144A.70, subdivision 6, is amended to read:

101.13 Subd. 6. **Supplemental nursing services agency.** "Supplemental nursing services
101.14 agency" means a person, ~~firm,~~ corporation, partnership, limited liability company, or
101.15 association engaged for hire in the business of providing or procuring temporary employment
101.16 in health care facilities for nurses, nursing assistants, nurse aides, and orderlies. Supplemental
101.17 nursing services agency does not include an individual who only engages in providing the
101.18 individual's services on a temporary basis to health care facilities. Supplemental nursing
101.19 services agency does not include a professional home care agency licensed under section
101.20 144A.471 that only provides staff to other home care providers.

101.21 Sec. 15. Minnesota Statutes 2022, section 144A.70, subdivision 7, is amended to read:

101.22 Subd. 7. **Oversight.** The commissioner is responsible for the oversight of supplemental
101.23 nursing services agencies through ~~annual~~ semiannual unannounced surveys and follow-up
101.24 surveys, complaint investigations under sections 144A.51 to 144A.53, and other actions
101.25 necessary to ensure compliance with sections 144A.70 to 144A.74.

101.26 Sec. 16. Minnesota Statutes 2022, section 144A.71, subdivision 2, is amended to read:

101.27 Subd. 2. **Application information and fee.** The commissioner shall establish forms and
101.28 procedures for processing each supplemental nursing services agency registration application.
101.29 An application for a supplemental nursing services agency registration must include at least
101.30 the following:

102.1 (1) the names and addresses of ~~the owner or owners~~ all owners and controlling persons
102.2 of the supplemental nursing services agency;

102.3 (2) if the owner is a corporation, copies of its articles of incorporation and current bylaws,
102.4 together with the names and addresses of its officers and directors;

102.5 (3) ~~satisfactory proof of compliance with section 144A.72, subdivision 1, clauses (5) to~~
102.6 ~~(7)~~ if the owner is a limited liability company, copies of its articles of organization and
102.7 operating agreement, together with the names and addresses of its officers and directors;

102.8 (4) documentation that the supplemental nursing services agency has medical malpractice
102.9 insurance to insure against the loss, damage, or expense of a claim arising out of the death
102.10 or injury of any person as the result of negligence or malpractice in the provision of health
102.11 care services by the supplemental nursing services agency or by any employee of the agency;

102.12 (5) documentation that the supplemental nursing services agency has an employee
102.13 dishonesty bond in the amount of \$10,000;

102.14 (6) documentation that the supplemental nursing services agency has insurance coverage
102.15 for workers' compensation for all nurses, nursing assistants, nurse aides, and orderlies
102.16 provided or procured by the agency;

102.17 (7) documentation that the supplemental nursing services agency filed with the
102.18 commissioner of revenue: (i) the name and address of the bank, savings bank, or savings
102.19 association in which the supplemental nursing services agency deposits all employee income
102.20 tax withholdings; and (ii) the name and address of any nurse, nursing assistant, nurse aide,
102.21 or orderly whose income is derived from placement by the agency, if the agency purports
102.22 the income is not subject to withholding;

102.23 ~~(4)~~ (8) any other relevant information that the commissioner determines is necessary to
102.24 properly evaluate an application for registration;

102.25 ~~(5)~~ (9) a policy and procedure that describes how the supplemental nursing services
102.26 agency's records will be immediately available at all times to the commissioner and facility;
102.27 and

102.28 ~~(6)~~ (10) a nonrefundable registration fee of \$2,035.

102.29 If a supplemental nursing services agency fails to provide the items in this subdivision
102.30 to the department, the commissioner shall immediately suspend or refuse to issue the
102.31 supplemental nursing services agency registration. The supplemental nursing services agency
102.32 may appeal the commissioner's findings according to section 144A.475, subdivisions 3a

103.1 and 7, except that the hearing must be conducted by an administrative law judge within 60
103.2 calendar days of the request for hearing assignment.

103.3 Sec. 17. Minnesota Statutes 2022, section 144A.71, is amended by adding a subdivision
103.4 to read:

103.5 Subd. 2a. **Renewal applications.** An applicant for registration renewal must complete
103.6 the registration application form supplied by the department. An application must be
103.7 submitted at least 60 days before the expiration of the current registration.

103.8 Sec. 18. **[144A.715] PENALTIES.**

103.9 Subdivision 1. **Authority.** The fines imposed under this section are in accordance with
103.10 section 144.653, subdivision 6.

103.11 Subd. 2. **Fines.** Each violation of sections 144A.70 to 144A.74, not corrected at the time
103.12 of a follow-up survey, is subject to a fine. A fine must be assessed according to the schedules
103.13 established in the sections violated.

103.14 Subd. 3. **Failure to correct.** If, upon a subsequent follow-up survey after a fine has been
103.15 imposed under subdivision 2, a violation is still not corrected, another fine shall be assessed.
103.16 The fine shall be double the amount of the previous fine.

103.17 Subd. 4. **Payment of fines.** Payment of fines is due 15 business days from the registrant's
103.18 receipt of notice of the fine from the department.

103.19 Sec. 19. Minnesota Statutes 2022, section 144A.72, subdivision 1, is amended to read:

103.20 Subdivision 1. **Minimum criteria.** (a) The commissioner shall require that, as a condition
103.21 of registration:

103.22 (1) all owners and controlling persons must complete a background study under section
103.23 144.057 and receive a clearance or set aside of any disqualification;

103.24 ~~(1)~~ (2) the supplemental nursing services agency shall document that each temporary
103.25 employee provided to health care facilities currently meets the minimum licensing, training,
103.26 and continuing education standards for the position in which the employee will be working
103.27 and verifies competency for the position. A supplemental nursing services agency that
103.28 violates this clause may be subject to a fine of \$3,000;

103.29 ~~(2)~~ (3) the supplemental nursing services agency shall comply with all pertinent
103.30 requirements relating to the health and other qualifications of personnel employed in health
103.31 care facilities;

104.1 ~~(3)~~ (4) the supplemental nursing services agency must not restrict in any manner the
104.2 employment opportunities of its employees; A supplemental nursing services agency that
104.3 violates this clause may be subject to a fine of \$3,000;

104.4 ~~(4)~~ the supplemental nursing services agency shall carry medical malpractice insurance
104.5 to insure against the loss, damage, or expense incident to a claim arising out of the death
104.6 or injury of any person as the result of negligence or malpractice in the provision of health
104.7 care services by the supplemental nursing services agency or by any employee of the agency;

104.8 ~~(5)~~ the supplemental nursing services agency shall carry an employee dishonesty bond
104.9 in the amount of \$10,000;

104.10 ~~(6)~~ the supplemental nursing services agency shall maintain insurance coverage for
104.11 workers' compensation for all nurses, nursing assistants, nurse aides, and orderlies provided
104.12 or procured by the agency;

104.13 ~~(7)~~ the supplemental nursing services agency shall file with the commissioner of revenue:
104.14 ~~(i)~~ the name and address of the bank, savings bank, or savings association in which the
104.15 supplemental nursing services agency deposits all employee income tax withholdings; and
104.16 ~~(ii)~~ the name and address of any nurse, nursing assistant, nurse aide, or orderly whose income
104.17 is derived from placement by the agency, if the agency purports the income is not subject
104.18 to withholding;

104.19 ~~(8)~~ (5) the supplemental nursing services agency must not, in any contract with any
104.20 employee or health care facility, require the payment of liquidated damages, employment
104.21 fees, or other compensation should the employee be hired as a permanent employee of a
104.22 health care facility; A supplemental nursing services agency that violates this clause may
104.23 be subject to a fine of \$3,000;

104.24 ~~(9)~~ (6) the supplemental nursing services agency shall document that each temporary
104.25 employee provided to health care facilities is an employee of the agency and is not an
104.26 independent contractor; and

104.27 ~~(10)~~ (7) the supplemental nursing services agency shall retain all records for five calendar
104.28 years. All records of the supplemental nursing services agency must be immediately available
104.29 to the department.

104.30 (b) In order to retain registration, the supplemental nursing services agency must provide
104.31 services to a health care facility during the year in Minnesota within the past 12 months
104.32 preceding the supplemental nursing services agency's registration renewal date.

105.1 Sec. 20. Minnesota Statutes 2022, section 144A.73, is amended to read:

105.2 **144A.73 COMPLAINT SYSTEM.**

105.3 The commissioner shall establish a system for reporting complaints against a supplemental
105.4 nursing services agency or its employees. Complaints may be made by any member of the
105.5 public. Complaints against a supplemental nursing services agency shall be investigated by
105.6 the ~~Office of Health Facility Complaints~~ commissioner of health under sections 144A.51
105.7 to 144A.53.

105.8 Sec. 21. Minnesota Statutes 2022, section 149A.02, subdivision 3, is amended to read:

105.9 Subd. 3. **Arrangements for disposition.** "Arrangements for disposition" means any
105.10 action normally taken by a funeral provider in anticipation of or preparation for the
105.11 entombment, burial in a cemetery, alkaline hydrolysis, ~~or cremation,~~ or, effective July 1,
105.12 2025, natural organic reduction of a dead human body.

105.13 Sec. 22. Minnesota Statutes 2022, section 149A.02, subdivision 16, is amended to read:

105.14 Subd. 16. **Final disposition.** "Final disposition" means the acts leading to and the
105.15 entombment, burial in a cemetery, alkaline hydrolysis, ~~or cremation,~~ or, effective July 1,
105.16 2025, natural organic reduction of a dead human body.

105.17 Sec. 23. Minnesota Statutes 2022, section 149A.02, subdivision 26a, is amended to read:

105.18 Subd. 26a. **Inurnment.** "Inurnment" means placing hydrolyzed or cremated remains in
105.19 a hydrolyzed or cremated remains container suitable for placement, burial, or shipment.
105.20 Effective July 1, 2025, inurnment also includes placing naturally reduced remains in a
105.21 naturally reduced remains container suitable for placement, burial, or shipment.

105.22 Sec. 24. Minnesota Statutes 2022, section 149A.02, subdivision 27, is amended to read:

105.23 Subd. 27. **Licensee.** "Licensee" means any person or entity that has been issued a license
105.24 to practice mortuary science, to operate a funeral establishment, to operate an alkaline
105.25 hydrolysis facility, ~~or to operate a crematory,~~ or, effective July 1, 2025, to operate a natural
105.26 organic reduction facility by the Minnesota commissioner of health.

106.1 Sec. 25. Minnesota Statutes 2022, section 149A.02, is amended by adding a subdivision
106.2 to read:

106.3 Subd. 30b. **Natural organic reduction or naturally reduce.** "Natural organic reduction"
106.4 or "naturally reduce" means the contained, accelerated conversion of a dead human body
106.5 to soil. This subdivision is effective July 1, 2025.

106.6 Sec. 26. Minnesota Statutes 2022, section 149A.02, is amended by adding a subdivision
106.7 to read:

106.8 Subd. 30c. **Natural organic reduction facility.** "Natural organic reduction facility"
106.9 means a structure, room, or other space in a building or real property where natural organic
106.10 reduction of a dead human body occurs. This subdivision is effective July 1, 2025.

106.11 Sec. 27. Minnesota Statutes 2022, section 149A.02, is amended by adding a subdivision
106.12 to read:

106.13 Subd. 30d. **Natural organic reduction vessel.** "Natural organic reduction vessel" means
106.14 the enclosed container in which natural organic reduction takes place. This subdivision is
106.15 effective July 1, 2025.

106.16 Sec. 28. Minnesota Statutes 2022, section 149A.02, is amended by adding a subdivision
106.17 to read:

106.18 Subd. 30e. **Naturally reduced remains.** "Naturally reduced remains" means the soil
106.19 remains following the natural organic reduction of a dead human body and the accompanying
106.20 plant material. This subdivision is effective July 1, 2025.

106.21 Sec. 29. Minnesota Statutes 2022, section 149A.02, is amended by adding a subdivision
106.22 to read:

106.23 Subd. 30f. **Naturally reduced remains container.** "Naturally reduced remains container"
106.24 means a receptacle in which naturally reduced remains are placed. This subdivision is
106.25 effective July 1, 2025.

106.26 Sec. 30. Minnesota Statutes 2022, section 149A.02, subdivision 35, is amended to read:

106.27 Subd. 35. **Processing.** "Processing" means the removal of foreign objects, drying or
106.28 cooling, and the reduction of the hydrolyzed ~~or~~ remains, cremated remains, or, effective
106.29 July 1, 2025, naturally reduced remains by mechanical means including, but not limited to,

107.1 grinding, crushing, or pulverizing, to a granulated appearance appropriate for final disposition
107.2 or the final reduction to naturally reduced remains.

107.3 Sec. 31. Minnesota Statutes 2022, section 149A.02, subdivision 37c, is amended to read:

107.4 Subd. 37c. **Scattering.** "Scattering" means the authorized dispersal of hydrolyzed ~~or~~
107.5 remains, cremated remains, or, effective July 1, 2025, naturally reduced remains in a defined
107.6 area of a dedicated cemetery or in areas where no local prohibition exists provided that the
107.7 hydrolyzed ~~or~~, cremated, or naturally reduced remains are not distinguishable to the public,
107.8 are not in a container, and that the person who has control over disposition of the hydrolyzed
107.9 ~~or~~, cremated, or naturally reduced remains has obtained written permission of the property
107.10 owner or governing agency to scatter on the property.

107.11 Sec. 32. Minnesota Statutes 2022, section 149A.03, is amended to read:

107.12 **149A.03 DUTIES OF COMMISSIONER.**

107.13 The commissioner shall:

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

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

107.17 (ii) licensure and professional conduct of funeral directors, morticians, interns, practicum
107.18 students, and clinical students;

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

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

107.21 (v) licensing and operation of a crematory; and

107.22 (vi) effective July 1, 2025, licensing and operation of a natural organic reduction facility;

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

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

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

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

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

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

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

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

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

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

108.14 Sec. 33. **[149A.56] LICENSE TO OPERATE A NATURAL ORGANIC REDUCTION**
108.15 **FACILITY.**

108.16 Subdivision 1. License requirement. This section is effective July 1, 2025. Except as
108.17 provided in section 149A.01, subdivision 3, no person shall maintain, manage, or operate
108.18 a place or premises devoted to or used in the holding and natural organic reduction of a
108.19 dead human body without possessing a valid license to operate a natural organic reduction
108.20 facility issued by the commissioner of health.

108.21 Subd. 2. Requirements for natural organic reduction facility. (a) A natural organic
108.22 reduction facility licensed under this section must consist of:

108.23 (1) a building or structure that complies with applicable local and state building codes,
108.24 zoning laws and ordinances, and environmental standards, and that contains one or more
108.25 natural organic reduction vessels for the natural organic reduction of dead human bodies;

108.26 (2) a motorized mechanical device for processing the remains in natural reduction; and

108.27 (3) an appropriate refrigerated holding facility for dead human bodies awaiting natural
108.28 organic reduction.

108.29 (b) A natural organic reduction facility licensed under this section may also contain a
108.30 display room for funeral goods.

109.1 Subd. 3. **Application procedure; documentation; initial inspection.** (a) An applicant
109.2 for a license to operate a natural organic reduction facility shall submit a completed
109.3 application to the commissioner. A completed application includes:

109.4 (1) a completed application form, as provided by the commissioner;

109.5 (2) proof of business form and ownership; and

109.6 (3) proof of liability insurance coverage or other financial documentation, as determined
109.7 by the commissioner, that demonstrates the applicant's ability to respond in damages for
109.8 liability arising from the ownership, maintenance, management, or operation of a natural
109.9 organic reduction facility.

109.10 (b) Upon receipt of the application and appropriate fee, the commissioner shall review
109.11 and verify all information. Upon completion of the verification process and resolution of
109.12 any deficiencies in the application information, the commissioner shall conduct an initial
109.13 inspection of the premises to be licensed. After the inspection and resolution of any
109.14 deficiencies found and any reinspections as may be necessary, the commissioner shall make
109.15 a determination, based on all the information available, to grant or deny licensure. If the
109.16 commissioner's determination is to grant the license, the applicant shall be notified and the
109.17 license shall issue and remain valid for a period prescribed on the license, but not to exceed
109.18 one calendar year from the date of issuance of the license. If the commissioner's determination
109.19 is to deny the license, the commissioner must notify the applicant, in writing, of the denial
109.20 and provide the specific reason for denial.

109.21 Subd. 4. **Nontransferability of license.** A license to operate a natural organic reduction
109.22 facility is not assignable or transferable and shall not be valid for any entity other than the
109.23 one named. Each license issued to operate a natural organic reduction facility is valid only
109.24 for the location identified on the license. A 50 percent or more change in ownership or
109.25 location of the natural organic reduction facility automatically terminates the license. Separate
109.26 licenses shall be required of two or more persons or other legal entities operating from the
109.27 same location.

109.28 Subd. 5. **Display of license.** Each license to operate a natural organic reduction facility
109.29 must be conspicuously displayed in the natural organic reduction facility at all times.
109.30 "Conspicuous display" means in a location where a member of the general public within
109.31 the natural organic reduction facility is able to observe and read the license.

109.32 Subd. 6. **Period of licensure.** All licenses to operate a natural organic reduction facility
109.33 issued by the commissioner are valid for a period of one calendar year beginning on July 1
109.34 and ending on June 30, regardless of the date of issuance.

110.1 Subd. 7. **Reporting changes in license information.** Any change of license information
110.2 must be reported to the commissioner, on forms provided by the commissioner, no later
110.3 than 30 calendar days after the change occurs. Failure to report changes is grounds for
110.4 disciplinary action.

110.5 Subd. 8. **Licensing information.** Section 13.41 applies to data collected and maintained
110.6 by the commissioner pursuant to this section.

110.7 Sec. 34. **[149A.57] RENEWAL OF LICENSE TO OPERATE A NATURAL**
110.8 **ORGANIC REDUCTION FACILITY.**

110.9 Subdivision 1. **Renewal required.** This section is effective July 1, 2025. All licenses
110.10 to operate a natural organic reduction facility issued by the commissioner expire on June
110.11 30 following the date of issuance of the license and must be renewed to remain valid.

110.12 Subd. 2. **Renewal procedure and documentation.** (a) Licensees who wish to renew
110.13 their licenses must submit to the commissioner a completed renewal application no later
110.14 than June 30 following the date the license was issued. A completed renewal application
110.15 includes:

110.16 (1) a completed renewal application form, as provided by the commissioner; and

110.17 (2) proof of liability insurance coverage or other financial documentation, as determined
110.18 by the commissioner, that demonstrates the applicant's ability to respond in damages for
110.19 liability arising from the ownership, maintenance, management, or operation of a natural
110.20 organic reduction facility.

110.21 (b) Upon receipt of the completed renewal application, the commissioner shall review
110.22 and verify the information. Upon completion of the verification process and resolution of
110.23 any deficiencies in the renewal application information, the commissioner shall make a
110.24 determination, based on all the information available, to reissue or refuse to reissue the
110.25 license. If the commissioner's determination is to reissue the license, the applicant shall be
110.26 notified and the license shall issue and remain valid for a period prescribed on the license,
110.27 but not to exceed one calendar year from the date of issuance of the license. If the
110.28 commissioner's determination is to refuse to reissue the license, section 149A.09, subdivision
110.29 2, applies.

110.30 Subd. 3. **Penalty for late filing.** Renewal applications received after the expiration date
110.31 of a license will result in the assessment of a late filing penalty. The late filing penalty must
110.32 be paid before the reissuance of the license and received by the commissioner no later than
110.33 31 calendar days after the expiration date of the license.

111.1 Subd. 4. **Lapse of license.** A license to operate a natural organic reduction facility shall
111.2 automatically lapse when a completed renewal application is not received by the
111.3 commissioner within 31 calendar days after the expiration date of a license, or a late filing
111.4 penalty assessed under subdivision 3 is not received by the commissioner within 31 calendar
111.5 days after the expiration of a license.

111.6 Subd. 5. **Effect of lapse of license.** Upon the lapse of a license, the person to whom the
111.7 license was issued is no longer licensed to operate a natural organic reduction facility in
111.8 Minnesota. The commissioner shall issue a cease and desist order to prevent the lapsed
111.9 license holder from operating a natural organic reduction facility in Minnesota and may
111.10 pursue any additional lawful remedies as justified by the case.

111.11 Subd. 6. **Restoration of lapsed license.** The commissioner may restore a lapsed license
111.12 upon receipt and review of a completed renewal application, receipt of the late filing penalty,
111.13 and reinspection of the premises, provided that the receipt is made within one calendar year
111.14 from the expiration date of the lapsed license and the cease and desist order issued by the
111.15 commissioner has not been violated. If a lapsed license is not restored within one calendar
111.16 year from the expiration date of the lapsed license, the holder of the lapsed license cannot
111.17 be relicensed until the requirements in section 149A.56 are met.

111.18 Subd. 7. **Reporting changes in license information.** Any change of license information
111.19 must be reported to the commissioner, on forms provided by the commissioner, no later
111.20 than 30 calendar days after the change occurs. Failure to report changes is grounds for
111.21 disciplinary action.

111.22 Subd. 8. **Licensing information.** Section 13.41 applies to data collected and maintained
111.23 by the commissioner pursuant to this section.

111.24 Sec. 35. Minnesota Statutes 2022, section 149A.65, is amended by adding a subdivision
111.25 to read:

111.26 Subd. 6a. **Natural organic reduction facilities.** This subdivision is effective July 1,
111.27 2025. The initial and renewal fee for a natural organic reduction facility is \$425. The late
111.28 fee charge for a license renewal is \$100.

111.29 Sec. 36. Minnesota Statutes 2022, section 149A.70, subdivision 1, is amended to read:

111.30 Subdivision 1. **Use of titles.** Only a person holding a valid license to practice mortuary
111.31 science issued by the commissioner may use the title of mortician, funeral director, or any
111.32 other title implying that the licensee is engaged in the business or practice of mortuary

112.1 science. Only the holder of a valid license to operate an alkaline hydrolysis facility issued
 112.2 by the commissioner may use the title of alkaline hydrolysis facility, water cremation,
 112.3 water-reduction, biocremation, green-cremation, resomation, dissolution, or any other title,
 112.4 word, or term implying that the licensee operates an alkaline hydrolysis facility. Only the
 112.5 holder of a valid license to operate a funeral establishment issued by the commissioner may
 112.6 use the title of funeral home, funeral chapel, funeral service, or any other title, word, or
 112.7 term implying that the licensee is engaged in the business or practice of mortuary science.
 112.8 Only the holder of a valid license to operate a crematory issued by the commissioner may
 112.9 use the title of crematory, crematorium, green-cremation, or any other title, word, or term
 112.10 implying that the licensee operates a crematory or crematorium. Effective July 1, 2025,
 112.11 only the holder of a valid license to operate a natural organic reduction facility issued by
 112.12 the commissioner may use the title of natural organic reduction facility, human composting,
 112.13 or any other title, word, or term implying that the licensee operates a natural organic reduction
 112.14 facility.

112.15 Sec. 37. Minnesota Statutes 2022, section 149A.70, subdivision 2, is amended to read:

112.16 Subd. 2. **Business location.** A funeral establishment, alkaline hydrolysis facility, ~~or~~
 112.17 crematory, or, effective July 1, 2025, natural organic reduction facility shall not do business
 112.18 in a location that is not licensed as a funeral establishment, alkaline hydrolysis facility, ~~or~~
 112.19 crematory, or natural organic reduction facility and shall not advertise a service that is
 112.20 available from an unlicensed location.

112.21 Sec. 38. Minnesota Statutes 2022, section 149A.70, subdivision 3, is amended to read:

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

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

112.28 (2) using any name other than the names under which the funeral establishment, alkaline
 112.29 hydrolysis facility, ~~or~~ crematory, or, effective July 1, 2025, natural organic reduction facility
 112.30 is known to or licensed by the commissioner;

112.31 (3) using a surname not directly, actively, or presently associated with a licensed funeral
 112.32 establishment, alkaline hydrolysis facility, ~~or~~ crematory, or, effective July 1, 2025, natural
 112.33 organic reduction facility, unless the surname had been previously and continuously used

113.1 by the licensed funeral establishment, alkaline hydrolysis facility, ~~or~~ crematory, or natural
113.2 organic reduction facility; and

113.3 (4) using a founding or establishing date or total years of service not directly or
113.4 continuously related to a name under which the funeral establishment, alkaline hydrolysis
113.5 facility, ~~or~~ crematory, or, effective July 1, 2025, natural organic reduction facility is currently
113.6 or was previously licensed.

113.7 Any advertising or other printed material that contains the names or pictures of persons
113.8 affiliated with a funeral establishment, alkaline hydrolysis facility, ~~or~~ crematory, or, effective
113.9 July 1, 2025, natural organic reduction facility shall state the position held by the persons
113.10 and shall identify each person who is licensed or unlicensed under this chapter.

113.11 Sec. 39. Minnesota Statutes 2022, section 149A.70, subdivision 5, is amended to read:

113.12 Subd. 5. **Reimbursement prohibited.** No licensee, clinical student, practicum student,
113.13 or intern shall offer, solicit, or accept a commission, fee, bonus, rebate, or other
113.14 reimbursement in consideration for recommending or causing a dead human body to be
113.15 disposed of by a specific body donation program, funeral establishment, alkaline hydrolysis
113.16 facility, crematory, mausoleum, ~~or~~ cemetery, or, effective July 1, 2025, natural organic
113.17 reduction facility.

113.18 Sec. 40. Minnesota Statutes 2022, section 149A.71, subdivision 2, is amended to read:

113.19 Subd. 2. **Preventive requirements.** (a) To prevent unfair or deceptive acts or practices,
113.20 the requirements of this subdivision must be met. This subdivision applies to natural organic
113.21 reduction and naturally reduced remains goods and services effective July 1, 2025.

113.22 (b) Funeral providers must tell persons who ask by telephone about the funeral provider's
113.23 offerings or prices any accurate information from the price lists described in paragraphs (c)
113.24 to (e) and any other readily available information that reasonably answers the questions
113.25 asked.

113.26 (c) Funeral providers must make available for viewing to people who inquire in person
113.27 about the offerings or prices of funeral goods or burial site goods, separate printed or
113.28 typewritten price lists using a ten-point font or larger. Each funeral provider must have a
113.29 separate price list for each of the following types of goods that are sold or offered for sale:

113.30 (1) caskets;

113.31 (2) alternative containers;

- 114.1 (3) outer burial containers;
- 114.2 (4) alkaline hydrolysis containers;
- 114.3 (5) cremation containers;
- 114.4 (6) hydrolyzed remains containers;
- 114.5 (7) cremated remains containers;
- 114.6 (8) markers; ~~and~~
- 114.7 (9) headstones; and
- 114.8 (10) naturally reduced remains containers.

114.9 (d) Each separate price list must contain the name of the funeral provider's place of
114.10 business, address, and telephone number and a caption describing the list as a price list for
114.11 one of the types of funeral goods or burial site goods described in paragraph (c), clauses
114.12 (1) to ~~(9)~~ (10). The funeral provider must offer the list upon beginning discussion of, but
114.13 in any event before showing, the specific funeral goods or burial site goods and must provide
114.14 a photocopy of the price list, for retention, if so asked by the consumer. The list must contain,
114.15 at least, the retail prices of all the specific funeral goods and burial site goods offered which
114.16 do not require special ordering, enough information to identify each, and the effective date
114.17 for the price list. However, funeral providers are not required to make a specific price list
114.18 available if the funeral providers place the information required by this paragraph on the
114.19 general price list described in paragraph (e).

114.20 (e) Funeral providers must give a printed price list, for retention, to persons who inquire
114.21 in person about the funeral goods, funeral services, burial site goods, or burial site services
114.22 or prices offered by the funeral provider. The funeral provider must give the list upon
114.23 beginning discussion of either the prices of or the overall type of funeral service or disposition
114.24 or specific funeral goods, funeral services, burial site goods, or burial site services offered
114.25 by the provider. This requirement applies whether the discussion takes place in the funeral
114.26 establishment or elsewhere. However, when the deceased is removed for transportation to
114.27 the funeral establishment, an in-person request for authorization to embalm does not, by
114.28 itself, trigger the requirement to offer the general price list. If the provider, in making an
114.29 in-person request for authorization to embalm, discloses that embalming is not required by
114.30 law except in certain special cases, the provider is not required to offer the general price
114.31 list. Any other discussion during that time about prices or the selection of funeral goods,
114.32 funeral services, burial site goods, or burial site services triggers the requirement to give

115.1 the consumer a general price list. The general price list must contain the following
115.2 information:

115.3 (1) the name, address, and telephone number of the funeral provider's place of business;

115.4 (2) a caption describing the list as a "general price list";

115.5 (3) the effective date for the price list;

115.6 (4) the retail prices, in any order, expressed either as a flat fee or as the prices per hour,
115.7 mile, or other unit of computation, and other information described as follows:

115.8 (i) forwarding of remains to another funeral establishment, together with a list of the
115.9 services provided for any quoted price;

115.10 (ii) receiving remains from another funeral establishment, together with a list of the
115.11 services provided for any quoted price;

115.12 (iii) separate prices for each alkaline hydrolysis, natural organic reduction, or cremation
115.13 offered by the funeral provider, with the price including an alternative container or alkaline
115.14 hydrolysis facility or cremation container; any alkaline hydrolysis, natural organic reduction
115.15 facility, or crematory charges; and a description of the services and container included in
115.16 the price, where applicable, and the price of alkaline hydrolysis or cremation where the
115.17 purchaser provides the container;

115.18 (iv) separate prices for each immediate burial offered by the funeral provider, including
115.19 a casket or alternative container, and a description of the services and container included
115.20 in that price, and the price of immediate burial where the purchaser provides the casket or
115.21 alternative container;

115.22 (v) transfer of remains to the funeral establishment or other location;

115.23 (vi) embalming;

115.24 (vii) other preparation of the body;

115.25 (viii) use of facilities, equipment, or staff for viewing;

115.26 (ix) use of facilities, equipment, or staff for funeral ceremony;

115.27 (x) use of facilities, equipment, or staff for memorial service;

115.28 (xi) use of equipment or staff for graveside service;

115.29 (xii) hearse or funeral coach;

115.30 (xiii) limousine; and

116.1 (xiv) separate prices for all cemetery-specific goods and services, including all goods
116.2 and services associated with interment and burial site goods and services and excluding
116.3 markers and headstones;

116.4 (5) the price range for the caskets offered by the funeral provider, together with the
116.5 statement "A complete price list will be provided at the funeral establishment or casket sale
116.6 location." or the prices of individual caskets, as disclosed in the manner described in
116.7 paragraphs (c) and (d);

116.8 (6) the price range for the alternative containers or shrouds offered by the funeral provider,
116.9 together with the statement "A complete price list will be provided at the funeral
116.10 establishment or alternative container sale location." or the prices of individual alternative
116.11 containers, as disclosed in the manner described in paragraphs (c) and (d);

116.12 (7) the price range for the outer burial containers offered by the funeral provider, together
116.13 with the statement "A complete price list will be provided at the funeral establishment or
116.14 outer burial container sale location." or the prices of individual outer burial containers, as
116.15 disclosed in the manner described in paragraphs (c) and (d);

116.16 (8) the price range for the alkaline hydrolysis container offered by the funeral provider,
116.17 together with the statement "A complete price list will be provided at the funeral
116.18 establishment or alkaline hydrolysis container sale location." or the prices of individual
116.19 alkaline hydrolysis containers, as disclosed in the manner described in paragraphs (c) and
116.20 (d);

116.21 (9) the price range for the hydrolyzed remains container offered by the funeral provider,
116.22 together with the statement "A complete price list will be provided at the funeral
116.23 establishment or hydrolyzed remains container sale location." or the prices of individual
116.24 hydrolyzed remains container, as disclosed in the manner described in paragraphs (c) and
116.25 (d);

116.26 (10) the price range for the cremation containers offered by the funeral provider, together
116.27 with the statement "A complete price list will be provided at the funeral establishment or
116.28 cremation container sale location." or the prices of individual cremation containers, as
116.29 disclosed in the manner described in paragraphs (c) and (d);

116.30 (11) the price range for the cremated remains containers offered by the funeral provider,
116.31 together with the statement, "A complete price list will be provided at the funeral
116.32 establishment or cremated remains container sale location," or the prices of individual
116.33 cremation containers as disclosed in the manner described in paragraphs (c) and (d);

117.1 (12) the price range for the naturally reduced remains containers offered by the funeral
117.2 provider, together with the statement, "A complete price list will be provided at the funeral
117.3 establishment or naturally reduced remains container sale location," or the prices of individual
117.4 naturally reduced remains containers as disclosed in the manner described in paragraphs
117.5 (c) and (d);

117.6 ~~(12)~~ (13) the price for the basic services of funeral provider and staff, together with a
117.7 list of the principal basic services provided for any quoted price and, if the charge cannot
117.8 be declined by the purchaser, the statement "This fee for our basic services will be added
117.9 to the total cost of the funeral arrangements you select. (This fee is already included in our
117.10 charges for alkaline hydrolysis, natural organic reduction, direct cremations, immediate
117.11 burials, and forwarding or receiving remains.)" If the charge cannot be declined by the
117.12 purchaser, the quoted price shall include all charges for the recovery of unallocated funeral
117.13 provider overhead, and funeral providers may include in the required disclosure the phrase
117.14 "and overhead" after the word "services." This services fee is the only funeral provider fee
117.15 for services, facilities, or unallocated overhead permitted by this subdivision to be
117.16 nondeclinable, unless otherwise required by law;

117.17 ~~(13)~~ (14) the price range for the markers and headstones offered by the funeral provider,
117.18 together with the statement "A complete price list will be provided at the funeral
117.19 establishment or marker or headstone sale location." or the prices of individual markers and
117.20 headstones, as disclosed in the manner described in paragraphs (c) and (d); and

117.21 ~~(14)~~ (15) any package priced funerals offered must be listed in addition to and following
117.22 the information required in paragraph (e) and must clearly state the funeral goods and
117.23 services being offered, the price being charged for those goods and services, and the
117.24 discounted savings.

117.25 (f) Funeral providers must give an itemized written statement, for retention, to each
117.26 consumer who arranges an at-need funeral or other disposition of human remains at the
117.27 conclusion of the discussion of the arrangements. The itemized written statement must be
117.28 signed by the consumer selecting the goods and services as required in section 149A.80. If
117.29 the statement is provided by a funeral establishment, the statement must be signed by the
117.30 licensed funeral director or mortician planning the arrangements. If the statement is provided
117.31 by any other funeral provider, the statement must be signed by an authorized agent of the
117.32 funeral provider. The statement must list the funeral goods, funeral services, burial site
117.33 goods, or burial site services selected by that consumer and the prices to be paid for each
117.34 item, specifically itemized cash advance items (these prices must be given to the extent then
117.35 known or reasonably ascertainable if the prices are not known or reasonably ascertainable,

118.1 a good faith estimate shall be given and a written statement of the actual charges shall be
 118.2 provided before the final bill is paid), and the total cost of goods and services selected. At
 118.3 the conclusion of an at-need arrangement, the funeral provider is required to give the
 118.4 consumer a copy of the signed itemized written contract that must contain the information
 118.5 required in this paragraph.

118.6 (g) Upon receiving actual notice of the death of an individual with whom a funeral
 118.7 provider has entered a preneed funeral agreement, the funeral provider must provide a copy
 118.8 of all preneed funeral agreement documents to the person who controls final disposition of
 118.9 the human remains or to the designee of the person controlling disposition. The person
 118.10 controlling final disposition shall be provided with these documents at the time of the
 118.11 person's first in-person contact with the funeral provider, if the first contact occurs in person
 118.12 at a funeral establishment, alkaline hydrolysis facility, crematory, natural organic reduction
 118.13 facility, or other place of business of the funeral provider. If the contact occurs by other
 118.14 means or at another location, the documents must be provided within 24 hours of the first
 118.15 contact.

118.16 Sec. 41. Minnesota Statutes 2022, section 149A.71, subdivision 4, is amended to read:

118.17 Subd. 4. **Casket, alternate container, alkaline hydrolysis container, naturally reduced**
 118.18 **remains container, and cremation container sales; records; required disclosures.** Any
 118.19 funeral provider who sells or offers to sell a casket, alternate container, alkaline hydrolysis
 118.20 container, hydrolyzed remains container, cremation container, ~~or~~ cremated remains container,
 118.21 or, effective July 1, 2025, naturally reduced remains container to the public must maintain
 118.22 a record of each sale that includes the name of the purchaser, the purchaser's mailing address,
 118.23 the name of the decedent, the date of the decedent's death, and the place of death. These
 118.24 records shall be open to inspection by the regulatory agency. Any funeral provider selling
 118.25 a casket, alternate container, or cremation container to the public, and not having charge of
 118.26 the final disposition of the dead human body, shall provide a copy of the statutes and rules
 118.27 controlling the removal, preparation, transportation, arrangements for disposition, and final
 118.28 disposition of a dead human body. This subdivision does not apply to morticians, funeral
 118.29 directors, funeral establishments, crematories, or wholesale distributors of caskets, alternate
 118.30 containers, alkaline hydrolysis containers, or cremation containers.

118.31 Sec. 42. Minnesota Statutes 2022, section 149A.72, subdivision 3, is amended to read:

118.32 Subd. 3. **Casket for alkaline hydrolysis, natural organic reduction, or cremation**
 118.33 **provisions; deceptive acts or practices.** In selling or offering to sell funeral goods or

119.1 funeral services to the public, it is a deceptive act or practice for a funeral provider to
119.2 represent that a casket is required for alkaline hydrolysis ~~or~~, cremations, or, effective July
119.3 1, 2025, natural organic reduction by state or local law or otherwise.

119.4 Sec. 43. Minnesota Statutes 2022, section 149A.72, subdivision 9, is amended to read:

119.5 Subd. 9. **Deceptive acts or practices.** In selling or offering to sell funeral goods, funeral
119.6 services, burial site goods, or burial site services to the public, it is a deceptive act or practice
119.7 for a funeral provider to represent that federal, state, or local laws, or particular cemeteries,
119.8 alkaline hydrolysis facilities, ~~or~~ crematories, or, effective July 1, 2025, natural organic
119.9 reduction facilities require the purchase of any funeral goods, funeral services, burial site
119.10 goods, or burial site services when that is not the case.

119.11 Sec. 44. Minnesota Statutes 2022, section 149A.73, subdivision 1, is amended to read:

119.12 Subdivision 1. **Casket for alkaline hydrolysis, natural organic reduction, or cremation**
119.13 **provisions; deceptive acts or practices.** In selling or offering to sell funeral goods, funeral
119.14 services, burial site goods, or burial site services to the public, it is a deceptive act or practice
119.15 for a funeral provider to require that a casket be purchased for alkaline hydrolysis ~~or~~,
119.16 cremation, or, effective July 1, 2025, natural organic reduction.

119.17 Sec. 45. Minnesota Statutes 2022, section 149A.74, subdivision 1, is amended to read:

119.18 Subdivision 1. **Services provided without prior approval; deceptive acts or**
119.19 **practices.** In selling or offering to sell funeral goods or funeral services to the public, it is
119.20 a deceptive act or practice for any funeral provider to embalm a dead human body unless
119.21 state or local law or regulation requires embalming in the particular circumstances regardless
119.22 of any funeral choice which might be made, or prior approval for embalming has been
119.23 obtained from an individual legally authorized to make such a decision. In seeking approval
119.24 to embalm, the funeral provider must disclose that embalming is not required by law except
119.25 in certain circumstances; that a fee will be charged if a funeral is selected which requires
119.26 embalming, such as a funeral with viewing; and that no embalming fee will be charged if
119.27 the family selects a service which does not require embalming, such as direct alkaline
119.28 hydrolysis, direct cremation, ~~or~~ immediate burial, or, effective July 1, 2025, natural organic
119.29 reduction.

120.1 Sec. 46. Minnesota Statutes 2022, section 149A.93, subdivision 3, is amended to read:

120.2 Subd. 3. **Disposition permit.** A disposition permit is required before a body can be
120.3 buried, entombed, alkaline hydrolyzed, ~~or cremated~~, or, effective July 1, 2025, naturally
120.4 reduced. No disposition permit shall be issued until a fact of death record has been completed
120.5 and filed with the state registrar of vital records.

120.6 Sec. 47. Minnesota Statutes 2022, section 149A.94, subdivision 1, is amended to read:

120.7 Subdivision 1. **Generally.** Every dead human body lying within the state, except
120.8 unclaimed bodies delivered for dissection by the medical examiner, those delivered for
120.9 anatomical study pursuant to section 149A.81, subdivision 2, or lawfully carried through
120.10 the state for the purpose of disposition elsewhere; and the remains of any dead human body
120.11 after dissection or anatomical study, shall be decently buried or entombed in a public or
120.12 private cemetery, alkaline hydrolyzed, ~~or cremated~~, or, effective July 1, 2025, naturally
120.13 reduced within a reasonable time after death. Where final disposition of a body will not be
120.14 accomplished, or, effective July 1, 2025, when natural organic reduction will not be initiated,
120.15 within 72 hours following death or release of the body by a competent authority with
120.16 jurisdiction over the body, the body must be properly embalmed, refrigerated, or packed
120.17 with dry ice. A body may not be kept in refrigeration for a period exceeding six calendar
120.18 days, or packed in dry ice for a period that exceeds four calendar days, from the time of
120.19 death or release of the body from the coroner or medical examiner.

120.20 Sec. 48. Minnesota Statutes 2022, section 149A.94, subdivision 3, is amended to read:

120.21 Subd. 3. **Permit required.** No dead human body shall be buried, entombed, ~~or cremated,~~
120.22 alkaline hydrolyzed, or, effective July 1, 2025, naturally reduced without a disposition
120.23 permit. The disposition permit must be filed with the person in charge of the place of final
120.24 disposition. Where a dead human body will be transported out of this state for final
120.25 disposition, the body must be accompanied by a certificate of removal.

120.26 Sec. 49. Minnesota Statutes 2022, section 149A.94, subdivision 4, is amended to read:

120.27 Subd. 4. **Alkaline hydrolysis ~~or~~, cremation, or natural organic reduction.** Inurnment
120.28 of alkaline hydrolyzed ~~or~~ remains, cremated remains, or, effective July 1, 2025, naturally
120.29 reduced remains and release to an appropriate party is considered final disposition and no
120.30 further permits or authorizations are required for transportation, interment, entombment, or
120.31 placement of the ~~cremated~~ remains, except as provided in section 149A.95, subdivision 16.

121.1 **Sec. 50. [149A.955] NATURAL ORGANIC REDUCTION FACILITIES AND**
121.2 **NATURAL ORGANIC REDUCTION.**

121.3 **Subdivision 1. License required.** This section is effective July 1, 2025. A dead human
121.4 body may only undergo natural organic reduction in this state at a natural organic reduction
121.5 facility licensed by the commissioner of health.

121.6 **Subd. 2. General requirements.** Any building to be used as a natural organic reduction
121.7 facility must comply with all applicable local and state building codes, zoning laws and
121.8 ordinances, and environmental standards. A natural organic reduction facility must have on
121.9 site a natural organic reduction system approved by the commissioner and a motorized
121.10 mechanical device for processing the remains in natural reduction and must have in the
121.11 building a refrigerated holding facility for the retention of dead human bodies awaiting
121.12 natural organic reduction. The holding facility must be secure from access by anyone except
121.13 the authorized personnel of the natural organic reduction facility, preserve the dignity of
121.14 the remains, and protect the health and safety of the natural organic reduction facility
121.15 personnel.

121.16 **Subd. 3. Aerobic reduction vessel.** A natural organic reduction facility must use as a
121.17 natural organic reduction vessel a contained reduction vessel that is designed to promote
121.18 aerobic reduction and that minimizes odors.

121.19 **Subd. 4. Any room where body is prepared.** Any room where the deceased will be
121.20 prepared for natural organic reduction must be properly lit and ventilated with an exhaust
121.21 fan. It must be equipped with a functional sink with hot and cold running water. It must
121.22 have nonporous flooring, such that a sanitary condition is provided. The walls and ceiling
121.23 of the room must run from floor to ceiling and be covered with tile, or by plaster or sheetrock
121.24 painted with washable paint or other appropriate material, such that a sanitary condition is
121.25 provided. The doors, walls, ceiling, and windows must be constructed to prevent odors from
121.26 entering any other part of the building.

121.27 **Subd. 5. Access and privacy.** (a) The room where a licensed mortician prepares a body
121.28 must be private and must not have a general passageway through it. All windows or other
121.29 openings to the outside must be treated in a manner that prevents viewing into the room
121.30 where the deceased will be prepared for natural organic reduction. A viewing window for
121.31 authorized family members or their designees is not a violation of this subdivision.

121.32 (b) The room must, at all times, be secure from the entrance of unauthorized persons.

121.33 (c) For purposes of this section, "authorized persons" are:

- 122.1 (1) licensed morticians;
122.2 (2) registered interns or students as described in section 149A.91, subdivision 6;
122.3 (3) public officials or representatives in the discharge of their official duties;
122.4 (4) trained natural organic reduction facility operators; and
122.5 (5) the person or persons with the right to control the dead human body as defined in
122.6 section 149A.80, subdivision 2, and their designees.

122.7 (d) Each door allowing ingress or egress must carry a sign that indicates that the room
122.8 is private and access is limited. All authorized persons who are present in or enter the room
122.9 while a body is being prepared for final disposition must be attired according to all applicable
122.10 state and federal regulations regarding the control of infectious disease and occupational
122.11 and workplace health and safety.

122.12 Subd. 6. **Areas for vessels or naturally organic reduction operations.** Any rooms or
122.13 areas where the vessels reside or where any operation takes place involving the handling
122.14 of the vessels or the remains must be ventilated with exhaust fans. The doors, walls, ceiling,
122.15 and windows shall be constructed to prevent odors from entering any other part of the
122.16 building. All windows must be treated in a manner that maintains privacy when the remains
122.17 are handled. A sanitary condition must be provided. Any area where human remains are
122.18 transferred, prepared, or processed must have nonpourous flooring, and the walls and ceiling
122.19 of the rooms must run from floor to ceiling and be covered with tile, or by plaster, sheetrock,
122.20 or concrete painted with washable paint or other appropriate material, such that a sanitary
122.21 condition is provided. Access to the vessel holding area must only be granted to individuals
122.22 outlined in subdivision 5 and to authorized visitors at the discretion of the licensed facility
122.23 under the direct supervision of trained facility staff, provided that such access does not
122.24 violate subdivision 18.

122.25 Subd. 7. **Equipment and supplies.** The natural organic reduction facility must have a
122.26 functional emergency eye wash and quick drench shower.

122.27 Subd. 8. **Sanitary conditions and permitted use.** The room where the deceased will
122.28 be prepared for natural organic reduction, the area where the natural organic reduction
122.29 vessels are located or where the natural organic reduction operations are undertaken, and
122.30 all fixtures, equipment, instruments, receptacles, clothing, and other appliances or supplies
122.31 stored or used in these operations must be maintained in a clean and sanitary condition at
122.32 all times.

123.1 Subd. 9. **Occupational and workplace safety.** All applicable provisions of state and
123.2 federal regulations regarding exposure to workplace hazards and accidents must be followed
123.3 to protect the health and safety of all authorized persons at the natural organic reduction
123.4 facility.

123.5 Subd. 10. **Unlicensed personnel.** A licensed natural organic reduction facility may
123.6 employ unlicensed personnel, provided that all applicable provisions of this chapter are
123.7 followed. It is the duty of the licensed natural organic reduction facility to provide proper
123.8 training for all unlicensed personnel, and the licensed natural organic reduction facility shall
123.9 be strictly accountable for compliance with this chapter and other applicable state and federal
123.10 regulations regarding occupational and workplace health and safety.

123.11 Subd. 11. **Authorization to naturally reduce.** No natural organic reduction facility
123.12 shall naturally reduce or cause to be naturally reduced any dead human body or identifiable
123.13 body part without receiving written authorization to do so from the person or persons who
123.14 have the legal right to control disposition as described in section 149A.80 or the person's
123.15 legal designee. The written authorization must include:

123.16 (1) the name of the deceased and the date of death of the deceased;

123.17 (2) a statement authorizing the natural organic reduction facility to naturally reduce the
123.18 body;

123.19 (3) the name, address, phone number, relationship to the deceased, and signature of the
123.20 person or persons with the legal right to control final disposition or a legal designee;

123.21 (4) directions for the disposition of any non-naturally reduced materials or items recovered
123.22 from the natural organic reduction vessel;

123.23 (5) acknowledgment that some of the remains will be mechanically reduced to a
123.24 granulated appearance and returned to the natural reduction vessel with the remains for final
123.25 reduction; and

123.26 (6) directions for the ultimate disposition of the naturally reduced remains.

123.27 Subd. 12. **Limitation of liability.** The limitations in section 149A.95, subdivision 5,
123.28 apply to natural organic reduction facilities.

123.29 Subd. 13. **Acceptance of delivery of body.** (a) No dead human body shall be accepted
123.30 for final disposition by natural organic reduction unless the body is:

123.31 (1) wrapped in a container, such as a pouch, that is impermeable or leak-resistant;

124.1 (2) accompanied by a disposition permit issued pursuant to section 149A.93, subdivision
124.2 3, including a photocopy of the complete death record or a signed release authorizing natural
124.3 organic reduction received from a coroner or medical examiner; and

124.4 (3) accompanied by a natural organic reduction authorization that complies with
124.5 subdivision 5.

124.6 (b) A natural organic reduction facility shall refuse to accept delivery of the dead human
124.7 body:

124.8 (1) where there is a known dispute concerning natural organic reduction of the body
124.9 delivered;

124.10 (2) where there is a reasonable basis for questioning any of the representations made on
124.11 the written authorization to naturally reduce; or

124.12 (3) for any other lawful reason.

124.13 (c) When a container or pouch containing a dead human body shows evidence of leaking
124.14 bodily fluid, the container or pouch and the body must be returned to the contracting funeral
124.15 establishment, or the body must be transferred to a new container or pouch by a licensed
124.16 mortician.

124.17 (d) If a dead human body is delivered to a natural organic reduction facility in a container
124.18 or pouch that is not suitable for placement in a natural organic reduction vessel, the transfer
124.19 of the body to the vessel must be performed by a licensed mortician.

124.20 Subd. 14. **Bodies awaiting natural organic reduction.** A dead human body must be
124.21 placed in the natural organic reduction vessel to initiate the natural reduction process within
124.22 24 hours after the natural organic reduction facility accepts legal and physical custody of
124.23 the body.

124.24 Subd. 15. **Handling of dead human bodies.** All natural organic reduction facility
124.25 employees handling the containers or pouches for dead human bodies shall use universal
124.26 precautions and otherwise exercise all reasonable precautions to minimize the risk of
124.27 transmitting any communicable disease from the body. No dead human body shall be
124.28 removed from the container or pouch in which it is delivered to the natural organic reduction
124.29 facility without express written authorization of the person or persons with legal right to
124.30 control the disposition and only by a licensed mortician. The remains shall be considered
124.31 a dead human body until after the final reduction. The person or persons with the legal right
124.32 to control the body may be involved with preparation of the body pursuant to section
124.33 149A.01, subdivision 3, paragraph (c).

125.1 Subd. 16. **Identification of the body.** All licensed natural organic reduction facilities
125.2 shall develop, implement, and maintain an identification procedure whereby dead human
125.3 bodies can be identified from the time the natural organic reduction facility accepts delivery
125.4 of the body until the naturally reduced remains are released to an authorized party. After
125.5 natural organic reduction, an identifying disk, tab, or other permanent label shall be placed
125.6 within the naturally reduced remains container or containers before the remains are released
125.7 from the natural organic reduction facility. Each identification disk, tab, or label shall have
125.8 a number that shall be recorded on all paperwork regarding the decedent. This procedure
125.9 shall be designed to reasonably ensure that the proper body is naturally reduced and that
125.10 the remains are returned to the appropriate party. Loss of all or part of the remains or the
125.11 inability to individually identify the remains is a violation of this subdivision.

125.12 Subd. 17. **Natural organic reduction vessel for human remains.** A licensed natural
125.13 organic reduction facility shall knowingly naturally reduce only dead human bodies or
125.14 human remains in a natural organic reduction vessel.

125.15 Subd. 18. **Natural organic reduction procedures; privacy.** The final disposition of
125.16 dead human bodies by natural organic reduction shall be done in privacy. Unless there is
125.17 written authorization from the person with the legal right to control the final disposition,
125.18 only authorized natural organic reduction facility personnel shall be permitted in the natural
125.19 organic reduction area while any human body is awaiting placement or being placed in a
125.20 natural organic reduction vessel, being removed from the vessel, or being processed for
125.21 placement for final reduction. This does not prohibit an in-person laying-in ceremony to
125.22 honor the deceased and the transition prior to the placement.

125.23 Subd. 19. **Natural organic reduction procedures; commingling of bodies**
125.24 **prohibited.** Except with the express written permission of the person with the legal right
125.25 to control the final disposition, no natural organic reduction facility shall naturally reduce
125.26 more than one dead human body at the same time and in the same natural organic reduction
125.27 vessel or introduce a second dead human body into same natural organic reduction vessel
125.28 until reasonable efforts have been employed to remove all fragments of remains from the
125.29 preceding natural organic reduction. This subdivision does not apply where commingling
125.30 of human remains during natural organic reduction is otherwise provided by law. The fact
125.31 that there is incidental and unavoidable residue in the natural organic reduction vessel used
125.32 in a prior natural organic reduction is not a violation of this subdivision.

125.33 Subd. 20. **Natural organic reduction procedures; removal from natural organic**
125.34 **reduction vessel.** Upon completion of the natural organic reduction process, reasonable
125.35 efforts shall be made to remove from the natural organic reduction vessel all the recoverable

126.1 remains. The remains shall be transported to the processing area, and any non-naturally
 126.2 reducible materials or items shall be separated from the remains and disposed of, in any
 126.3 lawful manner, by the natural organic reduction facility.

126.4 Subd. 21. **Natural organic reduction procedures; processing remains.** The remains
 126.5 that remain intact shall be reduced by a motorized mechanical processor to a granulated
 126.6 appearance. The granulated remains and the rest of the naturally reduced remains shall be
 126.7 returned to a natural organic reduction vessel for final reduction. The remains shall be
 126.8 considered a dead human body until after the final reduction.

126.9 Subd. 22. **Natural organic reduction procedures; commingling of remains**
 126.10 **prohibited.** Except with the express written permission of the person with the legal right
 126.11 to control the final deposition or otherwise provided by law, no natural organic reduction
 126.12 facility shall mechanically process the remains of more than one body at a time in the same
 126.13 mechanical processor or introduce the remains of a second body into a mechanical processor
 126.14 until reasonable efforts have been employed to remove all fragments of remains already in
 126.15 the processor. The fact that there is incidental and unavoidable residue in the mechanical
 126.16 processor is not a violation of this subdivision.

126.17 Subd. 23. **Natural organic reduction procedures; testing naturally reduced**
 126.18 **remains.** A natural organic reduction facility must:

126.19 (1) ensure that the material in the natural organic reduction vessel naturally reaches and
 126.20 maintains a minimum temperature of 131 degrees Fahrenheit for a minimum of 72
 126.21 consecutive hours during the process of natural organic reduction;

126.22 (2) analyze each instance of the naturally reduced remains for physical contaminants,
 126.23 including but not limited to intact bone, dental fillings, and medical implants, and ensure
 126.24 naturally reduced remains have less than 0.01 mg/kg dry weight of any physical contaminants;

126.25 (3) collect material samples for analysis that are representative of each instance of natural
 126.26 organic reduction, using a sampling method such as those described in the U.S. Composting
 126.27 Council 2002 Test Methods for the Examination of Composting and Compost, method
 126.28 02.01-A through E;

126.29 (4) develop and use a natural organic reduction process in which the naturally reduced
 126.30 remains from the process do not exceed the following limits:

126.31	<u>Metals and other testing</u>	<u>Limit (mg/kg dry weight), unless otherwise</u>
126.32	<u>parameters</u>	<u>specified</u>
126.33	<u>Fecal coliform</u>	<u>Less than 1,000 most probable number per gram</u>
126.34		<u>of total solids (dry weight)</u>

127.1		<u>Less than 3 most probable number per 4 grams</u>
127.2	<u>Salmonella</u>	<u>of total solids (dry weight)</u>
127.3	<u>Arsenic</u>	<u>Less than or equal to 11 ppm</u>
127.4	<u>Cadmium</u>	<u>Less than or equal to 7.1 ppm</u>
127.5	<u>Lead</u>	<u>Less than or equal to 150 ppm</u>
127.6	<u>Mercury</u>	<u>Less than or equal to 5 ppm</u>
127.7	<u>Selenium</u>	<u>Less than or equal to 18 ppm;</u>

127.8 (5) analyze, using a third-party laboratory, the natural organic reduction facility's material
127.9 samples of naturally reduced remains according to the following schedule:

127.10 (i) the natural organic reduction facility must analyze each of the first 20 instances of
127.11 naturally reduced remains for the parameters in clause (4);

127.12 (ii) if any of the first 20 instances of naturally reduced remains yield results exceeding
127.13 the limits in clause (4), the natural organic reduction facility must conduct appropriate
127.14 processes to correct the levels of the substances in clause (4) and have the resultant remains
127.15 tested to ensure they fall within the identified limits;

127.16 (iii) if any of the first 20 instances of naturally reduced remains yield results exceeding
127.17 the limits in clause (4), the natural organic reduction facility must analyze each additional
127.18 instance of naturally reduced remains for the parameters in clause (4) until a total of 20
127.19 samples, not including those from remains that were reprocessed as required in item (ii),
127.20 have yielded results within the limits in clause (4) on initial testing;

127.21 (iv) after 20 material samples of naturally reduced remains have met the limits in clause
127.22 (4), the natural organic reduction facility must analyze at least 25 percent of the natural
127.23 organic reduction facility's monthly instances of naturally reduced remains for the parameters
127.24 in clause (4) until 80 total material samples of naturally reduced remains are found to meet
127.25 the limits in clause (4), not including any samples that required reprocessing to meet those
127.26 limits; and

127.27 (v) after 80 material samples of naturally reduced remains are found to meet the limits
127.28 in clause (4), the natural organic reduction facility must analyze at least one randomly chosen
127.29 instance of naturally reduced remains each month for the parameters in clause (4). If fecal
127.30 coliform or salmonella in the tested remains exceeds the limit for that substance in clause
127.31 (4), the natural organic reduction facility must analyze each subsequent instance of naturally
127.32 reduced remains for fecal coliform and salmonella until ten total material samples are found
127.33 to meet the limits for those substances in clause (4) on initial testing, demonstrating the
127.34 natural organic reduction process was effectively corrected;

128.1 (6) comply with any testing requirements established by the commissioner for content
128.2 parameters in addition to those specified in clause (4);

128.3 (7) not release any naturally reduced remains that exceed the limits in clause (4); and

128.4 (8) prepare, maintain, and provide to the commissioner upon request, a report for each
128.5 calendar year detailing the natural organic reduction facility's activities during the previous
128.6 calendar year. The report must include the following information:

128.7 (i) the name and address of the natural organic reduction facility;

128.8 (ii) the calendar year covered by the report;

128.9 (iii) the annual quantity of naturally reduced remains;

128.10 (iv) the results of any laboratory analyses of naturally reduced remains; and

128.11 (v) any additional information required by the commissioner.

128.12 **Subd. 24. Natural organic reduction procedures; use of more than one naturally**
128.13 **reduced remains container.** If the naturally reduced remains are to be separated into two
128.14 or more naturally reduced remains containers according to the directives provided in the
128.15 written authorization for natural organic reduction, all of the containers shall contain duplicate
128.16 identification disks, tabs, or permanent labels and all paperwork regarding the given body
128.17 shall include a notation of the number of and disposition of each container, as provided in
128.18 the written authorization.

128.19 **Subd. 25. Natural organic reduction procedures; disposition of accumulated**
128.20 **residue.** Every natural organic reduction facility shall provide for the removal and disposition
128.21 of any accumulated residue from any natural organic reduction vessel, mechanical processor,
128.22 or other equipment used in natural organic reduction. Disposition of accumulated residue
128.23 shall be by any lawful manner deemed appropriate.

128.24 **Subd. 26. Natural organic reduction procedures; release of naturally reduced**
128.25 **remains.** Following completion of the natural organic reduction process, the inurned naturally
128.26 reduced remains shall be released according to the instructions given on the written
128.27 authorization for natural organic reduction. If the remains are to be shipped, they must be
128.28 securely packaged and transported by a method that has an internal tracing system available
128.29 and which provides a receipt signed by the person accepting delivery. Where there is a
128.30 dispute over release or disposition of the naturally reduced remains, a natural organic
128.31 reduction facility may deposit the naturally reduced remains in accordance with the directives
128.32 of a court of competent jurisdiction pending resolution of the dispute or retain the naturally
128.33 reduced remains until the person with the legal right to control disposition presents

129.1 satisfactory indication that the dispute is resolved. A natural organic reduction facility must
129.2 make every effort to ensure naturally reduced remains are not sold or used for commercial
129.3 purposes.

129.4 Subd. 27. **Unclaimed naturally reduced remains.** If, after 30 calendar days following
129.5 the inurnment, the naturally reduced remains are not claimed or disposed of according to
129.6 the written authorization for natural organic reduction, the natural organic reduction facility
129.7 shall give written notice, by certified mail, to the person with the legal right to control the
129.8 final disposition or a legal designee, that the naturally reduced remains are unclaimed and
129.9 requesting further release directions. Should the naturally reduced remains be unclaimed
129.10 120 calendar days following the mailing of the written notification, the natural organic
129.11 reduction facility may return the remains to the earth respectfully in any lawful manner
129.12 deemed appropriate.

129.13 Subd. 28. **Required records.** Every natural organic reduction facility shall create and
129.14 maintain on its premises or other business location in Minnesota an accurate record of every
129.15 natural organic reduction provided. The record shall include all of the following information
129.16 for each natural organic reduction:

129.17 (1) the name of the person or funeral establishment delivering the body for natural
129.18 organic reduction;

129.19 (2) the name of the deceased and the identification number assigned to the body;

129.20 (3) the date of acceptance of delivery;

129.21 (4) the names of the operator of the natural organic reduction process and mechanical
129.22 processor operator;

129.23 (5) the times and dates that the body was placed in and removed from the natural organic
129.24 reduction vessel;

129.25 (6) the time and date that processing and inurnment of the naturally reduced remains
129.26 was completed;

129.27 (7) the time, date, and manner of release of the naturally reduced remains;

129.28 (8) the name and address of the person who signed the authorization for natural organic
129.29 reduction;

129.30 (9) all supporting documentation, including any transit or disposition permits, a photocopy
129.31 of the death record, and the authorization for natural organic reduction; and

129.32 (10) the type of natural organic reduction vessel.

130.1 Subd. 29. **Retention of records.** Records required under subdivision 28 shall be
130.2 maintained for a period of three calendar years after the release of the naturally reduced
130.3 remains. Following this period and subject to any other laws requiring retention of records,
130.4 the natural organic reduction facility may then place the records in storage or reduce them
130.5 to microfilm, a digital format, or any other method that can produce an accurate reproduction
130.6 of the original record, for retention for a period of ten calendar years from the date of release
130.7 of the naturally reduced remains. At the end of this period and subject to any other laws
130.8 requiring retention of records, the natural organic reduction facility may destroy the records
130.9 by shredding, incineration, or any other manner that protects the privacy of the individuals
130.10 identified.

130.11 Sec. 51. **STILLBIRTH PREVENTION THROUGH TRACKING FETAL**
130.12 **MOVEMENT PILOT PROGRAM.**

130.13 Subdivision 1. **Grant.** The commissioner of health shall issue a grant to a grant recipient
130.14 to support a stillbirth prevention through tracking fetal movement pilot program and to
130.15 provide evidence of the efficacy of tracking fetal movements in preventing stillbirths in
130.16 Minnesota. The pilot program shall operate in fiscal years 2025, 2026, and 2027.

130.17 Subd. 2. **Use of grant funds.** The grant recipient must use grant funds:

130.18 (1) for activities to ensure that expectant parents in Minnesota receive information about
130.19 the importance of tracking fetal movement in the third trimester of pregnancy, by providing
130.20 evidence-based information to organizations that include but are not limited to community
130.21 organizations, hospitals, birth centers, maternal health providers, and higher education
130.22 institutions that educate maternal health providers;

130.23 (2) to provide maternal health providers and expectant parents in Minnesota with access
130.24 to free, evidence-based educational materials on fetal movement tracking, including
130.25 brochures, posters, reminder cards, continuing education materials, and digital resources;

130.26 (3) to assist in raising awareness with health care providers about:

130.27 (i) the availability of free fetal movement tracking education for providers through an
130.28 initial education campaign;

130.29 (ii) the importance of tracking fetal movement in the third trimester of pregnancy by
130.30 offering at least three to five webinars and conferences per year; and

130.31 (iii) the importance of tracking fetal movement in the third trimester of pregnancy through
130.32 provider participation in a public relations campaign; and

131.1 (4) to assist in raising public awareness about the availability of free fetal movement
131.2 tracking resources through social media marketing and traditional marketing throughout
131.3 Minnesota.

131.4 Subd. 3. **Data-sharing and monitoring.** (a) During the operation of the pilot program,
131.5 the grant recipient shall provide the following information to the commissioner on at least
131.6 a quarterly basis:

131.7 (1) the number of educational materials distributed under the pilot program, broken
131.8 down by zip code and the type of facility or organization that ordered the materials, including
131.9 hospitals, birth centers, maternal health clinics, WIC clinics, and community organizations;

131.10 (2) the number of fetal movement tracking application downloads that may be attributed
131.11 to the pilot program, broken down by zip code;

131.12 (3) the reach of and engagement with marketing materials provided under the pilot
131.13 program; and

131.14 (4) provider attendance and participation in awareness-raising events under the pilot
131.15 program, such as webinars and conferences.

131.16 (b) Each year during the pilot program and at the conclusion of the pilot program, the
131.17 grant recipient shall provide the commissioner with an annual report that includes information
131.18 on how the pilot program has affected:

131.19 (1) fetal death rates in Minnesota;

131.20 (2) fetal death rates in Minnesota among American Indian, Black, Hispanic, and Asian
131.21 Pacific Islander populations; and

131.22 (3) fetal death rates by region in Minnesota.

131.23 Subd. 4. **Reports.** The commissioner must submit to the legislative committees with
131.24 jurisdiction over public health an interim report and a final report on the operation of the
131.25 pilot program. The interim report must be submitted by December 1, 2025, and the final
131.26 report must be submitted by December 1, 2027. Each report must at least describe the pilot
131.27 program's operations and provide information, to the extent available, on the effectiveness
131.28 of the pilot program in preventing stillbirths in Minnesota, including lessons learned in
131.29 implementing the pilot program and recommendations for future action.

132.1 **ARTICLE 6**132.2 **DEPARTMENT OF HEALTH POLICY**

132.3 Section 1. Minnesota Statutes 2022, section 62D.14, subdivision 1, is amended to read:

132.4 Subdivision 1. **Examination authority.** The commissioner of health may make an
132.5 examination of the affairs of any health maintenance organization and its contracts,
132.6 agreements, or other arrangements with any participating entity as often as the commissioner
132.7 of health deems necessary for the protection of the interests of the people of this state, but
132.8 not less frequently than once every ~~three~~ five years. Examinations of participating entities
132.9 pursuant to this subdivision shall be limited to their dealings with the health maintenance
132.10 organization and its enrollees, except that examinations of major participating entities may
132.11 include inspection of the entity's financial statements kept in the ordinary course of business.
132.12 The commissioner may require major participating entities to submit the financial statements
132.13 directly to the commissioner. Financial statements of major participating entities are subject
132.14 to the provisions of section 13.37, subdivision 1, clause (b), upon request of the major
132.15 participating entity or the health maintenance organization with which it contracts.

132.16 Sec. 2. **[62J.461] 340B COVERED ENTITY REPORT.**

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

132.19 (b) "340B covered entity" or "covered entity" means a covered entity as defined in United
132.20 States Code, title 42, section 256b(a)(4), with a service address in Minnesota as of January
132.21 1 of the reporting year. 340B covered entity includes all entity types and grantees. All
132.22 facilities that are identified as child sites or grantee associated sites under the federal 340B
132.23 Drug Pricing Program are considered part of the 340B covered entity.

132.24 (c) "340B Drug Pricing Program" or "340B program" means the drug discount program
132.25 established under United States Code, title 42, section 256b.

132.26 (d) "340B entity type" is the designation of the 340B covered entity according to the
132.27 entity types specified in United States Code, title 42, section 256b(a)(4).

132.28 (e) "340B ID" is the unique identification number provided by the Health Resources
132.29 and Services Administration to identify a 340B-eligible entity in the 340B Office of Pharmacy
132.30 Affairs Information System.

132.31 (f) "Contract pharmacy" means a pharmacy with which a 340B covered entity has an
132.32 arrangement to dispense drugs purchased under the 340B Drug Pricing Program.

133.1 (g) "Pricing unit" means the smallest dispensable amount of a prescription drug product
133.2 that can be dispensed or administered.

133.3 Subd. 2. **Current registration.** Beginning April 1, 2024, each 340B covered entity must
133.4 maintain a current registration with the commissioner in a form and manner prescribed by
133.5 the commissioner. The registration must include the following information:

133.6 (1) the name of the 340B covered entity;

133.7 (2) the 340B ID of the 340B covered entity;

133.8 (3) the servicing address of the 340B covered entity; and

133.9 (4) the 340B entity type of the 340B covered entity.

133.10 Subd. 3. **Reporting by covered entities to the commissioner.** (a) Each 340B covered
133.11 entity shall report to the commissioner by April 1 of each year the following information
133.12 for transactions conducted by the 340B covered entity or on its behalf, and related to its
133.13 participation in the federal 340B program for the previous calendar year:

133.14 (1) the aggregated acquisition cost for prescription drugs obtained under the 340B
133.15 program;

133.16 (2) the aggregated payment amount received for drugs obtained under the 340B program
133.17 and dispensed or administered to patients;

133.18 (3) the number of pricing units dispensed or administered for prescription drugs described
133.19 in clause (2); and

133.20 (4) the aggregated payments made:

133.21 (i) to contract pharmacies to dispense drugs obtained under the 340B program;

133.22 (ii) to any other entity that is not the covered entity and is not a contract pharmacy for
133.23 managing any aspect of the covered entity's 340B program; and

133.24 (iii) for all other expenses related to administering the 340B program.

133.25 The information under clauses (2) and (3) must be reported by payer type, including but
133.26 not limited to commercial insurance, medical assistance, MinnesotaCare, and Medicare, in
133.27 the form and manner prescribed by the commissioner.

133.28 (b) For covered entities that are hospitals, the information required under paragraph (a),
133.29 clauses (1) to (3), must also be reported at the national drug code level for the 50 most
133.30 frequently dispensed or administered drugs by the facility under the 340B program.

134.1 (c) Data submitted to the commissioner under paragraphs (a) and (b) are classified as
 134.2 nonpublic data, as defined in section 13.02, subdivision 9.

134.3 Subd. 4. **Enforcement and exceptions.** (a) Any health care entity subject to reporting
 134.4 under this section that fails to provide data in the form and manner prescribed by the
 134.5 commissioner is subject to a fine paid to the commissioner of up to \$500 for each day the
 134.6 data are past due. Any fine levied against the entity under this subdivision is subject to the
 134.7 contested case and judicial review provisions of sections 14.57 and 14.69.

134.8 (b) The commissioner may grant an entity an extension of or exemption from the reporting
 134.9 obligations under this subdivision, upon a showing of good cause by the entity.

134.10 Subd. 5. **Reports to the legislature.** By November 15, 2024, and by November 15 of
 134.11 each year thereafter, the commissioner shall submit to the chairs and ranking minority
 134.12 members of the legislative committees with jurisdiction over health care finance and policy,
 134.13 a report that aggregates the data submitted under subdivision 3, paragraphs (a) and (b). The
 134.14 following information must be included in the report for all 340B entities whose net 340B
 134.15 revenue constitutes a significant share, as determined by the commissioner, of all net 340B
 134.16 revenue across all 340B covered entities in Minnesota:

134.17 (1) the information submitted under subdivision 2; and

134.18 (2) for each 340B entity identified in subdivision 2, that entity's 340B net revenue as
 134.19 calculated using the data submitted under subdivision 3, paragraph (a), with net revenue
 134.20 being subdivision 3, paragraph (a), clause (2), less the sum of subdivision 3, paragraph (a),
 134.21 clauses (1) and (4).

134.22 For all other entities, the data in the report must be aggregated to the entity type or groupings
 134.23 of entity types in a manner that prevents the identification of an individual entity and any
 134.24 entity's specific data value reported for an individual data element.

134.25 Sec. 3. Minnesota Statutes 2022, section 62J.61, subdivision 5, is amended to read:

134.26 Subd. 5. ~~Biennial review of rulemaking procedures and rules~~ Opportunity for
 134.27 comment. The commissioner shall ~~biennially seek comments from affected parties~~ maintain
 134.28 an email address for submission of comments from interested parties to provide input about
 134.29 the effectiveness of and continued need for the rulemaking procedures set out in subdivision
 134.30 2 and about the quality and effectiveness of rules adopted using these procedures. The
 134.31 commissioner shall seek comments by holding a meeting and by publishing a notice in the
 134.32 State Register that contains the date, time, and location of the meeting and a statement that
 134.33 invites oral or written comments. The notice must be published at least 30 days before the

135.1 ~~meeting date. The commissioner shall write a report summarizing the comments and shall~~
135.2 ~~submit the report to the Minnesota Health Data Institute and to the Minnesota Administrative~~
135.3 ~~Uniformity Committee by January 15 of every even-numbered year~~ may seek additional
135.4 input and provide additional opportunities for input as needed.

135.5 Sec. 4. Minnesota Statutes 2023 Supplement, section 62J.84, subdivision 10, is amended
135.6 to read:

135.7 Subd. 10. **Notice of prescription drugs of substantial public interest.** (a) No later than
135.8 January 31, 2024, and quarterly thereafter, the commissioner shall produce and post on the
135.9 department's website a list of prescription drugs that the commissioner determines to represent
135.10 a substantial public interest and for which the commissioner intends to request data under
135.11 subdivisions 11 to 14, subject to paragraph (c). The commissioner shall base its inclusion
135.12 of prescription drugs on any information the commissioner determines is relevant to providing
135.13 greater consumer awareness of the factors contributing to the cost of prescription drugs in
135.14 the state, and the commissioner shall consider drug product families that include prescription
135.15 drugs:

135.16 (1) that triggered reporting under subdivision 3 or 4 during the previous calendar quarter;

135.17 (2) for which average claims paid amounts exceeded 125 percent of the price as of the
135.18 claim incurred date during the most recent calendar quarter for which claims paid amounts
135.19 are available; or

135.20 (3) that are identified by members of the public during a public comment process.

135.21 (b) Not sooner than 30 days after publicly posting the list of prescription drugs under
135.22 paragraph (a), the department shall notify, via email, reporting entities registered with the
135.23 department of the requirement to report under subdivisions 11 to 14.

135.24 (c) The commissioner must not designate more than 500 prescription drugs as having a
135.25 substantial public interest in any one notice.

135.26 (d) Notwithstanding subdivision 16, the commissioner is exempt from chapter 14,
135.27 including section 14.386, in implementing this subdivision.

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

135.29 Sec. 5. Minnesota Statutes 2022, section 144.05, subdivision 6, is amended to read:

135.30 Subd. 6. **Reports on interagency agreements and intra-agency transfers.** The
135.31 commissioner of health shall provide quarterly reports to the chairs and ranking minority

136.1 members of the legislative committees with jurisdiction over health and human services
136.2 policy and finance on:

136.3 (1) interagency agreements or service-level agreements and any renewals or extensions
136.4 of existing interagency or service-level agreements with a state department under section
136.5 15.01, state agency under section 15.012, or the Department of Information Technology
136.6 Services, with a value of more than \$100,000, or related agreements with the same department
136.7 or agency with a cumulative value of more than \$100,000; and

136.8 (2) transfers of appropriations of more than \$100,000 between accounts within or between
136.9 agencies.

136.10 The report must include the statutory citation authorizing the agreement, transfer or dollar
136.11 amount, purpose, and effective date of the agreement, and duration of the agreement, ~~and~~
136.12 ~~a copy of the agreement.~~

136.13 Sec. 6. Minnesota Statutes 2022, section 144.05, subdivision 7, is amended to read:

136.14 Subd. 7. **Expiration of report mandates.** (a) If the submission of a report by the
136.15 commissioner of health to the legislature is mandated by statute and the enabling legislation
136.16 does not include a date for the submission of a final report, the mandate to submit the report
136.17 shall expire in accordance with this section.

136.18 (b) If the mandate requires the submission of an annual report and the mandate was
136.19 enacted before January 1, 2021, the mandate shall expire on January 1, 2023. If the mandate
136.20 requires the submission of a biennial or less frequent report and the mandate was enacted
136.21 before January 1, 2021, the mandate shall expire on January 1, 2024.

136.22 (c) Any reporting mandate enacted on or after January 1, 2021, shall expire three years
136.23 after the date of enactment if the mandate requires the submission of an annual report and
136.24 shall expire five years after the date of enactment if the mandate requires the submission
136.25 of a biennial or less frequent report, unless the enacting legislation provides for a different
136.26 expiration date.

136.27 (d) The commissioner shall submit a list to the chairs and ranking minority members of
136.28 the legislative committees with jurisdiction over health by February 15 of each year,
136.29 beginning February 15, 2022, of all reports set to expire during the following calendar year
136.30 in accordance with this section. The mandate to submit a report to the legislature under this
136.31 paragraph does not expire.

136.32 **EFFECTIVE DATE.** This section is effective retroactively from January 1, 2024.

137.1 Sec. 7. Minnesota Statutes 2023 Supplement, section 144.0526, subdivision 1, is amended
137.2 to read:

137.3 Subdivision 1. **Establishment.** The commissioner of health shall establish the Minnesota
137.4 One Health Antimicrobial Stewardship Collaborative. The commissioner shall ~~appoint~~ hire
137.5 a director to execute operations, conduct health education, and provide technical assistance.

137.6 Sec. 8. Minnesota Statutes 2022, section 144.058, is amended to read:

137.7 **144.058 INTERPRETER SERVICES QUALITY INITIATIVE.**

137.8 (a) The commissioner of health shall establish a voluntary statewide roster, and develop
137.9 a plan for a registry and certification process for interpreters who provide high quality,
137.10 spoken language health care interpreter services. The roster, registry, and certification
137.11 process shall be based on the findings and recommendations set forth by the Interpreter
137.12 Services Work Group required under Laws 2007, chapter 147, article 12, section 13.

137.13 (b) By January 1, 2009, the commissioner shall establish a roster of all available
137.14 interpreters to address access concerns, particularly in rural areas.

137.15 (c) By January 15, 2010, the commissioner shall:

137.16 (1) develop a plan for a registry of spoken language health care interpreters, including:

137.17 (i) development of standards for registration that set forth educational requirements,
137.18 training requirements, demonstration of language proficiency and interpreting skills,
137.19 agreement to abide by a code of ethics, and a criminal background check;

137.20 (ii) recommendations for appropriate alternate requirements in languages for which
137.21 testing and training programs do not exist;

137.22 (iii) recommendations for appropriate fees; and

137.23 (iv) recommendations for establishing and maintaining the standards for inclusion in
137.24 the registry; and

137.25 (2) develop a plan for implementing a certification process based on national testing and
137.26 certification processes for spoken language interpreters 12 months after the establishment
137.27 of a national certification process.

137.28 (d) The commissioner shall consult with the Interpreter Stakeholder Group of the Upper
137.29 Midwest Translators and Interpreters Association for advice on the standards required to
137.30 plan for the development of a registry and certification process.

138.1 (e) The commissioner shall charge an annual fee of \$50 to include an interpreter in the
 138.2 roster. Fee revenue shall be deposited in the state government special revenue fund. All fees
 138.3 are nonrefundable.

138.4 Sec. 9. Minnesota Statutes 2022, section 144.0724, subdivision 2, is amended to read:

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

138.7 (a) "Assessment reference date" or "ARD" means the specific end point for look-back
 138.8 periods in the MDS assessment process. This look-back period is also called the observation
 138.9 or assessment period.

138.10 (b) "Case mix index" means the weighting factors assigned to the ~~RUG-IV~~ case mix
 138.11 reimbursement classifications determined by an assessment.

138.12 (c) "Index maximization" means classifying a resident who could be assigned to more
 138.13 than one category, to the category with the highest case mix index.

138.14 (d) "Minimum Data Set" or "MDS" means a core set of screening, clinical assessment,
 138.15 and functional status elements, that include common definitions and coding categories
 138.16 specified by the Centers for Medicare and Medicaid Services and designated by the
 138.17 Department of Health.

138.18 (e) "Representative" means a person who is the resident's guardian or conservator, the
 138.19 person authorized to pay the nursing home expenses of the resident, a representative of the
 138.20 Office of Ombudsman for Long-Term Care whose assistance has been requested, or any
 138.21 other individual designated by the resident.

138.22 ~~(f) "Resource utilization groups" or "RUG" means the system for grouping a nursing~~
 138.23 ~~facility's residents according to their clinical and functional status identified in data supplied~~
 138.24 ~~by the facility's Minimum Data Set.~~

138.25 ~~(g)~~ (f) "Activities of daily living" includes personal hygiene, dressing, bathing,
 138.26 transferring, bed mobility, locomotion, eating, and toileting.

138.27 ~~(h)~~ (g) "Nursing facility level of care determination" means the assessment process that
 138.28 results in a determination of a resident's or prospective resident's need for nursing facility
 138.29 level of care as established in subdivision 11 for purposes of medical assistance payment
 138.30 of long-term care services for:

138.31 (1) nursing facility services under ~~section 256B.434~~ or chapter 256R;

138.32 (2) elderly waiver services under chapter 256S;

139.1 (3) CADI and BI waiver services under section 256B.49; and

139.2 (4) state payment of alternative care services under section 256B.0913.

139.3 Sec. 10. Minnesota Statutes 2022, section 144.0724, subdivision 3a, is amended to read:

139.4 Subd. 3a. **Resident reimbursement case mix reimbursement classifications beginning**

139.5 **January 1, 2012.** (a) ~~Beginning January 1, 2012,~~ Resident reimbursement case mix

139.6 reimbursement classifications shall be based on the Minimum Data Set, version 3.0

139.7 assessment instrument, or its successor version mandated by the Centers for Medicare and

139.8 Medicaid Services that nursing facilities are required to complete for all residents. ~~The~~

139.9 ~~commissioner of health shall establish resident classifications according to the RUG-IV,~~

139.10 ~~48 group, resource utilization groups. Resident classification must be established based on~~

139.11 ~~the individual items on the Minimum Data Set, which must be completed according to the~~

139.12 ~~Long Term Care Facility Resident Assessment Instrument User's Manual Version 3.0 or its~~

139.13 ~~successor issued by the Centers for Medicare and Medicaid Services.~~ Case mix

139.14 reimbursement classifications shall also be based on assessments required under subdivision

139.15 4. Assessments must be completed according to the Long Term Care Facility Resident

139.16 Assessment Instrument User's Manual Version 3.0 or a successor manual issued by the

139.17 Centers for Medicare and Medicaid Services. The optional state assessment must be

139.18 completed according to the OSA Manual Version 1.0 v.2.

139.19 (b) Each resident must be classified based on the information from the Minimum Data

139.20 Set according to the general categories issued by the Minnesota Department of Health,

139.21 utilized for reimbursement purposes.

139.22 Sec. 11. Minnesota Statutes 2022, section 144.0724, subdivision 4, is amended to read:

139.23 Subd. 4. **Resident assessment schedule.** (a) A facility must conduct and electronically

139.24 submit to the federal database MDS assessments that conform with the assessment schedule

139.25 defined by the Long Term Care Facility Resident Assessment Instrument User's Manual,

139.26 version 3.0, or its successor issued by the Centers for Medicare and Medicaid Services. The

139.27 commissioner of health may substitute successor manuals or question and answer documents

139.28 published by the United States Department of Health and Human Services, Centers for

139.29 Medicare and Medicaid Services, to replace or supplement the current version of the manual

139.30 or document.

139.31 (b) The assessments required under the Omnibus Budget Reconciliation Act of 1987

139.32 (OBRA) used to determine a case mix reimbursement classification ~~for reimbursement~~

139.33 include:

140.1 (1) a new admission comprehensive assessment, which must have an assessment reference
140.2 date (ARD) within 14 calendar days after admission, excluding readmissions;

140.3 (2) an annual comprehensive assessment, which must have an ARD within 92 days of
140.4 a previous quarterly review assessment or a previous comprehensive assessment, which
140.5 must occur at least once every 366 days;

140.6 (3) a significant change in status comprehensive assessment, which must have an ARD
140.7 within 14 days after the facility determines, or should have determined, that there has been
140.8 a significant change in the resident's physical or mental condition, whether an improvement
140.9 or a decline, and regardless of the amount of time since the last comprehensive assessment
140.10 or quarterly review assessment;

140.11 (4) a quarterly review assessment must have an ARD within 92 days of the ARD of the
140.12 previous quarterly review assessment or a previous comprehensive assessment;

140.13 (5) any significant correction to a prior comprehensive assessment, if the assessment
140.14 being corrected is the current one being used for RUG reimbursement classification;

140.15 (6) any significant correction to a prior quarterly review assessment, if the assessment
140.16 being corrected is the current one being used for RUG reimbursement classification; and

140.17 ~~(7) a required significant change in status assessment when:~~

140.18 ~~(i) all speech, occupational, and physical therapies have ended. If the most recent OBRA~~
140.19 ~~comprehensive or quarterly assessment completed does not result in a rehabilitation case~~
140.20 ~~mix classification, then the significant change in status assessment is not required. The ARD~~
140.21 ~~of this assessment must be set on day eight after all therapy services have ended; and~~

140.22 ~~(ii) isolation for an infectious disease has ended. If isolation was not coded on the most~~
140.23 ~~recent OBRA comprehensive or quarterly assessment completed, then the significant change~~
140.24 ~~in status assessment is not required. The ARD of this assessment must be set on day 15 after~~
140.25 ~~isolation has ended; and~~

140.26 (8) (7) any modifications to the most recent assessments under clauses (1) to ~~(7)~~ (6).

140.27 (c) The optional state assessment must accompany all OBRA assessments. The optional
140.28 state assessment is also required to determine reimbursement when:

140.29 (i) all speech, occupational, and physical therapies have ended. If the most recent optional
140.30 state assessment completed does not result in a rehabilitation case mix reimbursement
140.31 classification, then the optional state assessment is not required. The ARD of this assessment
140.32 must be set on day eight after all therapy services have ended; and

141.1 (ii) isolation for an infectious disease has ended. If isolation was not coded on the most
 141.2 recent optional state assessment completed, then the optional state assessment is not required.
 141.3 The ARD of this assessment must be set on day 15 after isolation has ended.

141.4 ~~(e)~~ (d) In addition to the assessments listed in ~~paragraph~~ paragraphs (b) and (c), the
 141.5 assessments used to determine nursing facility level of care include the following:

141.6 (1) preadmission screening completed under section 256.975, subdivisions 7a to 7c, by
 141.7 the Senior LinkAge Line or other organization under contract with the Minnesota Board on
 141.8 Aging; and

141.9 (2) a nursing facility level of care determination as provided for under section 256B.0911,
 141.10 subdivision 26, as part of a face-to-face long-term care consultation assessment completed
 141.11 under section 256B.0911, by a county, tribe, or managed care organization under contract
 141.12 with the Department of Human Services.

141.13 Sec. 12. Minnesota Statutes 2022, section 144.0724, subdivision 6, is amended to read:

141.14 Subd. 6. **Penalties for late or nonsubmission.** (a) A facility that fails to complete or
 141.15 submit an assessment according to subdivisions 4 and 5 for a ~~RUG-IV~~ case mix
 141.16 reimbursement classification ~~within seven days of the time requirements listed in the~~
 141.17 ~~Long-Term Care Facility Resident Assessment Instrument User's Manual~~ when the
 141.18 assessment is due is subject to a reduced rate for that resident. The reduced rate shall be the
 141.19 lowest rate for that facility. The reduced rate is effective on the day of admission for new
 141.20 admission assessments, on the ARD for significant change in status assessments, or on the
 141.21 day that the assessment was due for all other assessments and continues in effect until the
 141.22 first day of the month following the date of submission and acceptance of the resident's
 141.23 assessment.

141.24 (b) If loss of revenue due to penalties incurred by a facility for any period of 92 days
 141.25 are equal to or greater than 0.1 percent of the total operating costs on the facility's most
 141.26 recent annual statistical and cost report, a facility may apply to the commissioner of human
 141.27 services for a reduction in the total penalty amount. The commissioner of human services,
 141.28 in consultation with the commissioner of health, may, at the sole discretion of the
 141.29 commissioner of human services, limit the penalty for residents covered by medical assistance
 141.30 to ten days.

142.1 Sec. 13. Minnesota Statutes 2022, section 144.0724, subdivision 7, is amended to read:

142.2 Subd. 7. **Notice of resident ~~reimbursement~~ case mix reimbursement classification.** (a)

142.3 The commissioner of health shall provide to a nursing facility a notice for each resident of
 142.4 the classification established under subdivision 1. The notice must inform the resident of
 142.5 the case mix reimbursement classification assigned, the opportunity to review the
 142.6 documentation supporting the classification, the opportunity to obtain clarification from the
 142.7 commissioner, ~~and~~ the opportunity to request a reconsideration of the classification, and
 142.8 the address and telephone number of the Office of Ombudsman for Long-Term Care. The
 142.9 commissioner must transmit the notice of resident classification by electronic means to the
 142.10 nursing facility. The nursing facility is responsible for the distribution of the notice to each
 142.11 resident or the resident's representative. This notice must be distributed within three business
 142.12 days after the facility's receipt.

142.13 (b) If a facility submits a ~~modifying~~ modified assessment resulting in a change in the
 142.14 case mix reimbursement classification, the facility must provide a written notice to the
 142.15 resident or the resident's representative regarding the item or items that were modified and
 142.16 the reason for the modifications. The written notice must be provided within three business
 142.17 days after distribution of the resident case mix reimbursement classification notice.

142.18 Sec. 14. Minnesota Statutes 2022, section 144.0724, subdivision 8, is amended to read:

142.19 Subd. 8. **Request for reconsideration of resident classifications.** (a) The resident, ~~or~~
 142.20 the resident's representative, ~~or~~ the nursing facility, or the boarding care home may request
 142.21 that the commissioner of health reconsider the assigned ~~reimbursement~~ case mix
 142.22 reimbursement classification and any item or items changed during the audit process. The
 142.23 request for reconsideration must be submitted in writing to the commissioner of health.

142.24 (b) For reconsideration requests initiated by the resident or the resident's representative:

142.25 (1) The resident or the resident's representative must submit in writing a reconsideration
 142.26 request to the facility administrator within 30 days of receipt of the resident classification
 142.27 notice. The written request must include the reasons for the reconsideration request.

142.28 (2) Within three business days of receiving the reconsideration request, the nursing
 142.29 facility must submit to the commissioner of health a completed reconsideration request
 142.30 form, a copy of the resident's or resident's representative's written request, and all supporting
 142.31 documentation used to complete the assessment being ~~considered~~ reconsidered. If the facility
 142.32 fails to provide the required information, the reconsideration will be completed with the

143.1 information submitted and the facility cannot make further reconsideration requests on this
143.2 classification.

143.3 (3) Upon written request and within three business days, the nursing facility must give
143.4 the resident or the resident's representative a copy of the assessment being reconsidered and
143.5 all supporting documentation used to complete the assessment. Notwithstanding any law
143.6 to the contrary, the facility may not charge a fee for providing copies of the requested
143.7 documentation. If a facility fails to provide the required documents within this time, it is
143.8 subject to the issuance of a correction order and penalty assessment under sections 144.653
143.9 and 144A.10. Notwithstanding those sections, any correction order issued under this
143.10 subdivision must require that the nursing facility immediately comply with the request for
143.11 information, and as of the date of the issuance of the correction order, the facility shall
143.12 forfeit to the state a \$100 fine for the first day of noncompliance, and an increase in the
143.13 \$100 fine by \$50 increments for each day the noncompliance continues.

143.14 (c) For reconsideration requests initiated by the facility:

143.15 (1) The facility is required to inform the resident or the resident's representative in writing
143.16 that a reconsideration of the resident's case mix reimbursement classification is being
143.17 requested. The notice must inform the resident or the resident's representative:

143.18 (i) of the date and reason for the reconsideration request;

143.19 (ii) of the potential for a case mix reimbursement classification change and subsequent
143.20 rate change;

143.21 (iii) of the extent of the potential rate change;

143.22 (iv) that copies of the request and supporting documentation are available for review;

143.23 and

143.24 (v) that the resident or the resident's representative has the right to request a
143.25 reconsideration also.

143.26 (2) Within 30 days of receipt of the audit exit report or resident classification notice, the
143.27 facility must submit to the commissioner of health a completed reconsideration request
143.28 form, all supporting documentation used to complete the assessment being reconsidered,
143.29 and a copy of the notice informing the resident or the resident's representative that a
143.30 reconsideration of the resident's classification is being requested.

143.31 (3) If the facility fails to provide the required information, the reconsideration request
143.32 may be denied and the facility may not make further reconsideration requests on this
143.33 classification.

144.1 (d) Reconsideration by the commissioner must be made by individuals not involved in
144.2 reviewing the assessment, audit, or reconsideration that established the disputed classification.
144.3 The reconsideration must be based upon the assessment that determined the classification
144.4 and upon the information provided to the commissioner of health under paragraphs (a) to
144.5 (c). If necessary for evaluating the reconsideration request, the commissioner may conduct
144.6 on-site reviews. Within 15 business days of receiving the request for reconsideration, the
144.7 commissioner shall affirm or modify the original resident classification. The original
144.8 classification must be modified if the commissioner determines that the assessment resulting
144.9 in the classification did not accurately reflect characteristics of the resident at the time of
144.10 the assessment. The commissioner must transmit the reconsideration classification notice
144.11 by electronic means to the nursing facility. The nursing facility is responsible for the
144.12 distribution of the notice to the resident or the resident's representative. The notice must be
144.13 distributed by the nursing facility within three business days after receipt. A decision by
144.14 the commissioner under this subdivision is the final administrative decision of the agency
144.15 for the party requesting reconsideration.

144.16 (e) The case mix reimbursement classification established by the commissioner shall be
144.17 the classification which applies to the resident while the request for reconsideration is
144.18 pending. If a request for reconsideration applies to an assessment used to determine nursing
144.19 facility level of care under subdivision 4, paragraph ~~(e)~~ (d), the resident shall continue to
144.20 be eligible for nursing facility level of care while the request for reconsideration is pending.

144.21 (f) The commissioner may request additional documentation regarding a reconsideration
144.22 necessary to make an accurate reconsideration determination.

144.23 (g) Data collected as part of the reconsideration process under this section is classified
144.24 as private data on individuals and nonpublic data pursuant to section 13.02. Notwithstanding
144.25 the classification of these data as private or nonpublic, the commissioner is authorized to
144.26 share these data with the U.S. Centers for Medicare and Medicaid Services and the
144.27 commissioner of human services as necessary for reimbursement purposes.

144.28 Sec. 15. Minnesota Statutes 2022, section 144.0724, subdivision 9, is amended to read:

144.29 Subd. 9. **Audit authority.** (a) The commissioner shall audit the accuracy of resident
144.30 assessments performed under section 256R.17 through any of the following: desk audits;
144.31 on-site review of residents and their records; and interviews with staff, residents, or residents'
144.32 families. The commissioner shall reclassify a resident if the commissioner determines that
144.33 the resident was incorrectly classified.

144.34 (b) The commissioner is authorized to conduct on-site audits on an unannounced basis.

145.1 (c) A facility must grant the commissioner access to examine the medical records relating
145.2 to the resident assessments selected for audit under this subdivision. The commissioner may
145.3 also observe and speak to facility staff and residents.

145.4 (d) The commissioner shall consider documentation under the time frames for coding
145.5 items on the minimum data set as set out in the Long-Term Care Facility Resident Assessment
145.6 Instrument User's Manual or OSA Manual version 1.0 v.2 published by the Centers for
145.7 Medicare and Medicaid Services.

145.8 (e) The commissioner shall develop an audit selection procedure that includes the
145.9 following factors:

145.10 (1) Each facility shall be audited annually. If a facility has two successive audits in which
145.11 the percentage of change is five percent or less and the facility has not been the subject of
145.12 a special audit in the past 36 months, the facility may be audited biannually. A stratified
145.13 sample of 15 percent, with a minimum of ten assessments, of the most current assessments
145.14 shall be selected for audit. If more than 20 percent of the ~~RUG-IV~~ case mix reimbursement
145.15 classifications are changed as a result of the audit, the audit shall be expanded to a second
145.16 15 percent sample, with a minimum of ten assessments. If the total change between the first
145.17 and second samples is 35 percent or greater, the commissioner may expand the audit to all
145.18 of the remaining assessments.

145.19 (2) If a facility qualifies for an expanded audit, the commissioner may audit the facility
145.20 again within six months. If a facility has two expanded audits within a 24-month period,
145.21 that facility will be audited at least every six months for the next 18 months.

145.22 (3) The commissioner may conduct special audits if the commissioner determines that
145.23 circumstances exist that could alter or affect the validity of case mix reimbursement
145.24 classifications of residents. These circumstances include, but are not limited to, the following:

145.25 (i) frequent changes in the administration or management of the facility;

145.26 (ii) an unusually high percentage of residents in a specific case mix reimbursement
145.27 classification;

145.28 (iii) a high frequency in the number of reconsideration requests received from a facility;

145.29 (iv) frequent adjustments of case mix reimbursement classifications as the result of
145.30 reconsiderations or audits;

145.31 (v) a criminal indictment alleging provider fraud;

145.32 (vi) other similar factors that relate to a facility's ability to conduct accurate assessments;

146.1 (vii) an atypical pattern of scoring minimum data set items;

146.2 (viii) nonsubmission of assessments;

146.3 (ix) late submission of assessments; or

146.4 (x) a previous history of audit changes of 35 percent or greater.

146.5 (f) If the audit results in a case mix reimbursement classification change, the
146.6 commissioner must transmit the audit classification notice by electronic means to the nursing
146.7 facility within 15 business days of completing an audit. The nursing facility is responsible
146.8 for distribution of the notice to each resident or the resident's representative. This notice
146.9 must be distributed by the nursing facility within three business days after receipt. The
146.10 notice must inform the resident of the case mix reimbursement classification assigned, the
146.11 opportunity to review the documentation supporting the classification, the opportunity to
146.12 obtain clarification from the commissioner, the opportunity to request a reconsideration of
146.13 the classification, and the address and telephone number of the Office of Ombudsman for
146.14 Long-Term Care.

146.15 Sec. 16. Minnesota Statutes 2022, section 144.0724, subdivision 11, is amended to read:

146.16 Subd. 11. **Nursing facility level of care.** (a) For purposes of medical assistance payment
146.17 of long-term care services, a recipient must be determined, using assessments defined in
146.18 subdivision 4, to meet one of the following nursing facility level of care criteria:

146.19 (1) the person requires formal clinical monitoring at least once per day;

146.20 (2) the person needs the assistance of another person or constant supervision to begin
146.21 and complete at least four of the following activities of living: bathing, bed mobility, dressing,
146.22 eating, grooming, toileting, transferring, and walking;

146.23 (3) the person needs the assistance of another person or constant supervision to begin
146.24 and complete toileting, transferring, or positioning and the assistance cannot be scheduled;

146.25 (4) the person has significant difficulty with memory, using information, daily decision
146.26 making, or behavioral needs that require intervention;

146.27 (5) the person has had a qualifying nursing facility stay of at least 90 days;

146.28 (6) the person meets the nursing facility level of care criteria determined 90 days after
146.29 admission or on the first quarterly assessment after admission, whichever is later; or

146.30 (7) the person is determined to be at risk for nursing facility admission or readmission
146.31 through a face-to-face long-term care consultation assessment as specified in section

147.1 256B.0911, subdivision 17 to 21, 23, 24, 27, or 28, by a county, tribe, or managed care
147.2 organization under contract with the Department of Human Services. The person is
147.3 considered at risk under this clause if the person currently lives alone or will live alone or
147.4 be homeless without the person's current housing and also meets one of the following criteria:

147.5 (i) the person has experienced a fall resulting in a fracture;

147.6 (ii) the person has been determined to be at risk of maltreatment or neglect, including
147.7 self-neglect; or

147.8 (iii) the person has a sensory impairment that substantially impacts functional ability
147.9 and maintenance of a community residence.

147.10 (b) The assessment used to establish medical assistance payment for nursing facility
147.11 services must be the most recent assessment performed under subdivision 4, ~~paragraph~~
147.12 paragraphs (b) and (c), that occurred no more than 90 calendar days before the effective
147.13 date of medical assistance eligibility for payment of long-term care services. In no case
147.14 shall medical assistance payment for long-term care services occur prior to the date of the
147.15 determination of nursing facility level of care.

147.16 (c) The assessment used to establish medical assistance payment for long-term care
147.17 services provided under chapter 256S and section 256B.49 and alternative care payment
147.18 for services provided under section 256B.0913 must be the most recent face-to-face
147.19 assessment performed under section 256B.0911, subdivisions 17 to 21, 23, 24, 27, or 28,
147.20 that occurred no more than 60 calendar days before the effective date of medical assistance
147.21 eligibility for payment of long-term care services.

147.22 Sec. 17. Minnesota Statutes 2022, section 144.1464, subdivision 1, is amended to read:

147.23 Subdivision 1. **Summer internships.** The commissioner of health, through a contract
147.24 with a nonprofit organization as required by subdivision 4, shall award grants, within
147.25 available appropriations, to hospitals, clinics, nursing facilities, assisted living facilities,
147.26 and home care providers to establish a secondary and postsecondary summer health care
147.27 intern program. The purpose of the program is to expose interested secondary and
147.28 postsecondary pupils to various careers within the health care profession.

147.29 Sec. 18. Minnesota Statutes 2022, section 144.1464, subdivision 2, is amended to read:

147.30 Subd. 2. **Criteria.** (a) The commissioner, through the organization under contract, shall
147.31 award grants to hospitals, clinics, nursing facilities, assisted living facilities, and home care
147.32 providers that agree to:

148.1 (1) provide secondary and postsecondary summer health care interns with formal exposure
148.2 to the health care profession;

148.3 (2) provide an orientation for the secondary and postsecondary summer health care
148.4 interns;

148.5 (3) pay one-half the costs of employing the secondary and postsecondary summer health
148.6 care intern;

148.7 (4) interview and hire secondary and postsecondary pupils for a minimum of six weeks
148.8 and a maximum of 12 weeks; and

148.9 (5) employ at least one secondary student for each postsecondary student employed, to
148.10 the extent that there are sufficient qualifying secondary student applicants.

148.11 (b) In order to be eligible to be hired as a secondary summer health intern by a hospital,
148.12 clinic, nursing facility, assisted living facility, or home care provider, a pupil must:

148.13 (1) intend to complete high school graduation requirements and be between the junior
148.14 and senior year of high school; and

148.15 (2) be from a school district in proximity to the facility.

148.16 (c) In order to be eligible to be hired as a postsecondary summer health care intern by
148.17 a hospital or clinic, a pupil must:

148.18 (1) intend to complete a health care training program or a two-year or four-year degree
148.19 program and be planning on enrolling in or be enrolled in that training program or degree
148.20 program; and

148.21 (2) be enrolled in a Minnesota educational institution or be a resident of the state of
148.22 Minnesota; priority must be given to applicants from a school district or an educational
148.23 institution in proximity to the facility.

148.24 (d) Hospitals, clinics, nursing facilities, assisted living facilities, and home care providers
148.25 awarded grants may employ pupils as secondary and postsecondary summer health care
148.26 interns ~~beginning on or after June 15, 1993~~, if they agree to pay the intern, during the period
148.27 before disbursement of state grant money, with money designated as the facility's 50 percent
148.28 contribution towards internship costs.

148.29 Sec. 19. Minnesota Statutes 2022, section 144.1464, subdivision 3, is amended to read:

148.30 Subd. 3. **Grants.** The commissioner, through the organization under contract, shall
148.31 award separate grants to hospitals, clinics, nursing facilities, assisted living facilities, and

149.1 home care providers meeting the requirements of subdivision 2. The grants must be used
149.2 to pay one-half of the costs of employing secondary and postsecondary pupils in a hospital,
149.3 clinic, nursing facility, assisted living facility, or home care setting during the course of the
149.4 program. No more than 50 percent of the participants may be postsecondary students, unless
149.5 the program does not receive enough qualified secondary applicants per fiscal year. No
149.6 more than five pupils may be selected from any secondary or postsecondary institution to
149.7 participate in the program and no more than one-half of the number of pupils selected may
149.8 be from the seven-county metropolitan area.

149.9 Sec. 20. Minnesota Statutes 2023 Supplement, section 144.1505, subdivision 2, is amended
149.10 to read:

149.11 Subd. 2. **Programs.** (a) For advanced practice provider clinical training expansion grants,
149.12 the commissioner of health shall award health professional training site grants to eligible
149.13 physician assistant, advanced practice registered nurse, pharmacy, dental therapy, and mental
149.14 health professional programs to plan and implement expanded clinical training. A planning
149.15 grant shall not exceed \$75,000, and a three-year training grant shall not exceed ~~\$150,000~~
149.16 ~~for the first year, \$100,000 for the second year, and \$50,000 for the third year~~ \$300,000 per
149.17 program project. The commissioner may provide a one-year, no-cost extension for grants.

149.18 (b) For health professional rural and underserved clinical rotations grants, the
149.19 commissioner of health shall award health professional training site grants to eligible
149.20 physician, physician assistant, advanced practice registered nurse, pharmacy, dentistry,
149.21 dental therapy, and mental health professional programs to augment existing clinical training
149.22 programs to add rural and underserved rotations or clinical training experiences, such as
149.23 credential or certificate rural tracks or other specialized training. For physician and dentist
149.24 training, the expanded training must include rotations in primary care settings such as
149.25 community clinics, hospitals, health maintenance organizations, or practices in rural
149.26 communities.

149.27 (c) Funds may be used for:

149.28 (1) establishing or expanding rotations and clinical training;

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

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

149.32 (4) travel and lodging for students;

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

- 150.1 (6) development and implementation of cultural competency training;
- 150.2 (7) evaluations;
- 150.3 (8) training site improvements, fees, equipment, and supplies required to establish,
- 150.4 maintain, or expand a training program; and
- 150.5 (9) supporting clinical education in which trainees are part of a primary care team model.

150.6 Sec. 21. Minnesota Statutes 2022, section 144.1911, subdivision 2, is amended to read:

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

150.8 meanings given.

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

150.10 (c) "Immigrant international medical graduate" means an international medical graduate

150.11 who was born outside the United States, now resides permanently in the United States or

150.12 who has entered the United States on a temporary status based on urgent humanitarian or

150.13 significant public benefit reasons, and who did not enter the United States on a J1 or similar

150.14 nonimmigrant visa following acceptance into a United States medical residency or fellowship

150.15 program.

150.16 (d) "International medical graduate" means a physician who received a basic medical

150.17 degree or qualification from a medical school located outside the United States and Canada.

150.18 (e) "Minnesota immigrant international medical graduate" means an immigrant

150.19 international medical graduate who has lived in Minnesota for at least two years.

150.20 (f) "Rural community" means a statutory and home rule charter city or township that is

150.21 outside the seven-county metropolitan area as defined in section 473.121, subdivision 2,

150.22 excluding the cities of Duluth, Mankato, Moorhead, Rochester, and St. Cloud.

150.23 (g) "Underserved community" means a Minnesota area or population included in the

150.24 list of designated primary medical care health professional shortage areas, medically

150.25 underserved areas, or medically underserved populations (MUPs) maintained and updated

150.26 by the United States Department of Health and Human Services.

150.27 Sec. 22. Minnesota Statutes 2022, section 144.212, is amended by adding a subdivision

150.28 to read:

150.29 Subd. 5a. **Replacement.** "Replacement" means a completion, addition, removal, or

150.30 change made to certification items on a vital record after a vital event is registered and a

151.1 record is established that has no notation of a change on a certificate and seals the prior vital
151.2 record.

151.3 Sec. 23. Minnesota Statutes 2022, section 144.216, subdivision 2, is amended to read:

151.4 Subd. 2. **Status of foundling reports.** A report registered under subdivision 1 shall
151.5 constitute the record of birth for the child. Information about the newborn shall be registered
151.6 by the state registrar in accordance with Minnesota Rules, part 4601.0600, subpart 4, item
151.7 C. If the child is identified and a record of birth is found or obtained, the report registered
151.8 under subdivision 1 shall be confidential pursuant to section 13.02, subdivision 3, and shall
151.9 not be disclosed except pursuant to court order.

151.10 Sec. 24. Minnesota Statutes 2022, section 144.216, is amended by adding a subdivision
151.11 to read:

151.12 Subd. 3. **Reporting safe place newborns.** Hospitals that receive a newborn under section
151.13 145.902 shall report the birth of the newborn to the Office of Vital Records within five days
151.14 after receiving the newborn. Information about the newborn shall be registered by the state
151.15 registrar in accordance with Minnesota Rules, part 4601.0600, subpart 4, item C.

151.16 Sec. 25. Minnesota Statutes 2022, section 144.216, is amended by adding a subdivision
151.17 to read:

151.18 Subd. 4. **Status of safe place birth reports and registrations.** (a) Information about a
151.19 safe place newborn registered under subdivision 3 shall constitute the record of birth for
151.20 the child. The record shall be confidential pursuant to section 13.02, subdivision 3.
151.21 Information on the birth record or a birth certificate issued from the birth record shall be
151.22 disclosed only to the responsible social services agency or pursuant to a court order.

151.23 (b) Information about a safe place newborn registered under subdivision 3 shall constitute
151.24 the record of birth for the child. If the safe place newborn was born in a hospital and it is
151.25 known that a record of birth was registered, filed, or amended, the original birth record
151.26 registered under section 144.215 shall be replaced pursuant to section 144.218, subdivision
151.27 6.

151.28 Sec. 26. Minnesota Statutes 2022, section 144.218, is amended by adding a subdivision
151.29 to read:

151.30 Subd. 6. **Safe place newborn; birth record.** If a safe place infant birth is registered
151.31 pursuant to section 144.216, subdivision 4, paragraph (b), the state registrar shall issue a

152.1 replacement birth record free of information that identifies a parent. The prior vital record
152.2 shall be confidential pursuant to section 13.02, subdivision 3, and shall not be disclosed
152.3 except pursuant to a court order.

152.4 Sec. 27. Minnesota Statutes 2022, section 144.493, is amended by adding a subdivision
152.5 to read:

152.6 Subd. 2a. **Thrombectomy-capable stroke center.** A hospital meets the criteria for a
152.7 thrombectomy-capable stroke center if the hospital has been certified as a
152.8 thrombectomy-capable stroke center by the joint commission or another nationally recognized
152.9 accreditation entity, or is a primary stroke center that is not certified as a thrombectomy-based
152.10 capable stroke center but the hospital has attained a level of stroke care distinction by offering
152.11 mechanical endovascular therapies and has been certified by a department approved certifying
152.12 body that is a nationally recognized guidelines-based organization.

152.13 Sec. 28. Minnesota Statutes 2022, section 144.494, subdivision 2, is amended to read:

152.14 Subd. 2. **Designation.** A hospital that voluntarily meets the criteria for a comprehensive
152.15 stroke center, thrombectomy-capable stroke center, primary stroke center, or acute stroke
152.16 ready hospital may apply to the commissioner for designation, and upon the commissioner's
152.17 review and approval of the application, shall be designated as a comprehensive stroke center,
152.18 a thrombectomy-capable stroke center, a primary stroke center, or an acute stroke ready
152.19 hospital for a three-year period. If a hospital loses its certification as a comprehensive stroke
152.20 center or primary stroke center from the joint commission or other nationally recognized
152.21 accreditation entity, or no longer participates in the Minnesota stroke registry program, its
152.22 Minnesota designation shall be immediately withdrawn. Prior to the expiration of the
152.23 ~~three-year~~ designation period, a hospital seeking to remain part of the voluntary acute stroke
152.24 system may reapply to the commissioner for designation.

152.25 Sec. 29. Minnesota Statutes 2022, section 144.551, subdivision 1, is amended to read:

152.26 Subdivision 1. **Restricted construction or modification.** (a) The following construction
152.27 or modification may not be commenced:

152.28 (1) any erection, building, alteration, reconstruction, modernization, improvement,
152.29 extension, lease, or other acquisition by or on behalf of a hospital that increases the bed
152.30 capacity of a hospital, relocates hospital beds from one physical facility, complex, or site
152.31 to another, or otherwise results in an increase or redistribution of hospital beds within the
152.32 state; and

153.1 (2) the establishment of a new hospital.

153.2 (b) This section does not apply to:

153.3 (1) construction or relocation within a county by a hospital, clinic, or other health care
153.4 facility that is a national referral center engaged in substantial programs of patient care,
153.5 medical research, and medical education meeting state and national needs that receives more
153.6 than 40 percent of its patients from outside the state of Minnesota;

153.7 (2) a project for construction or modification for which a health care facility held an
153.8 approved certificate of need on May 1, 1984, regardless of the date of expiration of the
153.9 certificate;

153.10 (3) a project for which a certificate of need was denied before July 1, 1990, if a timely
153.11 appeal results in an order reversing the denial;

153.12 (4) a project exempted from certificate of need requirements by Laws 1981, chapter 200,
153.13 section 2;

153.14 (5) a project involving consolidation of pediatric specialty hospital services within the
153.15 Minneapolis-St. Paul metropolitan area that would not result in a net increase in the number
153.16 of pediatric specialty hospital beds among the hospitals being consolidated;

153.17 (6) a project involving the temporary relocation of pediatric-orthopedic hospital beds to
153.18 an existing licensed hospital that will allow for the reconstruction of a new philanthropic,
153.19 pediatric-orthopedic hospital on an existing site and that will not result in a net increase in
153.20 the number of hospital beds. Upon completion of the reconstruction, the licenses of both
153.21 hospitals must be reinstated at the capacity that existed on each site before the relocation;

153.22 (7) the relocation or redistribution of hospital beds within a hospital building or
153.23 identifiable complex of buildings provided the relocation or redistribution does not result
153.24 in: (i) an increase in the overall bed capacity at that site; (ii) relocation of hospital beds from
153.25 one physical site or complex to another; or (iii) redistribution of hospital beds within the
153.26 state or a region of the state;

153.27 (8) relocation or redistribution of hospital beds within a hospital corporate system that
153.28 involves the transfer of beds from a closed facility site or complex to an existing site or
153.29 complex provided that: (i) no more than 50 percent of the capacity of the closed facility is
153.30 transferred; (ii) the capacity of the site or complex to which the beds are transferred does
153.31 not increase by more than 50 percent; (iii) the beds are not transferred outside of a federal
153.32 health systems agency boundary in place on July 1, 1983; (iv) the relocation or redistribution
153.33 does not involve the construction of a new hospital building; and (v) the transferred beds

154.1 are used first to replace within the hospital corporate system the total number of beds
154.2 previously used in the closed facility site or complex for mental health services and substance
154.3 use disorder services. Only after the hospital corporate system has fulfilled the requirements
154.4 of this item may the remainder of the available capacity of the closed facility site or complex
154.5 be transferred for any other purpose;

154.6 (9) a construction project involving up to 35 new beds in a psychiatric hospital in Rice
154.7 County that primarily serves adolescents and that receives more than 70 percent of its
154.8 patients from outside the state of Minnesota;

154.9 (10) a project to replace a hospital or hospitals with a combined licensed capacity of
154.10 130 beds or less if: (i) the new hospital site is located within five miles of the current site;
154.11 and (ii) the total licensed capacity of the replacement hospital, either at the time of
154.12 construction of the initial building or as the result of future expansion, will not exceed ~~70~~
154.13 100 licensed hospital beds, or the combined licensed capacity of the hospitals, whichever
154.14 is less;

154.15 (11) the relocation of licensed hospital beds from an existing state facility operated by
154.16 the commissioner of human services to a new or existing facility, building, or complex
154.17 operated by the commissioner of human services; from one regional treatment center site
154.18 to another; or from one building or site to a new or existing building or site on the same
154.19 campus;

154.20 (12) the construction or relocation of hospital beds operated by a hospital having a
154.21 statutory obligation to provide hospital and medical services for the indigent that does not
154.22 result in a net increase in the number of hospital beds, notwithstanding section 144.552, 27
154.23 beds, of which 12 serve mental health needs, may be transferred from Hennepin County
154.24 Medical Center to Regions Hospital under this clause;

154.25 (13) a construction project involving the addition of up to 31 new beds in an existing
154.26 nonfederal hospital in Beltrami County;

154.27 (14) a construction project involving the addition of up to eight new beds in an existing
154.28 nonfederal hospital in Otter Tail County with 100 licensed acute care beds;

154.29 (15) a construction project involving the addition of 20 new hospital beds in an existing
154.30 hospital in Carver County serving the southwest suburban metropolitan area;

154.31 (16) a project for the construction or relocation of up to 20 hospital beds for the operation
154.32 of up to two psychiatric facilities or units for children provided that the operation of the
154.33 facilities or units have received the approval of the commissioner of human services;

155.1 (17) a project involving the addition of 14 new hospital beds to be used for rehabilitation
155.2 services in an existing hospital in Itasca County;

155.3 (18) a project to add 20 licensed beds in existing space at a hospital in Hennepin County
155.4 that closed 20 rehabilitation beds in 2002, provided that the beds are used only for
155.5 rehabilitation in the hospital's current rehabilitation building. If the beds are used for another
155.6 purpose or moved to another location, the hospital's licensed capacity is reduced by 20 beds;

155.7 (19) a critical access hospital established under section 144.1483, clause (9), and section
155.8 1820 of the federal Social Security Act, United States Code, title 42, section 1395i-4, that
155.9 delicensed beds since enactment of the Balanced Budget Act of 1997, Public Law 105-33,
155.10 to the extent that the critical access hospital does not seek to exceed the maximum number
155.11 of beds permitted such hospital under federal law;

155.12 (20) notwithstanding section 144.552, a project for the construction of a new hospital
155.13 in the city of Maple Grove with a licensed capacity of up to 300 beds provided that:

155.14 (i) the project, including each hospital or health system that will own or control the entity
155.15 that will hold the new hospital license, is approved by a resolution of the Maple Grove City
155.16 Council as of March 1, 2006;

155.17 (ii) the entity that will hold the new hospital license will be owned or controlled by one
155.18 or more not-for-profit hospitals or health systems that have previously submitted a plan or
155.19 plans for a project in Maple Grove as required under section 144.552, and the plan or plans
155.20 have been found to be in the public interest by the commissioner of health as of April 1,
155.21 2005;

155.22 (iii) the new hospital's initial inpatient services must include, but are not limited to,
155.23 medical and surgical services, obstetrical and gynecological services, intensive care services,
155.24 orthopedic services, pediatric services, noninvasive cardiac diagnostics, behavioral health
155.25 services, and emergency room services;

155.26 (iv) the new hospital:

155.27 (A) will have the ability to provide and staff sufficient new beds to meet the growing
155.28 needs of the Maple Grove service area and the surrounding communities currently being
155.29 served by the hospital or health system that will own or control the entity that will hold the
155.30 new hospital license;

155.31 (B) will provide uncompensated care;

155.32 (C) will provide mental health services, including inpatient beds;

156.1 (D) will be a site for workforce development for a broad spectrum of health-care-related
156.2 occupations and have a commitment to providing clinical training programs for physicians
156.3 and other health care providers;

156.4 (E) will demonstrate a commitment to quality care and patient safety;

156.5 (F) will have an electronic medical records system, including physician order entry;

156.6 (G) will provide a broad range of senior services;

156.7 (H) will provide emergency medical services that will coordinate care with regional
156.8 providers of trauma services and licensed emergency ambulance services in order to enhance
156.9 the continuity of care for emergency medical patients; and

156.10 (I) will be completed by December 31, 2009, unless delayed by circumstances beyond
156.11 the control of the entity holding the new hospital license; and

156.12 (v) as of 30 days following submission of a written plan, the commissioner of health
156.13 has not determined that the hospitals or health systems that will own or control the entity
156.14 that will hold the new hospital license are unable to meet the criteria of this clause;

156.15 (21) a project approved under section 144.553;

156.16 (22) a project for the construction of a hospital with up to 25 beds in Cass County within
156.17 a 20-mile radius of the state Ah-Gwah-Ching facility, provided the hospital's license holder
156.18 is approved by the Cass County Board;

156.19 (23) a project for an acute care hospital in Fergus Falls that will increase the bed capacity
156.20 from 108 to 110 beds by increasing the rehabilitation bed capacity from 14 to 16 and closing
156.21 a separately licensed 13-bed skilled nursing facility;

156.22 (24) notwithstanding section 144.552, a project for the construction and expansion of a
156.23 specialty psychiatric hospital in Hennepin County for up to 50 beds, exclusively for patients
156.24 who are under 21 years of age on the date of admission. The commissioner conducted a
156.25 public interest review of the mental health needs of Minnesota and the Twin Cities
156.26 metropolitan area in 2008. No further public interest review shall be conducted for the
156.27 construction or expansion project under this clause;

156.28 (25) a project for a 16-bed psychiatric hospital in the city of Thief River Falls, if the
156.29 commissioner finds the project is in the public interest after the public interest review
156.30 conducted under section 144.552 is complete;

156.31 (26)(i) a project for a 20-bed psychiatric hospital, within an existing facility in the city
156.32 of Maple Grove, exclusively for patients who are under 21 years of age on the date of

157.1 admission, if the commissioner finds the project is in the public interest after the public
157.2 interest review conducted under section 144.552 is complete;

157.3 (ii) this project shall serve patients in the continuing care benefit program under section
157.4 256.9693. The project may also serve patients not in the continuing care benefit program;
157.5 and

157.6 (iii) if the project ceases to participate in the continuing care benefit program, the
157.7 commissioner must complete a subsequent public interest review under section 144.552. If
157.8 the project is found not to be in the public interest, the license must be terminated six months
157.9 from the date of that finding. If the commissioner of human services terminates the contract
157.10 without cause or reduces per diem payment rates for patients under the continuing care
157.11 benefit program below the rates in effect for services provided on December 31, 2015, the
157.12 project may cease to participate in the continuing care benefit program and continue to
157.13 operate without a subsequent public interest review;

157.14 (27) a project involving the addition of 21 new beds in an existing psychiatric hospital
157.15 in Hennepin County that is exclusively for patients who are under 21 years of age on the
157.16 date of admission;

157.17 (28) a project to add 55 licensed beds in an existing safety net, level I trauma center
157.18 hospital in Ramsey County as designated under section 383A.91, subdivision 5, of which
157.19 15 beds are to be used for inpatient mental health and 40 are to be used for other services.
157.20 In addition, five unlicensed observation mental health beds shall be added;

157.21 (29) upon submission of a plan to the commissioner for public interest review under
157.22 section 144.552 and the addition of the 15 inpatient mental health beds specified in clause
157.23 (28), to its bed capacity, a project to add 45 licensed beds in an existing safety net, level I
157.24 trauma center hospital in Ramsey County as designated under section 383A.91, subdivision
157.25 5. Five of the 45 additional beds authorized under this clause must be designated for use
157.26 for inpatient mental health and must be added to the hospital's bed capacity before the
157.27 remaining 40 beds are added. Notwithstanding section 144.552, the hospital may add licensed
157.28 beds under this clause prior to completion of the public interest review, provided the hospital
157.29 submits its plan by the 2021 deadline and adheres to the timelines for the public interest
157.30 review described in section 144.552;

157.31 (30) upon submission of a plan to the commissioner for public interest review under
157.32 section 144.552, a project to add up to 30 licensed beds in an existing psychiatric hospital
157.33 in Hennepin County that exclusively provides care to patients who are under 21 years of
157.34 age on the date of admission. Notwithstanding section 144.552, the psychiatric hospital

158.1 may add licensed beds under this clause prior to completion of the public interest review,
158.2 provided the hospital submits its plan by the 2021 deadline and adheres to the timelines for
158.3 the public interest review described in section 144.552;

158.4 (31) any project to add licensed beds in a hospital located in Cook County or Mahanomen
158.5 County that: (i) is designated as a critical access hospital under section 144.1483, clause
158.6 (9), and United States Code, title 42, section 1395i-4; (ii) has a licensed bed capacity of
158.7 fewer than 25 beds; and (iii) has an attached nursing home, so long as the total number of
158.8 licensed beds in the hospital after the bed addition does not exceed 25 beds. Notwithstanding
158.9 section 144.552, a public interest review is not required for a project authorized under this
158.10 clause;

158.11 (32) upon submission of a plan to the commissioner for public interest review under
158.12 section 144.552, a project to add 22 licensed beds at a Minnesota freestanding children's
158.13 hospital in St. Paul that is part of an independent pediatric health system with freestanding
158.14 inpatient hospitals located in Minneapolis and St. Paul. The beds shall be utilized for pediatric
158.15 inpatient behavioral health services. Notwithstanding section 144.552, the hospital may add
158.16 licensed beds under this clause prior to completion of the public interest review, provided
158.17 the hospital submits its plan by the 2022 deadline and adheres to the timelines for the public
158.18 interest review described in section 144.552; ~~or~~

158.19 (33) a project for a 144-bed psychiatric hospital on the site of the former Bethesda
158.20 hospital in the city of Saint Paul, Ramsey County, if the commissioner finds the project is
158.21 in the public interest after the public interest review conducted under section 144.552 is
158.22 complete. Following the completion of the construction project, the commissioner of health
158.23 shall monitor the hospital, including by assessing the hospital's case mix and payer mix,
158.24 patient transfers, and patient diversions. The hospital must have an intake and assessment
158.25 area. The hospital must accommodate patients with acute mental health needs, whether they
158.26 walk up to the facility, are delivered by ambulances or law enforcement, or are transferred
158.27 from other facilities. The hospital must comply with subdivision 1a, paragraph (b). The
158.28 hospital must annually submit de-identified data to the department in the format and manner
158.29 defined by the commissioner; or

158.30 (34) a project involving the relocation of up to 26 licensed long-term acute care hospital
158.31 beds from an existing long-term care hospital located in Hennepin County with a licensed
158.32 capacity prior to the relocation of 92 beds to dedicated space on the campus of an existing
158.33 safety net, level I trauma center hospital in Ramsey County as designated under section
158.34 383A.91, subdivision 5, provided both the commissioner finds the project is in the public
158.35 interest after the public interest review conducted under section 144.552 is complete and

159.1 the relocated beds continue to be used as long-term acute care hospital beds after the
 159.2 relocation.

159.3 Sec. 30. Minnesota Statutes 2022, section 144.605, is amended by adding a subdivision
 159.4 to read:

159.5 Subd. 10. **Chapter 16C waiver.** Pursuant to subdivisions 4, paragraph (b), and 5,
 159.6 paragraph (b), the commissioner of administration may waive provisions of chapter 16C
 159.7 for the purposes of approving contracts for independent clinical teams.

159.8 Sec. 31. Minnesota Statutes 2023 Supplement, section 144.651, subdivision 10a, is amended
 159.9 to read:

159.10 Subd. 10a. **Designated support person for pregnant patient or other patient.** (a)
 159.11 Subject to paragraph (c), a health care provider and a health care facility must allow, at a
 159.12 minimum, one designated support person ~~of a pregnant patient's choosing~~ chosen by a
 159.13 patient, including but not limited to a pregnant patient, to be physically present while the
 159.14 patient is receiving health care services including during a hospital stay.

159.15 (b) For purposes of this subdivision, "designated support person" means any person
 159.16 chosen by the patient to provide comfort to the patient including but not limited to the
 159.17 patient's spouse, partner, family member, or another person related by affinity. Certified
 159.18 doulas and traditional midwives may not be counted toward the limit of one designated
 159.19 support person.

159.20 (c) A facility may restrict or prohibit the presence of a designated support person in
 159.21 treatment rooms, procedure rooms, and operating rooms when such a restriction or prohibition
 159.22 is strictly necessary to meet the appropriate standard of care. A facility may also restrict or
 159.23 prohibit the presence of a designated support person if the designated support person is
 159.24 acting in a violent or threatening manner toward others. Any restriction or prohibition of a
 159.25 designated support person by the facility is subject to the facility's written internal grievance
 159.26 procedure required by subdivision 20.

159.27 Sec. 32. **[144.6985] COMMUNITY HEALTH NEEDS ASSESSMENT; COMMUNITY**
 159.28 **HEALTH IMPROVEMENT SERVICES; IMPLEMENTATION.**

159.29 Subdivision 1. **Community health needs assessment.** A nonprofit hospital that is exempt
 159.30 from taxation under section 501(c)(3) of the Internal Revenue Code must make available
 159.31 to the public and submit to the commissioner of health, by January 15, 2026, the most recent
 159.32 community health needs assessment submitted by the hospital to the Internal Revenue

160.1 Service. Each time the hospital conducts a subsequent community health needs assessment,
160.2 the hospital must, within 15 business days after submitting the subsequent community health
160.3 needs assessment to the Internal Revenue Service, make the subsequent assessment available
160.4 to the public and submit the subsequent assessment to the commissioner.

160.5 Subd. 2. **Description of community.** A nonprofit hospital subject to subdivision 1 must
160.6 make available to the public and submit to the commissioner of health a description of the
160.7 community served by the hospital. The description must include a geographic description
160.8 of the area where the hospital is located, a description of the general population served by
160.9 the hospital, and demographic information about the community served by the hospital,
160.10 such as leading causes of death, levels of chronic illness, and descriptions of the medically
160.11 underserved, low-income, minority, or chronically ill populations in the community. A
160.12 hospital is not required to separately make the information available to the public or
160.13 separately submit the information to the commissioner if the information is included in the
160.14 hospital's community health needs assessment made available and submitted under
160.15 subdivision 1.

160.16 Subd. 3. **Addendum; community health improvement services.** (a) A nonprofit hospital
160.17 subject to subdivision 1 must annually submit to the commissioner an addendum which
160.18 details information about hospital activities identified as community health improvement
160.19 services with a cost of \$5,000 or more. The addendum must include the type of activity, the
160.20 method through which the activity was delivered, how the activity relates to an identified
160.21 community need in the community health needs assessment, the target population for the
160.22 activity, strategies to reach the target population, identified outcome metrics, the cost to the
160.23 hospital to provide the activity, the methodology used to calculate the hospital's costs, and
160.24 the number of people served by the activity. If a community health improvement service is
160.25 administered by an entity other than the hospital, the administering entity must be identified
160.26 in the addendum. This paragraph does not apply to hospitals required to submit an addendum
160.27 under paragraph (b).

160.28 (b) A nonprofit hospital subject to subdivision 1 must annually submit to the
160.29 commissioner an addendum which details information about the ten highest-cost activities
160.30 of the hospital identified as community health improvement services if the nonprofit hospital:

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

160.33 (2) meets the definition of sole community hospital in section 62Q.19, subdivision 1,
160.34 paragraph (a), clause (5); or

161.1 (3) meets the definition of rural emergency hospital in United States Code, title 42,
 161.2 section 1395x(kkk)(2).

161.3 The addendum must include the type of activity, the method in which the activity was
 161.4 delivered, how the activity relates to an identified community need in the community health
 161.5 needs assessment, the target population for the activity, strategies to reach the target
 161.6 population, identified outcome metrics, the cost to the hospital to provide the activity, the
 161.7 methodology used to calculate the hospital's costs, and the number of people served by the
 161.8 activity. If a community health improvement service is administered by an entity other than
 161.9 the hospital, the administering entity must be identified in the addendum.

161.10 Subd. 4. **Community benefit implementation strategy.** A nonprofit hospital subject
 161.11 to subdivision 1 must make available to the public, within one year after completing each
 161.12 community health needs assessment, a community benefit implementation strategy. In
 161.13 developing the community benefit implementation strategy, the hospital must consult with
 161.14 community-based organizations, stakeholders, local public health organizations, and others
 161.15 as determined by the hospital. The implementation strategy must include how the hospital
 161.16 shall address the top three community health priorities identified in the community health
 161.17 needs assessment. Implementation strategies must be evidence-based, when available, and
 161.18 development and implementation of innovative programs and strategies may be supported
 161.19 by evaluation measures.

161.20 Subd. 5. **Information made available to the public.** A nonprofit hospital required to
 161.21 make information available to the public under this section may do so by posting the
 161.22 information on the hospital's website in a consolidated location and with clear labeling.
 161.23 This section is effective January 1, 2026.

161.24 Sec. 33. Minnesota Statutes 2022, section 144.7067, subdivision 2, is amended to read:

161.25 Subd. 2. **Duty to analyze reports; communicate findings.** (a) The commissioner shall:

161.26 (1) analyze adverse event reports, corrective action plans, and findings of the root cause
 161.27 analyses to determine patterns of systemic failure in the health care system and successful
 161.28 methods to correct these failures;

161.29 (2) communicate to individual facilities the commissioner's conclusions, if any, regarding
 161.30 an adverse event reported by the facility;

161.31 (3) communicate with relevant health care facilities any recommendations for corrective
 161.32 action resulting from the commissioner's analysis of submissions from facilities; and

162.1 (4) publish an annual report:

162.2 (i) describing, by institution, adverse events reported;

162.3 (ii) outlining, in aggregate, corrective action plans and the findings of root cause analyses;

162.4 and

162.5 (iii) making recommendations for modifications of state health care operations.

162.6 (b) Notwithstanding section 144.05, subdivision 7, the mandate to publish an annual
162.7 report under this subdivision does not expire.

162.8 **EFFECTIVE DATE.** This section is effective retroactively from January 1, 2023.

162.9 Sec. 34. Minnesota Statutes 2022, section 144.99, subdivision 3, is amended to read:

162.10 Subd. 3. **Correction orders.** (a) The commissioner may issue correction orders that
162.11 require a person to correct a violation of the statutes, rules, and other actions listed in
162.12 subdivision 1. The correction order must state the deficiencies that constitute the violation;
162.13 the specific statute, rule, or other action; and the time by which the violation must be
162.14 corrected.

162.15 (b) If the person believes that the information contained in the commissioner's correction
162.16 order is in error, the person may ask the commissioner to reconsider the parts of the order
162.17 that are alleged to be in error. The request must be in writing, delivered to the commissioner
162.18 by certified mail within ~~seven~~ 15 calendar days after receipt of the order, and:

162.19 (1) specify which parts of the order for corrective action are alleged to be in error;

162.20 (2) explain why they are in error; and

162.21 (3) provide documentation to support the allegation of error.

162.22 The commissioner must respond to requests made under this paragraph within 15 calendar
162.23 days after receiving a request. A request for reconsideration does not stay the correction
162.24 order; however, after reviewing the request for reconsideration, the commissioner may
162.25 provide additional time to comply with the order if necessary. The commissioner's disposition
162.26 of a request for reconsideration is final.

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

162.28 Sec. 35. Minnesota Statutes 2022, section 144A.10, subdivision 15, is amended to read:

162.29 Subd. 15. **Informal dispute resolution.** The commissioner shall respond in writing to
162.30 a request from a nursing facility certified under the federal Medicare and Medicaid programs

163.1 for an informal dispute resolution within ~~30 days of the exit date of the facility's survey~~ ten
 163.2 calendar days of the facility's receipt of the notice of deficiencies. The commissioner's
 163.3 response shall identify the commissioner's decision regarding ~~the continuation of each~~
 163.4 deficiency citation challenged by the nursing facility, as well as a statement of any changes
 163.5 in findings, level of severity or scope, and proposed remedies or sanctions for each deficiency
 163.6 citation.

163.7 **EFFECTIVE DATE.** This section is effective August 1, 2024.

163.8 Sec. 36. Minnesota Statutes 2022, section 144A.10, subdivision 16, is amended to read:

163.9 Subd. 16. **Independent informal dispute resolution.** (a) Notwithstanding subdivision
 163.10 15, a facility certified under the federal Medicare or Medicaid programs that has been
 163.11 assessed a civil money penalty as provided by Code of Federal Regulations, title 42, section
 163.12 488.430, may request from the commissioner, in writing, an independent informal dispute
 163.13 resolution process regarding any deficiency ~~citation issued to the facility.~~ The facility must
 163.14 ~~specify in its written request each deficiency citation that it disputes. The commissioner~~
 163.15 ~~shall provide a hearing under sections 14.57 to 14.62. Upon the written request of the facility,~~
 163.16 ~~the parties must submit the issues raised to arbitration by an administrative law judge~~ submit
 163.17 its request in writing within ten calendar days of receiving notice that a civil money penalty
 163.18 will be imposed.

163.19 (b) The facility and commissioner have the right to be represented by an attorney at the
 163.20 hearing.

163.21 (c) An independent informal dispute resolution may not be requested for any deficiency
 163.22 that is the subject of an active informal dispute resolution requested under subdivision 15.
 163.23 The facility must withdraw its informal dispute resolution prior to requesting independent
 163.24 informal dispute resolution.

163.25 ~~(b) Upon~~ (d) Within five calendar days of receipt of a written request for an arbitration
 163.26 ~~proceeding independent informal dispute resolution,~~ the commissioner shall file with the
 163.27 Office of Administrative Hearings a request for the appointment of an ~~arbitrator~~
 163.28 administrative law judge from the Office of Administrative Hearings and simultaneously
 163.29 serve the facility with notice of the request. ~~The arbitrator for the dispute shall be an~~
 163.30 ~~administrative law judge appointed by the Office of Administrative Hearings. The disclosure~~
 163.31 ~~provisions of section 572B.12 and the notice provisions of section 572B.15, subsection (c),~~
 163.32 ~~apply. The facility and the commissioner have the right to be represented by an attorney.~~

164.1 (e) An independent informal dispute resolution proceeding shall be scheduled to occur
164.2 within 30 calendar days of the commissioner's request to the Office of Administrative
164.3 Hearings, unless the parties agree otherwise or the chief administrative law judge deems
164.4 the timing to be unreasonable. The independent informal dispute resolution process must
164.5 be completed within 60 calendar days of the facility's request.

164.6 ~~(e)~~ (f) Five working days in advance of the scheduled proceeding, the commissioner
164.7 and the facility may present must submit written statements and arguments, documentary
164.8 evidence, depositions, and oral statements and arguments at the arbitration proceeding. Oral
164.9 statements and arguments may be made by telephone any other materials supporting their
164.10 position to the administrative law judge.

164.11 (g) The independent informal dispute resolution proceeding shall be informal and
164.12 conducted in a manner so as to allow the parties to fully present their positions and respond
164.13 to the opposing party's positions. This may include presentation of oral statements and
164.14 arguments at the proceeding.

164.15 ~~(d)~~ (h) Within ten working days of the close of the arbitration proceeding, the
164.16 administrative law judge shall issue findings and recommendations regarding each of the
164.17 deficiencies in dispute. The findings shall be one or more of the following:

164.18 (1) Supported in full. The citation is supported in full, with no deletion of findings and
164.19 no change in the scope or severity assigned to the deficiency citation.

164.20 (2) Supported in substance. The citation is supported, but one or more findings are
164.21 deleted without any change in the scope or severity assigned to the deficiency.

164.22 (3) Deficient practice cited under wrong requirement of participation. The citation is
164.23 amended by moving it to the correct requirement of participation.

164.24 (4) Scope not supported. The citation is amended through a change in the scope assigned
164.25 to the citation.

164.26 (5) Severity not supported. The citation is amended through a change in the severity
164.27 assigned to the citation.

164.28 (6) No deficient practice. The citation is deleted because the findings did not support
164.29 the citation or the negative resident outcome was unavoidable. ~~The findings of the arbitrator~~
164.30 ~~are not binding on the commissioner.~~

164.31 (i) The findings and recommendations of the administrative law judge are not binding
164.32 on the commissioner.

165.1 (j) Within ten calendar days of receiving the administrative law judge's findings and
 165.2 recommendations, the commissioner shall issue a recommendation to the Center for Medicare
 165.3 and Medicaid Services.

165.4 ~~(e)(k) The commissioner shall reimburse the Office of Administrative Hearings for the~~
 165.5 ~~costs incurred by that office for the arbitration proceeding. The facility shall reimburse the~~
 165.6 ~~commissioner for the proportion of the costs that represent the sum of deficiency citations~~
 165.7 ~~supported in full under paragraph (d), clause (1), or in substance under paragraph (d), clause~~
 165.8 ~~(2), divided by the total number of deficiencies disputed. A deficiency citation for which~~
 165.9 ~~the administrative law judge's sole finding is that the deficient practice was cited under the~~
 165.10 ~~wrong requirements of participation shall not be counted in the numerator or denominator~~
 165.11 ~~in the calculation of the proportion of costs.~~

165.12 **EFFECTIVE DATE.** This section is effective October 1, 2024, or upon federal approval,
 165.13 whichever is later, and applies to appeals of deficiencies which are issued after October 1,
 165.14 2024, or on or after the date upon which federal approval is obtained, whichever is later.
 165.15 The commissioner of health shall notify the revisor of statutes when federal approval is
 165.16 obtained.

165.17 Sec. 37. Minnesota Statutes 2022, section 144A.471, is amended by adding a subdivision
 165.18 to read:

165.19 Subd. 1a. **Licensure under other law.** A home care licensee must not provide sleeping
 165.20 accommodations as a provision of home care services. For purposes of this subdivision, the
 165.21 provision of sleeping accommodations and assisted living services under section 144G.08,
 165.22 subdivision 9, requires assisted living facility licensure under chapter 144G. This subdivision
 165.23 does not apply to those settings exempt from assisted living facility licensure under section
 165.24 144G.08, subdivision 7.

165.25 Sec. 38. Minnesota Statutes 2022, section 144A.474, subdivision 13, is amended to read:

165.26 Subd. 13. **Home care surveyor training.** (a) Before conducting a home care survey,
 165.27 each home care surveyor must receive training on the following topics:

165.28 (1) Minnesota home care licensure requirements;

165.29 (2) Minnesota home care bill of rights;

165.30 (3) Minnesota Vulnerable Adults Act and reporting of maltreatment of minors;

165.31 (4) principles of documentation;

- 166.1 (5) survey protocol and processes;
- 166.2 (6) Offices of the Ombudsman roles;
- 166.3 (7) Office of Health Facility Complaints;
- 166.4 (8) Minnesota landlord-tenant ~~and housing with services~~ laws;
- 166.5 (9) types of payors for home care services; and
- 166.6 (10) Minnesota Nurse Practice Act for nurse surveyors.

166.7 (b) Materials used for the training in paragraph (a) shall be posted on the department
 166.8 website. Requisite understanding of these topics will be reviewed as part of the quality
 166.9 improvement plan in section 144A.483.

166.10 Sec. 39. Minnesota Statutes 2023 Supplement, section 144A.4791, subdivision 10, is
 166.11 amended to read:

166.12 **Subd. 10. Termination of service plan.** (a) If a home care provider terminates a service
 166.13 plan with a client, and the client continues to need home care services, the home care provider
 166.14 shall provide the client and the client's representative, if any, with a written notice of
 166.15 termination which includes the following information:

166.16 (1) the effective date of termination;

166.17 (2) the reason for termination;

166.18 (3) for clients age 18 or older, a statement that the client may contact the Office of
 166.19 Ombudsman for Long-Term Care to request an advocate to assist regarding the termination
 166.20 and contact information for the office, including the office's central telephone number;

166.21 (4) a list of known licensed home care providers in the client's immediate geographic
 166.22 area;

166.23 (5) a statement that the home care provider will participate in a coordinated transfer of
 166.24 care of the client to another home care provider, health care provider, or caregiver, as
 166.25 required by the home care bill of rights, section 144A.44, subdivision 1, clause (17); and

166.26 (6) the name and contact information of a person employed by the home care provider
 166.27 with whom the client may discuss the notice of termination; ~~and.~~

166.28 ~~(7) if applicable, a statement that the notice of termination of home care services does~~
 166.29 ~~not constitute notice of termination of any housing contract.~~

167.1 (b) When the home care provider voluntarily discontinues services to all clients, the
167.2 home care provider must notify the commissioner, lead agencies, and ombudsman for
167.3 long-term care about its clients and comply with the requirements in this subdivision.

167.4 Sec. 40. Minnesota Statutes 2022, section 144E.16, subdivision 7, is amended to read:

167.5 Subd. 7. **Stroke transport protocols.** Regional emergency medical services programs
167.6 and any ambulance service licensed under this chapter must develop stroke transport
167.7 protocols. The protocols must include standards of care for triage and transport of acute
167.8 stroke patients within a specific time frame from symptom onset until transport to the most
167.9 appropriate designated acute stroke ready hospital, primary stroke center,
167.10 thrombectomy-capable stroke center, or comprehensive stroke center.

167.11 Sec. 41. Minnesota Statutes 2022, section 144G.08, subdivision 29, is amended to read:

167.12 Subd. 29. **Licensed health professional.** "Licensed health professional" means a person
167.13 ~~licensed in Minnesota to practice a profession described in section 214.01, subdivision 2,~~
167.14 other than a registered nurse or licensed practical nurse, who provides assisted living services
167.15 within the scope of practice of that person's health occupation license, registration, or
167.16 certification as a regulated person who is licensed by an appropriate Minnesota state board
167.17 or agency.

167.18 Sec. 42. Minnesota Statutes 2022, section 144G.10, is amended by adding a subdivision
167.19 to read:

167.20 Subd. 5. **Protected title; restriction on use.** (a) Effective January 1, 2026, no person
167.21 or entity may use the phrase "assisted living," whether alone or in combination with other
167.22 words and whether orally or in writing, to: advertise; market; or otherwise describe, offer,
167.23 or promote itself, or any housing, service, service package, or program that it provides
167.24 within this state, unless the person or entity is a licensed assisted living facility that meets
167.25 the requirements of this chapter. A person or entity entitled to use the phrase "assisted living"
167.26 shall use the phrase only in the context of its participation that meets the requirements of
167.27 this chapter.

167.28 (b) Effective January 1, 2026, the licensee's name for a new assisted living facility may
167.29 not include the terms "home care" or "nursing home."

168.1 Sec. 43. Minnesota Statutes 2022, section 144G.16, subdivision 6, is amended to read:

168.2 Subd. 6. **Requirements for notice and transfer.** A provisional licensee whose license
 168.3 is denied must comply with the requirements for notification and the coordinated move of
 168.4 residents in sections 144G.52 and 144G.55. If the license denial is upheld by the
 168.5 reconsideration process, the licensee must submit a draft closure plan as required by section
 168.6 144G.57 within ten calendar days of receipt of the reconsideration decision, must work with
 168.7 the commissioner on any revisions needed to the draft plan, and must have a final closure
 168.8 plan submitted and approved within 30 calendar days of receipt of the reconsideration
 168.9 decision.

168.10 Sec. 44. Minnesota Statutes 2023 Supplement, section 145.561, subdivision 4, is amended
 168.11 to read:

168.12 Subd. 4. **988 telecommunications fee.** (a) In compliance with the National Suicide
 168.13 Hotline Designation Act of 2020, ~~the commissioner shall impose a monthly statewide fee~~
 168.14 ~~on~~ each subscriber of a wireline, wireless, or IP-enabled voice service ~~at a rate that provides~~
 168.15 must pay a monthly fee to provide for the robust creation, operation, and maintenance of a
 168.16 statewide 988 suicide prevention and crisis system.

168.17 ~~(b) The commissioner shall annually recommend to the Public Utilities Commission an~~
 168.18 ~~adequate and appropriate fee to implement this section. The amount of the fee must comply~~
 168.19 ~~with the limits in paragraph (c). The commissioner shall provide telecommunication service~~
 168.20 ~~providers and carriers a minimum of 45 days' notice of each fee change.~~

168.21 ~~(e)~~ (b) The amount of the 988 telecommunications fee ~~must not be more than 25~~ is 12
 168.22 cents per month ~~on or after January 1, 2024,~~ for each consumer access line, including trunk
 168.23 equivalents as designated by the ~~commission~~ Public Utilities Commission pursuant to section
 168.24 403.11, subdivision 1. The 988 telecommunications fee must be the same for all subscribers.

168.25 ~~(d)~~ (c) Each wireline, wireless, and IP-enabled voice telecommunication service provider
 168.26 shall collect the 988 telecommunications fee and transfer the amounts collected to the
 168.27 commissioner of public safety in the same manner as provided in section 403.11, subdivision
 168.28 1, paragraph (d).

168.29 ~~(e)~~ (d) The commissioner of public safety shall deposit the money collected from the
 168.30 988 telecommunications fee to the 988 special revenue account established in subdivision
 168.31 3.

168.32 ~~(f)~~ (e) All 988 telecommunications fee revenue must be used to supplement, and not
 168.33 supplant, federal, state, and local funding for suicide prevention.

169.1 ~~(g)~~ (f) The 988 telecommunications fee amount shall be adjusted as needed to provide
169.2 for continuous operation of the lifeline centers and 988 hotline, volume increases, and
169.3 maintenance.

169.4 ~~(h)~~ (g) The commissioner shall annually report to the Federal Communications
169.5 Commission on revenue generated by the 988 telecommunications fee.

169.6 **EFFECTIVE DATE.** This section is effective September 1, 2024.

169.7 Sec. 45. Minnesota Statutes 2022, section 146B.03, subdivision 7a, is amended to read:

169.8 Subd. 7a. **Supervisors.** (a) A technician must have been licensed in Minnesota or in a
169.9 jurisdiction with which Minnesota has reciprocity for at least:

169.10 (1) two years as a tattoo technician licensed under section 146B.03, subdivision 4, 6, or
169.11 8, in order to supervise a temporary tattoo technician; or

169.12 (2) one year as a body piercing technician licensed under section 146B.03, subdivision
169.13 4, 6, or 8, or must have performed at least 500 body piercings, in order to supervise a
169.14 temporary body piercing technician.

169.15 (b) Any technician who agrees to supervise more than two temporary tattoo technicians
169.16 during the same time period, or more than four body piercing technicians during the same
169.17 time period, must provide to the commissioner a supervisory plan that describes how the
169.18 technician will provide supervision to each temporary technician in accordance with section
169.19 146B.01, subdivision 28.

169.20 (c) The supervisory plan must include, at a minimum:

169.21 (1) the areas of practice under supervision;

169.22 (2) the anticipated supervision hours per week;

169.23 (3) the anticipated duration of the training period; and

169.24 (4) the method of providing supervision if there are multiple technicians being supervised
169.25 during the same time period.

169.26 (d) If the supervisory plan is terminated before completion of the technician's supervised
169.27 practice, the supervisor must notify the commissioner in writing within 14 days of the change
169.28 in supervision and include an explanation of why the plan was not completed.

169.29 (e) The commissioner may refuse to approve as a supervisor a technician who has been
169.30 disciplined in Minnesota or in another jurisdiction after considering the criteria in section
169.31 146B.02, subdivision 10, paragraph (b).

170.1 Sec. 46. Minnesota Statutes 2022, section 146B.10, subdivision 1, is amended to read:

170.2 Subdivision 1. **Licensing fees.** (a) The fee for the initial technician licensure application
170.3 and biennial licensure renewal application is \$420.

170.4 (b) The fee for temporary technician licensure application is \$240.

170.5 (c) The fee for the temporary guest artist license application is \$140.

170.6 (d) The fee for a dual body art technician license application is \$420.

170.7 (e) The fee for a provisional establishment license application required in section 146B.02,
170.8 subdivision 5, paragraph (c), is \$1,500.

170.9 (f) The fee for an initial establishment license application and the two-year license
170.10 renewal period application required in section 146B.02, subdivision 2, paragraph (b), is
170.11 \$1,500.

170.12 (g) The fee for a temporary body art establishment event permit application is \$200.

170.13 (h) The commissioner shall prorate the initial two-year technician license fee based on
170.14 the number of months in the initial licensure period. The commissioner shall prorate the
170.15 first renewal fee for the establishment license based on the number of months from issuance
170.16 of the provisional license to the first renewal.

170.17 (i) The fee for verification of licensure to other states is \$25.

170.18 ~~(j) The fee to reissue a provisional establishment license that relocates prior to inspection~~
170.19 ~~and removal of provisional status is \$350. The expiration date of the provisional license~~
170.20 ~~does not change.~~

170.21 ~~(k)~~ (j) The fee to change an establishment name or establishment type, such as tattoo,
170.22 piercing, or dual, is \$50.

170.23 Sec. 47. Minnesota Statutes 2022, section 146B.10, subdivision 3, is amended to read:

170.24 Subd. 3. **Deposit.** Fees collected by the commissioner under this section must be deposited
170.25 in the state government special revenue fund. All fees are nonrefundable.

170.26 Sec. 48. Minnesota Statutes 2022, section 149A.02, subdivision 3b, is amended to read:

170.27 Subd. 3b. **Burial site services.** "Burial site services" means any services sold or offered
170.28 for sale directly to the public for use in connection with the final disposition of a dead human
170.29 body but does not include services provided under a transportation protection agreement.

171.1 Sec. 49. Minnesota Statutes 2022, section 149A.02, subdivision 23, is amended to read:

171.2 Subd. 23. **Funeral services.** (a) "Funeral services" means any services which may be
171.3 used to: (1) care for and prepare dead human bodies for burial, alkaline hydrolysis, cremation,
171.4 or other final disposition; and (2) arrange, supervise, or conduct the funeral ceremony or
171.5 the final disposition of dead human bodies.

171.6 (b) Funeral service does not include a transportation protection agreement.

171.7 Sec. 50. Minnesota Statutes 2022, section 149A.02, is amended by adding a subdivision
171.8 to read:

171.9 Subd. 38a. **Transportation protection agreement.** "Transportation protection agreement"
171.10 means an agreement that is primarily for the purpose of transportation and subsequent
171.11 transportation of the remains of a dead human body.

171.12 Sec. 51. Minnesota Statutes 2022, section 149A.65, is amended to read:

171.13 **149A.65 FEES.**

171.14 Subdivision 1. **Generally.** This section establishes the application fees for registrations,
171.15 examinations, initial and renewal licenses, and late fees authorized under the provisions of
171.16 this chapter.

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

171.18 (1) \$75 for the initial and renewal registration of a mortuary science intern;

171.19 (2) \$125 for the mortuary science examination;

171.20 (3) \$200 for ~~issuance of~~ initial and renewal mortuary science ~~licenses~~ license applications;

171.21 (4) \$100 late fee charge for a license renewal application; and

171.22 (5) \$250 for ~~issuing a~~ an application for mortuary science license by endorsement.

171.23 Subd. 3. **Funeral directors.** The license renewal application fee for funeral directors is
171.24 \$200. The late fee charge for a license renewal is \$100.

171.25 Subd. 4. **Funeral establishments.** The initial and renewal application fee for funeral
171.26 establishments is \$425. The late fee charge for a license renewal is \$100.

171.27 Subd. 5. **Crematories.** The initial and renewal application fee for a crematory is \$425.
171.28 The late fee charge for a license renewal is \$100.

172.1 Subd. 6. **Alkaline hydrolysis facilities.** The initial and renewal application fee for an
172.2 alkaline hydrolysis facility is \$425. The late fee charge for a license renewal is \$100.

172.3 Subd. 7. **State government special revenue fund.** Fees collected by the commissioner
172.4 under this section must be deposited in the state treasury and credited to the state government
172.5 special revenue fund. All fees are nonrefundable.

172.6 Sec. 52. Minnesota Statutes 2022, section 149A.97, subdivision 2, is amended to read:

172.7 Subd. 2. **Scope and requirements.** This section shall not apply to a transportation
172.8 protection agreement or to any funeral goods or burial site goods purchased and delivered,
172.9 either at purchase or within a commercially reasonable amount of time thereafter. When
172.10 prior to the death of any person, that person or another, on behalf of that person, enters into
172.11 any transaction, makes a contract, or any series or combination of transactions or contracts
172.12 with a funeral provider lawfully doing business in Minnesota, other than an insurance
172.13 company licensed to do business in Minnesota selling approved insurance or annuity
172.14 products, by the terms of which, goods or services related to the final disposition of that
172.15 person will be furnished at-need, then the total of all money paid by the terms of the
172.16 transaction, contract, or series or combination of transactions or contracts shall be held in
172.17 trust for the purpose for which it has been paid. The person for whose benefit the money
172.18 was paid shall be known as the beneficiary, the person or persons who paid the money shall
172.19 be known as the purchaser, and the funeral provider shall be known as the depositor.

172.20 Sec. 53. Minnesota Statutes 2022, section 256R.02, subdivision 20, is amended to read:

172.21 Subd. 20. **Facility average case mix index.** "Facility average case mix index" or "CMI"
172.22 means a numerical score that describes the relative resource use for all residents within the
172.23 case mix ~~classifications under the resource utilization group (RUG)~~ classification system
172.24 prescribed by the commissioner based on an assessment of each resident. The facility average
172.25 CMI shall be computed as the standardized days divided by the sum of the facility's resident
172.26 days. The case mix indices used shall be based on the system prescribed in section 256R.17.

172.27 Sec. 54. Minnesota Statutes 2022, section 259.52, subdivision 2, is amended to read:

172.28 Subd. 2. **Requirement to search registry before adoption petition can be granted;**
172.29 **proof of search.** No petition for adoption may be granted unless the agency supervising
172.30 the adoptive placement, the birth mother of the child, the putative father who registered or
172.31 the legal father, or, in the case of a stepparent or relative adoption, the county agency
172.32 responsible for the report required under section 259.53, subdivision 1, requests that the

173.1 commissioner of health search the registry to determine whether a putative father is registered
 173.2 in relation to a child who is or may be the subject of an adoption petition. The search required
 173.3 by this subdivision must be conducted no sooner than 31 days following the birth of the
 173.4 child. A search of the registry may be proven by the production of a certified copy of the
 173.5 registration form or by a certified statement of the commissioner of health that after a search
 173.6 no registration of a putative father in relation to a child who is or may be the subject of an
 173.7 adoption petition could be located. The filing of a certified copy of an order from a juvenile
 173.8 protection matter under chapter 260C containing a finding that certification of the requisite
 173.9 search of the Minnesota Fathers' Adoption Registry was filed with the court in that matter
 173.10 shall also constitute proof of search. Certification that the Minnesota Fathers' Adoption
 173.11 Registry has been searched must be filed with the court prior to entry of any final order of
 173.12 adoption. In addition to the search required by this subdivision, the agency supervising the
 173.13 adoptive placement, the birth mother of the child, or, in the case of a stepparent or relative
 173.14 adoption, the social services agency responsible for the report under section 259.53,
 173.15 subdivision 1, or the responsible social services agency that is a petitioner in a juvenile
 173.16 protection matter under chapter 260C may request that the commissioner of health search
 173.17 the registry at any time. Search requirements of this section do not apply when the responsible
 173.18 social services agency is proceeding under Safe Place for Newborns, section 260C.139.

173.19 Sec. 55. Minnesota Statutes 2022, section 259.52, subdivision 4, is amended to read:

173.20 Subd. 4. **Classification of registry data.** (a) Data in the fathers' adoption registry,
 173.21 including all data provided in requesting the search of the registry, are private data on
 173.22 individuals, as defined in section 13.02, subdivision 2, and are nonpublic data with respect
 173.23 to data not on individuals, as defined in section 13.02, subdivision 9. Data in the registry
 173.24 may be released to:

173.25 (1) a person who is required to search the registry under subdivision 2, if the data relate
 173.26 to the child who is or may be the subject of the adoption petition;

173.27 (2) the mother of the child listed on the putative father's registration form who the
 173.28 commissioner of health is required to notify under subdivision 1, paragraph (c);

173.29 (3) the putative father who registered himself or the legal father;

173.30 (4) a public authority as provided in subdivision 3; or

173.31 ~~(4)~~ (5) an attorney who has signed an affidavit from the commissioner of health attesting
 173.32 that the attorney represents the birth mother, the putative or legal father, or the prospective
 173.33 adoptive parents.

174.1 (b) A person who receives data under this subdivision may use the data only for purposes
174.2 authorized under this section or other law.

174.3 Sec. 56. REVISOR INSTRUCTION.

174.4 The revisor of statutes shall substitute the term "employee" with the term "staff" in the
174.5 following sections of Minnesota Statutes and make any grammatical changes needed without
174.6 changing the meaning of the sentence: Minnesota Statutes, sections 144G.08, subdivisions
174.7 18 and 36; 144G.13, subdivision 1, paragraph (c); 144G.20, subdivisions 1, 2, and 21;
174.8 144G.30, subdivision 5; 144G.42, subdivision 8; 144G.45, subdivision 2; 144G.60,
174.9 subdivisions 1, paragraph (c), and 3, paragraph (a); 144G.63, subdivision 2, paragraph (a),
174.10 clause (9); 144G.64, paragraphs (a), clauses (2), (3), and (5), and (c); 144G.70, subdivision
174.11 7; and 144G.92, subdivisions 1 and 3.

174.12 Sec. 57. REPEALER.

174.13 (a) Minnesota Statutes 2022, sections 144.218, subdivision 3; 144.497; and 256R.02,
174.14 subdivision 46, are repealed.

174.15 (b) Minnesota Statutes 2023 Supplement, section 62J.312, subdivision 6, is repealed.

174.16 **ARTICLE 7**

174.17 **PHARMACY BOARD AND PRACTICE**

174.18 Section 1. Minnesota Statutes 2023 Supplement, section 62Q.46, subdivision 1, is amended
174.19 to read:

174.20 Subdivision 1. **Coverage for preventive items and services.** (a) "Preventive items and
174.21 services" has the meaning specified in the Affordable Care Act. Preventive items and services
174.22 includes:

174.23 (1) evidence-based items or services that have in effect a rating of A or B in the current
174.24 recommendations of the United States Preventive Services Task Force with respect to the
174.25 individual involved;

174.26 (2) immunizations for routine use in children, adolescents, and adults that have in effect
174.27 a recommendation from the Advisory Committee on Immunization Practices of the Centers
174.28 for Disease Control and Prevention with respect to the individual involved. For purposes
174.29 of this clause, a recommendation from the Advisory Committee on Immunization Practices
174.30 of the Centers for Disease Control and Prevention is considered in effect after the
174.31 recommendation has been adopted by the Director of the Centers for Disease Control and

175.1 Prevention, and a recommendation is considered to be for routine use if the recommendation
175.2 is listed on the Immunization Schedules of the Centers for Disease Control and Prevention;

175.3 (3) with respect to infants, children, and adolescents, evidence-informed preventive care
175.4 and screenings provided for in comprehensive guidelines supported by the Health Resources
175.5 and Services Administration;

175.6 (4) with respect to women, additional preventive care and screenings that are not listed
175.7 with a rating of A or B by the United States Preventive Services Task Force but that are
175.8 provided for in comprehensive guidelines supported by the Health Resources and Services
175.9 Administration;

175.10 (5) all contraceptive methods established in guidelines published by the United States
175.11 Food and Drug Administration;

175.12 (6) screenings for human immunodeficiency virus for:

175.13 (i) all individuals at least 15 years of age but less than 65 years of age; and

175.14 (ii) all other individuals with increased risk of human immunodeficiency virus infection
175.15 according to guidance from the Centers for Disease Control;

175.16 (7) all preexposure prophylaxis when used for the prevention or treatment of human
175.17 immunodeficiency virus, including but not limited to all preexposure prophylaxis, as defined
175.18 in any guidance by the United States Preventive Services Task Force or the Centers for
175.19 Disease Control, including the June 11, 2019, Preexposure Prophylaxis for the Prevention
175.20 of HIV Infection United States Preventive Services Task Force Recommendation Statement;
175.21 and

175.22 (8) all postexposure prophylaxis when used for the prevention or treatment of human
175.23 immunodeficiency virus, including but not limited to all postexposure prophylaxis as defined
175.24 in any guidance by the United States Preventive Services Task Force or the Centers for
175.25 Disease Control.

175.26 (b) A health plan company must provide coverage for preventive items and services at
175.27 a participating provider without imposing cost-sharing requirements, including a deductible,
175.28 coinsurance, or co-payment. Nothing in this section prohibits a health plan company that
175.29 has a network of providers from excluding coverage or imposing cost-sharing requirements
175.30 for preventive items or services that are delivered by an out-of-network provider.

175.31 (c) A health plan company is not required to provide coverage for any items or services
175.32 specified in any recommendation or guideline described in paragraph (a) if the
175.33 recommendation or guideline is no longer included as a preventive item or service as defined

176.1 in paragraph (a). Annually, a health plan company must determine whether any additional
176.2 items or services must be covered without cost-sharing requirements or whether any items
176.3 or services are no longer required to be covered.

176.4 (d) Nothing in this section prevents a health plan company from using reasonable medical
176.5 management techniques to determine the frequency, method, treatment, or setting for a
176.6 preventive item or service to the extent not specified in the recommendation or guideline.

176.7 (e) A health plan shall not require prior authorization or step therapy for preexposure
176.8 prophylaxis or postexposure prophylaxis, except that: if the United States Food and Drug
176.9 Administration has approved one or more therapeutic equivalents of a drug, device, or
176.10 product for the prevention of HIV, this paragraph does not require a health plan to cover
176.11 all of the therapeutically equivalent versions without prior authorization or step therapy, if
176.12 at least one therapeutically equivalent version is covered without prior authorization or step
176.13 therapy.

176.14 ~~(e)~~ (f) This section does not apply to grandfathered plans.

176.15 ~~(f)~~ (g) This section does not apply to plans offered by the Minnesota Comprehensive
176.16 Health Association.

176.17 **EFFECTIVE DATE.** This section is effective January 1, 2026, and applies to health
176.18 plans offered, issued, or renewed on or after that date.

176.19 Sec. 2. Minnesota Statutes 2022, section 151.01, subdivision 23, is amended to read:

176.20 Subd. 23. **Practitioner.** "Practitioner" means a licensed doctor of medicine, licensed
176.21 doctor of osteopathic medicine duly licensed to practice medicine, licensed doctor of
176.22 dentistry, licensed doctor of optometry, licensed podiatrist, licensed veterinarian, licensed
176.23 advanced practice registered nurse, or licensed physician assistant. For purposes of sections
176.24 151.15, subdivision 4; 151.211, subdivision 3; 151.252, subdivision 3; 151.37, subdivision
176.25 2, paragraph (b); and 151.461, "practitioner" also means a dental therapist authorized to
176.26 dispense and administer under chapter 150A. For purposes of sections 151.252, subdivision
176.27 3, and 151.461, "practitioner" also means a pharmacist authorized to prescribe
176.28 self-administered hormonal contraceptives, nicotine replacement medications, or opiate
176.29 antagonists under section 151.37, subdivision 14, 15, or 16, or authorized to prescribe drugs
176.30 to prevent the acquisition of human immunodeficiency virus (HIV) under section 151.37,
176.31 subdivision 17.

176.32 **EFFECTIVE DATE.** This section is effective January 1, 2025.

177.1 Sec. 3. Minnesota Statutes 2022, section 151.01, subdivision 27, is amended to read:

177.2 Subd. 27. **Practice of pharmacy.** "Practice of pharmacy" means:

177.3 (1) interpretation and evaluation of prescription drug orders;

177.4 (2) compounding, labeling, and dispensing drugs and devices (except labeling by a
177.5 manufacturer or packager of nonprescription drugs or commercially packaged legend drugs
177.6 and devices);

177.7 (3) participation in clinical interpretations and monitoring of drug therapy for assurance
177.8 of safe and effective use of drugs, including ~~the performance of~~ ordering and performing
177.9 laboratory tests that are waived under the federal Clinical Laboratory Improvement Act of
177.10 1988, United States Code, title 42, section 263a et seq., ~~provided that a pharmacist may~~
177.11 ~~interpret the results of laboratory tests but may modify~~ A pharmacist may collect specimens,
177.12 interpret results, notify the patient of results, and refer the patient to other health care
177.13 providers for follow-up care and may initiate, modify, or discontinue drug therapy only
177.14 pursuant to a protocol or collaborative practice agreement. A pharmacist may delegate the
177.15 authority to administer tests under this clause to a pharmacy technician or pharmacy intern.
177.16 A pharmacy technician or pharmacy intern may perform tests authorized under this clause
177.17 if the technician or intern is working under the direct supervision of a pharmacist;

177.18 (4) participation in drug and therapeutic device selection; drug administration for first
177.19 dosage and medical emergencies; intramuscular and subcutaneous drug administration under
177.20 a prescription drug order; drug regimen reviews; and drug or drug-related research;

177.21 (5) drug administration, through intramuscular and subcutaneous administration used
177.22 to treat mental illnesses as permitted under the following conditions:

177.23 (i) upon the order of a prescriber and the prescriber is notified after administration is
177.24 complete; or

177.25 (ii) pursuant to a protocol or collaborative practice agreement as defined by section
177.26 151.01, subdivisions 27b and 27c, and participation in the initiation, management,
177.27 modification, administration, and discontinuation of drug therapy is according to the protocol
177.28 or collaborative practice agreement between the pharmacist and a dentist, optometrist,
177.29 physician, physician assistant, podiatrist, or veterinarian, or an advanced practice registered
177.30 nurse authorized to prescribe, dispense, and administer under section 148.235. Any changes
177.31 in drug therapy or medication administration made pursuant to a protocol or collaborative
177.32 practice agreement must be documented by the pharmacist in the patient's medical record
177.33 or reported by the pharmacist to a practitioner responsible for the patient's care;

178.1 (6) ~~participation in administration of influenza vaccines and~~ initiating, ordering, and
 178.2 administering influenza and COVID-19 or SARS-CoV-2 vaccines authorized or approved
 178.3 by the United States Food and Drug Administration related to COVID-19 or SARS-CoV-2
 178.4 to all eligible individuals six three years of age and older and all other United States Food
 178.5 and Drug Administration-approved vaccines to patients ~~13~~ six years of age and older by
 178.6 ~~written protocol with a physician licensed under chapter 147, a physician assistant authorized~~
 178.7 ~~to prescribe drugs under chapter 147A, or an advanced practice registered nurse authorized~~
 178.8 ~~to prescribe drugs under section 148.235, provided that~~ according to the federal Advisory
 178.9 Committee on Immunization Practices recommendations. A pharmacist may delegate the
 178.10 authority to administer vaccines under this clause to a pharmacy technician or pharmacy
 178.11 intern who has completed training in vaccine administration if:

178.12 (i) ~~the protocol includes, at a minimum:~~

178.13 ~~(A) the name, dose, and route of each vaccine that may be given;~~

178.14 ~~(B) the patient population for whom the vaccine may be given;~~

178.15 ~~(C) contraindications and precautions to the vaccine;~~

178.16 ~~(D) the procedure for handling an adverse reaction;~~

178.17 ~~(E) the name, signature, and address of the physician, physician assistant, or advanced~~
 178.18 ~~practice registered nurse;~~

178.19 ~~(F) a telephone number at which the physician, physician assistant, or advanced practice~~
 178.20 ~~registered nurse can be contacted; and~~

178.21 ~~(G) the date and time period for which the protocol is valid;~~

178.22 ~~(ii) (i) the pharmacist has~~ and the pharmacy technician or pharmacy intern have

178.23 successfully completed a program approved by the Accreditation Council for Pharmacy
 178.24 Education (ACPE) specifically for the administration of immunizations or a program
 178.25 approved by the board;

178.26 ~~(iii) (ii) the pharmacist utilizes the Minnesota Immunization Information Connection to~~
 178.27 assess the immunization status of individuals prior to the administration of vaccines, except
 178.28 when administering influenza vaccines to individuals age nine and older;

178.29 ~~(iv) (iii) the pharmacist reports the administration of the immunization to the Minnesota~~
 178.30 Immunization Information Connection; and

178.31 ~~(v) the pharmacist complies with guidelines for vaccines and immunizations established~~
 178.32 by the federal Advisory Committee on Immunization Practices, except that a pharmacist

179.1 ~~does not need to comply with those portions of the guidelines that establish immunization~~
179.2 ~~schedules when administering a vaccine pursuant to a valid, patient-specific order issued~~
179.3 ~~by a physician licensed under chapter 147, a physician assistant authorized to prescribe~~
179.4 ~~drugs under chapter 147A, or an advanced practice registered nurse authorized to prescribe~~
179.5 ~~drugs under section 148.235, provided that the order is consistent with the United States~~
179.6 ~~Food and Drug Administration approved labeling of the vaccine;~~

179.7 (iv) if the patient is 18 years of age or younger, the pharmacist, pharmacy technician,
179.8 or pharmacy intern informs the patient and any adult caregiver accompanying the patient
179.9 of the importance of a well-child visit with a pediatrician or other licensed primary care
179.10 provider; and

179.11 (v) in the case of a pharmacy technician administering vaccinations while being
179.12 supervised by a licensed pharmacist:

179.13 (A) the supervision is in-person and must not be done through telehealth as defined
179.14 under section 62A.673, subdivision 2;

179.15 (B) the pharmacist is readily and immediately available to the immunizing pharmacy
179.16 technician;

179.17 (C) the pharmacy technician has a current certificate in basic cardiopulmonary
179.18 resuscitation;

179.19 (D) the pharmacy technician has completed a minimum of two hours of ACPE-approved,
179.20 immunization-related continuing pharmacy education as part of the pharmacy technician's
179.21 two-year continuing education schedule; and

179.22 (E) the pharmacy technician has completed one of two training programs listed under
179.23 Minnesota Rules, part 6800.3850, subpart 1h, item B;

179.24 (7) participation in the initiation, management, modification, and discontinuation of
179.25 drug therapy according to a written protocol or collaborative practice agreement between:
179.26 (i) one or more pharmacists and one or more dentists, optometrists, physicians, physician
179.27 assistants, podiatrists, or veterinarians; or (ii) one or more pharmacists and one or more
179.28 physician assistants authorized to prescribe, dispense, and administer under chapter 147A,
179.29 or advanced practice registered nurses authorized to prescribe, dispense, and administer
179.30 under section 148.235. Any changes in drug therapy made pursuant to a protocol or
179.31 collaborative practice agreement must be documented by the pharmacist in the patient's
179.32 medical record or reported by the pharmacist to a practitioner responsible for the patient's
179.33 care;

- 180.1 (8) participation in the storage of drugs and the maintenance of records;
- 180.2 (9) patient counseling on therapeutic values, content, hazards, and uses of drugs and
180.3 devices;
- 180.4 (10) offering or performing those acts, services, operations, or transactions necessary
180.5 in the conduct, operation, management, and control of a pharmacy;
- 180.6 (11) participation in the initiation, management, modification, and discontinuation of
180.7 therapy with opiate antagonists, as defined in section 604A.04, subdivision 1, pursuant to:
- 180.8 (i) a written protocol as allowed under clause (7); or
- 180.9 (ii) a written protocol with a community health board medical consultant or a practitioner
180.10 designated by the commissioner of health, as allowed under section 151.37, subdivision 13;
- 180.11 (12) prescribing self-administered hormonal contraceptives; nicotine replacement
180.12 medications; and opiate antagonists for the treatment of an acute opiate overdose pursuant
180.13 to section 151.37, subdivision 14, 15, or 16; ~~and~~
- 180.14 (13) participation in the placement of drug monitoring devices according to a prescription,
180.15 protocol, or collaborative practice agreement;
- 180.16 (14) prescribing, dispensing, and administering drugs for preventing the acquisition of
180.17 human immunodeficiency virus (HIV) if the pharmacist meets the requirements in section
180.18 151.37, subdivision 17; and
- 180.19 (15) ordering, conducting, and interpreting laboratory tests necessary for therapies that
180.20 use drugs for preventing the acquisition of HIV, if the pharmacist meets the requirements
180.21 in section 151.37, subdivision 17.

180.22 **EFFECTIVE DATE.** This section is effective July 1, 2024, except that clauses (14)
180.23 and (15) are effective January 1, 2026.

180.24 Sec. 4. Minnesota Statutes 2022, section 151.065, is amended by adding a subdivision to
180.25 read:

180.26 **Subd. 4a. Application and fee; relocation.** A person who is registered with or licensed
180.27 by the board must submit a new application to the board before relocating the physical
180.28 location of the person's business. An application must be submitted for each affected license.
180.29 The application must set forth the proposed change of location on a form established by the
180.30 board. If the licensee or registrant remitted payment for the full amount during the state's
180.31 fiscal year, the relocation application fee is the same as the application fee in subdivision
180.32 1, except that the fees in clauses (6) to (9) and (11) to (16) are reduced by \$5,000 and the

181.1 fee in clause (16) is reduced by \$55,000. If the application is made within 60 days before
181.2 the date of the original license or registration expiration, the applicant must pay the full
181.3 application fee provided in subdivision 1. Upon approval of an application for a relocation,
181.4 the board shall issue a new license or registration.

181.5 Sec. 5. Minnesota Statutes 2022, section 151.065, is amended by adding a subdivision to
181.6 read:

181.7 Subd. 4b. **Application and fee; change of ownership.** A person who is registered with
181.8 or licensed by the board must submit a new application to the board before changing the
181.9 ownership of the licensee or registrant. An application must be submitted for each affected
181.10 license. The application must set forth the proposed change of ownership on a form
181.11 established by the board. If the licensee or registrant remitted payment for the full amount
181.12 during the state's fiscal year, the application fee is the same as the application fee in
181.13 subdivision 1, except that the fees in clauses (6) to (9) and (11) to (16) are reduced by \$5,000
181.14 and the fee in clause (16) is reduced by \$55,000. If the application is made within 60 days
181.15 before the date of the original license or registration expiration, the applicant must pay the
181.16 full application fee provided in subdivision 1. Upon approval of an application for a change
181.17 of ownership, the board shall issue a new license or registration.

181.18 Sec. 6. Minnesota Statutes 2022, section 151.065, is amended by adding a subdivision to
181.19 read:

181.20 Subd. 8. **Transfer of licenses.** Licenses and registrations granted by the board are not
181.21 transferable.

181.22 Sec. 7. Minnesota Statutes 2022, section 151.066, subdivision 1, is amended to read:

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

181.25 (b) "Manufacturer" means a manufacturer licensed under section 151.252 ~~that is engaged~~
181.26 ~~in the manufacturing of an opiate,~~ excluding those exclusively licensed to manufacture
181.27 medical gas.

181.28 (c) "Opiate" means any opiate-containing controlled substance listed in section 152.02,
181.29 subdivisions 3 to 5, that is distributed, delivered, sold, or dispensed into or within this state.

181.30 (d) "Third-party logistics provider" means a third-party logistics provider licensed under
181.31 section 151.471.

182.1 (e) "Wholesaler" means a wholesale drug distributor licensed under section 151.47 that
182.2 is engaged in the wholesale drug distribution of an opiate, excluding those exclusively
182.3 licensed to distribute medical gas.

182.4 Sec. 8. Minnesota Statutes 2022, section 151.066, subdivision 2, is amended to read:

182.5 Subd. 2. **Reporting requirements.** (a) By March 1 of each year, beginning March 1,
182.6 2020, each manufacturer and each wholesaler must report to the board every sale, delivery,
182.7 or other distribution within or into this state of any opiate that is made to any practitioner,
182.8 pharmacy, hospital, veterinary hospital, or other person who is permitted by section 151.37
182.9 to possess controlled substances for administration or dispensing to patients that occurred
182.10 during the previous calendar year. Reporting must be in the automation of reports and
182.11 consolidated orders system format unless otherwise specified by the board. If no reportable
182.12 distributions occurred for a given year, notification must be provided to the board in a
182.13 manner specified by the board. If a manufacturer or wholesaler fails to provide information
182.14 required under this paragraph on a timely basis, the board may assess an administrative
182.15 penalty of \$500 per day. This penalty shall not be considered a form of disciplinary action.

182.16 (b) By March 1 of each year, beginning March 1, 2020, each owner of a pharmacy with
182.17 at least one location within this state must report to the board any intracompany delivery
182.18 or distribution into this state, of any opiate, to the extent that those deliveries and distributions
182.19 are not reported to the board by a licensed wholesaler owned by, under contract to, or
182.20 otherwise operating on behalf of the owner of the pharmacy. Reporting must be in the
182.21 manner and format specified by the board for deliveries and distributions that occurred
182.22 during the previous calendar year. The report must include the name of the manufacturer
182.23 or wholesaler from which the owner of the pharmacy ultimately purchased the opiate, and
182.24 the amount and date that the purchase occurred.

182.25 (c) By March 1 of each year, beginning March 1, 2025, each third-party logistics provider
182.26 must report to the board any delivery or distribution into this state of any opiate, to the
182.27 extent that those deliveries and distributions are not reported to the board by a licensed
182.28 wholesaler or manufacturer. Reporting must be in the manner and format specified by the
182.29 board for deliveries and distributions that occurred during the previous calendar year.

182.30 Sec. 9. Minnesota Statutes 2022, section 151.066, subdivision 3, is amended to read:

182.31 Subd. 3. **Determination of an opiate product registration fee.** (a) The board shall
182.32 annually assess an opiate product registration fee on any manufacturer of an opiate that

183.1 annually sells, delivers, or distributes an opiate within or into the state in a quantity of
183.2 2,000,000 or more units as reported to the board under subdivision 2.

183.3 (b) For purposes of assessing the annual registration fee under this section and
183.4 determining the number of opiate units a manufacturer sold, delivered, or distributed within
183.5 or into the state, the board shall not consider any opiate that is used for substance use disorder
183.6 treatment with medications for opioid use disorder.

183.7 (c) The annual registration fee for each manufacturer meeting the requirement under
183.8 paragraph (a) is \$250,000.

183.9 (d) In conjunction with the data reported under this section, and notwithstanding section
183.10 152.126, subdivision 6, the board may use the data reported under section 152.126,
183.11 subdivision 4, to determine which manufacturers meet the requirement under paragraph (a)
183.12 and are required to pay the registration fees under this subdivision.

183.13 (e) By April 1 of each year, beginning April 1, 2020, the board shall notify a manufacturer
183.14 that the manufacturer meets the requirement in paragraph (a) and is required to pay the
183.15 annual registration fee in accordance with section 151.252, subdivision 1, paragraph (b).

183.16 (f) A manufacturer may dispute the board's determination that the manufacturer must
183.17 pay the registration fee no later than 30 days after the date of notification. However, the
183.18 manufacturer must still remit the fee as required by section 151.252, subdivision 1, paragraph
183.19 (b). The dispute must be filed with the board in the manner and using the forms specified
183.20 by the board. A manufacturer must submit, with the required forms, data satisfactory to the
183.21 board that demonstrates that the assessment of the registration fee was incorrect. The board
183.22 must make a decision concerning a dispute no later than 60 days after receiving the required
183.23 dispute forms. If the board determines that the manufacturer has satisfactorily demonstrated
183.24 that the fee was incorrectly assessed, the board must refund the amount paid in error.

183.25 (g) For purposes of this subdivision, a unit means the individual dosage form of the
183.26 particular drug product that is prescribed to the patient. One unit equals one tablet, capsule,
183.27 patch, syringe, milliliter, or gram.

183.28 (h) For the purposes of this subdivision, an opiate's units will be assigned to the
183.29 manufacturer holding the New Drug Application (NDA) or Abbreviated New Drug
183.30 Application (ANDA), as listed by the United States Food and Drug Administration.

183.31 Sec. 10. Minnesota Statutes 2022, section 151.212, is amended by adding a subdivision
183.32 to read:

183.33 Subd. 4. Accessible prescription drug container labels. (a) A pharmacy must:

184.1 (1) make reasonable efforts to inform the public that an accessible prescription drug
184.2 container label is available at no additional cost, upon request of the patient or the patient's
184.3 representative, to any patient who has difficulty seeing or reading standard printed labels
184.4 on prescription drug containers; and

184.5 (2) if the pharmacy knows that the patient has difficulty seeing or reading standard
184.6 printed labels on prescription drug containers, inform a patient that an accessible prescription
184.7 drug container label is available at no additional cost upon request of the patient or the
184.8 patient's representative.

184.9 (b) Subject to paragraph (e), if a patient requests an accessible container label, the
184.10 pharmacy must provide the patient with a prescription drug container label in large print,
184.11 Braille, or may provide any other method included in the best practices for access to
184.12 prescription drug labeling information by the United States Access Board, or its successor
184.13 organization, depending on the need and preference of the patient. The pharmacy must make
184.14 reasonable efforts to ensure patient safety and access during the time it takes to provide the
184.15 requested method of accessibility.

184.16 (c) The accessible container label must:

184.17 (1) be affixed on the container in compliance with section 151.212, subdivision 1;

184.18 (2) last for at least the duration of the prescription;

184.19 (3) contain the information required under subdivisions 1 and 2;

184.20 (4) be available in a timely manner relative to the industry standard time required to
184.21 produce the accessible container label; and

184.22 (5) conform with the best practices established by the United States Access Board, or
184.23 its successor organization, for large print and Braille accessible container labels.

184.24 (d) By January 1, 2025, the commissioner of health must publish a list of pharmacies
184.25 that have informed the commissioner that the pharmacy has the technological capacity to
184.26 provide an accessible container label to a patient in the timely manner required by paragraph
184.27 (c), clause (4). The commissioner must update this list on a quarterly basis until January 1,
184.28 2026.

184.29 (e) Until January 1, 2026, if the pharmacy does not have the technological capacity to
184.30 provide an accessible container label to a patient in the timely manner required by paragraph
184.31 (c), clause (4), the pharmacy is not required to provide an accessible container label to a
184.32 patient requesting such a label, but the pharmacy must inform the patient of the list of
184.33 pharmacies with such capacity required pursuant to paragraph (d), if such list is published.

185.1 (f) On and after January 1, 2026, all pharmacies must be able to provide an accessible
185.2 container label in the timely manner required by paragraph (c), clause (4).

185.3 (g) This subdivision does not apply to prescription drugs dispensed and administered
185.4 by a correctional institution.

185.5 **EFFECTIVE DATE.** This section is effective January 1, 2025.

185.6 Sec. 11. Minnesota Statutes 2022, section 151.37, is amended by adding a subdivision to
185.7 read:

185.8 **Subd. 17. Drugs for preventing the acquisition of HIV.** (a) A pharmacist is authorized
185.9 to prescribe and administer drugs to prevent the acquisition of human immunodeficiency
185.10 virus (HIV) in accordance with this subdivision.

185.11 (b) By January 1, 2025, the Board of Pharmacy shall develop a standardized protocol
185.12 for a pharmacist to follow in prescribing the drugs described in paragraph (a). In developing
185.13 the protocol, the board may consult with community health advocacy groups, the Board of
185.14 Medical Practice, the Board of Nursing, the commissioner of health, professional pharmacy
185.15 associations, and professional associations for physicians, physician assistants, and advanced
185.16 practice registered nurses.

185.17 (c) Before a pharmacist is authorized to prescribe a drug described in paragraph (a), the
185.18 pharmacist must successfully complete a training program specifically developed for
185.19 prescribing drugs for preventing the acquisition of HIV that is offered by a college of
185.20 pharmacy, a continuing education provider that is accredited by the Accreditation Council
185.21 for Pharmacy Education, or a program approved by the board. To maintain authorization
185.22 to prescribe, the pharmacist shall complete continuing education requirements as specified
185.23 by the board.

185.24 (d) Before prescribing a drug described in paragraph (a), the pharmacist shall follow the
185.25 appropriate standardized protocol developed under paragraph (b) and, if appropriate, may
185.26 dispense to a patient a drug described in paragraph (a).

185.27 (e) Before dispensing a drug described in paragraph (a) that is prescribed by the
185.28 pharmacist, the pharmacist must provide counseling to the patient on the use of the drugs
185.29 and must provide the patient with a fact sheet that includes the indications and
185.30 contraindications for the use of these drugs, the appropriate method for using these drugs,
185.31 the need for medical follow up, and any additional information listed in Minnesota Rules,
185.32 part 6800.0910, subpart 2, that is required to be provided to a patient during the counseling
185.33 process.

186.1 (f) A pharmacist is prohibited from delegating the prescribing authority provided under
186.2 this subdivision to any other person. A pharmacist intern registered under section 151.101
186.3 may prepare the prescription, but before the prescription is processed or dispensed, a
186.4 pharmacist authorized to prescribe under this subdivision must review, approve, and sign
186.5 the prescription.

186.6 (g) Nothing in this subdivision prohibits a pharmacist from participating in the initiation,
186.7 management, modification, and discontinuation of drug therapy according to a protocol as
186.8 authorized in this section and in section 151.01, subdivision 27.

186.9 **EFFECTIVE DATE.** This section is effective January 1, 2025, except that paragraph
186.10 (b) is effective the day following final enactment.

186.11 Sec. 12. Minnesota Statutes 2023 Supplement, section 151.555, subdivision 1, is amended
186.12 to read:

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

186.15 (b) "Central repository" means a wholesale distributor that meets the requirements under
186.16 subdivision 3 and enters into a contract with the Board of Pharmacy in accordance with this
186.17 section.

186.18 (c) "Distribute" means to deliver, other than by administering or dispensing.

186.19 (d) "Donor" means:

186.20 (1) ~~a health care facility as defined in this subdivision~~ an individual at least 18 years of
186.21 age, provided that the drug or medical supply that is donated was obtained legally and meets
186.22 the requirements of this section for donation; or

186.23 (2) ~~a skilled nursing facility licensed under chapter 144A;~~ any entity legally authorized
186.24 to possess medicine with a license or permit in good standing in the state in which it is
186.25 located, without further restrictions, including but not limited to a health care facility, skilled
186.26 nursing facility, assisted living facility, pharmacy, wholesaler, and drug manufacturer.

186.27 (3) ~~an assisted living facility licensed under chapter 144G;~~

186.28 (4) ~~a pharmacy licensed under section 151.19, and located either in the state or outside~~
186.29 ~~the state;~~

186.30 (5) ~~a drug wholesaler licensed under section 151.47;~~

186.31 (6) ~~a drug manufacturer licensed under section 151.252; or~~

187.1 ~~(7) an individual at least 18 years of age, provided that the drug or medical supply that~~
187.2 ~~is donated was obtained legally and meets the requirements of this section for donation.~~

187.3 (e) "Drug" means any prescription drug that has been approved for medical use in the
187.4 United States, is listed in the United States Pharmacopoeia or National Formulary, and
187.5 meets the criteria established under this section for donation; or any over-the-counter
187.6 medication that meets the criteria established under this section for donation. This definition
187.7 includes cancer drugs and antirejection drugs, but does not include controlled substances,
187.8 as defined in section 152.01, subdivision 4, or a prescription drug that can only be dispensed
187.9 to a patient registered with the drug's manufacturer in accordance with federal Food and
187.10 Drug Administration requirements.

187.11 (f) "Health care facility" means:

187.12 (1) a physician's office or health care clinic where licensed practitioners provide health
187.13 care to patients;

187.14 (2) a hospital licensed under section 144.50;

187.15 (3) a pharmacy licensed under section 151.19 and located in Minnesota; or

187.16 (4) a nonprofit community clinic, including a federally qualified health center; a rural
187.17 health clinic; public health clinic; or other community clinic that provides health care utilizing
187.18 a sliding fee scale to patients who are low-income, uninsured, or underinsured.

187.19 (g) "Local repository" means a health care facility that elects to accept donated drugs
187.20 and medical supplies and meets the requirements of subdivision 4.

187.21 (h) "Medical supplies" or "supplies" means any prescription or nonprescription medical
187.22 supplies needed to administer a drug.

187.23 (i) "Original, sealed, unopened, tamper-evident packaging" means packaging that is
187.24 sealed, unopened, and tamper-evident, including a manufacturer's original unit dose or
187.25 unit-of-use container, a repackager's original unit dose or unit-of-use container, or unit-dose
187.26 packaging prepared by a licensed pharmacy according to the standards of Minnesota Rules,
187.27 part 6800.3750.

187.28 (j) "Practitioner" has the meaning given in section 151.01, subdivision 23, except that
187.29 it does not include a veterinarian.

188.1 Sec. 13. Minnesota Statutes 2023 Supplement, section 151.555, subdivision 4, is amended
188.2 to read:

188.3 Subd. 4. **Local repository requirements.** (a) To be eligible for participation in the
188.4 medication repository program, a health care facility must agree to comply with all applicable
188.5 federal and state laws, rules, and regulations pertaining to the medication repository program,
188.6 drug storage, and dispensing. The facility must also agree to maintain in good standing any
188.7 required state license or registration that may apply to the facility.

188.8 (b) A local repository may elect to participate in the program by submitting the following
188.9 information to the central repository on a form developed by the board and made available
188.10 on the board's website:

188.11 (1) the name, street address, and telephone number of the health care facility and any
188.12 state-issued license or registration number issued to the facility, including the issuing state
188.13 agency;

188.14 (2) the name and telephone number of a responsible pharmacist or practitioner who is
188.15 employed by or under contract with the health care facility; and

188.16 (3) a statement signed and dated by the responsible pharmacist or practitioner indicating
188.17 that the health care facility meets the eligibility requirements under this section and agrees
188.18 to comply with this section.

188.19 (c) Participation in the medication repository program is voluntary. A local repository
188.20 may withdraw from participation in the medication repository program at any time by
188.21 providing written notice to the central repository on a form developed by the board and
188.22 made available on the board's website. ~~The central repository shall provide the board with~~
188.23 ~~a copy of the withdrawal notice within ten business days from the date of receipt of the~~
188.24 ~~withdrawal notice.~~

188.25 Sec. 14. Minnesota Statutes 2023 Supplement, section 151.555, subdivision 5, is amended
188.26 to read:

188.27 Subd. 5. **Individual eligibility and application requirements.** ~~(a) To be eligible for~~
188.28 ~~the medication repository program~~ At the time of or before receiving donated drugs or
188.29 supplies as a new eligible patient, an individual must submit to a local repository an electronic
188.30 or physical intake application form that is signed by the individual and attests that the
188.31 individual:

188.32 (1) is a resident of Minnesota;

189.1 (2) is uninsured ~~and is not enrolled in the medical assistance program under chapter~~
189.2 ~~256B or the MinnesotaCare program under chapter 256L~~, has no prescription drug coverage,
189.3 or is underinsured;

189.4 (3) acknowledges that the drugs or medical supplies to be received through the program
189.5 may have been donated; and

189.6 (4) consents to a waiver of the child-resistant packaging requirements of the federal
189.7 Poison Prevention Packaging Act.

189.8 ~~(b) Upon determining that an individual is eligible for the program, the local repository~~
189.9 ~~shall furnish the individual with an identification card. The card shall be valid for one year~~
189.10 ~~from the date of issuance and may be used at any local repository. A new identification card~~
189.11 ~~may be issued upon expiration once the individual submits a new application form.~~

189.12 ~~(e)~~ (b) The local repository shall send a copy of the intake application form to the central
189.13 repository by regular mail, facsimile, or secured email within ten days from the date the
189.14 application is approved by the local repository.

189.15 ~~(d)~~ (c) The board shall develop and make available on the board's website an application
189.16 form ~~and the format for the identification card.~~

189.17 Sec. 15. Minnesota Statutes 2023 Supplement, section 151.555, subdivision 6, is amended
189.18 to read:

189.19 Subd. 6. **Standards and procedures for accepting donations of drugs and supplies.** (a)
189.20 Notwithstanding any other law or rule, a donor may donate drugs or medical supplies to
189.21 the central repository or a local repository if the drug or supply meets the requirements of
189.22 this section as determined by a pharmacist or practitioner who is employed by or under
189.23 contract with the central repository or a local repository.

189.24 (b) A drug is eligible for donation under the medication repository program if the
189.25 following requirements are met:

189.26 ~~(1) the donation is accompanied by a medication repository donor form described under~~
189.27 ~~paragraph (d) that is signed by an individual who is authorized by the donor to attest to the~~
189.28 ~~donor's knowledge in accordance with paragraph (d);~~

189.29 ~~(2)~~ (1) the drug's expiration date is at least six months after the date the drug was donated.
189.30 If a donated drug bears an expiration date that is less than six months from the donation
189.31 date, the drug may be accepted and distributed if the drug is in high demand and can be
189.32 dispensed for use by a patient before the drug's expiration date;

190.1 ~~(3)~~ (2) the drug is in its original, sealed, unopened, tamper-evident packaging that includes
 190.2 the expiration date. Single-unit-dose drugs may be accepted if the single-unit-dose packaging
 190.3 is unopened;

190.4 ~~(4)~~ (3) the drug or the packaging does not have any physical signs of tampering,
 190.5 misbranding, deterioration, compromised integrity, or adulteration;

190.6 ~~(5)~~ (4) the drug does not require storage temperatures other than normal room temperature
 190.7 as specified by the manufacturer or United States Pharmacopoeia, unless the drug is being
 190.8 donated directly by its manufacturer, a wholesale drug distributor, or a pharmacy located
 190.9 in Minnesota; and

190.10 ~~(6)~~ (5) the drug is not a controlled substance.

190.11 (c) A medical supply is eligible for donation under the medication repository program
 190.12 if the following requirements are met:

190.13 (1) the supply has no physical signs of tampering, misbranding, or alteration and there
 190.14 is no reason to believe it has been adulterated, tampered with, or misbranded;

190.15 (2) the supply is in its original, unopened, sealed packaging; and

190.16 ~~(3) the donation is accompanied by a medication repository donor form described under~~
 190.17 ~~paragraph (d) that is signed by an individual who is authorized by the donor to attest to the~~
 190.18 ~~donor's knowledge in accordance with paragraph (d); and~~

190.19 ~~(4)~~ (3) if the supply bears an expiration date, the date is at least six months later than
 190.20 the date the supply was donated. If the donated supply bears an expiration date that is less
 190.21 than six months from the date the supply was donated, the supply may be accepted and
 190.22 distributed if the supply is in high demand and can be dispensed for use by a patient before
 190.23 the supply's expiration date.

190.24 (d) The board shall develop the medication repository donor form and make it available
 190.25 on the board's website. ~~The form must state that to the best of the donor's knowledge the~~
 190.26 ~~donated drug or supply has been properly stored under appropriate temperature and humidity~~
 190.27 ~~conditions and that the drug or supply has never been opened, used, tampered with,~~
 190.28 ~~adulterated, or misbranded.~~ Prior to the first donation from a new donor, a central repository
 190.29 or local repository shall verify and record the following information on the donor form:

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

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

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

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

191.5 (e) Notwithstanding any other law or rule, a central repository or a local repository may
191.6 receive donated drugs from donors. Donated drugs and supplies may be shipped or delivered
191.7 to the premises of the central repository or a local repository, and shall be inspected by a
191.8 pharmacist or an authorized practitioner who is employed by or under contract with the
191.9 repository and who has been designated by the repository to accept donations prior to
191.10 dispensing. A drop box must not be used to deliver or accept donations.

191.11 (f) The central repository and local repository shall maintain a written or electronic
191.12 inventory of all drugs and supplies donated to the repository upon acceptance of each drug
191.13 or supply. For each drug, the inventory must include the drug's name, strength, quantity,
191.14 manufacturer, expiration date, and the date the drug was donated. For each medical supply,
191.15 the inventory must include a description of the supply, its manufacturer, the date the supply
191.16 was donated, and, if applicable, the supply's brand name and expiration date. The board
191.17 may waive the requirement under this paragraph if an entity is under common ownership
191.18 or control with a central repository or local repository and either the entity or the repository
191.19 maintains an inventory containing all the information required under this paragraph.

191.20 Sec. 16. Minnesota Statutes 2023 Supplement, section 151.555, subdivision 7, is amended
191.21 to read:

191.22 **Subd. 7. Standards and procedures for inspecting and storing donated drugs and**
191.23 **supplies.** (a) A pharmacist or authorized practitioner who is employed by or under contract
191.24 with the central repository or a local repository shall inspect all donated drugs and supplies
191.25 before the drug or supply is dispensed to determine, to the extent reasonably possible in the
191.26 professional judgment of the pharmacist or practitioner, that the drug or supply is not
191.27 adulterated or misbranded, has not been tampered with, is safe and suitable for dispensing,
191.28 has not been subject to a recall, and meets the requirements for donation. ~~The pharmacist~~
191.29 ~~or practitioner who inspects the drugs or supplies shall sign an inspection record stating that~~
191.30 ~~the requirements for donation have been met.~~ If a local repository receives drugs and supplies
191.31 from the central repository, the local repository does not need to reinspect the drugs and
191.32 supplies.

192.1 (b) The central repository and local repositories shall store donated drugs and supplies
192.2 in a secure storage area under environmental conditions appropriate for the drug or supply
192.3 being stored. Donated drugs and supplies may not be stored with nondonated inventory.

192.4 (c) The central repository and local repositories shall dispose of all drugs and medical
192.5 supplies that are not suitable for donation in compliance with applicable federal and state
192.6 statutes, regulations, and rules concerning hazardous waste.

192.7 (d) In the event that controlled substances or drugs that can only be dispensed to a patient
192.8 registered with the drug's manufacturer are shipped or delivered to a central or local repository
192.9 for donation, the shipment delivery must be documented by the repository and returned
192.10 immediately to the donor or the donor's representative that provided the drugs.

192.11 (e) Each repository must develop drug and medical supply recall policies and procedures.
192.12 If a repository receives a recall notification, the repository shall destroy all of the drug or
192.13 medical supply in its inventory that is the subject of the recall and complete a record of
192.14 destruction form in accordance with paragraph (f). If a drug or medical supply that is the
192.15 subject of a Class I or Class II recall has been dispensed, the repository shall immediately
192.16 notify the recipient of the recalled drug or medical supply. A drug that potentially is subject
192.17 to a recall need not be destroyed if its packaging bears a lot number and that lot of the drug
192.18 is not subject to the recall. If no lot number is on the drug's packaging, it must be destroyed.

192.19 (f) A record of destruction of donated drugs and supplies that are not dispensed under
192.20 subdivision 8, are subject to a recall under paragraph (e), or are not suitable for donation
192.21 shall be maintained by the repository for at least two years. For each drug or supply destroyed,
192.22 the record shall include the following information:

192.23 (1) the date of destruction;

192.24 (2) the name, strength, and quantity of the drug destroyed; and

192.25 (3) the name of the person or firm that destroyed the drug.

192.26 No other record of destruction is required.

192.27 Sec. 17. Minnesota Statutes 2023 Supplement, section 151.555, subdivision 8, is amended
192.28 to read:

192.29 Subd. 8. **Dispensing requirements.** (a) Donated prescription drugs and supplies may
192.30 be dispensed if the drugs or supplies are prescribed by a practitioner for use by an eligible
192.31 individual and are dispensed by a pharmacist or practitioner. A repository shall dispense
192.32 drugs and supplies to eligible individuals in the following priority order: (1) individuals

193.1 who are uninsured; (2) individuals with no prescription drug coverage; and (3) individuals
193.2 who are underinsured. A repository shall dispense donated drugs in compliance with
193.3 applicable federal and state laws and regulations for dispensing drugs, including all
193.4 requirements relating to packaging, labeling, record keeping, drug utilization review, and
193.5 patient counseling.

193.6 (b) Before dispensing or administering a drug or supply, the pharmacist or practitioner
193.7 shall visually inspect the drug or supply for adulteration, misbranding, tampering, and date
193.8 of expiration. Drugs or supplies that have expired or appear upon visual inspection to be
193.9 adulterated, misbranded, or tampered with in any way must not be dispensed or administered.

193.10 (c) Before a the first drug or supply is dispensed or administered to an individual, the
193.11 individual must sign a an electronic or physical drug repository recipient form acknowledging
193.12 that the individual understands ~~the information stated on the form. The board shall develop~~
193.13 ~~the form and make it available on the board's website. The form must include the following~~
193.14 ~~information:~~

193.15 (1) that the drug or supply being dispensed or administered has been donated and may
193.16 have been previously dispensed;

193.17 (2) that a visual inspection has been conducted by the pharmacist or practitioner to ensure
193.18 that the drug or supply has not expired, has not been adulterated or misbranded, and is in
193.19 its original, unopened packaging; and

193.20 (3) that the dispensing pharmacist, the dispensing or administering practitioner, the
193.21 central repository or local repository, the Board of Pharmacy, and any other participant of
193.22 the medication repository program cannot guarantee the safety of the drug or medical supply
193.23 being dispensed or administered and that the pharmacist or practitioner has determined that
193.24 the drug or supply is safe to dispense or administer based on the accuracy of the donor's
193.25 form submitted with the donated drug or medical supply and the visual inspection required
193.26 to be performed by the pharmacist or practitioner before dispensing or administering.

193.27 Sec. 18. Minnesota Statutes 2023 Supplement, section 151.555, subdivision 9, is amended
193.28 to read:

193.29 Subd. 9. **Handling fees.** (a) The central or local repository may charge the individual
193.30 receiving a drug or supply a handling fee of no more than 250 percent of the medical
193.31 assistance program dispensing fee for each drug or medical supply dispensed or administered
193.32 by that repository.

194.1 (b) A repository that dispenses or administers a drug or medical supply through the
194.2 medication repository program shall not receive reimbursement under the medical assistance
194.3 program or the MinnesotaCare program for that dispensed or administered drug or supply.

194.4 (c) A supply or handling fee must not be charged to an individual enrolled in the medical
194.5 assistance or MinnesotaCare program.

194.6 Sec. 19. Minnesota Statutes 2023 Supplement, section 151.555, subdivision 11, is amended
194.7 to read:

194.8 Subd. 11. **Forms and record-keeping requirements.** (a) The following forms developed
194.9 for the administration of this program ~~shall be utilized by the participants of the program~~
194.10 ~~and~~ shall be available on the board's website:

194.11 (1) intake application form described under subdivision 5;

194.12 (2) local repository participation form described under subdivision 4;

194.13 (3) local repository withdrawal form described under subdivision 4;

194.14 (4) medication repository donor form described under subdivision 6;

194.15 (5) record of destruction form described under subdivision 7; and

194.16 (6) medication repository recipient form described under subdivision 8.

194.17 Participants may use substantively similar electronic or physical forms.

194.18 (b) All records, including drug inventory, ~~inspection,~~ and disposal of donated drugs and
194.19 medical supplies, must be maintained by a repository for a minimum of two years. Records
194.20 required as part of this program must be maintained pursuant to all applicable practice acts.

194.21 (c) Data collected by the medication repository program from all local repositories shall
194.22 be submitted quarterly or upon request to the central repository. Data collected may consist
194.23 of the information, records, and forms required to be collected under this section.

194.24 (d) The central repository shall submit reports to the board as required by the contract
194.25 or upon request of the board.

194.26 Sec. 20. Minnesota Statutes 2023 Supplement, section 151.555, subdivision 12, is amended
194.27 to read:

194.28 Subd. 12. **Liability.** (a) The manufacturer of a drug or supply is not subject to criminal
194.29 or civil liability for injury, death, or loss to a person or to property for causes of action
194.30 described in clauses (1) and (2). A manufacturer is not liable for:

195.1 (1) the intentional or unintentional alteration of the drug or supply by a party not under
195.2 the control of the manufacturer; or

195.3 (2) the failure of a party not under the control of the manufacturer to transfer or
195.4 communicate product or consumer information or the expiration date of the donated drug
195.5 or supply.

195.6 (b) A health care facility participating in the program, a pharmacist dispensing a drug
195.7 or supply pursuant to the program, a practitioner dispensing or administering a drug or
195.8 supply pursuant to the program, ~~or a donor of a drug or medical supply, or a person or entity~~
195.9 that facilitates any of the above is immune from civil liability for an act or omission that
195.10 causes injury to or the death of an individual to whom the drug or supply is dispensed and
195.11 no disciplinary action by a health-related licensing board shall be taken against a ~~pharmacist~~
195.12 ~~or practitioner~~ person or entity so long as the drug or supply is donated, accepted, distributed,
195.13 and dispensed according to the requirements of this section. This immunity does not apply
195.14 if the act or omission involves reckless, wanton, or intentional misconduct, or malpractice
195.15 unrelated to the quality of the drug or medical supply.

195.16 Sec. 21. Minnesota Statutes 2022, section 256B.0625, subdivision 10, is amended to read:

195.17 Subd. 10. **Laboratory, x-ray, and opioid testing services.** (a) Medical assistance covers
195.18 laboratory and x-ray services.

195.19 (b) Medical assistance covers screening and urinalysis tests for opioids without lifetime
195.20 or annual limits.

195.21 (c) Medical assistance covers laboratory tests ordered and performed by a licensed
195.22 pharmacist, according to the requirements of section 151.01, subdivision 27, clause (3), at
195.23 no less than the rate for which the same services are covered when provided by any other
195.24 licensed practitioner.

195.25 **EFFECTIVE DATE.** This section is effective January 1, 2025, or upon federal approval,
195.26 whichever is later. The commissioner of human services shall notify the revisor of statutes
195.27 when federal approval is obtained.

195.28 Sec. 22. Minnesota Statutes 2023 Supplement, section 256B.0625, subdivision 13f, is
195.29 amended to read:

195.30 Subd. 13f. **Prior authorization.** (a) The Formulary Committee shall review and
195.31 recommend drugs which require prior authorization. The Formulary Committee shall
195.32 establish general criteria to be used for the prior authorization of brand-name drugs for

196.1 which generically equivalent drugs are available, but the committee is not required to review
196.2 each brand-name drug for which a generically equivalent drug is available.

196.3 (b) Prior authorization may be required by the commissioner before certain formulary
196.4 drugs are eligible for payment. The Formulary Committee may recommend drugs for prior
196.5 authorization directly to the commissioner. The commissioner may also request that the
196.6 Formulary Committee review a drug for prior authorization. Before the commissioner may
196.7 require prior authorization for a drug:

196.8 (1) the commissioner must provide information to the Formulary Committee on the
196.9 impact that placing the drug on prior authorization may have on the quality of patient care
196.10 and on program costs, information regarding whether the drug is subject to clinical abuse
196.11 or misuse, and relevant data from the state Medicaid program if such data is available;

196.12 (2) the Formulary Committee must review the drug, taking into account medical and
196.13 clinical data and the information provided by the commissioner; and

196.14 (3) the Formulary Committee must hold a public forum and receive public comment for
196.15 an additional 15 days.

196.16 The commissioner must provide a 15-day notice period before implementing the prior
196.17 authorization.

196.18 (c) Except as provided in subdivision 13j, prior authorization shall not be required or
196.19 utilized for any atypical antipsychotic drug prescribed for the treatment of mental illness
196.20 if:

196.21 (1) there is no generically equivalent drug available; and

196.22 (2) the drug was initially prescribed for the recipient prior to July 1, 2003; or

196.23 (3) the drug is part of the recipient's current course of treatment.

196.24 This paragraph applies to any multistate preferred drug list or supplemental drug rebate
196.25 program established or administered by the commissioner. Prior authorization shall
196.26 automatically be granted for 60 days for brand name drugs prescribed for treatment of mental
196.27 illness within 60 days of when a generically equivalent drug becomes available, provided
196.28 that the brand name drug was part of the recipient's course of treatment at the time the
196.29 generically equivalent drug became available.

196.30 (d) Prior authorization must not be required for liquid methadone if only one version of
196.31 liquid methadone is available. If more than one version of liquid methadone is available,

197.1 the commissioner shall ensure that at least one version of liquid methadone is available
197.2 without prior authorization.

197.3 (e) Prior authorization may be required for an oral liquid form of a drug, except as
197.4 described in paragraph (d). A prior authorization request under this paragraph must be
197.5 automatically approved within 24 hours if the drug is being prescribed for a Food and Drug
197.6 Administration-approved condition for a patient who utilizes an enteral tube for feedings
197.7 or medication administration, even if the patient has current or prior claims for pills for that
197.8 condition. If more than one version of the oral liquid form of a drug is available, the
197.9 commissioner may select the version that is able to be approved for a Food and Drug
197.10 Administration-approved condition for a patient who utilizes an enteral tube for feedings
197.11 or medication administration. This paragraph applies to any multistate preferred drug list
197.12 or supplemental drug rebate program established or administered by the commissioner. The
197.13 commissioner shall design and implement a streamlined prior authorization form for patients
197.14 who utilize an enteral tube for feedings or medication administration and are prescribed an
197.15 oral liquid form of a drug. The commissioner may require prior authorization for brand
197.16 name drugs whenever a generically equivalent product is available, even if the prescriber
197.17 specifically indicates "dispense as written-brand necessary" on the prescription as required
197.18 by section 151.21, subdivision 2.

197.19 (f) Notwithstanding this subdivision, the commissioner may automatically require prior
197.20 authorization, for a period not to exceed 180 days, for any drug that is approved by the
197.21 United States Food and Drug Administration on or after July 1, 2005. The 180-day period
197.22 begins no later than the first day that a drug is available for shipment to pharmacies within
197.23 the state. The Formulary Committee shall recommend to the commissioner general criteria
197.24 to be used for the prior authorization of the drugs, but the committee is not required to
197.25 review each individual drug. In order to continue prior authorizations for a drug after the
197.26 180-day period has expired, the commissioner must follow the provisions of this subdivision.

197.27 (g) Prior authorization under this subdivision shall comply with section 62Q.184.

197.28 (h) Any step therapy protocol requirements established by the commissioner must comply
197.29 with section 62Q.1841.

197.30 (i) Notwithstanding any law to the contrary, prior authorization or step therapy shall not
197.31 be required or utilized for any class of drugs that is approved by the United States Food and
197.32 Drug Administration for the treatment or prevention of HIV and AIDS.

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

198.1 Sec. 23. Minnesota Statutes 2022, section 256B.0625, subdivision 39, is amended to read:

198.2 Subd. 39. **Childhood immunizations.** (a) Providers who administer pediatric vaccines
198.3 within the scope of their licensure, and who are enrolled as a medical assistance provider,
198.4 must enroll in the pediatric vaccine administration program established by section 13631
198.5 of the Omnibus Budget Reconciliation Act of 1993. Medical assistance shall pay for
198.6 administration of the vaccine to children eligible for medical assistance. Medical assistance
198.7 does not pay for vaccines that are available at no cost from the pediatric vaccine
198.8 administration program unless the vaccines qualify for 100 percent federal funding or are
198.9 mandated by the Centers for Medicare and Medicaid Services to be covered outside of the
198.10 Vaccines for Children program.

198.11 (b) Medical assistance covers vaccines initiated, ordered, or administered by a licensed
198.12 pharmacist, according to the requirements of section 151.01, subdivision 27, clause (6), at
198.13 no less than the rate for which the same services are covered when provided by any other
198.14 licensed practitioner.

198.15 **EFFECTIVE DATE.** The amendment to paragraph (a) is effective July 1, 2024.
198.16 Paragraph (b) is effective January 1, 2025, or upon federal approval, whichever is later. The
198.17 commissioner of human services shall notify the revisor of statutes when federal approval
198.18 is obtained.

198.19 Sec. 24. **DIRECTION TO THE COMMISSIONER; ASSESSMENT OF LICENSED**
198.20 **OUTPATIENT PHARMACIES; REPORT.**

198.21 The commissioner of health, in consultation with the Board of Pharmacy, must conduct
198.22 an assessment of licensed outpatient pharmacies and vendors of audible container labels
198.23 and prescription readers to determine: (1) the approximate number of such pharmacies
198.24 currently providing accessible labels to individuals who cannot access large print or Braille
198.25 labels; and (2) the approximate cost to such pharmacies to provide accessible labels to
198.26 individuals who cannot access large print or Braille labels. By January 15, 2025, the
198.27 commissioner must submit a report to the chairs and ranking minority members of the
198.28 legislative committees with jurisdiction over health and human services finance and policy.
198.29 The report must include the assessment results and recommendations for providing accessible
198.30 labels to those who cannot access large print or Braille labels.

198.31 **EFFECTIVE DATE.** This section is effective July 1, 2024.

199.1 **Sec. 25. RULEMAKING; BOARD OF PHARMACY.**

199.2 The Board of Pharmacy must amend Minnesota Rules, part 6800.3400, to permit and
199.3 promote the inclusion of the following on a prescription label:

199.4 (1) the complete and unabbreviated generic name of the drug; and

199.5 (2) instructions written in plain language explaining the patient-specific indications for
199.6 the drug if the patient-specific indications are indicated on the prescription.

199.7 The Board of Pharmacy must comply with Minnesota Statutes, section 14.389, in adopting
199.8 the amendment to the rule.

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

199.10 **ARTICLE 8**

199.11 **BEHAVIORAL HEALTH**

199.12 Section 1. Minnesota Statutes 2022, section 245.462, subdivision 6, is amended to read:

199.13 **Subd. 6. Community support services program.** "Community support services program"
199.14 means services, other than inpatient or residential treatment services, provided or coordinated
199.15 by an identified program and staff under the treatment supervision of a mental health
199.16 professional designed to help adults with serious and persistent mental illness to function
199.17 and remain in the community. A community support services program includes:

199.18 (1) client outreach,

199.19 (2) medication monitoring,

199.20 (3) assistance in independent living skills,

199.21 (4) development of employability and work-related opportunities,

199.22 (5) crisis assistance,

199.23 (6) psychosocial rehabilitation,

199.24 (7) help in applying for government benefits, and

199.25 (8) housing support services.

199.26 The community support services program must be coordinated with the case management
199.27 services specified in section 245.4711. A program that meets the accreditation standards
199.28 for Clubhouse International model programs meets the requirements of this subdivision.

200.1 Sec. 2. Minnesota Statutes 2022, section 245.4663, subdivision 2, is amended to read:

200.2 Subd. 2. **Eligible providers.** In order to be eligible for a grant under this section, a mental
200.3 health provider must:

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

200.9 (2) primarily serve underrepresented communities as defined in section 148E.010,
200.10 subdivision 20; or

200.11 (3) provide services to people in a city or township that is not within the seven-county
200.12 metropolitan area as defined in section 473.121, subdivision 2, and is not the city of Duluth,
200.13 Mankato, Moorhead, Rochester, or St. Cloud.

200.14 Sec. 3. Minnesota Statutes 2023 Supplement, section 245.4889, subdivision 1, is amended
200.15 to read:

200.16 Subdivision 1. **Establishment and authority.** (a) The commissioner is authorized to
200.17 make grants from available appropriations to assist:

200.18 (1) counties;

200.19 (2) Indian tribes;

200.20 (3) children's collaboratives under section 124D.23 or 245.493; or

200.21 (4) mental health service providers.

200.22 (b) The following services are eligible for grants under this section:

200.23 (1) services to children with emotional disturbances as defined in section 245.4871,
200.24 subdivision 15, and their families;

200.25 (2) transition services under section 245.4875, subdivision 8, for young adults under
200.26 age 21 and their families;

200.27 (3) respite care services for children with emotional disturbances or severe emotional
200.28 disturbances who are at risk of ~~out-of-home placement or residential treatment or~~
200.29 hospitalization, who are already in out-of-home placement in family foster settings as defined
200.30 in chapter 245A and at risk of change in out-of-home placement or placement in a residential
200.31 facility or other higher level of care, who have utilized crisis services or emergency room

201.1 services, or who have experienced a loss of in-home staffing support. Allowable activities
201.2 and expenses for respite care services are defined under subdivision 4. A child is not required
201.3 to have case management services to receive respite care services. Counties must work to
201.4 provide access to regularly scheduled respite care;

201.5 (4) children's mental health crisis services;

201.6 (5) child-, youth-, and family-specific mobile response and stabilization services models;

201.7 (6) mental health services for people from cultural and ethnic minorities, including
201.8 supervision of clinical trainees who are Black, indigenous, or people of color;

201.9 (7) children's mental health screening and follow-up diagnostic assessment and treatment;

201.10 (8) services to promote and develop the capacity of providers to use evidence-based
201.11 practices in providing children's mental health services;

201.12 (9) school-linked mental health services under section 245.4901;

201.13 (10) building evidence-based mental health intervention capacity for children birth to
201.14 age five;

201.15 (11) suicide prevention and counseling services that use text messaging statewide;

201.16 (12) mental health first aid training;

201.17 (13) training for parents, collaborative partners, and mental health providers on the
201.18 impact of adverse childhood experiences and trauma and development of an interactive
201.19 website to share information and strategies to promote resilience and prevent trauma;

201.20 (14) transition age services to develop or expand mental health treatment and supports
201.21 for adolescents and young adults 26 years of age or younger;

201.22 (15) early childhood mental health consultation;

201.23 (16) evidence-based interventions for youth at risk of developing or experiencing a first
201.24 episode of psychosis, and a public awareness campaign on the signs and symptoms of
201.25 psychosis;

201.26 (17) psychiatric consultation for primary care practitioners; and

201.27 (18) providers to begin operations and meet program requirements when establishing a
201.28 new children's mental health program. These may be start-up grants.

201.29 (c) Services under paragraph (b) must be designed to help each child to function and
201.30 remain with the child's family in the community and delivered consistent with the child's

202.1 treatment plan. Transition services to eligible young adults under this paragraph must be
202.2 designed to foster independent living in the community.

202.3 (d) As a condition of receiving grant funds, a grantee shall obtain all available third-party
202.4 reimbursement sources, if applicable.

202.5 (e) The commissioner may establish and design a pilot program to expand the mobile
202.6 response and stabilization services model for children, youth, and families. The commissioner
202.7 may use grant funding to consult with a qualified expert entity to assist in the formulation
202.8 of measurable outcomes and explore and position the state to submit a Medicaid state plan
202.9 amendment to scale the model statewide.

202.10 Sec. 4. Minnesota Statutes 2023 Supplement, section 245.735, subdivision 3, is amended
202.11 to read:

202.12 Subd. 3. **Certified community behavioral health clinics.** (a) The commissioner shall
202.13 establish state certification and recertification processes for certified community behavioral
202.14 health clinics (CCBHCs) that satisfy all federal requirements necessary for CCBHCs certified
202.15 under this section to be eligible for reimbursement under medical assistance, without service
202.16 area limits based on geographic area or region. The commissioner shall consult with CCBHC
202.17 stakeholders before establishing and implementing changes in the certification or
202.18 recertification process and requirements. Any changes to the certification or recertification
202.19 process or requirements must be consistent with the most recently issued Certified
202.20 Community Behavioral Health Clinic Certification Criteria published by the Substance
202.21 Abuse and Mental Health Services Administration. The commissioner must allow a transition
202.22 period for CCBHCs to meet the revised criteria ~~prior to July 1, 2024~~ on or before January
202.23 1, 2025. The commissioner is authorized to amend the state's Medicaid state plan or the
202.24 terms of the demonstration to comply with federal requirements.

202.25 (b) As part of the state CCBHC certification and recertification processes, the
202.26 commissioner shall provide to entities applying for certification or requesting recertification
202.27 the standard requirements of the community needs assessment and the staffing plan that are
202.28 consistent with the most recently issued Certified Community Behavioral Health Clinic
202.29 Certification Criteria published by the Substance Abuse and Mental Health Services
202.30 Administration.

202.31 (c) The commissioner shall schedule a certification review that includes a site visit within
202.32 90 calendar days of receipt of an application for certification or recertification.

202.33 (d) Entities that choose to be CCBHCs must:

203.1 (1) complete a community needs assessment and complete a staffing plan that is
203.2 responsive to the needs identified in the community needs assessment and update both the
203.3 community needs assessment and the staffing plan no less frequently than every 36 months;

203.4 (2) comply with state licensing requirements and other requirements issued by the
203.5 commissioner;

203.6 (3) employ or contract with a medical director. A medical director must be a physician
203.7 licensed under chapter 147 and either certified by the American Board of Psychiatry and
203.8 Neurology, certified by the American Osteopathic Board of Neurology and Psychiatry, or
203.9 eligible for board certification in psychiatry. A registered nurse who is licensed under
203.10 sections 148.171 to 148.285 and is certified as a nurse practitioner in adult or family
203.11 psychiatric and mental health nursing by a national nurse certification organization may
203.12 serve as the medical director when a CCBHC is unable to employ or contract a qualified
203.13 physician;

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

203.18 (5) ensure that clinic services are available and accessible to individuals and families of
203.19 all ages and genders with access on evenings and weekends and that crisis management
203.20 services are available 24 hours per day;

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

203.24 (7) comply with quality assurance reporting requirements and other reporting
203.25 requirements included in the most recently issued Certified Community Behavioral Health
203.26 Clinic Certification Criteria published by the Substance Abuse and Mental Health Services
203.27 Administration;

203.28 (8) provide crisis mental health and substance use services, withdrawal management
203.29 services, emergency crisis intervention services, and stabilization services through existing
203.30 mobile crisis services; screening, assessment, and diagnosis services, including risk
203.31 assessments and level of care determinations; person- and family-centered treatment planning;
203.32 outpatient mental health and substance use services; targeted case management; psychiatric
203.33 rehabilitation services; peer support and counselor services and family support services;
203.34 and intensive community-based mental health services, including mental health services

204.1 for members of the armed forces and veterans. CCBHCs must directly provide the majority
204.2 of these services to enrollees, but may coordinate some services with another entity through
204.3 a collaboration or agreement, pursuant to subdivision 3a;

204.4 (9) provide coordination of care across settings and providers to ensure seamless
204.5 transitions for individuals being served across the full spectrum of health services, including
204.6 acute, chronic, and behavioral needs;

204.7 (10) be certified as a mental health clinic under section 245I.20;

204.8 (11) comply with standards established by the commissioner relating to CCBHC
204.9 screenings, assessments, and evaluations that are consistent with this section;

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

204.11 (13) be certified to provide children's therapeutic services and supports under section
204.12 256B.0943;

204.13 (14) be certified to provide adult rehabilitative mental health services under section
204.14 256B.0623;

204.15 (15) be enrolled to provide mental health crisis response services under section
204.16 256B.0624;

204.17 (16) be enrolled to provide mental health targeted case management under section
204.18 256B.0625, subdivision 20;

204.19 (17) provide services that comply with the evidence-based practices described in
204.20 subdivision 3d;

204.21 (18) provide peer services as defined in sections 256B.0615, 256B.0616, and 245G.07,
204.22 subdivision 2, clause (8), as applicable when peer services are provided; and

204.23 (19) inform all clients upon initiation of care of the full array of services available under
204.24 the CCBHC model.

204.25 **EFFECTIVE DATE.** This section is effective upon federal approval. The commissioner
204.26 of human services shall notify the revisor of statutes when federal approval is obtained.

204.27 Sec. 5. Minnesota Statutes 2022, section 245I.02, subdivision 17, is amended to read:

204.28 Subd. 17. **Functional assessment.** "Functional assessment" means the assessment of a
204.29 client's current level of functioning relative to functioning that is appropriate for someone
204.30 the client's age. ~~For a client five years of age or younger, a functional assessment is the~~
204.31 ~~Early Childhood Service Intensity Instrument (ESCI). For a client six to 17 years of age,~~

205.1 ~~a functional assessment is the Child and Adolescent Service Intensity Instrument (CASH).~~
205.2 ~~For a client 18 years of age or older, a functional assessment is the functional assessment~~
205.3 ~~described in section 245I.10, subdivision 9.~~

205.4 Sec. 6. Minnesota Statutes 2022, section 245I.02, subdivision 19, is amended to read:

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

205.12 Sec. 7. Minnesota Statutes 2022, section 245I.04, subdivision 6, is amended to read:

205.13 Subd. 6. **Clinical trainee qualifications.** (a) A clinical trainee is a staff person who: (1)
205.14 is enrolled in an accredited graduate program of study to prepare the staff person for
205.15 independent licensure as a mental health professional and who is participating in a practicum
205.16 or internship with the license holder through the individual's graduate program; ~~or~~ (2) has
205.17 completed an accredited graduate program of study to prepare the staff person for independent
205.18 licensure as a mental health professional and who is in compliance with the requirements
205.19 of the applicable health-related licensing board, including requirements for supervised
205.20 practice; or (3) has completed an accredited graduate program of study to prepare the staff
205.21 person for independent licensure as a mental health professional, has completed a practicum
205.22 or internship and has not yet taken or received the results from the required test or is waiting
205.23 for the final licensure decision.

205.24 (b) A clinical trainee is responsible for notifying and applying to a health-related licensing
205.25 board to ensure that the trainee meets the requirements of the health-related licensing board.
205.26 As permitted by a health-related licensing board, treatment supervision under this chapter
205.27 may be integrated into a plan to meet the supervisory requirements of the health-related
205.28 licensing board but does not supersede those requirements.

205.29 Sec. 8. Minnesota Statutes 2022, section 245I.10, subdivision 9, is amended to read:

205.30 Subd. 9. **Functional assessment; required elements.** (a) When a license holder is
205.31 completing a functional assessment for an adult client, the license holder must:

206.1 (1) complete a functional assessment of the client after completing the client's diagnostic
206.2 assessment;

206.3 (2) use a collaborative process that allows the client and the client's family and other
206.4 natural supports, the client's referral sources, and the client's providers to provide information
206.5 about how the client's symptoms of mental illness impact the client's functioning;

206.6 (3) if applicable, document the reasons that the license holder did not contact the client's
206.7 family and other natural supports;

206.8 (4) assess and document how the client's symptoms of mental illness impact the client's
206.9 functioning in the following areas:

206.10 (i) the client's mental health symptoms;

206.11 (ii) the client's mental health service needs;

206.12 (iii) the client's substance use;

206.13 (iv) the client's vocational and educational functioning;

206.14 (v) the client's social functioning, including the use of leisure time;

206.15 (vi) the client's interpersonal functioning, including relationships with the client's family
206.16 and other natural supports;

206.17 (vii) the client's ability to provide self-care and live independently;

206.18 (viii) the client's medical and dental health;

206.19 (ix) the client's financial assistance needs; and

206.20 (x) the client's housing and transportation needs;

206.21 ~~(5) include a narrative summarizing the client's strengths, resources, and all areas of~~
206.22 ~~functional impairment;~~

206.23 ~~(6)~~ (5) complete the client's functional assessment before the client's initial individual
206.24 treatment plan unless a service specifies otherwise; and

206.25 ~~(7)~~ (6) update the client's functional assessment with the client's current functioning
206.26 whenever there is a significant change in the client's functioning or at least every ~~180~~ 365
206.27 days, unless a service specifies otherwise.

206.28 (b) A license holder may use any available, validated measurement tool, including but
206.29 not limited to the Daily Living Activities-20, when completing the required elements of a
206.30 functional assessment under this subdivision.

207.1 Sec. 9. Minnesota Statutes 2022, section 245I.11, subdivision 1, is amended to read:

207.2 Subdivision 1. **Generally.** (a) If a license holder is licensed as a residential program,
207.3 stores or administers client medications, or observes clients self-administer medications,
207.4 the license holder must ensure that a staff person who is a registered nurse or licensed
207.5 prescriber is responsible for overseeing storage and administration of client medications
207.6 and observing as a client self-administers medications, including training according to
207.7 section 245I.05, subdivision 6, and documenting the occurrence according to section 245I.08,
207.8 subdivision 5.

207.9 (b) For purposes of this section, "observed self-administration" means the preparation
207.10 and administration of a medication by a client to themselves under the direct supervision
207.11 of a registered nurse or a staff member to whom a registered nurse delegates supervision
207.12 duty. Observed self-administration does not include a client's use of a medication that they
207.13 keep in their own possession while participating in a program.

207.14 Sec. 10. Minnesota Statutes 2022, section 245I.11, is amended by adding a subdivision
207.15 to read:

207.16 Subd. 6. **Medication administration in children's day treatment settings.** (a) For a
207.17 program providing children's day treatment services under section 256B.0943, the license
207.18 holder must maintain policies and procedures that state whether the program will store
207.19 medication and administer or allow observed self-administration.

207.20 (b) For a program providing children's day treatment services under section 256B.0943
207.21 that does not store medications but allows clients to use a medication that they keep in their
207.22 own possession while participating in a program, the license holder must maintain
207.23 documentation from a licensed prescriber regarding the safety of medications held by clients,
207.24 including:

207.25 (1) an evaluation that the client is capable of holding and administering the medication
207.26 safely;

207.27 (2) an evaluation of whether the medication is prone to diversion, misuse, or self-injury;
207.28 and

207.29 (3) any conditions under which the license holder should no longer allow the client to
207.30 maintain the medication in their own possession.

208.1 Sec. 11. Minnesota Statutes 2022, section 245I.20, subdivision 4, is amended to read:

208.2 Subd. 4. **Minimum staffing standards.** (a) A certification holder's treatment team must
208.3 consist of at least four mental health professionals. At least two of the mental health
208.4 professionals must be employed by or under contract with the mental health clinic for a
208.5 minimum of 35 hours per week each. ~~Each of the two mental health professionals must~~
208.6 ~~specialize in a different mental health discipline.~~

208.7 (b) The treatment team must include:

208.8 (1) a physician qualified as a mental health professional according to section 245I.04,
208.9 subdivision 2, clause (4), or a nurse qualified as a mental health professional according to
208.10 section 245I.04, subdivision 2, clause (1); and

208.11 (2) a psychologist qualified as a mental health professional according to section 245I.04,
208.12 subdivision 2, clause (3).

208.13 (c) The staff persons fulfilling the requirement in paragraph (b) must provide clinical
208.14 services at least:

208.15 (1) eight hours every two weeks if the mental health clinic has over 25.0 full-time
208.16 equivalent treatment team members;

208.17 (2) eight hours each month if the mental health clinic has 15.1 to 25.0 full-time equivalent
208.18 treatment team members;

208.19 (3) four hours each month if the mental health clinic has 5.1 to 15.0 full-time equivalent
208.20 treatment team members; or

208.21 (4) two hours each month if the mental health clinic has 2.0 to 5.0 full-time equivalent
208.22 treatment team members or only provides in-home services to clients.

208.23 (d) The certification holder must maintain a record that demonstrates compliance with
208.24 this subdivision.

208.25 Sec. 12. Minnesota Statutes 2022, section 245I.23, subdivision 14, is amended to read:

208.26 Subd. 14. **Weekly team meetings.** (a) The license holder must hold weekly team meetings
208.27 and ancillary meetings according to this subdivision.

208.28 (b) A mental health professional or certified rehabilitation specialist must hold at least
208.29 one team meeting each calendar week ~~and~~. The mental health professional or certified
208.30 rehabilitation specialist must lead and be physically present at the team meeting, except as
208.31 permitted under paragraph (e). All treatment team members, including treatment team

209.1 members who work on a part-time or intermittent basis, must participate in a minimum of
209.2 one team meeting during each calendar week when the treatment team member is working
209.3 for the license holder. The license holder must document all weekly team meetings, including
209.4 the names of meeting attendees, and indicate whether the meeting was conducted remotely
209.5 under paragraph (e).

209.6 (c) If a treatment team member cannot participate in a weekly team meeting, the treatment
209.7 team member must participate in an ancillary meeting. A mental health professional, certified
209.8 rehabilitation specialist, clinical trainee, or mental health practitioner who participated in
209.9 the most recent weekly team meeting may lead the ancillary meeting. During the ancillary
209.10 meeting, the treatment team member leading the ancillary meeting must review the
209.11 information that was shared at the most recent weekly team meeting, including revisions
209.12 to client treatment plans and other information that the treatment supervisors exchanged
209.13 with treatment team members. The license holder must document all ancillary meetings,
209.14 including the names of meeting attendees.

209.15 (d) If a treatment team member working only one shift during a week cannot participate
209.16 in a weekly team meeting or participate in an ancillary meeting, the treatment team member
209.17 must read the minutes of the weekly team meeting required to be documented in paragraph
209.18 (b). The treatment team member must sign to acknowledge receipt of this information, and
209.19 document pertinent information or questions. The mental health professional or certified
209.20 rehabilitation specialist must review any documented questions or pertinent information
209.21 before the next weekly team meeting.

209.22 (e) A license holder may permit a mental health professional or certified rehabilitation
209.23 specialist to lead the weekly meeting remotely due to medical or weather conditions. If the
209.24 conditions that do not permit physical presence persist for longer than one week, the license
209.25 holder must request a variance to conduct additional meetings remotely.

209.26 Sec. 13. Minnesota Statutes 2023 Supplement, section 254B.04, subdivision 1a, is amended
209.27 to read:

209.28 Subd. 1a. **Client eligibility.** (a) Persons eligible for benefits under Code of Federal
209.29 Regulations, title 25, part 20, who meet the income standards of section 256B.056,
209.30 subdivision 4, and are not enrolled in medical assistance, are entitled to behavioral health
209.31 fund services. State money appropriated for this paragraph must be placed in a separate
209.32 account established for this purpose.

209.33 (b) Persons with dependent children who are determined to be in need of substance use
209.34 disorder treatment pursuant to an assessment under section 260E.20, subdivision 1, or in

210.1 need of chemical dependency treatment pursuant to a case plan under section 260C.201,
210.2 subdivision 6, or 260C.212, shall be assisted by the local agency to access needed treatment
210.3 services. Treatment services must be appropriate for the individual or family, which may
210.4 include long-term care treatment or treatment in a facility that allows the dependent children
210.5 to stay in the treatment facility. The county shall pay for out-of-home placement costs, if
210.6 applicable.

210.7 (c) Notwithstanding paragraph (a), ~~persons~~ any person enrolled in medical assistance
210.8 ~~are~~ or MinnesotaCare is eligible for room and board services under section 254B.05,
210.9 subdivision 5, paragraph (b), clause ~~(12)~~ (9).

210.10 (d) A client is eligible to have substance use disorder treatment paid for with funds from
210.11 the behavioral health fund when the client:

210.12 (1) is eligible for MFIP as determined under chapter 256J;

210.13 (2) is eligible for medical assistance as determined under Minnesota Rules, parts
210.14 9505.0010 to 9505.0150;

210.15 (3) is eligible for general assistance, general assistance medical care, or work readiness
210.16 as determined under Minnesota Rules, parts 9500.1200 to 9500.1318; or

210.17 (4) has income that is within current household size and income guidelines for entitled
210.18 persons, as defined in this subdivision and subdivision 7.

210.19 (e) Clients who meet the financial eligibility requirement in paragraph (a) and who have
210.20 a third-party payment source are eligible for the behavioral health fund if the third-party
210.21 payment source pays less than 100 percent of the cost of treatment services for eligible
210.22 clients.

210.23 (f) A client is ineligible to have substance use disorder treatment services paid for with
210.24 behavioral health fund money if the client:

210.25 (1) has an income that exceeds current household size and income guidelines for entitled
210.26 persons as defined in this subdivision and subdivision 7; or

210.27 (2) has an available third-party payment source that will pay the total cost of the client's
210.28 treatment.

210.29 (g) A client who is disenrolled from a state prepaid health plan during a treatment episode
210.30 is eligible for continued treatment service that is paid for by the behavioral health fund until
210.31 the treatment episode is completed or the client is re-enrolled in a state prepaid health plan
210.32 if the client:

211.1 (1) continues to be enrolled in MinnesotaCare, medical assistance, or general assistance
211.2 medical care; or

211.3 (2) is eligible according to paragraphs (a) and (b) and is determined eligible by a local
211.4 agency under section 254B.04.

211.5 (h) When a county commits a client under chapter 253B to a regional treatment center
211.6 for substance use disorder services and the client is ineligible for the behavioral health fund,
211.7 the county is responsible for the payment to the regional treatment center according to
211.8 section 254B.05, subdivision 4.

211.9 (i) Persons enrolled in MinnesotaCare are eligible for room and board services when
211.10 provided through intensive residential treatment services and residential crisis services under
211.11 section 256B.0622.

211.12 **EFFECTIVE DATE.** This section is effective January 1, 2025.

211.13 Sec. 14. **[256B.0617] MENTAL HEALTH SERVICES PROVIDER**

211.14 **CERTIFICATION.**

211.15 (a) The commissioner of human services shall establish an initial provider entity
211.16 application and certification and recertification processes to determine whether a provider
211.17 entity has administrative and clinical infrastructures that meet the certification requirements.
211.18 This process applies to providers of the following services:

211.19 (1) children's intensive behavioral health services under section 256B.0946; and

211.20 (2) intensive nonresidential rehabilitative mental health services under section 256B.0947.

211.21 (b) The commissioner shall recertify a provider entity every three years using the
211.22 individual provider's certification anniversary or the calendar year end. The commissioner
211.23 may approve a recertification extension in the interest of sustaining services when a certain
211.24 date for recertification is identified.

211.25 (c) The commissioner shall establish a process for decertification of a provider entity
211.26 and shall require corrective action, medical assistance repayment, or decertification of a
211.27 provider entity that no longer meets the requirements in this section or that fails to meet the
211.28 clinical quality standards or administrative standards provided by the commissioner in the
211.29 application and certification process.

211.30 (d) The commissioner must provide the following to provider entities for the certification,
211.31 recertification, and decertification processes:

211.32 (1) a structured listing of required provider certification criteria;

212.1 (2) a formal written letter with a determination of certification, recertification, or
212.2 decertification signed by the commissioner or the appropriate division director; and

212.3 (3) a formal written communication outlining the process for necessary corrective action
212.4 and follow-up by the commissioner signed by the commissioner or their designee, if
212.5 applicable. In the case of corrective action, the commissioner may schedule interim
212.6 recertification site reviews to confirm certification or decertification.

212.7 **EFFECTIVE DATE.** This section is effective July 1, 2024, and the commissioner of
212.8 human services must implement all requirements of this section by September 1, 2024.

212.9 Sec. 15. Minnesota Statutes 2022, section 256B.0622, subdivision 2a, is amended to read:

212.10 Subd. 2a. **Eligibility for assertive community treatment.** (a) An eligible client for
212.11 assertive community treatment is an individual who meets the following criteria as assessed
212.12 by an ACT team:

212.13 (1) is age 18 or older. Individuals ages 16 and 17 may be eligible upon approval by the
212.14 commissioner;

212.15 (2) has a primary diagnosis of schizophrenia, schizoaffective disorder, major depressive
212.16 disorder with psychotic features, other psychotic disorders, or bipolar disorder. Individuals
212.17 with other psychiatric illnesses may qualify for assertive community treatment if they have
212.18 a serious mental illness and meet the criteria outlined in clauses (3) and (4), but no more
212.19 than ten percent of an ACT team's clients may be eligible based on this criteria. Individuals
212.20 with a primary diagnosis of a substance use disorder, intellectual developmental disabilities,
212.21 borderline personality disorder, antisocial personality disorder, traumatic brain injury, or
212.22 an autism spectrum disorder are not eligible for assertive community treatment;

212.23 (3) has significant functional impairment as demonstrated by at least one of the following
212.24 conditions:

212.25 (i) significant difficulty consistently performing the range of routine tasks required for
212.26 basic adult functioning in the community or persistent difficulty performing daily living
212.27 tasks without significant support or assistance;

212.28 (ii) significant difficulty maintaining employment at a self-sustaining level or significant
212.29 difficulty consistently carrying out the head-of-household responsibilities; or

212.30 (iii) significant difficulty maintaining a safe living situation;

212.31 (4) has a need for continuous high-intensity services as evidenced by at least two of the
212.32 following:

- 213.1 (i) two or more psychiatric hospitalizations or residential crisis stabilization services in
213.2 the previous 12 months;
- 213.3 (ii) frequent utilization of mental health crisis services in the previous six months;
- 213.4 (iii) 30 or more consecutive days of psychiatric hospitalization in the previous 24 months;
- 213.5 (iv) intractable, persistent, or prolonged severe psychiatric symptoms;
- 213.6 (v) coexisting mental health and substance use disorders lasting at least six months;
- 213.7 (vi) recent history of involvement with the criminal justice system or demonstrated risk
213.8 of future involvement;
- 213.9 (vii) significant difficulty meeting basic survival needs;
- 213.10 (viii) residing in substandard housing, experiencing homelessness, or facing imminent
213.11 risk of homelessness;
- 213.12 (ix) significant impairment with social and interpersonal functioning such that basic
213.13 needs are in jeopardy;
- 213.14 (x) coexisting mental health and physical health disorders lasting at least six months;
- 213.15 (xi) residing in an inpatient or supervised community residence but clinically assessed
213.16 to be able to live in a more independent living situation if intensive services are provided;
- 213.17 (xii) requiring a residential placement if more intensive services are not available; or
- 213.18 (xiii) difficulty effectively using traditional office-based outpatient services;
- 213.19 (5) there are no indications that other available community-based services would be
213.20 equally or more effective as evidenced by consistent and extensive efforts to treat the
213.21 individual; and
- 213.22 (6) in the written opinion of a licensed mental health professional, has the need for mental
213.23 health services that cannot be met with other available community-based services, or is
213.24 likely to experience a mental health crisis or require a more restrictive setting if assertive
213.25 community treatment is not provided.
- 213.26 (b) An individual meets the criteria for assertive community treatment under this section
213.27 if they have participated within the last year or are currently participating in a first episode
213.28 of psychosis program if the individual:
- 213.29 (1) meets the eligibility requirements outlined in paragraph (a), clauses (1), (2), (5), and
213.30 (6); and

214.1 (2) needs the level of intensity provided by an ACT team, in the opinion of the individual's
 214.2 first episode of psychosis program, in order to prevent crisis services use, hospitalization,
 214.3 homelessness, and involvement with the criminal justice system.

214.4 Sec. 16. Minnesota Statutes 2022, section 256B.0622, subdivision 3a, is amended to read:

214.5 Subd. 3a. **Provider certification and contract requirements for assertive community**
 214.6 **treatment.** (a) The assertive community treatment provider must:

214.7 ~~(1) have a contract with the host county to provide assertive community treatment~~
 214.8 ~~services; and~~

214.9 ~~(2)~~ have each ACT team be certified by the state following the certification process and
 214.10 procedures developed by the commissioner. The certification process determines whether
 214.11 the ACT team meets the standards for assertive community treatment under this section,
 214.12 the standards in chapter 245I as required in section 245I.011, subdivision 5, and minimum
 214.13 program fidelity standards as measured by a nationally recognized fidelity tool approved
 214.14 by the commissioner. Recertification must occur at least every three years.

214.15 (b) An ACT team certified under this subdivision must meet the following standards:

214.16 (1) have capacity to recruit, hire, manage, and train required ACT team members;

214.17 (2) have adequate administrative ability to ensure availability of services;

214.18 (3) ensure flexibility in service delivery to respond to the changing and intermittent care
 214.19 needs of a client as identified by the client and the individual treatment plan;

214.20 (4) keep all necessary records required by law;

214.21 (5) be an enrolled Medicaid provider; and

214.22 (6) establish and maintain a quality assurance plan to determine specific service outcomes
 214.23 and the client's satisfaction with services.

214.24 (c) The commissioner may intervene at any time and decertify an ACT team with cause.
 214.25 The commissioner shall establish a process for decertification of an ACT team and shall
 214.26 require corrective action, medical assistance repayment, or decertification of an ACT team
 214.27 that no longer meets the requirements in this section or that fails to meet the clinical quality
 214.28 standards or administrative standards provided by the commissioner in the application and
 214.29 certification process. The decertification is subject to appeal to the state.

215.1 Sec. 17. Minnesota Statutes 2022, section 256B.0622, subdivision 7a, is amended to read:

215.2 Subd. 7a. **Assertive community treatment team staff requirements and roles.** (a)

215.3 The required treatment staff qualifications and roles for an ACT team are:

215.4 (1) the team leader:

215.5 (i) shall be a mental health professional. Individuals who are not licensed but who are
215.6 eligible for licensure and are otherwise qualified may also fulfill this role ~~but must obtain~~
215.7 ~~full licensure within 24 months of assuming the role of team leader;~~

215.8 (ii) must be an active member of the ACT team and provide some direct services to
215.9 clients;

215.10 (iii) must be a single full-time staff member, dedicated to the ACT team, who is
215.11 responsible for overseeing the administrative operations of the team, ~~providing treatment~~
215.12 ~~supervision of services in conjunction with the psychiatrist or psychiatric care provider,~~ and
215.13 supervising team members to ensure delivery of best and ethical practices; and

215.14 (iv) must be available to ~~provide~~ ensure that overall treatment supervision to the ACT
215.15 team is available after regular business hours and on weekends and holidays. ~~The team~~
215.16 ~~leader may delegate this duty to another~~ and is provided by a qualified member of the ACT
215.17 team;

215.18 (2) the psychiatric care provider:

215.19 (i) must be a mental health professional permitted to prescribe psychiatric medications
215.20 as part of the mental health professional's scope of practice. The psychiatric care provider
215.21 must have demonstrated clinical experience working with individuals with serious and
215.22 persistent mental illness;

215.23 (ii) shall collaborate with the team leader in sharing overall clinical responsibility for
215.24 screening and admitting clients; monitoring clients' treatment and team member service
215.25 delivery; educating staff on psychiatric and nonpsychiatric medications, their side effects,
215.26 and health-related conditions; actively collaborating with nurses; and helping provide
215.27 treatment supervision to the team;

215.28 (iii) shall fulfill the following functions for assertive community treatment clients:
215.29 provide assessment and treatment of clients' symptoms and response to medications, including
215.30 side effects; provide brief therapy to clients; provide diagnostic and medication education
215.31 to clients, with medication decisions based on shared decision making; monitor clients'
215.32 nonpsychiatric medical conditions and nonpsychiatric medications; and conduct home and
215.33 community visits;

216.1 (iv) shall serve as the point of contact for psychiatric treatment if a client is hospitalized
216.2 for mental health treatment and shall communicate directly with the client's inpatient
216.3 psychiatric care providers to ensure continuity of care;

216.4 (v) shall have a minimum full-time equivalency that is prorated at a rate of 16 hours per
216.5 50 clients. Part-time psychiatric care providers shall have designated hours to work on the
216.6 team, with sufficient blocks of time on consistent days to carry out the provider's clinical,
216.7 supervisory, and administrative responsibilities. No more than two psychiatric care providers
216.8 may share this role; and

216.9 (vi) shall provide psychiatric backup to the program after regular business hours and on
216.10 weekends and holidays. The psychiatric care provider may delegate this duty to another
216.11 qualified psychiatric provider;

216.12 (3) the nursing staff:

216.13 (i) shall consist of one to three registered nurses or advanced practice registered nurses,
216.14 of whom at least one has a minimum of one-year experience working with adults with
216.15 serious mental illness and a working knowledge of psychiatric medications. No more than
216.16 two individuals can share a full-time equivalent position;

216.17 (ii) are responsible for managing medication, administering and documenting medication
216.18 treatment, and managing a secure medication room; and

216.19 (iii) shall develop strategies, in collaboration with clients, to maximize taking medications
216.20 as prescribed; screen and monitor clients' mental and physical health conditions and
216.21 medication side effects; engage in health promotion, prevention, and education activities;
216.22 communicate and coordinate services with other medical providers; facilitate the development
216.23 of the individual treatment plan for clients assigned; and educate the ACT team in monitoring
216.24 psychiatric and physical health symptoms and medication side effects;

216.25 (4) the co-occurring disorder specialist:

216.26 (i) shall be a full-time equivalent co-occurring disorder specialist who has received
216.27 specific training on co-occurring disorders that is consistent with national evidence-based
216.28 practices. The training must include practical knowledge of common substances and how
216.29 they affect mental illnesses, the ability to assess substance use disorders and the client's
216.30 stage of treatment, motivational interviewing, and skills necessary to provide counseling to
216.31 clients at all different stages of change and treatment. The co-occurring disorder specialist
216.32 may also be an individual who is a licensed alcohol and drug counselor as described in
216.33 section 148F.01, subdivision 5, or a counselor who otherwise meets the training, experience,

217.1 and other requirements in section 245G.11, subdivision 5. No more than two co-occurring
217.2 disorder specialists may occupy this role; and

217.3 (ii) shall provide or facilitate the provision of co-occurring disorder treatment to clients.

217.4 The co-occurring disorder specialist shall serve as a consultant and educator to fellow ACT
217.5 team members on co-occurring disorders;

217.6 (5) the vocational specialist:

217.7 (i) shall be a full-time vocational specialist who has at least one-year experience providing
217.8 employment services or advanced education that involved field training in vocational services
217.9 to individuals with mental illness. An individual who does not meet these qualifications
217.10 may also serve as the vocational specialist upon completing a training plan approved by the
217.11 commissioner;

217.12 (ii) shall provide or facilitate the provision of vocational services to clients. The vocational
217.13 specialist serves as a consultant and educator to fellow ACT team members on these services;

217.14 and

217.15 (iii) must not refer individuals to receive any type of vocational services or linkage by
217.16 providers outside of the ACT team;

217.17 (6) the mental health certified peer specialist:

217.18 (i) shall be a full-time equivalent. No more than two individuals can share this position.
217.19 The mental health certified peer specialist is a fully integrated team member who provides
217.20 highly individualized services in the community and promotes the self-determination and
217.21 shared decision-making abilities of clients. This requirement may be waived due to workforce
217.22 shortages upon approval of the commissioner;

217.23 (ii) must provide coaching, mentoring, and consultation to the clients to promote recovery,
217.24 self-advocacy, and self-direction, promote wellness management strategies, and assist clients
217.25 in developing advance directives; and

217.26 (iii) must model recovery values, attitudes, beliefs, and personal action to encourage
217.27 wellness and resilience, provide consultation to team members, promote a culture where
217.28 the clients' points of view and preferences are recognized, understood, respected, and
217.29 integrated into treatment, and serve in a manner equivalent to other team members;

217.30 (7) the program administrative assistant shall be a full-time office-based program
217.31 administrative assistant position assigned to solely work with the ACT team, providing a
217.32 range of supports to the team, clients, and families; and

218.1 (8) additional staff:

218.2 (i) shall be based on team size. Additional treatment team staff may include mental
218.3 health professionals; clinical trainees; certified rehabilitation specialists; mental health
218.4 practitioners; or mental health rehabilitation workers. These individuals shall have the
218.5 knowledge, skills, and abilities required by the population served to carry out rehabilitation
218.6 and support functions; and

218.7 (ii) shall be selected based on specific program needs or the population served.

218.8 (b) Each ACT team must clearly document schedules for all ACT team members.

218.9 (c) Each ACT team member must serve as a primary team member for clients assigned
218.10 by the team leader and are responsible for facilitating the individual treatment plan process
218.11 for those clients. The primary team member for a client is the responsible team member
218.12 knowledgeable about the client's life and circumstances and writes the individual treatment
218.13 plan. The primary team member provides individual supportive therapy or counseling, and
218.14 provides primary support and education to the client's family and support system.

218.15 (d) Members of the ACT team must have strong clinical skills, professional qualifications,
218.16 experience, and competency to provide a full breadth of rehabilitation services. Each staff
218.17 member shall be proficient in their respective discipline and be able to work collaboratively
218.18 as a member of a multidisciplinary team to deliver the majority of the treatment,
218.19 rehabilitation, and support services clients require to fully benefit from receiving assertive
218.20 community treatment.

218.21 (e) Each ACT team member must fulfill training requirements established by the
218.22 commissioner.

218.23 Sec. 18. Minnesota Statutes 2023 Supplement, section 256B.0622, subdivision 7b, is
218.24 amended to read:

218.25 Subd. 7b. **Assertive community treatment program size and opportunities scores.** (a)
218.26 Each ACT team shall maintain an annual average caseload that does not exceed 100 clients.
218.27 ~~Staff to client ratios shall be based on team size as follows:~~ must demonstrate that the team
218.28 attained a passing score according to the most recently issued Tool for Measurement of
218.29 Assertive Community Treatment (TMACT).

218.30 ~~(1) a small ACT team must:~~

218.31 ~~(i) employ at least six but no more than seven full-time treatment team staff, excluding~~
218.32 ~~the program assistant and the psychiatric care provider;~~

- 219.1 ~~(ii) serve an annual average maximum of no more than 50 clients;~~
- 219.2 ~~(iii) ensure at least one full-time equivalent position for every eight clients served;~~
- 219.3 ~~(iv) schedule ACT team staff on weekdays and on-call duty to provide crisis services~~
- 219.4 ~~and deliver services after hours when staff are not working;~~
- 219.5 ~~(v) provide crisis services during business hours if the small ACT team does not have~~
- 219.6 ~~sufficient staff numbers to operate an after-hours on-call system. During all other hours,~~
- 219.7 ~~the ACT team may arrange for coverage for crisis assessment and intervention services~~
- 219.8 ~~through a reliable crisis-intervention provider as long as there is a mechanism by which the~~
- 219.9 ~~ACT team communicates routinely with the crisis-intervention provider and the on-call~~
- 219.10 ~~ACT team staff are available to see clients face-to-face when necessary or if requested by~~
- 219.11 ~~the crisis-intervention services provider;~~
- 219.12 ~~(vi) adjust schedules and provide staff to carry out the needed service activities in the~~
- 219.13 ~~evenings or on weekend days or holidays, when necessary;~~
- 219.14 ~~(vii) arrange for and provide psychiatric backup during all hours the psychiatric care~~
- 219.15 ~~provider is not regularly scheduled to work. If availability of the ACT team's psychiatric~~
- 219.16 ~~care provider during all hours is not feasible, alternative psychiatric prescriber backup must~~
- 219.17 ~~be arranged and a mechanism of timely communication and coordination established in~~
- 219.18 ~~writing; and~~
- 219.19 ~~(viii) be composed of, at minimum, one full-time team leader, at least 16 hours each~~
- 219.20 ~~week per 50 clients of psychiatric provider time, or equivalent if fewer clients, one full-time~~
- 219.21 ~~equivalent nursing, one full-time co-occurring disorder specialist, one full-time equivalent~~
- 219.22 ~~mental health certified peer specialist, one full-time vocational specialist, one full-time~~
- 219.23 ~~program assistant, and at least one additional full-time ACT team member who has mental~~
- 219.24 ~~health professional, certified rehabilitation specialist, clinical trainee, or mental health~~
- 219.25 ~~practitioner status; and~~
- 219.26 ~~(2) a midsize ACT team shall:~~
- 219.27 ~~(i) be composed of, at minimum, one full-time team leader, at least 16 hours of psychiatry~~
- 219.28 ~~time for 51 clients, with an additional two hours for every six clients added to the team, 1.5~~
- 219.29 ~~to two full-time equivalent nursing staff, one full-time co-occurring disorder specialist, one~~
- 219.30 ~~full-time equivalent mental health certified peer specialist, one full-time vocational specialist,~~
- 219.31 ~~one full-time program assistant, and at least 1.5 to two additional full-time equivalent ACT~~
- 219.32 ~~members, with at least one dedicated full-time staff member with mental health professional~~

- 220.1 ~~status. Remaining team members may have mental health professional, certified rehabilitation~~
220.2 ~~specialist, clinical trainee, or mental health practitioner status;~~
- 220.3 ~~(ii) employ seven or more treatment team full-time equivalents, excluding the program~~
220.4 ~~assistant and the psychiatric care provider;~~
- 220.5 ~~(iii) serve an annual average maximum caseload of 51 to 74 clients;~~
- 220.6 ~~(iv) ensure at least one full-time equivalent position for every nine clients served;~~
- 220.7 ~~(v) schedule ACT team staff for a minimum of ten-hour shift coverage on weekdays~~
220.8 ~~and six to eight-hour shift coverage on weekends and holidays. In addition to these minimum~~
220.9 ~~specifications, staff are regularly scheduled to provide the necessary services on a~~
220.10 ~~client-by-client basis in the evenings and on weekends and holidays;~~
- 220.11 ~~(vi) schedule ACT team staff on-call duty to provide crisis services and deliver services~~
220.12 ~~when staff are not working;~~
- 220.13 ~~(vii) have the authority to arrange for coverage for crisis assessment and intervention~~
220.14 ~~services through a reliable crisis intervention provider as long as there is a mechanism by~~
220.15 ~~which the ACT team communicates routinely with the crisis intervention provider and the~~
220.16 ~~on-call ACT team staff are available to see clients face-to-face when necessary or if requested~~
220.17 ~~by the crisis intervention services provider; and~~
- 220.18 ~~(viii) arrange for and provide psychiatric backup during all hours the psychiatric care~~
220.19 ~~provider is not regularly scheduled to work. If availability of the psychiatric care provider~~
220.20 ~~during all hours is not feasible, alternative psychiatric prescriber backup must be arranged~~
220.21 ~~and a mechanism of timely communication and coordination established in writing;~~
- 220.22 ~~(3) a large ACT team must:~~
- 220.23 ~~(i) be composed of, at minimum, one full-time team leader, at least 32 hours each week~~
220.24 ~~per 100 clients, or equivalent of psychiatry time, three full-time equivalent nursing staff,~~
220.25 ~~one full-time co-occurring disorder specialist, one full-time equivalent mental health certified~~
220.26 ~~peer specialist, one full-time vocational specialist, one full-time program assistant, and at~~
220.27 ~~least two additional full-time equivalent ACT team members, with at least one dedicated~~
220.28 ~~full-time staff member with mental health professional status. Remaining team members~~
220.29 ~~may have mental health professional or mental health practitioner status;~~
- 220.30 ~~(ii) employ nine or more treatment team full-time equivalents, excluding the program~~
220.31 ~~assistant and psychiatric care provider;~~
- 220.32 ~~(iii) serve an annual average maximum caseload of 75 to 100 clients;~~

- 221.1 ~~(iv) ensure at least one full-time equivalent position for every nine individuals served;~~
- 221.2 ~~(v) schedule staff to work two eight-hour shifts, with a minimum of two staff on the~~
- 221.3 ~~second shift providing services at least 12 hours per day weekdays. For weekends and~~
- 221.4 ~~holidays, the team must operate and schedule ACT team staff to work one eight-hour shift,~~
- 221.5 ~~with a minimum of two staff each weekend day and every holiday;~~
- 221.6 ~~(vi) schedule ACT team staff on-call duty to provide crisis services and deliver services~~
- 221.7 ~~when staff are not working; and~~
- 221.8 ~~(vii) arrange for and provide psychiatric backup during all hours the psychiatric care~~
- 221.9 ~~provider is not regularly scheduled to work. If availability of the ACT team psychiatric care~~
- 221.10 ~~provider during all hours is not feasible, alternative psychiatric backup must be arranged~~
- 221.11 ~~and a mechanism of timely communication and coordination established in writing.~~
- 221.12 ~~(b) An ACT team of any size may have a staff-to-client ratio that is lower than the~~
- 221.13 ~~requirements described in paragraph (a) upon approval by the commissioner, but may not~~
- 221.14 ~~exceed a one-to-ten staff-to-client ratio.~~

221.15 Sec. 19. Minnesota Statutes 2022, section 256B.0622, subdivision 7d, is amended to read:

221.16 Subd. 7d. **Assertive community treatment assessment and individual treatment**

221.17 **plan.** (a) An initial assessment shall be completed the day of the client's admission to

221.18 assertive community treatment by the ACT team leader or the psychiatric care provider,

221.19 with participation by designated ACT team members and the client. The initial assessment

221.20 must include obtaining or completing a standard diagnostic assessment according to section

221.21 245I.10, subdivision 6, and completing a 30-day individual treatment plan. The team leader,

221.22 psychiatric care provider, or other mental health professional designated by the team leader

221.23 or psychiatric care provider, must update the client's diagnostic assessment ~~at least annually~~

221.24 as required under section 245I.10, subdivision 2, paragraphs (f) and (g).

221.25 (b) A functional assessment must be completed according to section 245I.10, subdivision

221.26 9. Each part of the functional assessment areas shall be completed by each respective team

221.27 specialist or an ACT team member with skill and knowledge in the area being assessed.

221.28 (c) Between 30 and 45 days after the client's admission to assertive community treatment,

221.29 the entire ACT team must hold a comprehensive case conference, where all team members,

221.30 including the psychiatric provider, present information discovered from the completed

221.31 assessments and provide treatment recommendations. The conference must serve as the

221.32 basis for the first individual treatment plan, which must be written by the primary team

221.33 member.

222.1 (d) The client's psychiatric care provider, primary team member, and individual treatment
222.2 team members shall assume responsibility for preparing the written narrative of the results
222.3 from the psychiatric and social functioning history timeline and the comprehensive
222.4 assessment.

222.5 (e) The primary team member and individual treatment team members shall be assigned
222.6 by the team leader in collaboration with the psychiatric care provider by the time of the first
222.7 treatment planning meeting or 30 days after admission, whichever occurs first.

222.8 (f) Individual treatment plans must be developed through the following treatment planning
222.9 process:

222.10 (1) The individual treatment plan shall be developed in collaboration with the client and
222.11 the client's preferred natural supports, and guardian, if applicable and appropriate. The ACT
222.12 team shall evaluate, together with each client, the client's needs, strengths, and preferences
222.13 and develop the individual treatment plan collaboratively. The ACT team shall make every
222.14 effort to ensure that the client and the client's family and natural supports, with the client's
222.15 consent, are in attendance at the treatment planning meeting, are involved in ongoing
222.16 meetings related to treatment, and have the necessary supports to fully participate. The
222.17 client's participation in the development of the individual treatment plan shall be documented.

222.18 (2) The client and the ACT team shall work together to formulate and prioritize the
222.19 issues, set goals, research approaches and interventions, and establish the plan. The plan is
222.20 individually tailored so that the treatment, rehabilitation, and support approaches and
222.21 interventions achieve optimum symptom reduction, help fulfill the personal needs and
222.22 aspirations of the client, take into account the cultural beliefs and realities of the individual,
222.23 and improve all the aspects of psychosocial functioning that are important to the client. The
222.24 process supports strengths, rehabilitation, and recovery.

222.25 (3) Each client's individual treatment plan shall identify service needs, strengths and
222.26 capacities, and barriers, and set specific and measurable short- and long-term goals for each
222.27 service need. The individual treatment plan must clearly specify the approaches and
222.28 interventions necessary for the client to achieve the individual goals, when the interventions
222.29 shall happen, and identify which ACT team member shall carry out the approaches and
222.30 interventions.

222.31 (4) The primary team member and the individual treatment team, together with the client
222.32 and the client's family and natural supports with the client's consent, are responsible for
222.33 reviewing and rewriting the treatment goals and individual treatment plan whenever there
222.34 is a major decision point in the client's course of treatment or at least every six months.

223.1 (5) The primary team member shall prepare a summary that thoroughly describes in
 223.2 writing the client's and the individual treatment team's evaluation of the client's progress
 223.3 and goal attainment, the effectiveness of the interventions, and the satisfaction with services
 223.4 since the last individual treatment plan. The client's most recent diagnostic assessment must
 223.5 be included with the treatment plan summary.

223.6 (6) The individual treatment plan and review must be approved or acknowledged by the
 223.7 client, the primary team member, the team leader, the psychiatric care provider, and all
 223.8 individual treatment team members. A copy of the approved individual treatment plan must
 223.9 be made available to the client.

223.10 Sec. 20. Minnesota Statutes 2022, section 256B.0623, subdivision 5, is amended to read:

223.11 Subd. 5. **Qualifications of provider staff.** Adult rehabilitative mental health services
 223.12 must be provided by qualified individual provider staff of a certified provider entity.

223.13 Individual provider staff must be qualified as:

223.14 (1) a mental health professional who is qualified according to section 245I.04, subdivision
 223.15 2;

223.16 (2) a certified rehabilitation specialist who is qualified according to section 245I.04,
 223.17 subdivision 8;

223.18 (3) a clinical trainee who is qualified according to section 245I.04, subdivision 6;

223.19 (4) a mental health practitioner qualified according to section 245I.04, subdivision 4;

223.20 (5) a mental health certified peer specialist who is qualified according to section 245I.04,
 223.21 subdivision 10; ~~or~~

223.22 (6) a mental health rehabilitation worker who is qualified according to section 245I.04,
 223.23 subdivision 14; or

223.24 (7) a licensed occupational therapist, as defined in section 148.6402, subdivision 14.

223.25 **EFFECTIVE DATE.** This section is effective upon federal approval. The commissioner
 223.26 of human services must notify the revisor of statutes when federal approval is obtained.

223.27 Sec. 21. Minnesota Statutes 2023 Supplement, section 256B.0625, subdivision 5m, is
 223.28 amended to read:

223.29 Subd. 5m. **Certified community behavioral health clinic services.** (a) Medical
 223.30 assistance covers services provided by a not-for-profit certified community behavioral health
 223.31 clinic (CCBHC) that meets the requirements of section 245.735, subdivision 3.

224.1 (b) The commissioner shall reimburse CCBHCs on a per-day basis for each day that an
224.2 eligible service is delivered using the CCBHC daily bundled rate system for medical
224.3 assistance payments as described in paragraph (c). The commissioner shall include a quality
224.4 incentive payment in the CCBHC daily bundled rate system as described in paragraph (e).
224.5 There is no county share for medical assistance services when reimbursed through the
224.6 CCBHC daily bundled rate system.

224.7 (c) The commissioner shall ensure that the CCBHC daily bundled rate system for CCBHC
224.8 payments under medical assistance meets the following requirements:

224.9 (1) the CCBHC daily bundled rate shall be a provider-specific rate calculated for each
224.10 CCBHC, based on the daily cost of providing CCBHC services and the total annual allowable
224.11 CCBHC costs divided by the total annual number of CCBHC visits. For calculating the
224.12 payment rate, total annual visits include visits covered by medical assistance and visits not
224.13 covered by medical assistance. Allowable costs include but are not limited to the salaries
224.14 and benefits of medical assistance providers; the cost of CCBHC services provided under
224.15 section 245.735, subdivision 3, paragraph (a), clauses (6) and (7); and other costs such as
224.16 insurance or supplies needed to provide CCBHC services;

224.17 (2) payment shall be limited to one payment per day per medical assistance enrollee
224.18 when an eligible CCBHC service is provided. A CCBHC visit is eligible for reimbursement
224.19 if at least one of the CCBHC services listed under section 245.735, subdivision 3, paragraph
224.20 (a), clause (6), is furnished to a medical assistance enrollee by a health care practitioner or
224.21 licensed agency employed by or under contract with a CCBHC;

224.22 (3) initial CCBHC daily bundled rates for newly certified CCBHCs under section 245.735,
224.23 subdivision 3, shall be established by the commissioner using a provider-specific rate based
224.24 on the newly certified CCBHC's audited historical cost report data adjusted for the expected
224.25 cost of delivering CCBHC services. Estimates are subject to review by the commissioner
224.26 and must include the expected cost of providing the full scope of CCBHC services and the
224.27 expected number of visits for the rate period;

224.28 (4) the commissioner shall rebase CCBHC rates once every two years following the last
224.29 rebasing and no less than 12 months following an initial rate or a rate change due to a change
224.30 in the scope of services. For CCBHCs certified after September 31, 2020, and before January
224.31 1, 2021, the commissioner shall rebase rates according to this clause for services provided
224.32 on or after January 1, 2024;

224.33 (5) the commissioner shall provide for a 60-day appeals process after notice of the results
224.34 of the rebasing;

225.1 (6) an entity that receives a CCBHC daily bundled rate that overlaps with another federal
225.2 Medicaid rate is not eligible for the CCBHC rate methodology;

225.3 (7) payments for CCBHC services to individuals enrolled in managed care shall be
225.4 coordinated with the state's phase-out of CCBHC wrap payments. The commissioner shall
225.5 complete the phase-out of CCBHC wrap payments within 60 days of the implementation
225.6 of the CCBHC daily bundled rate system in the Medicaid Management Information System
225.7 (MMIS), for CCBHCs reimbursed under this chapter, with a final settlement of payments
225.8 due made payable to CCBHCs no later than 18 months thereafter;

225.9 (8) the CCBHC daily bundled rate for each CCBHC shall be updated by trending each
225.10 provider-specific rate by the Medicare Economic Index for primary care services. This
225.11 update shall occur each year in between rebasing periods determined by the commissioner
225.12 in accordance with clause (4). CCBHCs must provide data on costs and visits to the state
225.13 annually using the CCBHC cost report established by the commissioner; and

225.14 (9) a CCBHC may request a rate adjustment for changes in the CCBHC's scope of
225.15 services when such changes are expected to result in an adjustment to the CCBHC payment
225.16 rate by 2.5 percent or more. The CCBHC must provide the commissioner with information
225.17 regarding the changes in the scope of services, including the estimated cost of providing
225.18 the new or modified services and any projected increase or decrease in the number of visits
225.19 resulting from the change. Estimated costs are subject to review by the commissioner. Rate
225.20 adjustments for changes in scope shall occur no more than once per year in between rebasing
225.21 periods per CCBHC and are effective on the date of the annual CCBHC rate update.

225.22 (d) Managed care plans and county-based purchasing plans shall reimburse CCBHC
225.23 providers at the CCBHC daily bundled rate. The commissioner shall monitor the effect of
225.24 this requirement on the rate of access to the services delivered by CCBHC providers. If, for
225.25 any contract year, federal approval is not received for this paragraph, the commissioner
225.26 must adjust the capitation rates paid to managed care plans and county-based purchasing
225.27 plans for that contract year to reflect the removal of this provision. Contracts between
225.28 managed care plans and county-based purchasing plans and providers to whom this paragraph
225.29 applies must allow recovery of payments from those providers if capitation rates are adjusted
225.30 in accordance with this paragraph. Payment recoveries must not exceed the amount equal
225.31 to any increase in rates that results from this provision. This paragraph expires if federal
225.32 approval is not received for this paragraph at any time.

225.33 (e) The commissioner shall implement a quality incentive payment program for CCBHCs
225.34 that meets the following requirements:

226.1 (1) a CCBHC shall receive a quality incentive payment upon meeting specific numeric
226.2 thresholds for performance metrics established by the commissioner, in addition to payments
226.3 for which the CCBHC is eligible under the CCBHC daily bundled rate system described in
226.4 paragraph (c);

226.5 (2) a CCBHC must be certified and enrolled as a CCBHC for the entire measurement
226.6 year to be eligible for incentive payments;

226.7 (3) each CCBHC shall receive written notice of the criteria that must be met in order to
226.8 receive quality incentive payments at least 90 days prior to the measurement year; and

226.9 (4) a CCBHC must provide the commissioner with data needed to determine incentive
226.10 payment eligibility within six months following the measurement year. The commissioner
226.11 shall notify CCBHC providers of their performance on the required measures and the
226.12 incentive payment amount within 12 months following the measurement year.

226.13 (f) All claims to managed care plans for CCBHC services as provided under this section
226.14 shall be submitted directly to, and paid by, the commissioner on the dates specified no later
226.15 than January 1 of the following calendar year, if:

226.16 (1) one or more managed care plans does not comply with the federal requirement for
226.17 payment of clean claims to CCBHCs, as defined in Code of Federal Regulations, title 42,
226.18 section 447.45(b), and the managed care plan does not resolve the payment issue within 30
226.19 days of noncompliance; and

226.20 (2) the total amount of clean claims not paid in accordance with federal requirements
226.21 by one or more managed care plans is 50 percent of, or greater than, the total CCBHC claims
226.22 eligible for payment by managed care plans.

226.23 If the conditions in this paragraph are met between January 1 and June 30 of a calendar
226.24 year, claims shall be submitted to and paid by the commissioner beginning on January 1 of
226.25 the following year. If the conditions in this paragraph are met between July 1 and December
226.26 31 of a calendar year, claims shall be submitted to and paid by the commissioner beginning
226.27 on July 1 of the following year.

226.28 (g) Peer services provided by a CCBHC certified under section 245.735 are a covered
226.29 service under medical assistance when a licensed mental health professional or alcohol and
226.30 drug counselor determines that peer services are medically necessary. Eligibility under this
226.31 subdivision for peer services provided by a CCBHC supersede eligibility standards under
226.32 sections 256B.0615, 256B.0616, and 245G.07, subdivision 2, clause (8).

227.1 Sec. 22. Minnesota Statutes 2023 Supplement, section 256B.0671, subdivision 3, is
227.2 amended to read:

227.3 Subd. 3. **Adult day treatment services.** (a) Medical assistance covers adult day treatment
227.4 (ADT) services that are provided under contract with the county board. Adult day treatment
227.5 payment is subject to the conditions in paragraphs (b) to (e). The provider must make
227.6 reasonable and good faith efforts to report individual client outcomes to the commissioner
227.7 using instruments, protocols, and forms approved by the commissioner.

227.8 (b) Adult day treatment is an intensive psychotherapeutic treatment to reduce or relieve
227.9 the effects of mental illness on a client to enable the client to benefit from a lower level of
227.10 care and to live and function more independently in the community. Adult day treatment
227.11 services must be provided to a client to stabilize the client's mental health and to improve
227.12 the client's independent living and socialization skills. Adult day treatment must consist of
227.13 at least one hour of group psychotherapy and must include group time focused on
227.14 rehabilitative interventions or other therapeutic services that a multidisciplinary team provides
227.15 to each client. Adult day treatment services are not a part of inpatient or residential treatment
227.16 services. The following providers may apply to become adult day treatment providers:

227.17 (1) a hospital ~~accredited by the Joint Commission on Accreditation of Health~~
227.18 ~~Organizations~~ with Centers for Medicare and Medicaid Services approved hospital
227.19 accreditation and licensed under sections 144.50 to 144.55;

227.20 (2) a community mental health center under section 256B.0625, subdivision 5; or

227.21 (3) an entity that is under contract with the county board to operate a program that meets
227.22 the requirements of section 245.4712, subdivision 2, and Minnesota Rules, parts 9505.0170
227.23 to 9505.0475.

227.24 (c) An adult day treatment services provider must:

227.25 (1) ensure that the commissioner has approved of the organization as an adult day
227.26 treatment provider organization;

227.27 (2) ensure that a multidisciplinary team provides ADT services to a group of clients. A
227.28 mental health professional must supervise each multidisciplinary staff person who provides
227.29 ADT services;

227.30 (3) make ADT services available to the client at least two days a week for at least three
227.31 consecutive hours per day. ADT services may be longer than three hours per day, but medical
227.32 assistance may not reimburse a provider for more than 15 hours per week;

228.1 (4) provide ADT services to each client that includes group psychotherapy by a mental
228.2 health professional or clinical trainee and daily rehabilitative interventions by a mental
228.3 health professional, clinical trainee, or mental health practitioner; and

228.4 (5) include ADT services in the client's individual treatment plan, when appropriate.

228.5 The adult day treatment provider must:

228.6 (i) complete a functional assessment of each client under section 245I.10, subdivision
228.7 9;

228.8 (ii) notwithstanding section 245I.10, subdivision 8, review the client's progress and
228.9 update the individual treatment plan at least every 90 days until the client is discharged
228.10 from the program; and

228.11 (iii) include a discharge plan for the client in the client's individual treatment plan.

228.12 (d) To be eligible for adult day treatment, a client must:

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

228.14 (2) not reside in a nursing facility, hospital, institute of mental disease, or state-operated
228.15 treatment center unless the client has an active discharge plan that indicates a move to an
228.16 independent living setting within 180 days;

228.17 (3) have the capacity to engage in rehabilitative programming, skills activities, and
228.18 psychotherapy in the structured, therapeutic setting of an adult day treatment program and
228.19 demonstrate measurable improvements in functioning resulting from participation in the
228.20 adult day treatment program;

228.21 (4) have a level of care assessment under section 245I.02, subdivision 19, recommending
228.22 that the client participate in services with the level of intensity and duration of an adult day
228.23 treatment program; and

228.24 (5) have the recommendation of a mental health professional for adult day treatment
228.25 services. The mental health professional must find that adult day treatment services are
228.26 medically necessary for the client.

228.27 (e) Medical assistance does not cover the following services as adult day treatment
228.28 services:

228.29 (1) services that are primarily recreational or that are provided in a setting that is not
228.30 under medical supervision, including sports activities, exercise groups, craft hours, leisure
228.31 time, social hours, meal or snack time, trips to community activities, and tours;

229.1 (2) social or educational services that do not have or cannot reasonably be expected to
 229.2 have a therapeutic outcome related to the client's mental illness;

229.3 (3) consultations with other providers or service agency staff persons about the care or
 229.4 progress of a client;

229.5 (4) prevention or education programs that are provided to the community;

229.6 (5) day treatment for clients with a primary diagnosis of a substance use disorder;

229.7 (6) day treatment provided in the client's home;

229.8 (7) psychotherapy for more than two hours per day; and

229.9 (8) participation in meal preparation and eating that is not part of a clinical treatment
 229.10 plan to address the client's eating disorder.

229.11 Sec. 23. Minnesota Statutes 2023 Supplement, section 256B.0671, subdivision 5, is
 229.12 amended to read:

229.13 Subd. 5. **Child and family psychoeducation services.** (a) Medical assistance covers
 229.14 child and family psychoeducation services provided to a child up to under age 21 with and
 229.15 the child's family members, when determined to be medically necessary due to a diagnosed
 229.16 mental health condition when or diagnosed mental illness identified in the child's individual
 229.17 treatment plan and provided by a mental health professional who is qualified under section
 229.18 245I.04, subdivision 2, and practicing within the scope of practice under section 245I.04,
 229.19 subdivision 3; a mental health practitioner who is qualified under section 245I.04, subdivision
 229.20 4, and practicing within the scope of practice under section 245I.04, subdivision 5; or a
 229.21 clinical trainee who has determined it medically necessary to involve family members in
 229.22 the child's care is qualified under section 245I.04, subdivision 6, and practicing within the
 229.23 scope of practice under section 245I.04, subdivision 7.

229.24 (b) "Child and family psychoeducation services" means information or demonstration
 229.25 provided to an individual or family as part of an individual, family, multifamily group, or
 229.26 peer group session to explain, educate, and support the child and family in understanding
 229.27 a child's symptoms of mental illness, the impact on the child's development, and needed
 229.28 components of treatment and skill development so that the individual, family, or group can
 229.29 help the child to prevent relapse, prevent the acquisition of comorbid disorders, and achieve
 229.30 optimal mental health and long-term resilience.

229.31 (c) Child and family psychoeducation services include individual, family, or group skills
 229.32 development or training to:

230.1 (1) support the development of psychosocial skills that are medically necessary to
230.2 rehabilitate the child to an age-appropriate developmental trajectory when the child's
230.3 development was disrupted by a mental health condition or diagnosed mental illness; or

230.4 (2) enable the child to self-monitor, compensate for, cope with, counteract, or replace
230.5 skills deficits or maladaptive skills acquired over the course of the child's mental health
230.6 condition or mental illness.

230.7 (d) Skills development or training delivered to a child or the child's family under this
230.8 subdivision must be targeted to the specific deficits related to the child's mental health
230.9 condition or mental illness and must be prescribed in the child's individual treatment plan.
230.10 Group skills training may be provided to multiple recipients who, because of the nature of
230.11 their emotional, behavioral, or social functional ability, may benefit from interaction in a
230.12 group setting.

230.13 **EFFECTIVE DATE.** This section is effective January 1, 2025, or upon federal approval,
230.14 whichever is later. The commissioner of human services shall notify the revisor of statutes
230.15 when federal approval is obtained.

230.16 Sec. 24. Minnesota Statutes 2022, section 256B.0943, subdivision 3, is amended to read:

230.17 **Subd. 3. Determination of client eligibility.** (a) A client's eligibility to receive children's
230.18 therapeutic services and supports under this section shall be determined based on a standard
230.19 diagnostic assessment by a mental health professional or a clinical trainee that is performed
230.20 within one year before the initial start of service and updated as required under section
230.21 245I.10, subdivision 2. The standard diagnostic assessment must:

230.22 (1) determine whether a child under age 18 has a diagnosis of emotional disturbance or,
230.23 if the person is between the ages of 18 and 21, whether the person has a mental illness;

230.24 (2) document children's therapeutic services and supports as medically necessary to
230.25 address an identified disability, functional impairment, and the individual client's needs and
230.26 goals; and

230.27 (3) be used in the development of the individual treatment plan.

230.28 (b) Notwithstanding paragraph (a), a client may be determined to be eligible for up to
230.29 five days of day treatment under this section based on a hospital's medical history and
230.30 presentation examination of the client.

230.31 (c) Children's therapeutic services and supports include development and rehabilitative
230.32 services that support a child's developmental treatment needs.

231.1 Sec. 25. Minnesota Statutes 2022, section 256B.0943, subdivision 12, is amended to read:

231.2 Subd. 12. **Excluded services.** The following services are not eligible for medical
231.3 assistance payment as children's therapeutic services and supports:

231.4 (1) service components of children's therapeutic services and supports simultaneously
231.5 provided by more than one provider entity unless prior authorization is obtained;

231.6 (2) treatment by multiple providers within the same agency at the same clock time,
231.7 unless one service is delivered to the child and the other service is delivered to the child's
231.8 family or treatment team without the child present;

231.9 (3) children's therapeutic services and supports provided in violation of medical assistance
231.10 policy in Minnesota Rules, part 9505.0220;

231.11 (4) mental health behavioral aide services provided by a personal care assistant who is
231.12 not qualified as a mental health behavioral aide and employed by a certified children's
231.13 therapeutic services and supports provider entity;

231.14 (5) service components of CTSS that are the responsibility of a residential or program
231.15 license holder, including foster care providers under the terms of a service agreement or
231.16 administrative rules governing licensure; and

231.17 (6) adjunctive activities that may be offered by a provider entity but are not otherwise
231.18 covered by medical assistance, including:

231.19 (i) a service that is primarily recreation oriented or that is provided in a setting that is
231.20 not medically supervised. This includes sports activities, exercise groups, activities such as
231.21 craft hours, leisure time, social hours, meal or snack time, trips to community activities,
231.22 and tours;

231.23 (ii) a social or educational service that does not have or cannot reasonably be expected
231.24 to have a therapeutic outcome related to the client's emotional disturbance;

231.25 (iii) prevention or education programs provided to the community; and

231.26 (iv) treatment for clients with primary diagnoses of alcohol or other drug abuse.

231.27 Sec. 26. Minnesota Statutes 2022, section 256B.0947, subdivision 5, is amended to read:

231.28 Subd. 5. **Standards for intensive nonresidential rehabilitative providers.** (a) Services
231.29 must meet the standards in this section and chapter 245I as required in section 245I.011,
231.30 subdivision 5.

232.1 (b) The treatment team must have specialized training in providing services to the specific
232.2 age group of youth that the team serves. An individual treatment team must serve youth
232.3 who are: (1) at least eight years of age or older and under 16 years of age, or (2) at least 14
232.4 years of age or older and under 21 years of age.

232.5 (c) The treatment team for intensive nonresidential rehabilitative mental health services
232.6 comprises both permanently employed core team members and client-specific team members
232.7 as follows:

232.8 (1) Based on professional qualifications and client needs, clinically qualified core team
232.9 members are assigned on a rotating basis as the client's lead worker to coordinate a client's
232.10 care. The core team must comprise at least four full-time equivalent direct care staff and
232.11 must minimally include:

232.12 (i) a mental health professional who serves as team leader to provide administrative
232.13 direction and treatment supervision to the team;

232.14 (ii) an advanced-practice registered nurse with certification in psychiatric or mental
232.15 health care or a board-certified child and adolescent psychiatrist, either of which must be
232.16 credentialed to prescribe medications;

232.17 ~~(iii) a licensed alcohol and drug counselor who is also trained in mental health~~
232.18 ~~interventions; and~~

232.19 ~~(iv)~~ (iii) a mental health certified peer specialist who is qualified according to section
232.20 245I.04, subdivision 10, and is also a former children's mental health consumer; and

232.21 (iv) a co-occurring disorder specialist who meets the requirements under section
232.22 256B.0622, subdivision 7a, paragraph (a), clause (4), who will provide or facilitate the
232.23 provision of co-occurring disorder treatment to clients.

232.24 (2) The core team may also include any of the following:

232.25 (i) additional mental health professionals;

232.26 (ii) a vocational specialist;

232.27 (iii) an educational specialist with knowledge and experience working with youth
232.28 regarding special education requirements and goals, special education plans, and coordination
232.29 of educational activities with health care activities;

232.30 (iv) a child and adolescent psychiatrist who may be retained on a consultant basis;

232.31 (v) a clinical trainee qualified according to section 245I.04, subdivision 6;

- 233.1 (vi) a mental health practitioner qualified according to section 245I.04, subdivision 4;
- 233.2 (vii) a case management service provider, as defined in section 245.4871, subdivision
233.3 4;
- 233.4 (viii) a housing access specialist; and
- 233.5 (ix) a family peer specialist as defined in subdivision 2, paragraph (j).
- 233.6 (3) A treatment team may include, in addition to those in clause (1) or (2), ad hoc
233.7 members not employed by the team who consult on a specific client and who must accept
233.8 overall clinical direction from the treatment team for the duration of the client's placement
233.9 with the treatment team and must be paid by the provider agency at the rate for a typical
233.10 session by that provider with that client or at a rate negotiated with the client-specific
233.11 member. Client-specific treatment team members may include:
- 233.12 (i) the mental health professional treating the client prior to placement with the treatment
233.13 team;
- 233.14 (ii) the client's current substance use counselor, if applicable;
- 233.15 (iii) a lead member of the client's individualized education program team or school-based
233.16 mental health provider, if applicable;
- 233.17 (iv) a representative from the client's health care home or primary care clinic, as needed
233.18 to ensure integration of medical and behavioral health care;
- 233.19 (v) the client's probation officer or other juvenile justice representative, if applicable;
233.20 and
- 233.21 (vi) the client's current vocational or employment counselor, if applicable.
- 233.22 (d) The treatment supervisor shall be an active member of the treatment team and shall
233.23 function as a practicing clinician at least on a part-time basis. The treatment team shall meet
233.24 with the treatment supervisor at least weekly to discuss recipients' progress and make rapid
233.25 adjustments to meet recipients' needs. The team meeting must include client-specific case
233.26 reviews and general treatment discussions among team members. Client-specific case
233.27 reviews and planning must be documented in the individual client's treatment record.
- 233.28 (e) The staffing ratio must not exceed ten clients to one full-time equivalent treatment
233.29 team position.
- 233.30 (f) The treatment team shall serve no more than 80 clients at any one time. Should local
233.31 demand exceed the team's capacity, an additional team must be established rather than
233.32 exceed this limit.

234.1 (g) Nonclinical staff shall have prompt access in person or by telephone to a mental
234.2 health practitioner, clinical trainee, or mental health professional. The provider shall have
234.3 the capacity to promptly and appropriately respond to emergent needs and make any
234.4 necessary staffing adjustments to ensure the health and safety of clients.

234.5 (h) The intensive nonresidential rehabilitative mental health services provider shall
234.6 participate in evaluation of the assertive community treatment for youth (Youth ACT) model
234.7 as conducted by the commissioner, including the collection and reporting of data and the
234.8 reporting of performance measures as specified by contract with the commissioner.

234.9 (i) A regional treatment team may serve multiple counties.

234.10 Sec. 27. Minnesota Statutes 2022, section 256B.76, subdivision 6, is amended to read:

234.11 Subd. 6. **Medicare relative value units.** (a) Effective for services rendered on or after
234.12 January 1, 2007, the commissioner shall make payments for physician and professional
234.13 services based on the Medicare relative value units (~~RVU's~~) (RVUs). This change shall be
234.14 budget neutral and the cost of implementing ~~RVU's~~ RVUs will be incorporated in the
234.15 established conversion factor.

234.16 (b) Effective for services rendered on or after January 1, 2025, rates for mental health
234.17 services reimbursed under the resource-based relative value scale (RBRVS) must be equal
234.18 to 83 percent of the Medicare Physician Fee Schedule.

234.19 (c) Effective for services rendered on or after January 1, 2025, the commissioner shall
234.20 increase capitation payments made to managed care plans and county-based purchasing
234.21 plans to reflect the rate increases provided under this subdivision. Managed care plans and
234.22 county-based purchasing plans must use the capitation rate increase provided under this
234.23 paragraph to increase payment rates to the providers corresponding to the rate increases.
234.24 The commissioner must monitor the effect of this rate increase on enrollee access to services
234.25 under this subdivision. If for any contract year federal approval is not received for this
234.26 paragraph, the commissioner must adjust the capitation rates paid to managed care plans
234.27 and county-based purchasing plans for that contract year to reflect the removal of this
234.28 paragraph. Contracts between managed care plans and county-based purchasing plans and
234.29 providers to whom this paragraph applies must allow recovery of payments from those
234.30 providers if capitation rates are adjusted in accordance with this paragraph. Payment
234.31 recoveries must not exceed the amount equal to any increase in rates that results from this
234.32 paragraph.

235.1 **EFFECTIVE DATE.** This section is effective January 1, 2025, or upon federal approval,
235.2 whichever is later. The commissioner of human services shall notify the revisor of statutes
235.3 when federal approval is obtained.

235.4 Sec. 28. Laws 2023, chapter 70, article 1, section 35, is amended to read:

235.5 Sec. 35. Minnesota Statutes 2022, section 256B.761, is amended to read:

235.6 **256B.761 REIMBURSEMENT FOR MENTAL HEALTH SERVICES.**

235.7 (a) Effective for services rendered on or after July 1, 2001, payment for medication
235.8 management provided to psychiatric patients, outpatient mental health services, day treatment
235.9 services, home-based mental health services, and family community support services shall
235.10 be paid at the lower of (1) submitted charges, or (2) 75.6 percent of the 50th percentile of
235.11 1999 charges.

235.12 (b) Effective July 1, 2001, the medical assistance rates for outpatient mental health
235.13 services provided by an entity that operates: (1) a Medicare-certified comprehensive
235.14 outpatient rehabilitation facility; and (2) a facility that was certified prior to January 1, 1993,
235.15 with at least 33 percent of the clients receiving rehabilitation services in the most recent
235.16 calendar year who are medical assistance recipients, will be increased by 38 percent, when
235.17 those services are provided within the comprehensive outpatient rehabilitation facility and
235.18 provided to residents of nursing facilities owned by the entity.

235.19 (c) In addition to rate increases otherwise provided, the commissioner may restructure
235.20 coverage policy and rates to improve access to adult rehabilitative mental health services
235.21 under section 256B.0623 and related mental health support services under section 256B.021,
235.22 subdivision 4, paragraph (f), clause (2). For state fiscal years 2015 and 2016, the projected
235.23 state share of increased costs due to this paragraph is transferred from adult mental health
235.24 grants under sections 245.4661 and 256E.12. The transfer for fiscal year 2016 is a permanent
235.25 base adjustment for subsequent fiscal years. Payments made to managed care plans and
235.26 county-based purchasing plans under sections 256B.69, 256B.692, and 256L.12 shall reflect
235.27 the rate changes described in this paragraph.

235.28 (d) Any rates effective before July 1, 2015, do not apply to early intensive
235.29 developmental and behavioral intervention (EIDBI) benefits described in section 256B.0949.

235.30 (e) Effective for services rendered on or after January 1, 2024, payment rates for
235.31 behavioral health services included in the rate analysis required by Laws 2021, First Special
235.32 Session chapter 7, article 17, section 18, except for adult day treatment services under section

236.1 256B.0671, subdivision 3; early intensive developmental and behavioral intervention services
236.2 under section 256B.0949; and substance use disorder services under chapter 254B, must be
236.3 increased by three percent from the rates in effect on December 31, 2023. Effective for
236.4 services rendered on or after January 1, 2025, payment rates for behavioral health services
236.5 included in the rate analysis required by Laws 2021, First Special Session chapter 7, article
236.6 17, section 18, ~~except for adult day treatment services under section 256B.0671, subdivision~~
236.7 ~~3~~; early intensive developmental behavioral intervention services under section 256B.0949;
236.8 and substance use disorder services under chapter 254B, must be annually adjusted according
236.9 to the change from the midpoint of the previous rate year to the midpoint of the rate year
236.10 for which the rate is being determined using the Centers for Medicare and Medicaid Services
236.11 Medicare Economic Index as forecasted in the fourth quarter of the calendar year before
236.12 the rate year. For payments made in accordance with this paragraph, if and to the extent
236.13 that the commissioner identifies that the state has received federal financial participation
236.14 for behavioral health services in excess of the amount allowed under United States Code,
236.15 title 42, section 447.321, the state shall repay the excess amount to the Centers for Medicare
236.16 and Medicaid Services with state money and maintain the full payment rate under this
236.17 paragraph. This paragraph does not apply to federally qualified health centers, rural health
236.18 centers, Indian health services, certified community behavioral health clinics, cost-based
236.19 rates, and rates that are negotiated with the county. This paragraph expires upon legislative
236.20 implementation of the new rate methodology resulting from the rate analysis required by
236.21 Laws 2021, First Special Session chapter 7, article 17, section 18.

236.22 (f) Effective January 1, 2024, the commissioner shall increase capitation payments made
236.23 to managed care plans and county-based purchasing plans to reflect the behavioral health
236.24 service rate increase provided in paragraph (e). Managed care and county-based purchasing
236.25 plans must use the capitation rate increase provided under this paragraph to increase payment
236.26 rates to behavioral health services providers. The commissioner must monitor the effect of
236.27 this rate increase on enrollee access to behavioral health services. If for any contract year
236.28 federal approval is not received for this paragraph, the commissioner must adjust the
236.29 capitation rates paid to managed care plans and county-based purchasing plans for that
236.30 contract year to reflect the removal of this provision. Contracts between managed care plans
236.31 and county-based purchasing plans and providers to whom this paragraph applies must
236.32 allow recovery of payments from those providers if capitation rates are adjusted in accordance
236.33 with this paragraph. Payment recoveries must not exceed the amount equal to any increase
236.34 in rates that results from this provision.

237.1 **EFFECTIVE DATE.** This section is effective January 1, 2025, or upon federal approval,
237.2 whichever is later. The commissioner of human services shall notify the revisor of statutes
237.3 when federal approval is obtained.

237.4 Sec. 29. **FIRST EPISODE PSYCHOSIS COORDINATED SPECIALITY CARE**
237.5 **MEDICAL ASSISTANCE BENEFIT.**

237.6 (a) The commissioner of human services must develop a First Episode Psychosis
237.7 Coordinated Specialty Care (FEP-CSC) medical assistance benefit.

237.8 (b) The benefit must cover medically necessary treatment. Services must include:

237.9 (1) assertive outreach and engagement strategies encouraging individuals' involvement;

237.10 (2) person-centered care, delivered in the home and community, extending beyond
237.11 typical hours of operation, such as evenings and weekends;

237.12 (3) crisis planning and intervention;

237.13 (4) team leadership from a mental health professional who provides ongoing consultation
237.14 to the team members, coordinates admission screening, and leads the weekly team meetings
237.15 to facilitate case review and entry to the program;

237.16 (5) employment and education services that enable individuals to function in workplace
237.17 and educational settings that support individual preferences;

237.18 (6) family education and support that builds on an individual's identified family and
237.19 natural support systems;

237.20 (7) individual and group psychotherapy that include but are not limited to cognitive
237.21 behavioral therapies;

237.22 (8) care coordination services in clinic, community, and home settings to assist individuals
237.23 with practical problem solving, such as securing transportation, addressing housing and
237.24 other basic needs, managing money, obtaining medical care, and coordinating care with
237.25 other providers; and

237.26 (9) pharmacotherapy, medication management, and primary care coordination provided
237.27 by a mental health professional who is permitted to prescribe psychiatric medications.

237.28 (c) An eligible recipient is an individual who:

237.29 (1) is between the ages of 15 and 40;

237.30 (2) is experiencing early signs of psychosis with the duration of onset being less than
237.31 two years; and

238.1 (3) has been on antipsychotic medications for less than a total of 12 months.

238.2 (d) By December 1, 2026, the commissioner must submit a report to the chairs and
238.3 ranking minority members of the legislative committees with jurisdiction over human
238.4 services policy and finance. The report must include:

238.5 (1) an overview of the recommended benefit;

238.6 (2) eligibility requirements;

238.7 (3) program standards;

238.8 (4) a reimbursement methodology that covers team-based bundled costs;

238.9 (5) performance evaluation criteria for programs; and

238.10 (6) draft legislation with the statutory changes necessary to implement the benefit.

238.11 **EFFECTIVE DATE.** This section is effective July 1, 2024.

238.12 Sec. 30. **MEDICAL ASSISTANCE CHILDREN'S RESIDENTIAL MENTAL**
238.13 **HEALTH CRISIS STABILIZATION.**

238.14 (a) The commissioner of human services must consult with providers, advocates, Tribal
238.15 Nations, counties, people with lived experience as or with a child in a mental health crisis,
238.16 and other interested community members to develop a covered benefit under medical
238.17 assistance to provide residential mental health crisis stabilization for children. The benefit
238.18 must:

238.19 (1) consist of evidence-based promising practices, or culturally responsive treatment
238.20 services for children under the age of 21 experiencing a mental health crisis;

238.21 (2) embody an integrative care model that supports individuals experiencing a mental
238.22 health crisis who may also be experiencing co-occurring conditions;

238.23 (3) qualify for federal financial participation; and

238.24 (4) include services that support children and families, including but not limited to:

238.25 (i) an assessment of the child's immediate needs and factors that led to the mental health
238.26 crisis;

238.27 (ii) individualized care to address immediate needs and restore the child to a precrisis
238.28 level of functioning;

238.29 (iii) 24-hour on-site staff and assistance;

238.30 (iv) supportive counseling and clinical services;

239.1 (v) skills training and positive support services, as identified in the child's individual
239.2 crisis stabilization plan;

239.3 (vi) referrals to other service providers in the community as needed and to support the
239.4 child's transition from residential crisis stabilization services;

239.5 (vii) development of an individualized and culturally responsive crisis response action
239.6 plan; and

239.7 (viii) assistance to access and store medication.

239.8 (b) When developing the new benefit, the commissioner must make recommendations
239.9 for providers to be reimbursed for room and board.

239.10 (c) The commissioner must consult with or contract with rate-setting experts to develop
239.11 a prospective data-based rate methodology for the children's residential mental health crisis
239.12 stabilization benefit.

239.13 (d) No later than October 1, 2025, the commissioner must submit to the chairs and
239.14 ranking minority members of the legislative committees with jurisdiction over human
239.15 services policy and finance a report detailing the children's residential mental health crisis
239.16 stabilization benefit and must include:

239.17 (1) eligibility criteria, clinical and service requirements, provider standards, licensing
239.18 requirements, and reimbursement rates;

239.19 (2) the process for community engagement, community input, and crisis models studied
239.20 in other states;

239.21 (3) a deadline for the commissioner to submit a state plan amendment to the Centers for
239.22 Medicare and Medicaid Services; and

239.23 (4) draft legislation with the statutory changes necessary to implement the benefit.

239.24 **EFFECTIVE DATE.** This section is effective July 1, 2024.

239.25 **Sec. 31. MEDICAL ASSISTANCE CLUBHOUSE BENEFIT ANALYSIS.**

239.26 The commissioner of human services must conduct an analysis to identify existing or
239.27 pending Medicaid Clubhouse benefits in other states, federal authorities used, populations
239.28 served, service and reimbursement design, and accreditation standards. By December 1,
239.29 2025, the commissioner must submit a report to the chairs and ranking minority members
239.30 of the legislative committees with jurisdiction over health and human services finance and

240.1 policy. The report must include a comparative analysis of Medicaid Clubhouse programs
240.2 and recommendations for designing a medical assistance benefit in Minnesota.

240.3 **Sec. 32. DIRECTION TO COMMISSIONER OF HUMAN SERVICES; MENTAL**
240.4 **HEALTH PROCEDURE CODES.**

240.5 The commissioner of human services must develop recommendations, in consultation
240.6 with external partners and medical coding and compliance experts, on simplifying mental
240.7 health procedure codes and the feasibility of converting mental health procedure codes to
240.8 the current procedural terminology (CPT) code structure. By October 1, 2025, the
240.9 commissioner must submit a report to the chairs and ranking minority members of the
240.10 legislative committees with jurisdiction over mental health on the recommendations and
240.11 methodology to simplify and restructure mental health procedure codes with corresponding
240.12 resource-based relative value scale (RBRVS) values.

240.13 **EFFECTIVE DATE.** This section is effective July 1, 2024.

240.14 **Sec. 33. MENTAL HEALTH SERVICES FORMULA-BASED ALLOCATION.**

240.15 The commissioner of human services shall consult with the commissioner of management
240.16 and budget, counties, Tribes, mental health providers, and advocacy organizations to develop
240.17 recommendations for moving from the children's and adult mental health grant funding
240.18 structure to a formula-based allocation structure for mental health services. The
240.19 recommendations must consider formula-based allocations for grants for respite care,
240.20 school-linked behavioral health, mobile crisis teams, and first episode of psychosis programs.

240.21 **Sec. 34. REVISOR INSTRUCTION.**

240.22 The revisor of statutes, in consultation with the Office of Senate Counsel, Research and
240.23 Fiscal Analysis; the House Research Department; and the commissioner of human services
240.24 shall prepare legislation for the 2025 legislative session to recodify Minnesota Statutes,
240.25 section 256B.0622, to move provisions related to assertive community treatment and intensive
240.26 residential treatment services into separate sections of statute. The revisor shall correct any
240.27 cross-references made necessary by this recodification.

ARTICLE 9**DEPARTMENT OF HUMAN SERVICES POLICY**

241.1
241.2
241.3 Section 1. Minnesota Statutes 2023 Supplement, section 245A.03, subdivision 2, as
241.4 amended by Laws 2024, chapter 85, section 52, and Laws 2024, chapter 80, article 2, section
241.5 35, is amended to read:

241.6 Subd. 2. **Exclusion from licensure.** (a) This chapter does not apply to:

241.7 (1) residential or nonresidential programs that are provided to a person by an individual
241.8 who is related;

241.9 (2) nonresidential programs that are provided by an unrelated individual to persons from
241.10 a single related family;

241.11 (3) residential or nonresidential programs that are provided to adults who do not misuse
241.12 substances or have a substance use disorder, a mental illness, a developmental disability, a
241.13 functional impairment, or a physical disability;

241.14 (4) sheltered workshops or work activity programs that are certified by the commissioner
241.15 of employment and economic development;

241.16 (5) programs operated by a public school for children 33 months or older;

241.17 (6) nonresidential programs primarily for children that provide care or supervision for
241.18 periods of less than three hours a day while the child's parent or legal guardian is in the
241.19 same building as the nonresidential program or present within another building that is
241.20 directly contiguous to the building in which the nonresidential program is located;

241.21 (7) nursing homes or hospitals licensed by the commissioner of health except as specified
241.22 under section 245A.02;

241.23 (8) board and lodge facilities licensed by the commissioner of health that do not provide
241.24 children's residential services under Minnesota Rules, chapter 2960, mental health or
241.25 substance use disorder treatment;

241.26 (9) programs licensed by the commissioner of corrections;

241.27 (10) recreation programs for children or adults that are operated or approved by a park
241.28 and recreation board whose primary purpose is to provide social and recreational activities;

241.29 (11) noncertified boarding care homes unless they provide services for five or more
241.30 persons whose primary diagnosis is mental illness or a developmental disability;

- 242.1 (12) programs for children such as scouting, boys clubs, girls clubs, and sports and art
242.2 programs, and nonresidential programs for children provided for a cumulative total of less
242.3 than 30 days in any 12-month period;
- 242.4 (13) residential programs for persons with mental illness, that are located in hospitals;
- 242.5 (14) camps licensed by the commissioner of health under Minnesota Rules, chapter
242.6 4630;
- 242.7 (15) mental health outpatient services for adults with mental illness or children with
242.8 emotional disturbance;
- 242.9 (16) residential programs serving school-age children whose sole purpose is cultural or
242.10 educational exchange, until the commissioner adopts appropriate rules;
- 242.11 (17) community support services programs as defined in section 245.462, subdivision
242.12 6, and family community support services as defined in section 245.4871, subdivision 17;
- 242.13 (18) ~~settings registered under chapter 144D which provide home care services licensed~~
242.14 ~~by the commissioner of health to fewer than seven adults~~ assisted living facilities licensed
242.15 by the commissioner of health under chapter 144G;
- 242.16 (19) substance use disorder treatment activities of licensed professionals in private
242.17 practice as defined in section 245G.01, subdivision 17;
- 242.18 (20) consumer-directed community support service funded under the Medicaid waiver
242.19 for persons with developmental disabilities when the individual who provided the service
242.20 is:
- 242.21 (i) the same individual who is the direct payee of these specific waiver funds or paid by
242.22 a fiscal agent, fiscal intermediary, or employer of record; and
- 242.23 (ii) not otherwise under the control of a residential or nonresidential program that is
242.24 required to be licensed under this chapter when providing the service;
- 242.25 (21) a county that is an eligible vendor under section 254B.05 to provide care coordination
242.26 and comprehensive assessment services;
- 242.27 (22) a recovery community organization that is an eligible vendor under section 254B.05
242.28 to provide peer recovery support services; or
- 242.29 (23) programs licensed by the commissioner of children, youth, and families in chapter
242.30 142B.

243.1 (b) For purposes of paragraph (a), clause (6), a building is directly contiguous to a
243.2 building in which a nonresidential program is located if it shares a common wall with the
243.3 building in which the nonresidential program is located or is attached to that building by
243.4 skyway, tunnel, atrium, or common roof.

243.5 ~~(b)~~ (c) Except for the home and community-based services identified in section 245D.03,
243.6 subdivision 1, nothing in this chapter shall be construed to require licensure for any services
243.7 provided and funded according to an approved federal waiver plan where licensure is
243.8 specifically identified as not being a condition for the services and funding.

243.9 Sec. 3. Minnesota Statutes 2022, section 245A.04, is amended by adding a subdivision to
243.10 read:

243.11 Subd. 7b. Notification to commissioner of changes in key staff positions; children's
243.12 residential facilities and detoxification programs. (a) A license holder must notify the
243.13 commissioner within five business days of a change or vacancy in a key staff position under
243.14 paragraph (b) or (c). The license holder must notify the commissioner of the staffing change
243.15 on a form approved by the commissioner and include the name of the staff person now
243.16 assigned to the key staff position and the staff person's qualifications for the position. The
243.17 license holder must notify the program licensor of a vacancy to discuss how the duties of
243.18 the key staff position will be fulfilled during the vacancy.

243.19 (b) The key staff position for a children's residential facility licensed according to
243.20 Minnesota Rules, parts 2960.0130 to 2960.0220, is a program director; and

243.21 (c) The key staff positions for a detoxification program licensed according to Minnesota
243.22 Rules, parts 9530.6510 to 9530.6590, are:

243.23 (1) a program director as required by Minnesota Rules, part 9530.6560, subpart 1;

243.24 (2) a registered nurse as required by Minnesota Rules, part 9530.6560, subpart 4; and

243.25 (3) a medical director as required by Minnesota Rules, part 9530.6560, subpart 5.

243.26 **EFFECTIVE DATE.** This section is effective January 1, 2025.

243.27 Sec. 2. Minnesota Statutes 2022, section 245A.043, subdivision 2, is amended to read:

243.28 Subd. 2. **Change in ownership.** (a) If the commissioner determines that there is a change
243.29 in ownership, the commissioner shall require submission of a new license application. This
243.30 subdivision does not apply to a licensed program or service located in a home where the
243.31 license holder resides. A change in ownership occurs when:

244.1 (1) except as provided in paragraph (b), the license holder sells or transfers 100 percent
244.2 of the property, stock, or assets;

244.3 (2) the license holder merges with another organization;

244.4 (3) the license holder consolidates with two or more organizations, resulting in the
244.5 creation of a new organization;

244.6 (4) there is a change to the federal tax identification number associated with the license
244.7 holder; or

244.8 (5) except as provided in paragraph (b), all controlling individuals ~~associated with~~ for
244.9 the original ~~application~~ license have changed.

244.10 (b) ~~Notwithstanding~~ For changes under paragraph (a), clauses (1) and or (5), no change
244.11 in ownership has occurred and a new license application is not required if at least one
244.12 controlling individual has been ~~listed~~ affiliated as a controlling individual for the license
244.13 for at least the previous 12 months immediately preceding the change.

244.14 **EFFECTIVE DATE.** This section is effective January 1, 2025.

244.15 Sec. 3. Minnesota Statutes 2023 Supplement, section 245A.043, subdivision 3, is amended
244.16 to read:

244.17 Subd. 3. **Standard change of ownership process.** (a) When a change in ownership is
244.18 proposed and the party intends to assume operation without an interruption in service longer
244.19 than 60 days after acquiring the program or service, the license holder must provide the
244.20 commissioner with written notice of the proposed change on a form provided by the
244.21 commissioner at least ~~60~~ 90 days before the anticipated date of the change in ownership.
244.22 For purposes of this ~~subdivision and subdivision 4~~ section, "party" means the party that
244.23 intends to operate the service or program.

244.24 (b) The party must submit a license application under this chapter on the form and in
244.25 the manner prescribed by the commissioner at least ~~30~~ 90 days before the change in
244.26 ownership is anticipated to be complete; and must include documentation to support the
244.27 upcoming change. The party must comply with background study requirements under chapter
244.28 245C and shall pay the application fee required under section 245A.10.

244.29 (c) A party that intends to assume operation without an interruption in service longer
244.30 than 60 days after acquiring the program or service is exempt from the requirements of
244.31 sections 245G.03, subdivision 2, paragraph (b), and 254B.03, subdivision 2, paragraphs (c)
244.32 and (d).

245.1 ~~(e)~~ (d) The commissioner may streamline application procedures when the party is an
245.2 existing license holder under this chapter and is acquiring a program licensed under this
245.3 chapter or service in the same service class as one or more licensed programs or services
245.4 the party operates and those licenses are in substantial compliance. For purposes of this
245.5 subdivision, "substantial compliance" means within the previous 12 months the commissioner
245.6 did not (1) issue a sanction under section 245A.07 against a license held by the party, or
245.7 (2) make a license held by the party conditional according to section 245A.06.

245.8 ~~(d) Except when a temporary change in ownership license is issued pursuant to~~
245.9 ~~subdivision 4~~ (e) While the standard change of ownership process is pending, the existing
245.10 license holder ~~is solely~~ remains responsible for operating the program according to applicable
245.11 laws and rules until a license under this chapter is issued to the party.

245.12 ~~(e)~~ (f) If a licensing inspection of the program or service was conducted within the
245.13 previous 12 months and the existing license holder's license record demonstrates substantial
245.14 compliance with the applicable licensing requirements, the commissioner may waive the
245.15 party's inspection required by section 245A.04, subdivision 4. The party must submit to the
245.16 commissioner (1) proof that the premises was inspected by a fire marshal or that the fire
245.17 marshal deemed that an inspection was not warranted, and (2) proof that the premises was
245.18 inspected for compliance with the building code or that no inspection was deemed warranted.

245.19 ~~(f)~~ (g) If the party is seeking a license for a program or service that has an outstanding
245.20 action under section 245A.06 or 245A.07, the party must submit a ~~letter~~ written plan as part
245.21 of the application process identifying how the party has or will come into full compliance
245.22 with the licensing requirements.

245.23 ~~(g)~~ (h) The commissioner shall evaluate the party's application according to section
245.24 245A.04, subdivision 6. If the commissioner determines that the party has remedied or
245.25 demonstrates the ability to remedy the outstanding actions under section 245A.06 or 245A.07
245.26 and has determined that the program otherwise complies with all applicable laws and rules,
245.27 the commissioner shall issue a license or conditional license under this chapter. A conditional
245.28 license issued under this section is final and not subject to reconsideration under section
245.29 245A.06, subdivision 4. The conditional license remains in effect until the commissioner
245.30 determines that the grounds for the action are corrected or no longer exist.

245.31 ~~(h)~~ (i) The commissioner may deny an application as provided in section 245A.05. An
245.32 applicant whose application was denied by the commissioner may appeal the denial according
245.33 to section 245A.05.

246.1 ~~(i)~~ (j) This subdivision does not apply to a licensed program or service located in a home
246.2 where the license holder resides.

246.3 **EFFECTIVE DATE.** This section is effective January 1, 2025.

246.4 Sec. 4. Minnesota Statutes 2022, section 245A.043, is amended by adding a subdivision
246.5 to read:

246.6 Subd. 3a. **Emergency change in ownership process.** (a) In the event of a death of a
246.7 license holder or sole controlling individual or a court order or other event that results in
246.8 the license holder being inaccessible or unable to operate the program or service, a party
246.9 may submit a request to the commissioner to allow the party to assume operation of the
246.10 program or service under an emergency change in ownership process to ensure persons
246.11 continue to receive services while the commissioner evaluates the party's license application.

246.12 (b) To request the emergency change of ownership process, the party must immediately:

246.13 (1) notify the commissioner of the event resulting in the inability of the license holder
246.14 to operate the program and of the party's intent to assume operations; and

246.15 (2) provide the commissioner with documentation that demonstrates the party has a legal
246.16 or legitimate ownership interest in the program or service if applicable and is able to operate
246.17 the program or service.

246.18 (c) If the commissioner approves the party to continue operating the program or service
246.19 under an emergency change in ownership process, the party must:

246.20 (1) request to be added as a controlling individual or license holder to the existing license;

246.21 (2) notify persons receiving services of the emergency change in ownership in a manner
246.22 approved by the commissioner;

246.23 (3) submit an application for a new license within 30 days of approval;

246.24 (4) comply with the background study requirements under chapter 245C; and

246.25 (5) pay the application fee required under section 245A.10.

246.26 (d) While the emergency change of ownership process is pending, a party approved
246.27 under this subdivision is responsible for operating the program under the existing license
246.28 according to applicable laws and rules until a new license under this chapter is issued.

246.29 (e) The provisions in subdivision 3, paragraphs (c), (d), and (f) to (i) apply to this
246.30 subdivision.

247.1 (f) Once a party is issued a new license or has decided not to seek a new license, the
247.2 commissioner must close the existing license.

247.3 (g) This subdivision applies to any program or service licensed under this chapter.

247.4 **EFFECTIVE DATE.** This section is effective January 1, 2025.

247.5 Sec. 5. Minnesota Statutes 2022, section 245A.043, subdivision 4, is amended to read:

247.6 Subd. 4. **Temporary change in ownership transitional license.** ~~(a) After receiving the~~
247.7 ~~party's application pursuant to subdivision 3, upon the written request of the existing license~~
247.8 ~~holder and the party, the commissioner may issue a temporary change in ownership license~~
247.9 ~~to the party while the commissioner evaluates the party's application. Until a decision is~~
247.10 ~~made to grant or deny a license under this chapter, the existing license holder and the party~~
247.11 ~~shall both be responsible for operating the program or service according to applicable laws~~
247.12 ~~and rules, and the sale or transfer of the existing license holder's ownership interest in the~~
247.13 ~~licensed program or service does not terminate the existing license.~~

247.14 ~~(b) The commissioner may issue a temporary change in ownership license when a license~~
247.15 ~~holder's death, divorce, or other event affects the ownership of the program and an applicant~~
247.16 ~~seeks to assume operation of the program or service to ensure continuity of the program or~~
247.17 ~~service while a license application is evaluated.~~

247.18 ~~(c) This subdivision applies to any program or service licensed under this chapter.~~

247.19 If a party's application under subdivision 2 is for a satellite license for a community
247.20 residential setting under section 245D.23 or day services facility under 245D.27 and if the
247.21 party already holds an active license to provide services under chapter 245D, the
247.22 commissioner may issue a temporary transitional license to the party for the community
247.23 residential setting or day services facility while the commissioner evaluates the party's
247.24 application. Until a decision is made to grant or deny a community residential setting or
247.25 day services facility satellite license, the party must be solely responsible for operating the
247.26 program according to applicable laws and rules, and the existing license must be closed.
247.27 The temporary transitional license expires after 12 months from the date it was issued or
247.28 upon issuance of the community residential setting or day services facility satellite license,
247.29 whichever occurs first.

247.30 **EFFECTIVE DATE.** This section is effective January 1, 2025.

248.1 Sec. 6. Minnesota Statutes 2022, section 245A.043, is amended by adding a subdivision
248.2 to read:

248.3 Subd. 5. **Failure to comply.** If the commissioner finds that the applicant or license holder
248.4 has not fully complied with this section, the commissioner may impose a licensing sanction
248.5 under section 245A.05, 245A.06, or 245A.07.

248.6 **EFFECTIVE DATE.** This section is effective January 1, 2025.

248.7 Sec. 7. Minnesota Statutes 2023 Supplement, section 245A.07, subdivision 1, as amended
248.8 by Laws 2024, chapter 80, article 2, section 44, is amended to read:

248.9 Subdivision 1. **Sanctions; appeals; license.** (a) In addition to making a license conditional
248.10 under section 245A.06, the commissioner may suspend or revoke the license, impose a fine,
248.11 or secure an injunction against the continuing operation of the program of a license holder
248.12 who does not comply with applicable law or rule.

248.13 When applying sanctions authorized under this section, the commissioner shall consider
248.14 the nature, chronicity, or severity of the violation of law or rule and the effect of the violation
248.15 on the health, safety, or rights of persons served by the program.

248.16 (b) If a license holder appeals the suspension or revocation of a license and the license
248.17 holder continues to operate the program pending a final order on the appeal, the commissioner
248.18 shall issue the license holder a temporary provisional license. The commissioner may include
248.19 terms the license holder must follow pending a final order on the appeal. Unless otherwise
248.20 specified by the commissioner, variances in effect on the date of the license sanction under
248.21 appeal continue under the temporary provisional license. If a license holder fails to comply
248.22 with applicable law or rule while operating under a temporary provisional license, the
248.23 commissioner may impose additional sanctions under this section and section 245A.06, and
248.24 may terminate any prior variance. If a temporary provisional license is set to expire, a new
248.25 temporary provisional license shall be issued to the license holder upon payment of any fee
248.26 required under section 245A.10. The temporary provisional license shall expire on the date
248.27 the final order is issued. If the license holder prevails on the appeal, a new nonprovisional
248.28 license shall be issued for the remainder of the current license period.

248.29 (c) If a license holder is under investigation and the license issued under this chapter is
248.30 due to expire before completion of the investigation, the program shall be issued a new
248.31 license upon completion of the reapplication requirements and payment of any applicable
248.32 license fee. Upon completion of the investigation, a licensing sanction may be imposed
248.33 against the new license under this section, section 245A.06, or 245A.08.

249.1 (d) Failure to reapply or closure of a license issued under this chapter by the license
249.2 holder prior to the completion of any investigation shall not preclude the commissioner
249.3 from issuing a licensing sanction under this section or section 245A.06 at the conclusion
249.4 of the investigation.

249.5 **EFFECTIVE DATE.** This section is effective January 1, 2025.

249.6 Sec. 8. Minnesota Statutes 2022, section 245A.07, subdivision 6, is amended to read:

249.7 Subd. 6. **Appeal of multiple sanctions.** (a) When the license holder appeals more than
249.8 one licensing action or sanction that were simultaneously issued by the commissioner, the
249.9 license holder shall specify the actions or sanctions that are being appealed.

249.10 (b) If there are different timelines prescribed in statutes for the licensing actions or
249.11 sanctions being appealed, the license holder must submit the appeal within the longest of
249.12 those timelines specified in statutes.

249.13 (c) The appeal must be made in writing by certified mail ~~or~~, by personal service, or
249.14 through the provider licensing and reporting hub. If mailed, the appeal must be postmarked
249.15 and sent to the commissioner within the prescribed timeline with the first day beginning
249.16 the day after the license holder receives the certified letter. If a request is made by personal
249.17 service, it must be received by the commissioner within the prescribed timeline with the
249.18 first day beginning the day after the license holder receives the certified letter. If the appeal
249.19 is made through the provider licensing and reporting hub, it must be received by the
249.20 commissioner within the prescribed timeline with the first day beginning the day after the
249.21 commissioner issued the order through the hub.

249.22 (d) When there are different timelines prescribed in statutes for the appeal of licensing
249.23 actions or sanctions simultaneously issued by the commissioner, the commissioner shall
249.24 specify in the notice to the license holder the timeline for appeal as specified under paragraph
249.25 (b).

249.26 Sec. 9. Minnesota Statutes 2023 Supplement, section 245A.11, subdivision 7, is amended
249.27 to read:

249.28 Subd. 7. **Adult foster care and community residential setting; variance for alternate**
249.29 **overnight supervision.** (a) The commissioner may grant a variance under section 245A.04,
249.30 subdivision 9, to statute or rule parts requiring a caregiver to be present in an adult foster
249.31 care home or a community residential setting during normal sleeping hours to allow for
249.32 alternative methods of overnight supervision. The commissioner may grant the variance if

250.1 the local county licensing agency recommends the variance and the county recommendation
250.2 includes documentation verifying that:

250.3 (1) the county has approved the license holder's plan for alternative methods of providing
250.4 overnight supervision and determined the plan protects the residents' health, safety, and
250.5 rights;

250.6 (2) the license holder has obtained written and signed informed consent from each
250.7 resident or each resident's legal representative documenting the resident's or legal
250.8 representative's agreement with the alternative method of overnight supervision; and

250.9 (3) the alternative method of providing overnight supervision, which may include the
250.10 use of technology, is specified for each resident in the resident's: (i) individualized plan of
250.11 care; (ii) ~~individual service~~ support plan under section 256B.092, subdivision 1b, if required;
250.12 or (iii) individual resident placement agreement under Minnesota Rules, part 9555.5105,
250.13 subpart 19, if required.

250.14 (b) To be eligible for a variance under paragraph (a), the adult foster care or community
250.15 residential setting license holder must not have had a conditional license issued under section
250.16 245A.06, or any other licensing sanction issued under section 245A.07 during the prior 24
250.17 months based on failure to provide adequate supervision, health care services, or resident
250.18 safety in the adult foster care home or a community residential setting.

250.19 (c) A license holder requesting a variance under this subdivision to utilize technology
250.20 as a component of a plan for alternative overnight supervision may request the commissioner's
250.21 review in the absence of a county recommendation. Upon receipt of such a request from a
250.22 license holder, the commissioner shall review the variance request with the county.

250.23 ~~(d) The variance requirements under this subdivision for alternative overnight supervision~~
250.24 ~~do not apply to community residential settings licensed under chapter 245D.~~

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

250.26 Sec. 10. Minnesota Statutes 2023 Supplement, section 245A.16, subdivision 1, as amended
250.27 by Laws 2024, chapter 80, article 2, section 65, is amended to read:

250.28 Subdivision 1. **Delegation of authority to agencies.** (a) County agencies that have been
250.29 designated by the commissioner to perform licensing functions and activities under section
250.30 245A.04; to recommend denial of applicants under section 245A.05; to issue correction
250.31 orders, to issue variances, and recommend a conditional license under section 245A.06; or
250.32 to recommend suspending or revoking a license or issuing a fine under section 245A.07,
250.33 shall comply with rules and directives of the commissioner governing those functions and

251.1 with this section. The following variances are excluded from the delegation of variance
251.2 authority and may be issued only by the commissioner:

251.3 (1) dual licensure of family child foster care and family adult foster care, dual licensure
251.4 of child foster residence setting and community residential setting, and dual licensure of
251.5 family adult foster care and family child care;

251.6 (2) adult foster care or community residential setting maximum capacity;

251.7 (3) adult foster care or community residential setting minimum age requirement;

251.8 (4) child foster care maximum age requirement;

251.9 (5) variances regarding disqualified individuals;

251.10 (6) the required presence of a caregiver in the adult foster care residence during normal
251.11 sleeping hours;

251.12 (7) variances to requirements relating to chemical use problems of a license holder or a
251.13 household member of a license holder; and

251.14 (8) variances to section 142B.46 for the use of a cradleboard for a cultural
251.15 accommodation.

251.16 (b) For family adult day services programs, the commissioner may authorize licensing
251.17 reviews every two years after a licensee has had at least one annual review.

251.18 (c) A license issued under this section may be issued for up to two years.

251.19 (d) During implementation of chapter 245D, the commissioner shall consider:

251.20 (1) the role of counties in quality assurance;

251.21 (2) the duties of county licensing staff; and

251.22 (3) the possible use of joint powers agreements, according to section 471.59, with counties
251.23 through which some licensing duties under chapter 245D may be delegated by the
251.24 commissioner to the counties.

251.25 Any consideration related to this paragraph must meet all of the requirements of the corrective
251.26 action plan ordered by the federal Centers for Medicare and Medicaid Services.

251.27 (e) Licensing authority specific to section 245D.06, subdivisions 5, 6, 7, and 8, or
251.28 successor provisions; and section 245D.061 or successor provisions, for family child foster
251.29 care programs providing out-of-home respite, as identified in section 245D.03, subdivision
251.30 1, paragraph (b), clause (1), is excluded from the delegation of authority to county agencies.

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

252.2 Sec. 11. Minnesota Statutes 2023 Supplement, section 245A.211, subdivision 4, is amended
252.3 to read:

252.4 Subd. 4. **Contraindicated physical restraints.** A license or certification holder must
252.5 not implement a restraint on a person receiving services in a program in a way that is
252.6 contraindicated for any of the person's known medical or psychological conditions. Prior
252.7 to using restraints on a person, ~~the license or certification holder must assess and document~~
252.8 ~~a determination of any~~ with a known medical or psychological conditions that restraints are
252.9 contraindicated for, the license or certification holder must document the contraindication
252.10 and the type of restraints that will not be used on the person based on this determination.

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

252.12 Sec. 12. Minnesota Statutes 2023 Supplement, section 245A.242, subdivision 2, is amended
252.13 to read:

252.14 Subd. 2. **Emergency overdose treatment.** (a) A license holder must maintain a supply
252.15 of opiate antagonists as defined in section 604A.04, subdivision 1, available for emergency
252.16 treatment of opioid overdose and must have a written standing order protocol by a physician
252.17 who is licensed under chapter 147, advanced practice registered nurse who is licensed under
252.18 chapter 148, or physician assistant who is licensed under chapter 147A, that permits the
252.19 license holder to maintain a supply of opiate antagonists on site. A license holder must
252.20 require staff to undergo training in the specific mode of administration used at the program,
252.21 which may include intranasal administration, intramuscular injection, or both.

252.22 (b) Notwithstanding any requirements to the contrary in Minnesota Rules, chapters 2960
252.23 and 9530, and Minnesota Statutes, chapters 245F, 245G, and 245I:

252.24 (1) emergency opiate antagonist medications are not required to be stored in a locked
252.25 area and staff and adult clients may carry this medication on them and store it in an unlocked
252.26 location;

252.27 (2) staff persons who only administer emergency opiate antagonist medications only
252.28 require the training required by paragraph (a), which any knowledgeable trainer may provide.
252.29 The trainer is not required to be a registered nurse or part of an accredited educational
252.30 institution; and

252.31 (3) nonresidential substance use disorder treatment programs that do not administer
252.32 client medications beyond emergency opiate antagonist medications are not required to

253.1 have the policies and procedures required in section 245G.08, subdivisions 5 and 6, and
253.2 must instead describe the program's procedures for administering opiate antagonist
253.3 medications in the license holder's description of health care services under section 245G.08,
253.4 subdivision 1.

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

253.6 Sec. 13. Minnesota Statutes 2023 Supplement, section 245C.02, subdivision 13e, is
253.7 amended to read:

253.8 Subd. 13e. **NETStudy 2.0.** (a) "NETStudy 2.0" means the commissioner's system that
253.9 replaces both NETStudy and the department's internal background study processing system.
253.10 NETStudy 2.0 is designed to enhance protection of children and vulnerable adults by
253.11 improving the accuracy of background studies through fingerprint-based criminal record
253.12 checks and expanding the background studies to include a review of information from the
253.13 Minnesota Court Information System and the national crime information database. NETStudy
253.14 2.0 is also designed to increase efficiencies in and the speed of the hiring process by:

253.15 (1) providing access to and updates from public web-based data related to employment
253.16 eligibility;

253.17 (2) decreasing the need for repeat studies through electronic updates of background
253.18 study subjects' criminal records;

253.19 (3) supporting identity verification using subjects' Social Security numbers and
253.20 photographs;

253.21 (4) using electronic employer notifications;

253.22 (5) issuing immediate verification of subjects' eligibility to provide services as more
253.23 studies are completed under the NETStudy 2.0 system; and

253.24 (6) providing electronic access to certain notices for entities and background study
253.25 subjects.

253.26 (b) Information obtained by entities from public web-based data through NETStudy 2.0
253.27 under paragraph (a), clause (1), or any other source that is not direct correspondence from
253.28 the commissioner is not a notice of disqualification from the commissioner under this
253.29 chapter.

254.1 **Sec. 14. [245C.041] EMERGENCY WAIVER TO TEMPORARILY MODIFY**
254.2 **BACKGROUND STUDY REQUIREMENTS.**

254.3 (a) In the event of an emergency identified by the commissioner, the commissioner may
254.4 temporarily waive or modify provisions in this chapter, except that the commissioner shall
254.5 not waive or modify:

254.6 (1) disqualification standards in section 245C.14 or 245C.15; or

254.7 (2) any provision regarding the scope of individuals required to be subject to a background
254.8 study conducted under this chapter.

254.9 (b) For the purposes of this section, an emergency may include, but is not limited to a
254.10 public health emergency, environmental emergency, natural disaster, or other unplanned
254.11 event that the commissioner has determined prevents the requirements in this chapter from
254.12 being met. This authority shall not exceed the amount of time needed to respond to the
254.13 emergency and reinstate the requirements of this chapter. The commissioner has the authority
254.14 to establish the process and time frame for returning to full compliance with this chapter.
254.15 The commissioner shall determine the length of time an emergency study is valid.

254.16 (c) At the conclusion of the emergency, entities must submit a new, compliant background
254.17 study application and fee for each individual who was the subject of background study
254.18 affected by the powers created in this section, referred to as an "emergency study" to have
254.19 a new study that fully complies with this chapter within a time frame and notice period
254.20 established by the commissioner.

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

254.22 Sec. 15. Minnesota Statutes 2022, section 245C.05, subdivision 5, is amended to read:

254.23 **Subd. 5. Fingerprints and photograph.** (a) Notwithstanding paragraph ~~(b)~~ (c), for
254.24 background studies conducted by the commissioner for child foster care, children's residential
254.25 facilities, adoptions, or a transfer of permanent legal and physical custody of a child, the
254.26 subject of the background study, who is 18 years of age or older, shall provide the
254.27 commissioner with a set of classifiable fingerprints obtained from an authorized agency for
254.28 a national criminal history record check.

254.29 (b) Notwithstanding paragraph (c), for background studies conducted by the commissioner
254.30 for Head Start programs, the subject of the background study shall provide the commissioner
254.31 with a set of classifiable fingerprints obtained from an authorized agency for a national
254.32 criminal history record check.

255.1 ~~(b)~~ (c) For background studies initiated on or after the implementation of NETStudy
255.2 2.0, except as provided under subdivision 5a, every subject of a background study must
255.3 provide the commissioner with a set of the background study subject's classifiable fingerprints
255.4 and photograph. The photograph and fingerprints must be recorded at the same time by the
255.5 authorized fingerprint collection vendor or vendors and sent to the commissioner through
255.6 the commissioner's secure data system described in section 245C.32, subdivision 1a,
255.7 paragraph (b).

255.8 ~~(e)~~ (d) The fingerprints shall be submitted by the commissioner to the Bureau of Criminal
255.9 Apprehension and, when specifically required by law, submitted to the Federal Bureau of
255.10 Investigation for a national criminal history record check.

255.11 ~~(d)~~ (e) The fingerprints must not be retained by the Department of Public Safety, Bureau
255.12 of Criminal Apprehension, or the commissioner. The Federal Bureau of Investigation will
255.13 not retain background study subjects' fingerprints.

255.14 ~~(e)~~ (f) The authorized fingerprint collection vendor or vendors shall, for purposes of
255.15 verifying the identity of the background study subject, be able to view the identifying
255.16 information entered into NETStudy 2.0 by the entity that initiated the background study,
255.17 but shall not retain the subject's fingerprints, photograph, or information from NETStudy
255.18 2.0. The authorized fingerprint collection vendor or vendors shall retain no more than the
255.19 name and date and time the subject's fingerprints were recorded and sent, only as necessary
255.20 for auditing and billing activities.

255.21 ~~(f)~~ (g) For any background study conducted under this chapter, the subject shall provide
255.22 the commissioner with a set of classifiable fingerprints when the commissioner has reasonable
255.23 cause to require a national criminal history record check as defined in section 245C.02,
255.24 subdivision 15a.

255.25 Sec. 16. Minnesota Statutes 2023 Supplement, section 245C.08, subdivision 1, is amended
255.26 to read:

255.27 Subdivision 1. **Background studies conducted by Department of Human Services.** (a)
255.28 For a background study conducted by the Department of Human Services, the commissioner
255.29 shall review:

255.30 (1) information related to names of substantiated perpetrators of maltreatment of
255.31 vulnerable adults that has been received by the commissioner as required under section
255.32 626.557, subdivision 9c, paragraph (j);

256.1 (2) the commissioner's records relating to the maltreatment of minors in licensed
256.2 programs, and from findings of maltreatment of minors as indicated through the social
256.3 service information system;

256.4 (3) information from juvenile courts as required ~~in subdivision 4 for individuals listed~~
256.5 ~~in section 245C.03, subdivision 1, paragraph (a),~~ for studies under this chapter when there
256.6 is reasonable cause;

256.7 (4) information from the Bureau of Criminal Apprehension, including information
256.8 regarding a background study subject's registration in Minnesota as a predatory offender
256.9 under section 243.166;

256.10 (5) except as provided in clause (6), information received as a result of submission of
256.11 fingerprints for a national criminal history record check, as defined in section 245C.02,
256.12 subdivision 13c, when the commissioner has reasonable cause for a national criminal history
256.13 record check as defined under section 245C.02, subdivision 15a, or as required under section
256.14 144.057, subdivision 1, clause (2);

256.15 (6) for a background study related to a child foster family setting application for licensure,
256.16 foster residence settings, children's residential facilities, a transfer of permanent legal and
256.17 physical custody of a child under sections 260C.503 to 260C.515, or adoptions, and for a
256.18 background study required for family child care, certified license-exempt child care, child
256.19 care centers, and legal nonlicensed child care authorized under chapter 119B, the
256.20 commissioner shall also review:

256.21 (i) information from the child abuse and neglect registry for any state in which the
256.22 background study subject has resided for the past five years;

256.23 (ii) when the background study subject is 18 years of age or older, or a minor under
256.24 section 245C.05, subdivision 5a, paragraph (c), information received following submission
256.25 of fingerprints for a national criminal history record check; and

256.26 (iii) when the background study subject is 18 years of age or older or a minor under
256.27 section 245C.05, subdivision 5a, paragraph (d), for licensed family child care, certified
256.28 license-exempt child care, licensed child care centers, and legal nonlicensed child care
256.29 authorized under chapter 119B, information obtained using non-fingerprint-based data
256.30 including information from the criminal and sex offender registries for any state in which
256.31 the background study subject resided for the past five years and information from the national
256.32 crime information database and the national sex offender registry;

257.1 (7) for a background study required for family child care, certified license-exempt child
257.2 care centers, licensed child care centers, and legal nonlicensed child care authorized under
257.3 chapter 119B, the background study shall also include, to the extent practicable, a name
257.4 and date-of-birth search of the National Sex Offender Public website; and

257.5 (8) for a background study required for treatment programs for sexual psychopathic
257.6 personalities or sexually dangerous persons, the background study shall only include a
257.7 review of the information required under paragraph (a), clauses (1) to (4).

257.8 (b) Except as otherwise provided in this paragraph, notwithstanding expungement by a
257.9 court, the commissioner may consider information obtained under paragraph (a), clauses
257.10 (3) and (4), unless:

257.11 (1) the commissioner received notice of the petition for expungement and the court order
257.12 for expungement is directed specifically to the commissioner; or

257.13 (2) the commissioner received notice of the expungement order issued pursuant to section
257.14 609A.017, 609A.025, or 609A.035, and the order for expungement is directed specifically
257.15 to the commissioner.

257.16 The commissioner may not consider information obtained under paragraph (a), clauses (3)
257.17 and (4), or from any other source that identifies a violation of chapter 152 without
257.18 determining if the offense involved the possession of marijuana or tetrahydrocannabinol
257.19 and, if so, whether the person received a grant of expungement or order of expungement,
257.20 or the person was resentenced to a lesser offense. If the person received a grant of
257.21 expungement or order of expungement, the commissioner may not consider information
257.22 related to that violation but may consider any other relevant information arising out of the
257.23 same incident.

257.24 (c) The commissioner shall also review criminal case information received according
257.25 to section 245C.04, subdivision 4a, from the Minnesota court information system that relates
257.26 to individuals who have already been studied under this chapter and who remain affiliated
257.27 with the agency that initiated the background study.

257.28 (d) When the commissioner has reasonable cause to believe that the identity of a
257.29 background study subject is uncertain, the commissioner may require the subject to provide
257.30 a set of classifiable fingerprints for purposes of completing a fingerprint-based record check
257.31 with the Bureau of Criminal Apprehension. Fingerprints collected under this paragraph
257.32 shall not be saved by the commissioner after they have been used to verify the identity of
257.33 the background study subject against the particular criminal record in question.

258.1 (e) The commissioner may inform the entity that initiated a background study under
258.2 NETStudy 2.0 of the status of processing of the subject's fingerprints.

258.3 Sec. 17. Minnesota Statutes 2022, section 245C.10, subdivision 18, is amended to read:

258.4 Subd. 18. **Applicants, licensees, and other occupations regulated by commissioner**
258.5 **of health.** The applicant or license holder is responsible for paying to the Department of
258.6 Human Services all fees associated with the preparation of the fingerprints, the criminal
258.7 records check consent form, and, through a fee of no more than \$44 per study, the criminal
258.8 background check.

258.9 Sec. 18. Minnesota Statutes 2022, section 245C.14, subdivision 1, is amended to read:

258.10 Subdivision 1. **Disqualification from direct contact.** (a) The commissioner shall
258.11 disqualify an individual who is the subject of a background study from any position allowing
258.12 direct contact with persons receiving services from the license holder or entity identified in
258.13 section 245C.03, upon receipt of information showing, or when a background study
258.14 completed under this chapter shows any of the following:

258.15 (1) a conviction of, admission to, or Alford plea to one or more crimes listed in section
258.16 245C.15, regardless of whether the conviction or admission is a felony, gross misdemeanor,
258.17 or misdemeanor level crime;

258.18 (2) a preponderance of the evidence indicates the individual has committed an act or
258.19 acts that meet the definition of any of the crimes listed in section 245C.15, regardless of
258.20 whether the preponderance of the evidence is for a felony, gross misdemeanor, or
258.21 misdemeanor level crime; ~~or~~

258.22 (3) an investigation results in an administrative determination listed under section
258.23 245C.15, subdivision 4, paragraph (b); or

258.24 (4) the individual's parental rights have been terminated under section 260C.301,
258.25 subdivision 1, paragraph (b), or section 260C.301, subdivision 3.

258.26 (b) No individual who is disqualified following a background study under section
258.27 245C.03, subdivisions 1 and 2, may be retained in a position involving direct contact with
258.28 persons served by a program or entity identified in section 245C.03, unless the commissioner
258.29 has provided written notice under section 245C.17 stating that:

258.30 (1) the individual may remain in direct contact during the period in which the individual
258.31 may request reconsideration as provided in section 245C.21, subdivision 2;

259.1 (2) the commissioner has set aside the individual's disqualification for that program or
259.2 entity identified in section 245C.03, as provided in section 245C.22, subdivision 4; or

259.3 (3) the license holder has been granted a variance for the disqualified individual under
259.4 section 245C.30.

259.5 (c) Notwithstanding paragraph (a), for the purposes of a background study affiliated
259.6 with a licensed family foster setting, the commissioner shall disqualify an individual who
259.7 is the subject of a background study from any position allowing direct contact with persons
259.8 receiving services from the license holder or entity identified in section 245C.03, upon
259.9 receipt of information showing or when a background study completed under this chapter
259.10 shows reason for disqualification under section 245C.15, subdivision 4a.

259.11 Sec. 19. Minnesota Statutes 2022, section 245C.14, is amended by adding a subdivision
259.12 to read:

259.13 Subd. 5. **Basis for disqualification.** Information obtained by entities from public
259.14 web-based data through NETStudy 2.0 or any other source that is not direct correspondence
259.15 from the commissioner is not a notice of disqualification from the commissioner under this
259.16 chapter.

259.17 Sec. 20. Minnesota Statutes 2023 Supplement, section 245C.15, subdivision 2, is amended
259.18 to read:

259.19 Subd. 2. **15-year disqualification.** (a) An individual is disqualified under section 245C.14
259.20 if: (1) less than 15 years have passed since the discharge of the sentence imposed, if any,
259.21 for the offense; and (2) the individual has committed a felony-level violation of any of the
259.22 following offenses: sections 152.021, subdivision 1 or 2b, (aggravated controlled substance
259.23 crime in the first degree; sale crimes); 152.022, subdivision 1 (controlled substance crime
259.24 in the second degree; sale crimes); 152.023, subdivision 1 (controlled substance crime in
259.25 the third degree; sale crimes); 152.024, subdivision 1 (controlled substance crime in the
259.26 fourth degree; sale crimes); 256.98 (wrongfully obtaining assistance); 268.182 (fraud);
259.27 393.07, subdivision 10, paragraph (c) (federal SNAP fraud); 518B.01, subdivision 14
259.28 (violation of an order for protection); 609.165 (felon ineligible to possess firearm); 609.2112,
259.29 609.2113, or 609.2114 (criminal vehicular homicide or injury); 609.215 (suicide); 609.223
259.30 or 609.2231 (assault in the third or fourth degree); repeat offenses under 609.224 (assault
259.31 in the fifth degree); 609.229 (crimes committed for benefit of a gang); 609.2325 (criminal
259.32 abuse of a vulnerable adult); 609.2335 (financial exploitation of a vulnerable adult); 609.235
259.33 (use of drugs to injure or facilitate crime); 609.24 (simple robbery); 609.247, subdivision

260.1 4 (carjacking in the third degree); 609.255 (false imprisonment); 609.2664 (manslaughter
260.2 of an unborn child in the first degree); 609.2665 (manslaughter of an unborn child in the
260.3 second degree); 609.267 (assault of an unborn child in the first degree); 609.2671 (assault
260.4 of an unborn child in the second degree); 609.268 (injury or death of an unborn child in the
260.5 commission of a crime); 609.27 (coercion); 609.275 (attempt to coerce); 609.466 (medical
260.6 assistance fraud); 609.495 (aiding an offender); 609.498, subdivision 1 or 1b (aggravated
260.7 first-degree or first-degree tampering with a witness); 609.52 (theft); 609.521 (possession
260.8 of shoplifting gear); 609.522 (organized retail theft); 609.525 (bringing stolen goods into
260.9 Minnesota); 609.527 (identity theft); 609.53 (receiving stolen property); 609.535 (issuance
260.10 of dishonored checks); 609.562 (arson in the second degree); 609.563 (arson in the third
260.11 degree); 609.582 (burglary); 609.59 (possession of burglary tools); 609.611 (insurance
260.12 fraud); 609.625 (aggravated forgery); 609.63 (forgery); 609.631 (check forgery; offering a
260.13 forged check); 609.635 (obtaining signature by false pretense); 609.66 (dangerous weapons);
260.14 609.67 (machine guns and short-barreled shotguns); 609.687 (adulteration); 609.71 (riot);
260.15 609.713 (terroristic threats); 609.746 (interference with privacy); 609.82 (fraud in obtaining
260.16 credit); 609.821 (financial transaction card fraud); 617.23 (indecent exposure), not involving
260.17 a minor; repeat offenses under 617.241 (obscene materials and performances; distribution
260.18 and exhibition prohibited; penalty); or 624.713 (certain persons not to possess firearms).

260.19 (b) An individual is disqualified under section 245C.14 if less than 15 years has passed
260.20 since the individual's aiding and abetting, attempt, or conspiracy to commit any of the
260.21 offenses listed in paragraph (a), as each of these offenses is defined in Minnesota Statutes.

260.22 (c) An individual is disqualified under section 245C.14 if less than 15 years has passed
260.23 since the termination of the individual's parental rights under section 260C.301, subdivision
260.24 1, paragraph (b), or subdivision 3.

260.25 (d) An individual is disqualified under section 245C.14 if less than 15 years has passed
260.26 since the discharge of the sentence imposed for an offense in any other state or country, the
260.27 elements of which are substantially similar to the elements of the offenses listed in paragraph
260.28 (a) or since the termination of parental rights in any other state or country, the elements of
260.29 which are substantially similar to the elements listed in paragraph (c).

260.30 (e) If the individual studied commits one of the offenses listed in paragraph (a), but the
260.31 sentence or level of offense is a gross misdemeanor or misdemeanor, the individual is
260.32 disqualified but the disqualification look-back period for the offense is the period applicable
260.33 to the gross misdemeanor or misdemeanor disposition.

261.1 (f) When a disqualification is based on a judicial determination other than a conviction,
 261.2 the disqualification period begins from the date of the court order. When a disqualification
 261.3 is based on an admission, the disqualification period begins from the date of an admission
 261.4 in court. When a disqualification is based on an Alford Plea, the disqualification period
 261.5 begins from the date the Alford Plea is entered in court. When a disqualification is based
 261.6 on a preponderance of evidence of a disqualifying act, the disqualification date begins from
 261.7 the date of the dismissal, the date of discharge of the sentence imposed for a conviction for
 261.8 a disqualifying crime of similar elements, or the date of the incident, whichever occurs last.

261.9 Sec. 21. Minnesota Statutes 2022, section 245C.15, subdivision 3, is amended to read:

261.10 Subd. 3. **Ten-year disqualification.** (a) An individual is disqualified under section
 261.11 245C.14 if: (1) less than ten years have passed since the discharge of the sentence imposed,
 261.12 if any, for the offense; and (2) the individual has committed a gross misdemeanor-level
 261.13 violation of any of the following offenses: sections 256.98 (wrongfully obtaining assistance);
 261.14 260B.425 (criminal jurisdiction for contributing to status as a juvenile petty offender or
 261.15 delinquency); 260C.425 (criminal jurisdiction for contributing to need for protection or
 261.16 services); 268.182 (fraud); 393.07, subdivision 10, paragraph (c) (federal SNAP fraud);
 261.17 609.2112, 609.2113, or 609.2114 (criminal vehicular homicide or injury); 609.221 or 609.222
 261.18 (assault in the first or second degree); 609.223 or 609.2231 (assault in the third or fourth
 261.19 degree); 609.224 (assault in the fifth degree); 609.224, subdivision 2, paragraph (c) (assault
 261.20 in the fifth degree by a caregiver against a vulnerable adult); 609.2242 and 609.2243
 261.21 (domestic assault); 609.23 (mistreatment of persons confined); 609.231 (mistreatment of
 261.22 residents or patients); 609.2325 (criminal abuse of a vulnerable adult); 609.233 (criminal
 261.23 neglect of a vulnerable adult); 609.2335 (financial exploitation of a vulnerable adult);
 261.24 609.234 (failure to report maltreatment of a vulnerable adult); 609.265 (abduction); 609.275
 261.25 (attempt to coerce); 609.324, subdivision 1a (other prohibited acts; minor engaged in
 261.26 prostitution); 609.33 (disorderly house); 609.377 (malicious punishment of a child); 609.378
 261.27 (neglect or endangerment of a child); 609.466 (medical assistance fraud); 609.52 (theft);
 261.28 609.522 (organized retail theft); 609.525 (bringing stolen goods into Minnesota); 609.527
 261.29 (identity theft); 609.53 (receiving stolen property); 609.535 (issuance of dishonored checks);
 261.30 609.582 (burglary); 609.59 (possession of burglary tools); 609.611 (insurance fraud); 609.631
 261.31 (check forgery; offering a forged check); 609.66 (dangerous weapons); 609.71 (riot); 609.72,
 261.32 subdivision 3 (disorderly conduct against a vulnerable adult); ~~repeat offenses under 609.746~~
 261.33 (~~interference with privacy~~); 609.749, subdivision 2 (harassment); 609.82 (fraud in obtaining
 261.34 credit); 609.821 (financial transaction card fraud); 617.23 (indecent exposure), not involving
 261.35 a minor; 617.241 (obscene materials and performances); 617.243 (indecent literature,

262.1 distribution); 617.293 (harmful materials; dissemination and display to minors prohibited);
262.2 or Minnesota Statutes 2012, section 609.21; or violation of an order for protection under
262.3 section 518B.01, subdivision 14.

262.4 (b) An individual is disqualified under section 245C.14 if less than ten years has passed
262.5 since the individual's aiding and abetting, attempt, or conspiracy to commit any of the
262.6 offenses listed in paragraph (a), as each of these offenses is defined in Minnesota Statutes.

262.7 (c) An individual is disqualified under section 245C.14 if less than ten years has passed
262.8 since the discharge of the sentence imposed for an offense in any other state or country, the
262.9 elements of which are substantially similar to the elements of any of the offenses listed in
262.10 paragraph (a).

262.11 (d) If the individual studied commits one of the offenses listed in paragraph (a), but the
262.12 sentence or level of offense is a misdemeanor disposition, the individual is disqualified but
262.13 the disqualification lookback period for the offense is the period applicable to misdemeanors.

262.14 (e) When a disqualification is based on a judicial determination other than a conviction,
262.15 the disqualification period begins from the date of the court order. When a disqualification
262.16 is based on an admission, the disqualification period begins from the date of an admission
262.17 in court. When a disqualification is based on an Alford Plea, the disqualification period
262.18 begins from the date the Alford Plea is entered in court. When a disqualification is based
262.19 on a preponderance of evidence of a disqualifying act, the disqualification date begins from
262.20 the date of the dismissal, the date of discharge of the sentence imposed for a conviction for
262.21 a disqualifying crime of similar elements, or the date of the incident, whichever occurs last.

262.22 Sec. 22. Minnesota Statutes 2022, section 245C.15, subdivision 4, is amended to read:

262.23 Subd. 4. **Seven-year disqualification.** (a) An individual is disqualified under section
262.24 245C.14 if: (1) less than seven years has passed since the discharge of the sentence imposed,
262.25 if any, for the offense; and (2) the individual has committed a misdemeanor-level violation
262.26 of any of the following offenses: sections 256.98 (wrongfully obtaining assistance); 260B.425
262.27 (criminal jurisdiction for contributing to status as a juvenile petty offender or delinquency);
262.28 260C.425 (criminal jurisdiction for contributing to need for protection or services); 268.182
262.29 (fraud); 393.07, subdivision 10, paragraph (c) (federal SNAP fraud); 609.2112, 609.2113,
262.30 or 609.2114 (criminal vehicular homicide or injury); 609.221 (assault in the first degree);
262.31 609.222 (assault in the second degree); 609.223 (assault in the third degree); 609.2231
262.32 (assault in the fourth degree); 609.224 (assault in the fifth degree); 609.2242 (domestic
262.33 assault); 609.2335 (financial exploitation of a vulnerable adult); 609.234 (failure to report
262.34 maltreatment of a vulnerable adult); 609.2672 (assault of an unborn child in the third degree);

263.1 609.27 (coercion); violation of an order for protection under 609.3232 (protective order
263.2 authorized; procedures; penalties); 609.466 (medical assistance fraud); 609.52 (theft);
263.3 609.522 (organized retail theft); 609.525 (bringing stolen goods into Minnesota); 609.527
263.4 (identity theft); 609.53 (receiving stolen property); 609.535 (issuance of dishonored checks);
263.5 609.611 (insurance fraud); 609.66 (dangerous weapons); 609.665 (spring guns); 609.746
263.6 (interference with privacy); 609.79 (obscene or harassing telephone calls); 609.795 (letter,
263.7 telegram, or package; opening; harassment); 609.82 (fraud in obtaining credit); 609.821
263.8 (financial transaction card fraud); 617.23 (indecent exposure), not involving a minor; 617.293
263.9 (harmful materials; dissemination and display to minors prohibited); or Minnesota Statutes
263.10 2012, section 609.21; or violation of an order for protection under section 518B.01 (Domestic
263.11 Abuse Act).

263.12 (b) An individual is disqualified under section 245C.14 if less than seven years has
263.13 passed since a determination or disposition of the individual's:

263.14 (1) failure to make required reports under section 260E.06 or 626.557, subdivision 3,
263.15 for incidents in which: (i) the final disposition under section 626.557 or chapter 260E was
263.16 substantiated maltreatment, and (ii) the maltreatment was recurring or serious; or

263.17 (2) substantiated serious or recurring maltreatment of a minor under chapter 260E, a
263.18 vulnerable adult under section 626.557, or serious or recurring maltreatment in any other
263.19 state, the elements of which are substantially similar to the elements of maltreatment under
263.20 section 626.557 or chapter 260E for which: (i) there is a preponderance of evidence that
263.21 the maltreatment occurred, and (ii) the subject was responsible for the maltreatment.

263.22 (c) An individual is disqualified under section 245C.14 if less than seven years has
263.23 passed since the individual's aiding and abetting, attempt, or conspiracy to commit any of
263.24 the offenses listed in paragraphs (a) and (b), as each of these offenses is defined in Minnesota
263.25 Statutes.

263.26 (d) An individual is disqualified under section 245C.14 if less than seven years has
263.27 passed since the discharge of the sentence imposed for an offense in any other state or
263.28 country, the elements of which are substantially similar to the elements of any of the offenses
263.29 listed in paragraphs (a) and (b).

263.30 (e) When a disqualification is based on a judicial determination other than a conviction,
263.31 the disqualification period begins from the date of the court order. When a disqualification
263.32 is based on an admission, the disqualification period begins from the date of an admission
263.33 in court. When a disqualification is based on an Alford Plea, the disqualification period
263.34 begins from the date the Alford Plea is entered in court. When a disqualification is based

264.1 on a preponderance of evidence of a disqualifying act, the disqualification date begins from
264.2 the date of the dismissal, the date of discharge of the sentence imposed for a conviction for
264.3 a disqualifying crime of similar elements, or the date of the incident, whichever occurs last.

264.4 (f) An individual is disqualified under section 245C.14 if less than seven years has passed
264.5 since the individual was disqualified under section 256.98, subdivision 8.

264.6 Sec. 23. Minnesota Statutes 2023 Supplement, section 245C.15, subdivision 4a, is amended
264.7 to read:

264.8 Subd. 4a. **Licensed family foster setting disqualifications.** (a) Notwithstanding
264.9 subdivisions 1 to 4, for a background study affiliated with a licensed family foster setting,
264.10 regardless of how much time has passed, an individual is disqualified under section 245C.14
264.11 if the individual committed an act that resulted in a felony-level conviction for sections:
264.12 609.185 (murder in the first degree); 609.19 (murder in the second degree); 609.195 (murder
264.13 in the third degree); 609.20 (manslaughter in the first degree); 609.205 (manslaughter in
264.14 the second degree); 609.2112 (criminal vehicular homicide); 609.221 (assault in the first
264.15 degree); 609.223, subdivision 2 (assault in the third degree, past pattern of child abuse);
264.16 609.223, subdivision 3 (assault in the third degree, victim under four); a felony offense
264.17 under sections 609.2242 and 609.2243 (domestic assault, spousal abuse, child abuse or
264.18 neglect, or a crime against children); 609.2247 (domestic assault by strangulation); 609.2325
264.19 (criminal abuse of a vulnerable adult resulting in the death of a vulnerable adult); 609.245
264.20 (aggravated robbery); 609.247, subdivision 2 or 3 (carjacking in the first or second degree);
264.21 609.25 (kidnapping); 609.255 (false imprisonment); 609.2661 (murder of an unborn child
264.22 in the first degree); 609.2662 (murder of an unborn child in the second degree); 609.2663
264.23 (murder of an unborn child in the third degree); 609.2664 (manslaughter of an unborn child
264.24 in the first degree); 609.2665 (manslaughter of an unborn child in the second degree);
264.25 609.267 (assault of an unborn child in the first degree); 609.2671 (assault of an unborn child
264.26 in the second degree); 609.268 (injury or death of an unborn child in the commission of a
264.27 crime); 609.322, subdivision 1 (solicitation, inducement, and promotion of prostitution; sex
264.28 trafficking in the first degree); 609.324, subdivision 1 (other prohibited acts; engaging in,
264.29 hiring, or agreeing to hire minor to engage in prostitution); 609.342 (criminal sexual conduct
264.30 in the first degree); 609.343 (criminal sexual conduct in the second degree); 609.344 (criminal
264.31 sexual conduct in the third degree); 609.345 (criminal sexual conduct in the fourth degree);
264.32 609.3451 (criminal sexual conduct in the fifth degree); 609.3453 (criminal sexual predatory
264.33 conduct); 609.3458 (sexual extortion); 609.352 (solicitation of children to engage in sexual
264.34 conduct); 609.377 (malicious punishment of a child); 609.378 (neglect or endangerment of
264.35 a child); 609.561 (arson in the first degree); 609.582, subdivision 1 (burglary in the first

265.1 degree); 609.746 (interference with privacy); 617.23 (indecent exposure); 617.246 (use of
265.2 minors in sexual performance prohibited); or 617.247 (possession of pictorial representations
265.3 of minors).

265.4 (b) Notwithstanding subdivisions 1 to 4, for the purposes of a background study affiliated
265.5 with a licensed family foster setting, an individual is disqualified under section 245C.14,
265.6 regardless of how much time has passed, if the individual:

265.7 (1) committed an action under paragraph (e) that resulted in death or involved sexual
265.8 abuse, as defined in section 260E.03, subdivision 20;

265.9 (2) committed an act that resulted in a gross misdemeanor-level conviction for section
265.10 609.3451 (criminal sexual conduct in the fifth degree);

265.11 (3) committed an act against or involving a minor that resulted in a felony-level conviction
265.12 for: section 609.222 (assault in the second degree); 609.223, subdivision 1 (assault in the
265.13 third degree); 609.2231 (assault in the fourth degree); or 609.224 (assault in the fifth degree);
265.14 or

265.15 (4) committed an act that resulted in a misdemeanor or gross misdemeanor-level
265.16 conviction for section 617.293 (dissemination and display of harmful materials to minors).

265.17 (c) Notwithstanding subdivisions 1 to 4, for a background study affiliated with a licensed
265.18 family foster setting, an individual is disqualified under section 245C.14 if fewer than 20
265.19 years have passed since the termination of the individual's parental rights under section
265.20 260C.301, subdivision 1, paragraph (b), or if the individual consented to a termination of
265.21 parental rights under section 260C.301, subdivision 1, paragraph (a), to settle a petition to
265.22 involuntarily terminate parental rights. An individual is disqualified under section 245C.14
265.23 if fewer than 20 years have passed since the termination of the individual's parental rights
265.24 in any other state or country, where the conditions for the individual's termination of parental
265.25 rights are substantially similar to the conditions in section 260C.301, subdivision 1, paragraph
265.26 (b).

265.27 (d) Notwithstanding subdivisions 1 to 4, for a background study affiliated with a licensed
265.28 family foster setting, an individual is disqualified under section 245C.14 if fewer than five
265.29 years have passed since a felony-level violation for sections: 152.021 (controlled substance
265.30 crime in the first degree); 152.022 (controlled substance crime in the second degree); 152.023
265.31 (controlled substance crime in the third degree); 152.024 (controlled substance crime in the
265.32 fourth degree); 152.025 (controlled substance crime in the fifth degree); 152.0261 (importing
265.33 controlled substances across state borders); 152.0262, subdivision 1, paragraph (b)
265.34 (possession of substance with intent to manufacture methamphetamine); 152.027, subdivision

266.1 6, paragraph (c) (sale or possession of synthetic cannabinoids); 152.096 (conspiracies
266.2 prohibited); 152.097 (simulated controlled substances); 152.136 (anhydrous ammonia;
266.3 prohibited conduct; criminal penalties; civil liabilities); 152.137 (methamphetamine-related
266.4 crimes involving children or vulnerable adults); 169A.24 (felony first-degree driving while
266.5 impaired); 243.166 (violation of predatory offender registration requirements); 609.2113
266.6 (criminal vehicular operation; bodily harm); 609.2114 (criminal vehicular operation; unborn
266.7 child); 609.228 (great bodily harm caused by distribution of drugs); 609.2325 (criminal
266.8 abuse of a vulnerable adult not resulting in the death of a vulnerable adult); 609.233 (criminal
266.9 neglect); 609.235 (use of drugs to injure or facilitate a crime); 609.24 (simple robbery);
266.10 609.247, subdivision 4 (carjacking in the third degree); 609.322, subdivision 1a (solicitation,
266.11 inducement, and promotion of prostitution; sex trafficking in the second degree); 609.498,
266.12 subdivision 1 (tampering with a witness in the first degree); 609.498, subdivision 1b
266.13 (aggravated first-degree witness tampering); 609.562 (arson in the second degree); 609.563
266.14 (arson in the third degree); 609.582, subdivision 2 (burglary in the second degree); 609.66
266.15 (felony dangerous weapons); 609.687 (adulteration); 609.713 (terroristic threats); 609.749,
266.16 subdivision 3, 4, or 5 (felony-level harassment or stalking); 609.855, subdivision 5 (shooting
266.17 at or in a public transit vehicle or facility); or 624.713 (certain people not to possess firearms).

266.18 (e) Notwithstanding subdivisions 1 to 4, except as provided in paragraph (a), for a
266.19 background study affiliated with a licensed family child foster care license, an individual
266.20 is disqualified under section 245C.14 if fewer than five years have passed since:

266.21 (1) a felony-level violation for an act not against or involving a minor that constitutes:
266.22 section 609.222 (assault in the second degree); 609.223, subdivision 1 (assault in the third
266.23 degree); 609.2231 (assault in the fourth degree); or 609.224, subdivision 4 (assault in the
266.24 fifth degree);

266.25 (2) a violation of an order for protection under section 518B.01, subdivision 14;

266.26 (3) a determination or disposition of the individual's failure to make required reports
266.27 under section 260E.06 or 626.557, subdivision 3, for incidents in which the final disposition
266.28 under chapter 260E or section 626.557 was substantiated maltreatment and the maltreatment
266.29 was recurring or serious;

266.30 (4) a determination or disposition of the individual's substantiated serious or recurring
266.31 maltreatment of a minor under chapter 260E, a vulnerable adult under section 626.557, or
266.32 serious or recurring maltreatment in any other state, the elements of which are substantially
266.33 similar to the elements of maltreatment under chapter 260E or section 626.557 and meet
266.34 the definition of serious maltreatment or recurring maltreatment;

267.1 (5) a gross misdemeanor-level violation for sections: 609.224, subdivision 2 (assault in
267.2 the fifth degree); 609.2242 and 609.2243 (domestic assault); 609.233 (criminal neglect);
267.3 609.377 (malicious punishment of a child); 609.378 (neglect or endangerment of a child);
267.4 609.746 (interference with privacy); 609.749 (stalking); or 617.23 (indecent exposure); or

267.5 (6) committing an act against or involving a minor that resulted in a misdemeanor-level
267.6 violation of section 609.224, subdivision 1 (assault in the fifth degree).

267.7 (f) For purposes of this subdivision, the disqualification begins from:

267.8 (1) the date of the alleged violation, if the individual was not convicted;

267.9 (2) the date of conviction, if the individual was convicted of the violation but not
267.10 committed to the custody of the commissioner of corrections; or

267.11 (3) the date of release from prison, if the individual was convicted of the violation and
267.12 committed to the custody of the commissioner of corrections.

267.13 Notwithstanding clause (3), if the individual is subsequently reincarcerated for a violation
267.14 of the individual's supervised release, the disqualification begins from the date of release
267.15 from the subsequent incarceration.

267.16 (g) An individual's aiding and abetting, attempt, or conspiracy to commit any of the
267.17 offenses listed in paragraphs (a) and (b), as each of these offenses is defined in Minnesota
267.18 Statutes, permanently disqualifies the individual under section 245C.14. An individual is
267.19 disqualified under section 245C.14 if fewer than five years have passed since the individual's
267.20 aiding and abetting, attempt, or conspiracy to commit any of the offenses listed in paragraphs
267.21 (d) and (e).

267.22 (h) An individual's offense in any other state or country, where the elements of the
267.23 offense are substantially similar to any of the offenses listed in paragraphs (a) and (b),
267.24 permanently disqualifies the individual under section 245C.14. An individual is disqualified
267.25 under section 245C.14 if fewer than five years have passed since an offense in any other
267.26 state or country, the elements of which are substantially similar to the elements of any
267.27 offense listed in paragraphs (d) and (e).

267.28 Sec. 24. Minnesota Statutes 2022, section 245C.22, subdivision 4, is amended to read:

267.29 Subd. 4. **Risk of harm; set aside.** (a) The commissioner may set aside the disqualification
267.30 if the commissioner finds that the individual has submitted sufficient information to
267.31 demonstrate that the individual does not pose a risk of harm to any person served by the
267.32 applicant, license holder, or other entities as provided in this chapter.

268.1 (b) In determining whether the individual has met the burden of proof by demonstrating
268.2 the individual does not pose a risk of harm, the commissioner shall consider:

268.3 (1) the nature, severity, and consequences of the event or events that led to the
268.4 disqualification;

268.5 (2) whether there is more than one disqualifying event;

268.6 (3) the age and vulnerability of the victim at the time of the event;

268.7 (4) the harm suffered by the victim;

268.8 (5) vulnerability of persons served by the program;

268.9 (6) the similarity between the victim and persons served by the program;

268.10 (7) the time elapsed without a repeat of the same or similar event;

268.11 (8) documentation of successful completion by the individual studied of training or
268.12 rehabilitation pertinent to the event; and

268.13 (9) any other information relevant to reconsideration.

268.14 (c) For an individual seeking a child foster care license who is a relative of the child,
268.15 the commissioner shall consider the importance of maintaining the child's relationship with
268.16 relatives as an additional significant factor in determining whether a background study
268.17 disqualification should be set aside.

268.18 ~~(e)~~ (d) If the individual requested reconsideration on the basis that the information relied
268.19 upon to disqualify the individual was incorrect or inaccurate and the commissioner determines
268.20 that the information relied upon to disqualify the individual is correct, the commissioner
268.21 must also determine if the individual poses a risk of harm to persons receiving services in
268.22 accordance with paragraph (b).

268.23 ~~(d)~~ (e) For an individual seeking employment in the substance use disorder treatment
268.24 field, the commissioner shall set aside the disqualification if the following criteria are met:

268.25 (1) the individual is not disqualified for a crime of violence as listed under section
268.26 624.712, subdivision 5, except for the following crimes: crimes listed under section 152.021,
268.27 subdivision 2 or 2a; 152.022, subdivision 2; 152.023, subdivision 2; 152.024; or 152.025;

268.28 (2) the individual is not disqualified under section 245C.15, subdivision 1;

268.29 (3) the individual is not disqualified under section 245C.15, subdivision 4, paragraph
268.30 (b);

269.1 (4) the individual provided documentation of successful completion of treatment, at least
269.2 one year prior to the date of the request for reconsideration, at a program licensed under
269.3 chapter 245G, and has had no disqualifying crimes or conduct under section 245C.15 after
269.4 the successful completion of treatment;

269.5 (5) the individual provided documentation demonstrating abstinence from controlled
269.6 substances, as defined in section 152.01, subdivision 4, for the period of one year prior to
269.7 the date of the request for reconsideration; and

269.8 (6) the individual is seeking employment in the substance use disorder treatment field.

269.9 Sec. 25. Minnesota Statutes 2022, section 245C.24, subdivision 2, is amended to read:

269.10 Subd. 2. **Permanent bar to set aside a disqualification.** (a) Except as provided in
269.11 paragraphs (b) to ~~(f)~~ (g), the commissioner may not set aside the disqualification of any
269.12 individual disqualified pursuant to this chapter, regardless of how much time has passed,
269.13 if the individual was disqualified for a crime or conduct listed in section 245C.15, subdivision
269.14 1.

269.15 (b) For an individual in the substance use disorder or corrections field who was
269.16 disqualified for a crime or conduct listed under section 245C.15, subdivision 1, and whose
269.17 disqualification was set aside prior to July 1, 2005, the commissioner must consider granting
269.18 a variance pursuant to section 245C.30 for the license holder for a program dealing primarily
269.19 with adults. A request for reconsideration evaluated under this paragraph must include a
269.20 letter of recommendation from the license holder that was subject to the prior set-aside
269.21 decision addressing the individual's quality of care to children or vulnerable adults and the
269.22 circumstances of the individual's departure from that service.

269.23 (c) If an individual who requires a background study for nonemergency medical
269.24 transportation services under section 245C.03, subdivision 12, was disqualified for a crime
269.25 or conduct listed under section 245C.15, subdivision 1, and if more than 40 years have
269.26 passed since the discharge of the sentence imposed, the commissioner may consider granting
269.27 a set-aside pursuant to section 245C.22. A request for reconsideration evaluated under this
269.28 paragraph must include a letter of recommendation from the employer. This paragraph does
269.29 not apply to a person disqualified based on a violation of sections 243.166; 609.185 to
269.30 609.205; 609.25; 609.342 to 609.3453; 609.352; 617.23, subdivision 2, clause (1), or 3,
269.31 clause (1); 617.246; or 617.247.

269.32 (d) When a licensed foster care provider adopts an individual who had received foster
269.33 care services from the provider for over six months, and the adopted individual is required

270.1 to receive a background study under section 245C.03, subdivision 1, paragraph (a), clause
270.2 (2) or (6), the commissioner may grant a variance to the license holder under section 245C.30
270.3 to permit the adopted individual with a permanent disqualification to remain affiliated with
270.4 the license holder under the conditions of the variance when the variance is recommended
270.5 by the county of responsibility for each of the remaining individuals in placement in the
270.6 home and the licensing agency for the home.

270.7 (e) For an individual 18 years of age or older affiliated with a licensed family foster
270.8 setting, the commissioner must not set aside or grant a variance for the disqualification of
270.9 any individual disqualified pursuant to this chapter, regardless of how much time has passed,
270.10 if the individual was disqualified for a crime or conduct listed in section 245C.15, subdivision
270.11 4a, paragraphs (a) and (b).

270.12 (f) In connection with a family foster setting license, the commissioner may grant a
270.13 variance to the disqualification for an individual who is under 18 years of age at the time
270.14 the background study is submitted.

270.15 (g) In connection with foster residence settings and children's residential facilities, the
270.16 commissioner must not set aside or grant a variance for the disqualification of any individual
270.17 disqualified pursuant to this chapter, regardless of how much time has passed, if the individual
270.18 was disqualified for a crime or conduct listed in section 245C.15, subdivision 4a, paragraph
270.19 (a) or (b).

270.20 Sec. 26. Minnesota Statutes 2022, section 245C.24, subdivision 5, is amended to read:

270.21 Subd. 5. **Five-year bar to set aside or variance disqualification; children's residential**
270.22 **facilities, foster residence settings.** The commissioner shall not set aside or grant a variance
270.23 for the disqualification of an individual in connection with a license for a children's residential
270.24 facility or foster residence setting who was convicted of a felony within the past five years
270.25 for: (1) physical assault or battery; or (2) a drug-related offense.

270.26 Sec. 27. Minnesota Statutes 2022, section 245C.30, is amended by adding a subdivision
270.27 to read:

270.28 Subd. 1b. **Child foster care variances.** For an individual seeking a child foster care
270.29 license who is a relative of the child, the commissioner shall consider the importance of
270.30 maintaining the child's relationship with relatives as an additional significant factor in
270.31 determining whether the individual should be granted a variance.

271.1 Sec. 28. Minnesota Statutes 2022, section 245F.09, subdivision 2, is amended to read:

271.2 Subd. 2. **Protective procedures plan.** A license holder must have a written policy and
271.3 procedure that establishes the protective procedures that program staff must follow when
271.4 a patient is in imminent danger of harming self or others. The policy must be appropriate
271.5 to the type of facility and the level of staff training. The protective procedures policy must
271.6 include:

271.7 (1) an approval signed and dated by the program director and medical director prior to
271.8 implementation. Any changes to the policy must also be approved, signed, and dated by the
271.9 current program director and the medical director prior to implementation;

271.10 (2) which protective procedures the license holder will use to prevent patients from
271.11 imminent danger of harming self or others;

271.12 (3) the emergency conditions under which the protective procedures are permitted to be
271.13 used, if any;

271.14 (4) the patient's health conditions that limit the specific procedures that may be used and
271.15 alternative means of ensuring safety;

271.16 (5) emergency resources the program staff must contact when a patient's behavior cannot
271.17 be controlled by the procedures established in the policy;

271.18 (6) the training that staff must have before using any protective procedure;

271.19 (7) documentation of approved therapeutic holds;

271.20 (8) the use of law enforcement personnel as described in subdivision 4;

271.21 (9) standards governing emergency use of seclusion. Seclusion must be used only when
271.22 less restrictive measures are ineffective or not feasible. The standards in items (i) to (vii)
271.23 must be met when seclusion is used with a patient:

271.24 (i) seclusion must be employed solely for the purpose of preventing a patient from
271.25 imminent danger of harming self or others;

271.26 (ii) seclusion rooms must be equipped in a manner that prevents patients from self-harm
271.27 using projections, windows, electrical fixtures, or hard objects, and must allow the patient
271.28 to be readily observed without being interrupted;

271.29 (iii) seclusion must be authorized by the program director, a licensed physician, a
271.30 registered nurse, or a licensed physician assistant. If one of these individuals is not present
271.31 in the facility, the program director or a licensed physician, registered nurse, or physician

272.1 assistant must be contacted and authorization must be obtained within 30 minutes of initiating
272.2 seclusion, according to written policies;

272.3 (iv) patients must not be placed in seclusion for more than 12 hours at any one time;

272.4 (v) once the condition of a patient in seclusion has been determined to be safe enough
272.5 to end continuous observation, a patient in seclusion must be observed at a minimum of
272.6 every 15 minutes for the duration of seclusion and must always be within hearing range of
272.7 program staff;

272.8 (vi) a process for program staff to use to remove a patient to other resources available
272.9 to the facility if seclusion does not sufficiently assure patient safety; and

272.10 (vii) a seclusion area may be used for other purposes, such as intensive observation, if
272.11 the room meets normal standards of care for the purpose and if the room is not locked; and

272.12 (10) physical holds may only be used when less restrictive measures are not feasible.

272.13 The standards in items (i) to (iv) must be met when physical holds are used with a patient:

272.14 (i) physical holds must be employed solely for preventing a patient from imminent
272.15 danger of harming self or others;

272.16 (ii) physical holds must be authorized by the program director, a licensed physician, a
272.17 registered nurse, or a physician assistant. If one of these individuals is not present in the
272.18 facility, the program director or a licensed physician, registered nurse, or physician assistant
272.19 must be contacted and authorization must be obtained within 30 minutes of initiating a
272.20 physical hold, according to written policies;

272.21 (iii) the patient's health concerns must be considered in deciding whether to use physical
272.22 holds and which holds are appropriate for the patient; and

272.23 (iv) only approved holds may be utilized. Prone and contraindicated holds are not allowed
272.24 according to section 245A.211 and must not be authorized.

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

272.26 Sec. 29. Minnesota Statutes 2022, section 245F.14, is amended by adding a subdivision
272.27 to read:

272.28 **Subd. 8. Notification to commissioner of changes in key staff positions.** A license
272.29 holder must notify the commissioner within five business days of a change or vacancy in a
272.30 key staff position. The key positions are a program director as required by subdivision 1, a
272.31 registered nurse as required by subdivision 4, and a medical director as required by
272.32 subdivision 5. The license holder must notify the commissioner of the staffing change on

273.1 a form approved by the commissioner and include the name of the staff person now assigned
 273.2 to the key staff position and the staff person's qualifications for the position. The license
 273.3 holder must notify the program licensor of a vacancy to discuss how the duties of the key
 273.4 staff position will be fulfilled during the vacancy.

273.5 **EFFECTIVE DATE.** This section is effective January 1, 2025.

273.6 Sec. 30. Minnesota Statutes 2022, section 245F.17, is amended to read:

273.7 **245F.17 PERSONNEL FILES.**

273.8 A license holder must maintain a separate personnel file for each staff member. At a
 273.9 minimum, the file must contain:

273.10 (1) a completed application for employment signed by the staff member that contains
 273.11 the staff member's qualifications for employment and documentation related to the applicant's
 273.12 background study data, as defined in chapter 245C;

273.13 (2) documentation of the staff member's current professional license or registration, if
 273.14 relevant;

273.15 (3) documentation of orientation and subsequent training; and

273.16 (4) ~~documentation of a statement of freedom from substance use problems; and~~

273.17 ~~(5) an annual job performance evaluation.~~

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

273.19 Sec. 31. Minnesota Statutes 2022, section 245G.07, subdivision 4, is amended to read:

273.20 **Subd. 4. Location of service provision.** ~~The license holder may provide services at any~~
 273.21 ~~of the license holder's licensed locations or at another suitable location including a school,~~
 273.22 ~~government building, medical or behavioral health facility, or social service organization,~~
 273.23 ~~upon notification and approval of the commissioner. If services are provided off site from~~
 273.24 ~~the licensed site, the reason for the provision of services remotely must be documented.~~
 273.25 ~~The license holder may provide additional services under subdivision 2, clauses (2) to (5),~~
 273.26 ~~off site if the license holder includes a policy and procedure detailing the off-site location~~
 273.27 ~~as a part of the treatment service description and the program abuse prevention plan.~~

273.28 (a) The license holder must provide all treatment services a client receives at one of the
 273.29 license holder's substance use disorder treatment licensed locations or at a location allowed
 273.30 under paragraphs (b) to (f). If the services are provided at the locations in paragraphs (b) to
 273.31 (d), the license holder must document in the client record the location services were provided.

274.1 (b) The license holder may provide nonresidential individual treatment services at a
274.2 client's home or place of residence.

274.3 (c) If the license holder provides treatment services by telehealth, the services must be
274.4 provided according to this paragraph:

274.5 (1) the license holder must maintain a licensed physical location in Minnesota where
274.6 the license holder must offer all treatment services in subdivision 1, paragraph (a), clauses
274.7 (1) to (4), physically in-person to each client;

274.8 (2) the license holder must meet all requirements for the provision of telehealth in sections
274.9 254B.05, subdivision 5, paragraph (f), and 256B.0625, subdivision 3b. The license holder
274.10 must document all items in section 256B.0625, subdivision 3b, paragraph (c), for each client
274.11 receiving services by telehealth, regardless of payment type or whether the client is a medical
274.12 assistance enrollee;

274.13 (3) the license holder may provide treatment services by telehealth to clients individually;

274.14 (4) the license holder may provide treatment services by telehealth to a group of clients
274.15 that are each in a separate physical location;

274.16 (5) the license holder must not provide treatment services remotely by telehealth to a
274.17 group of clients meeting together in person, unless permitted under clause (7);

274.18 (6) clients and staff may join an in-person group by telehealth if a staff member qualified
274.19 to provide the treatment service is physically present with the group of clients meeting
274.20 together in person; and

274.21 (7) the qualified professional providing a residential group treatment service by telehealth
274.22 must be physically present on-site at the licensed residential location while the service is
274.23 being provided. If weather conditions or short-term illness prohibit a qualified professional
274.24 from traveling to the residential program and another qualified professional is not available
274.25 to provide the service, a qualified professional may provide a residential group treatment
274.26 service by telehealth from a location away from the licensed residential location. In such
274.27 circumstances, the license holder must ensure that a qualified professional does not provide
274.28 a residential group treatment service by telehealth from a location away from the licensed
274.29 residential location for more than one day at a time, must ensure that a staff person who
274.30 qualifies as a paraprofessional is physically present with the group of clients, and must
274.31 document the reason for providing the remote telehealth service in the records of clients
274.32 receiving the service. The license holder must document the dates that residential group
274.33 treatment services were provided by telehealth from a location away from the licensed

275.1 residential location in a central log and must provide the log to the commissioner upon
275.2 request.

275.3 (d) The license holder may provide the additional treatment services under subdivision
275.4 2, clauses (2) to (6) and (8), away from the licensed location at a suitable location appropriate
275.5 to the treatment service.

275.6 (e) Upon written approval from the commissioner for each satellite location, the license
275.7 holder may provide nonresidential treatment services at satellite locations that are in a
275.8 school, jail, or nursing home. A satellite location may only provide services to students of
275.9 the school, inmates of the jail, or residents of the nursing home. Schools, jails, and nursing
275.10 homes are exempt from the licensing requirements in section 245A.04, subdivision 2a, to
275.11 document compliance with building codes, fire and safety codes, health rules, and zoning
275.12 ordinances.

275.13 (f) The commissioner may approve other suitable locations as satellite locations for
275.14 nonresidential treatment services. The commissioner may require satellite locations under
275.15 this paragraph to meet all applicable licensing requirements. The license holder may not
275.16 have more than two satellite locations per license under this paragraph.

275.17 (g) The license holder must provide the commissioner access to all files, documentation,
275.18 staff persons, and any other information the commissioner requires at the main licensed
275.19 location for all clients served at any location under paragraphs (b) to (f).

275.20 (h) Notwithstanding sections 245A.65, subdivision 2, and 626.557, subdivision 14, a
275.21 program abuse prevention plan is not required for satellite or other locations under paragraphs
275.22 (b) to (e). An individual abuse prevention plan is still required for any client that is a
275.23 vulnerable adult as defined in section 626.5572, subdivision 21.

275.24 **EFFECTIVE DATE.** This section is effective January 1, 2025.

275.25 Sec. 32. Minnesota Statutes 2022, section 245G.08, subdivision 5, is amended to read:

275.26 **Subd. 5. Administration of medication and assistance with self-medication.** (a) A
275.27 license holder must meet the requirements in this subdivision if a service provided includes
275.28 the administration of medication.

275.29 (b) A staff member, other than a licensed practitioner or nurse, who is delegated by a
275.30 licensed practitioner or a registered nurse the task of administration of medication or assisting
275.31 with self-medication, must:

276.1 (1) successfully complete a medication administration training program for unlicensed
276.2 personnel through an accredited Minnesota postsecondary educational institution. A staff
276.3 member's completion of the course must be documented in writing and placed in the staff
276.4 member's personnel file;

276.5 (2) be trained according to a formalized training program that is taught by a registered
276.6 nurse and offered by the license holder. ~~The training must include the process for~~
276.7 ~~administration of naloxone, if naloxone is kept on site.~~ A staff member's completion of the
276.8 training must be documented in writing and placed in the staff member's personnel records;
276.9 or

276.10 (3) demonstrate to a registered nurse competency to perform the delegated activity. A
276.11 registered nurse must be employed or contracted to develop the policies and procedures for
276.12 administration of medication or assisting with self-administration of medication, or both.

276.13 (c) A registered nurse must provide supervision as defined in section 148.171, subdivision
276.14 23. The registered nurse's supervision must include, at a minimum, monthly on-site
276.15 supervision or more often if warranted by a client's health needs. The policies and procedures
276.16 must include:

276.17 (1) a provision that a delegation of administration of medication is limited to a method
276.18 a staff member has been trained to administer and limited to:

276.19 (i) a medication that is administered orally, topically, or as a suppository, an eye drop,
276.20 an ear drop, an inhalant, or an intranasal; and

276.21 (ii) an intramuscular injection of ~~naloxone~~ an opiate antagonist as defined in section
276.22 604A.04, subdivision 1, or epinephrine;

276.23 (2) a provision that each client's file must include documentation indicating whether
276.24 staff must conduct the administration of medication or the client must self-administer
276.25 medication, or both;

276.26 (3) a provision that a client may carry emergency medication such as nitroglycerin as
276.27 instructed by the client's physician, advanced practice registered nurse, or physician assistant;

276.28 (4) a provision for the client to self-administer medication when a client is scheduled to
276.29 be away from the facility;

276.30 (5) a provision that if a client self-administers medication when the client is present in
276.31 the facility, the client must self-administer medication under the observation of a trained
276.32 staff member;

277.1 (6) a provision that when a license holder serves a client who is a parent with a child,
277.2 the parent may only administer medication to the child under a staff member's supervision;

277.3 (7) requirements for recording the client's use of medication, including staff signatures
277.4 with date and time;

277.5 (8) guidelines for when to inform a nurse of problems with self-administration of
277.6 medication, including a client's failure to administer, refusal of a medication, adverse
277.7 reaction, or error; and

277.8 (9) procedures for acceptance, documentation, and implementation of a prescription,
277.9 whether written, verbal, telephonic, or electronic.

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

277.11 Sec. 33. Minnesota Statutes 2022, section 245G.08, subdivision 6, is amended to read:

277.12 Subd. 6. **Control of drugs.** A license holder must have and implement written policies
277.13 and procedures developed by a registered nurse that contain:

277.14 (1) a requirement that each drug must be stored in a locked compartment. A Schedule
277.15 II drug, as defined by section 152.02, subdivision 3, must be stored in a separately locked
277.16 compartment, permanently affixed to the physical plant or medication cart;

277.17 (2) a system which accounts for all scheduled drugs each shift;

277.18 (3) a procedure for recording the client's use of medication, including the signature of
277.19 the staff member who completed the administration of the medication with the time and
277.20 date;

277.21 (4) a procedure to destroy a discontinued, outdated, or deteriorated medication;

277.22 (5) a statement that only authorized personnel are permitted access to the keys to a locked
277.23 compartment;

277.24 (6) a statement that no legend drug supply for one client shall be given to another client;
277.25 and

277.26 (7) a procedure for monitoring the available supply of ~~naloxone~~ an opiate antagonist as
277.27 defined in section 604A.04, subdivision 1, on site; and replenishing the naloxone supply
277.28 when needed, and destroying naloxone according to clause (4).

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

278.1 Sec. 34. Minnesota Statutes 2022, section 245G.10, is amended by adding a subdivision
278.2 to read:

278.3 Subd. 6. Notification to commissioner of changes in key staff positions. A license
278.4 holder must notify the commissioner within five business days of a change or vacancy in a
278.5 key staff position. The key positions are a treatment director as required by subdivision 1,
278.6 an alcohol and drug counselor supervisor as required by subdivision 2, and a registered
278.7 nurse as required by section 245G.08, subdivision 5, paragraph (c). The license holder must
278.8 notify the commissioner of the staffing change on a form approved by the commissioner
278.9 and include the name of the staff person now assigned to the key staff position and the staff
278.10 person's qualifications for the position. The license holder must notify the program licensor
278.11 of a vacancy to discuss how the duties of the key staff position will be fulfilled during the
278.12 vacancy.

278.13 **EFFECTIVE DATE.** This section is effective January 1, 2025.

278.14 Sec. 35. Minnesota Statutes 2023 Supplement, section 245G.22, subdivision 2, is amended
278.15 to read:

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

278.18 (b) "Diversion" means the use of a medication for the treatment of opioid addiction being
278.19 diverted from intended use of the medication.

278.20 (c) "Guest dose" means administration of a medication used for the treatment of opioid
278.21 addiction to a person who is not a client of the program that is administering or dispensing
278.22 the medication.

278.23 (d) "Medical director" means a practitioner licensed to practice medicine in the
278.24 jurisdiction that the opioid treatment program is located who assumes responsibility for
278.25 administering all medical services performed by the program, either by performing the
278.26 services directly or by delegating specific responsibility to a practitioner of the opioid
278.27 treatment program.

278.28 (e) "Medication used for the treatment of opioid use disorder" means a medication
278.29 approved by the Food and Drug Administration for the treatment of opioid use disorder.

278.30 (f) "Minnesota health care programs" has the meaning given in section 256B.0636.

278.31 (g) "Opioid treatment program" has the meaning given in Code of Federal Regulations,
278.32 title 42, section 8.12, and includes programs licensed under this chapter.

279.1 (h) "Practitioner" means a staff member holding a current, unrestricted license to practice
 279.2 medicine issued by the Board of Medical Practice or nursing issued by the Board of Nursing
 279.3 and is currently registered with the Drug Enforcement Administration to order or dispense
 279.4 controlled substances in Schedules II to V under the Controlled Substances Act, United
 279.5 States Code, title 21, part B, section 821. ~~Practitioner includes an advanced practice registered~~
 279.6 ~~nurse and physician assistant if the staff member receives a variance by the state opioid~~
 279.7 ~~treatment authority under section 254A.03 and the federal Substance Abuse and Mental~~
 279.8 ~~Health Services Administration.~~

279.9 (i) "Unsupervised use" or "take-home" means the use of a medication for the treatment
 279.10 of opioid use disorder dispensed for use by a client outside of the program setting.

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

279.12 Sec. 36. Minnesota Statutes 2022, section 245G.22, subdivision 6, is amended to read:

279.13 Subd. 6. **Criteria for unsupervised use.** (a) To limit the potential for diversion of
 279.14 medication used for the treatment of opioid use disorder to the illicit market, medication
 279.15 dispensed to a client for unsupervised use shall be subject to the requirements of this
 279.16 subdivision. Any client in an opioid treatment program may receive ~~a single unsupervised~~
 279.17 ~~use dose for a day that the clinic is closed for business, including Sundays and state and~~
 279.18 ~~federal holidays~~ their individualized take-home doses as ordered for days that the clinic is
 279.19 closed for business, on one weekend day (e.g., Sunday) and state and federal holidays, no
 279.20 matter their length of time in treatment, as allowed under Code of Federal Regulations, title
 279.21 42, part 8.12 (i)(1).

279.22 (b) For take-home doses beyond those allowed by paragraph (a), a practitioner with
 279.23 authority to prescribe must review and document the criteria in this paragraph and paragraph
 279.24 ~~(e)~~ the Code of Federal Regulations, title 42, part 8.12 (i)(2), when determining whether
 279.25 dispensing medication for a client's unsupervised use is safe and it is appropriate to
 279.26 implement, increase, or extend the amount of time between visits to the program. The criteria
 279.27 are:

279.28 ~~(1) absence of recent abuse of drugs including but not limited to opioids, non-narcotics,~~
 279.29 ~~and alcohol;~~

279.30 ~~(2) regularity of program attendance;~~

279.31 ~~(3) absence of serious behavioral problems at the program;~~

279.32 ~~(4) absence of known recent criminal activity such as drug dealing;~~

280.1 ~~(5) stability of the client's home environment and social relationships;~~

280.2 ~~(6) length of time in comprehensive maintenance treatment;~~

280.3 ~~(7) reasonable assurance that unsupervised use medication will be safely stored within~~
280.4 ~~the client's home; and~~

280.5 ~~(8) whether the rehabilitative benefit the client derived from decreasing the frequency~~
280.6 ~~of program attendance outweighs the potential risks of diversion or unsupervised use.~~

280.7 (c) The determination, including the basis of the determination must be documented by
280.8 a practitioner in the client's medical record.

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

280.10 Sec. 37. Minnesota Statutes 2022, section 245G.22, subdivision 7, is amended to read:

280.11 **Subd. 7. Restrictions for unsupervised use of methadone hydrochloride.** (a) If a
280.12 ~~medical director or prescribing practitioner assesses and, determines, and documents~~ that
280.13 a client meets the criteria in subdivision 6 ~~and may be dispensed a medication used for the~~
280.14 ~~treatment of opioid addiction, the restrictions in this subdivision must be followed when~~
280.15 ~~the medication to be dispensed is methadone hydrochloride. The results of the assessment~~
280.16 ~~must be contained in the client file. The number of unsupervised use medication doses per~~
280.17 ~~week in paragraphs (b) to (d) is in addition to the number of unsupervised use medication~~
280.18 ~~doses a client may receive for days the clinic is closed for business as allowed by subdivision~~
280.19 ~~6, paragraph (a) and that a patient is safely able to manage unsupervised doses of methadone,~~
280.20 the number of take-home doses the client receives must be limited by the number allowed
280.21 by the Code of Federal Regulations, title 42, part 8.12 (i)(3).

280.22 ~~(b) During the first 90 days of treatment, the unsupervised use medication supply must~~
280.23 ~~be limited to a maximum of a single dose each week and the client shall ingest all other~~
280.24 ~~doses under direct supervision.~~

280.25 ~~(c) In the second 90 days of treatment, the unsupervised use medication supply must be~~
280.26 ~~limited to two doses per week.~~

280.27 ~~(d) In the third 90 days of treatment, the unsupervised use medication supply must not~~
280.28 ~~exceed three doses per week.~~

280.29 ~~(e) In the remaining months of the first year, a client may be given a maximum six-day~~
280.30 ~~unsupervised use medication supply.~~

280.31 ~~(f) After one year of continuous treatment, a client may be given a maximum two-week~~
280.32 ~~unsupervised use medication supply.~~

281.1 ~~(g) After two years of continuous treatment, a client may be given a maximum one-month~~
281.2 ~~unsupervised use medication supply, but must make monthly visits to the program.~~

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

281.4 Sec. 38. Minnesota Statutes 2023 Supplement, section 245G.22, subdivision 17, is amended
281.5 to read:

281.6 Subd. 17. **Policies and procedures.** (a) A license holder must develop and maintain the
281.7 policies and procedures required in this subdivision.

281.8 (b) For a program that is not open every day of the year, the license holder must maintain
281.9 a policy and procedure that covers requirements under section 245G.22, subdivisions 6 and
281.10 7. Unsupervised use of medication used for the treatment of opioid use disorder for days
281.11 that the program is closed for business, ~~including but not limited to Sundays~~ on one weekend
281.12 day and state and federal holidays, must meet the requirements under section 245G.22,
281.13 subdivisions 6 and 7.

281.14 (c) The license holder must maintain a policy and procedure that includes specific
281.15 measures to reduce the possibility of diversion. The policy and procedure must:

281.16 (1) specifically identify and define the responsibilities of the medical and administrative
281.17 staff for performing diversion control measures; and

281.18 (2) include a process for contacting no less than five percent of clients who have
281.19 unsupervised use of medication, excluding clients approved solely under subdivision 6,
281.20 paragraph (a), to require clients to physically return to the program each month. The system
281.21 must require clients to return to the program within a stipulated time frame and turn in all
281.22 unused medication containers related to opioid use disorder treatment. The license holder
281.23 must document all related contacts on a central log and the outcome of the contact for each
281.24 client in the client's record. The medical director must be informed of each outcome that
281.25 results in a situation in which a possible diversion issue was identified.

281.26 (d) Medication used for the treatment of opioid use disorder must be ordered,
281.27 administered, and dispensed according to applicable state and federal regulations and the
281.28 standards set by applicable accreditation entities. If a medication order requires assessment
281.29 by the person administering or dispensing the medication to determine the amount to be
281.30 administered or dispensed, the assessment must be completed by an individual whose
281.31 professional scope of practice permits an assessment. For the purposes of enforcement of
281.32 this paragraph, the commissioner has the authority to monitor the person administering or
281.33 dispensing the medication for compliance with state and federal regulations and the relevant

282.1 standards of the license holder's accreditation agency and may issue licensing actions
282.2 according to sections 245A.05, 245A.06, and 245A.07, based on the commissioner's
282.3 determination of noncompliance.

282.4 (e) A counselor in an opioid treatment program must not supervise more than 50 clients.

282.5 (f) Notwithstanding paragraph (e), from July 1, 2023, to June 30, 2024, a counselor in
282.6 an opioid treatment program may supervise up to 60 clients. The license holder may continue
282.7 to serve a client who was receiving services at the program on June 30, 2024, at a counselor
282.8 to client ratio of up to one to 60 and is not required to discharge any clients in order to return
282.9 to the counselor to client ratio of one to 50. The license holder may not, however, serve a
282.10 new client after June 30, 2024, unless the counselor who would supervise the new client is
282.11 supervising fewer than 50 existing clients.

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

282.13 Sec. 39. Minnesota Statutes 2023 Supplement, section 256B.064, subdivision 4, is amended
282.14 to read:

282.15 Subd. 4. **Notice.** (a) The department shall serve the notice required under subdivision 2
282.16 ~~by certified mail at~~ using a signature-verified confirmed delivery method to the address
282.17 submitted to the department by the individual or entity. Service is complete upon mailing.

282.18 (b) The department shall give notice in writing to a recipient placed in the Minnesota
282.19 restricted recipient program under section 256B.0646 and Minnesota Rules, part 9505.2200.
282.20 The department shall send the notice by first class mail to the recipient's current address on
282.21 file with the department. A recipient placed in the Minnesota restricted recipient program
282.22 may contest the placement by submitting a written request for a hearing to the department
282.23 within 90 days of the notice being mailed.

282.24 Sec. 40. Minnesota Statutes 2022, section 256B.0757, subdivision 4a, is amended to read:

282.25 Subd. 4a. **Behavioral health home services provider requirements.** A behavioral
282.26 health home services provider must:

282.27 (1) be an enrolled Minnesota Health Care Programs provider;

282.28 (2) provide a medical assistance covered primary care or behavioral health service;

282.29 (3) utilize an electronic health record;

282.30 (4) utilize an electronic patient registry that contains data elements required by the
282.31 commissioner;

- 283.1 (5) demonstrate the organization's capacity to administer screenings approved by the
283.2 commissioner for substance use disorder or alcohol and tobacco use;
- 283.3 (6) demonstrate the organization's capacity to refer an individual to resources appropriate
283.4 to the individual's screening results;
- 283.5 (7) have policies and procedures to track referrals to ensure that the referral met the
283.6 individual's needs;
- 283.7 (8) conduct a brief needs assessment when an individual begins receiving behavioral
283.8 health home services. The brief needs assessment must be completed with input from the
283.9 individual and the individual's identified supports. The brief needs assessment must address
283.10 the individual's immediate safety and transportation needs and potential barriers to
283.11 participating in behavioral health home services;
- 283.12 (9) conduct a health wellness assessment within 60 days after intake that contains all
283.13 required elements identified by the commissioner;
- 283.14 (10) conduct a health action plan that contains all required elements identified by the
283.15 commissioner. The plan must be completed within 90 days after intake and must be updated
283.16 at least once every six months, or more frequently if significant changes to an individual's
283.17 needs or goals occur;
- 283.18 (11) agree to cooperate with and participate in the state's monitoring and evaluation of
283.19 behavioral health home services; and
- 283.20 (12) obtain the individual's ~~written~~ consent to begin receiving behavioral health home
283.21 services using a form approved by the commissioner.

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

283.23 Sec. 41. Minnesota Statutes 2022, section 256B.0757, subdivision 4d, is amended to read:

283.24 Subd. 4d. **Behavioral health home services delivery standards.** (a) A behavioral health
283.25 home services provider must meet the following service delivery standards:

283.26 (1) establish and maintain processes to support the coordination of an individual's primary
283.27 care, behavioral health, and dental care;

283.28 (2) maintain a team-based model of care, including regular coordination and
283.29 communication between behavioral health home services team members;

- 284.1 (3) use evidence-based practices that recognize and are tailored to the medical, social,
284.2 economic, behavioral health, functional impairment, cultural, and environmental factors
284.3 affecting the individual's health and health care choices;
- 284.4 (4) use person-centered planning practices to ensure the individual's health action plan
284.5 accurately reflects the individual's preferences, goals, resources, and optimal outcomes for
284.6 the individual and the individual's identified supports;
- 284.7 (5) use the patient registry to identify individuals and population subgroups requiring
284.8 specific levels or types of care and provide or refer the individual to needed treatment,
284.9 intervention, or services;
- 284.10 (6) ~~utilize the Department of Human Services Partner Portal to~~ identify past and current
284.11 treatment or services and identify potential gaps in care using a tool approved by the
284.12 commissioner;
- 284.13 (7) deliver services consistent with the standards for frequency and face-to-face contact
284.14 required by the commissioner;
- 284.15 (8) ensure that a diagnostic assessment is completed for each individual receiving
284.16 behavioral health home services within six months of the start of behavioral health home
284.17 services;
- 284.18 (9) deliver services in locations and settings that meet the needs of the individual;
- 284.19 (10) provide a central point of contact to ensure that individuals and the individual's
284.20 identified supports can successfully navigate the array of services that impact the individual's
284.21 health and well-being;
- 284.22 (11) have capacity to assess an individual's readiness for change and the individual's
284.23 capacity to integrate new health care or community supports into the individual's life;
- 284.24 (12) offer or facilitate the provision of wellness and prevention education on
284.25 evidenced-based curriculums specific to the prevention and management of common chronic
284.26 conditions;
- 284.27 (13) help an individual set up and prepare for medical, behavioral health, social service,
284.28 or community support appointments, including accompanying the individual to appointments
284.29 as appropriate, and providing follow-up with the individual after these appointments;
- 284.30 (14) offer or facilitate the provision of health coaching related to chronic disease
284.31 management and how to navigate complex systems of care to the individual, the individual's
284.32 family, and identified supports;

285.1 (15) connect an individual, the individual's family, and identified supports to appropriate
285.2 support services that help the individual overcome access or service barriers, increase
285.3 self-sufficiency skills, and improve overall health;

285.4 (16) provide effective referrals and timely access to services; and

285.5 (17) establish a continuous quality improvement process for providing behavioral health
285.6 home services.

285.7 (b) The behavioral health home services provider must also create a plan, in partnership
285.8 with the individual and the individual's identified supports, to support the individual after
285.9 discharge from a hospital, residential treatment program, or other setting. The plan must
285.10 include protocols for:

285.11 (1) maintaining contact between the behavioral health home services team member, the
285.12 individual, and the individual's identified supports during and after discharge;

285.13 (2) linking the individual to new resources as needed;

285.14 (3) reestablishing the individual's existing services and community and social supports;
285.15 and

285.16 (4) following up with appropriate entities to transfer or obtain the individual's service
285.17 records as necessary for continued care.

285.18 (c) If the individual is enrolled in a managed care plan, a behavioral health home services
285.19 provider must:

285.20 (1) notify the behavioral health home services contact designated by the managed care
285.21 plan within 30 days of when the individual begins behavioral health home services; and

285.22 (2) adhere to the managed care plan communication and coordination requirements
285.23 described in the behavioral health home services manual.

285.24 (d) Before terminating behavioral health home services, the behavioral health home
285.25 services provider must:

285.26 (1) provide a 60-day notice of termination of behavioral health home services to all
285.27 individuals receiving behavioral health home services, the commissioner, and managed care
285.28 plans, if applicable; and

285.29 (2) refer individuals receiving behavioral health home services to a new behavioral
285.30 health home services provider.

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

286.1 Sec. 42. Minnesota Statutes 2023 Supplement, section 256D.01, subdivision 1a, is amended
286.2 to read:

286.3 Subd. 1a. **Standards.** (a) A principal objective in providing general assistance is to
286.4 provide for single adults, childless couples, or children as defined in section 256D.02,
286.5 subdivision 2b, ineligible for federal programs who are unable to provide for themselves.
286.6 The minimum standard of assistance determines the total amount of the general assistance
286.7 grant without separate standards for shelter, utilities, or other needs.

286.8 (b) The standard of assistance for an assistance unit consisting of a recipient who is
286.9 childless and unmarried or living apart from children and spouse and who does not live with
286.10 a parent or parents or a legal custodian, or consisting of a childless couple, is \$350 per month
286.11 effective October 1, 2024, and must be adjusted by a percentage equal to the change in the
286.12 consumer price index as of January 1 every year, beginning October 1, 2025.

286.13 (c) For an assistance unit consisting of a single adult who lives with a parent or parents,
286.14 the general assistance standard of assistance is \$350 per month effective October 1, 2023,
286.15 2024, and must be adjusted by a percentage equal to the change in the consumer price index
286.16 as of January 1 every year, beginning October 1, 2025. Benefits received by a responsible
286.17 relative of the assistance unit under the Supplemental Security Income program, a workers'
286.18 compensation program, the Minnesota supplemental aid program, or any other program
286.19 based on the responsible relative's disability, and any benefits received by a responsible
286.20 relative of the assistance unit under the Social Security retirement program, may not be
286.21 counted in the determination of eligibility or benefit level for the assistance unit. Except as
286.22 provided below, the assistance unit is ineligible for general assistance if the available
286.23 resources or the countable income of the assistance unit and the parent or parents with whom
286.24 the assistance unit lives are such that a family consisting of the assistance unit's parent or
286.25 parents, the parent or parents' other family members and the assistance unit as the only or
286.26 additional minor child would be financially ineligible for general assistance. For the purposes
286.27 of calculating the countable income of the assistance unit's parent or parents, the calculation
286.28 methods must follow the provisions under section 256P.06.

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

286.30 Sec. 43. Minnesota Statutes 2022, section 256I.04, subdivision 2f, is amended to read:

286.31 Subd. 2f. **Required services.** (a) In ~~licensed and registered~~ authorized settings under
286.32 subdivision 2a, providers shall ensure that participants have at a minimum:

286.33 (1) food preparation and service for three nutritional meals a day on site;

287.1 (2) a bed, clothing storage, linen, bedding, laundering, and laundry supplies or service;
287.2 (3) housekeeping, including cleaning and lavatory supplies or service; and
287.3 (4) maintenance and operation of the building and grounds, including heat, water, garbage
287.4 removal, electricity, telephone for the site, cooling, supplies, and parts and tools to repair
287.5 and maintain equipment and facilities.

287.6 (b) In addition, when providers serve participants described in subdivision 1, paragraph
287.7 (c), the providers are required to assist the participants in applying for continuing housing
287.8 support payments before the end of the eligibility period.

287.9 Sec. 44. Minnesota Statutes 2023 Supplement, section 256I.05, subdivision 1a, is amended
287.10 to read:

287.11 Subd. 1a. **Supplementary service rates.** (a) Subject to the provisions of section 256I.04,
287.12 subdivision 3, the agency may negotiate a payment not to exceed \$494.91 for other services
287.13 necessary to provide room and board if the residence is licensed by or registered by the
287.14 Department of Health, or licensed by the Department of Human Services to provide services
287.15 in addition to room and board, and if the provider of services is not also concurrently
287.16 receiving funding for services for a recipient in the residence under the following programs
287.17 or funding sources: (1) home and community-based waiver services under chapter 256S or
287.18 section 256B.0913, 256B.092, or 256B.49; (2) personal care assistance under section
287.19 256B.0659; (3) community first services and supports under section 256B.85; or (4) services
287.20 for adults with mental illness grants under section 245.73. If funding is available for other
287.21 necessary services through a home and community-based waiver under chapter 256S, or
287.22 section 256B.0913, 256B.092, or 256B.49; personal care assistance services under section
287.23 256B.0659; community first services and supports under section 256B.85; or services for
287.24 adults with mental illness grants under section 245.73, then the housing support rate is
287.25 limited to the rate set in subdivision 1. Unless otherwise provided in law, in no case may
287.26 the supplementary service rate exceed \$494.91. The registration and licensure requirement
287.27 does not apply to establishments which are exempt from state licensure because they are
287.28 located on Indian reservations and for which the tribe has prescribed health and safety
287.29 requirements. Service payments under this section may be prohibited under rules to prevent
287.30 the supplanting of federal funds with state funds.

287.31 ~~(b) The commissioner is authorized to make cost-neutral transfers from the housing~~
287.32 ~~support fund for beds under this section to other funding programs administered by the~~
287.33 ~~department after consultation with the agency in which the affected beds are located. The~~
287.34 ~~commissioner may also make cost-neutral transfers from the housing support fund to agencies~~

288.1 ~~for beds permanently removed from the housing support census under a plan submitted by~~
 288.2 ~~the agency and approved by the commissioner. The commissioner shall report the amount~~
 288.3 ~~of any transfers under this provision annually to the legislature.~~

288.4 ~~(e)~~ (b) Agencies must not negotiate supplementary service rates with providers of housing
 288.5 support that are licensed as board and lodging with special services and that do not encourage
 288.6 a policy of sobriety on their premises and make referrals to available community services
 288.7 for volunteer and employment opportunities for residents.

288.8 Sec. 45. Minnesota Statutes 2023 Supplement, section 256I.05, subdivision 11, is amended
 288.9 to read:

288.10 Subd. 11. ~~Transfer of emergency shelter funds~~ Cost-neutral transfers from the
 288.11 housing support fund. (a) The commissioner is authorized to make cost-neutral transfers
 288.12 from the housing support fund for beds under this section to other funding programs
 288.13 administered by the department after consultation with the agency in which the affected
 288.14 beds are located.

288.15 (b) The commissioner may also make cost-neutral transfers from the housing support
 288.16 fund to agencies for beds removed from the housing support census under a plan submitted
 288.17 by the agency and approved by the commissioner.

288.18 ~~(a)~~ (c) The commissioner shall make a cost-neutral transfer of funding from the housing
 288.19 support fund to the agency for emergency shelter beds removed from the housing support
 288.20 census under a ~~biennial~~ plan submitted by the agency and approved by the commissioner.
 288.21 Plans submitted under this paragraph must include anticipated and actual outcomes for
 288.22 persons experiencing homelessness in emergency shelters.

288.23 ~~The plan~~ (d) Plans submitted under paragraph (b) or (c) must describe: (1) anticipated
 288.24 ~~and actual outcomes for persons experiencing homelessness in emergency shelters;~~ (2)
 288.25 improved efficiencies in administration; ~~(3)~~ (2) requirements for individual eligibility; and
 288.26 ~~(4)~~ (3) plans for quality assurance monitoring and quality assurance outcomes. The
 288.27 commissioner shall review ~~the agency plan~~ plans to monitor implementation and outcomes
 288.28 at least biennially, and more frequently if the commissioner deems necessary.

288.29 ~~(b)~~ (e) Funding under paragraph ~~(a)~~ (b), (c), or (d) may be used for the provision
 288.30 of room and board or supplemental services according to section 256I.03, subdivisions 14a
 288.31 and 14b. Providers must meet the requirements of section 256I.04, subdivisions 2a to 2f.
 288.32 Funding must be allocated annually, and the room and board portion of the allocation shall
 288.33 be adjusted according to the percentage change in the housing support room and board rate.

289.1 ~~The room and board portion of the allocation shall be determined at the time of transfer.~~
289.2 The commissioner or agency may return beds to the housing support fund with 180 days'
289.3 notice, including financial reconciliation.

289.4 Sec. 46. Minnesota Statutes 2022, section 260E.33, subdivision 2, as amended by Laws
289.5 2024, chapter 80, article 8, section 44, is amended to read:

289.6 Subd. 2. **Request for reconsideration.** (a) Except as provided under subdivision 5, an
289.7 individual or facility that the commissioner of human services; commissioner of children,
289.8 youth, and families; a local welfare agency; or the commissioner of education determines
289.9 has maltreated a child, an interested person acting on behalf of the child, regardless of the
289.10 determination, who contests the investigating agency's final determination regarding
289.11 maltreatment may request the investigating agency to reconsider its final determination
289.12 regarding maltreatment. The request for reconsideration must be submitted in writing or
289.13 submitted in the provider licensing and reporting hub to the investigating agency within 15
289.14 calendar days after receipt of notice of the final determination regarding maltreatment or,
289.15 if the request is made by an interested person who is not entitled to notice, within 15 days
289.16 after receipt of the notice by the parent or guardian of the child. If mailed, the request for
289.17 reconsideration must be postmarked and sent to the investigating agency within 15 calendar
289.18 days of the individual's or facility's receipt of the final determination. If the request for
289.19 reconsideration is made by personal service, it must be received by the investigating agency
289.20 within 15 calendar days after the individual's or facility's receipt of the final determination.
289.21 Upon implementation of the provider licensing and reporting hub, the individual or facility
289.22 must use the hub to request reconsideration. The reconsideration must be received by the
289.23 commissioner within 15 calendar days of the individual's receipt of the notice of
289.24 disqualification.

289.25 (b) An individual who was determined to have maltreated a child under this chapter and
289.26 who was disqualified on the basis of serious or recurring maltreatment under sections
289.27 245C.14 and 245C.15 may request reconsideration of the maltreatment determination and
289.28 the disqualification. The request for reconsideration of the maltreatment determination and
289.29 the disqualification must be submitted within 30 calendar days of the individual's receipt
289.30 of the notice of disqualification under sections 245C.16 and 245C.17. If mailed, the request
289.31 for reconsideration of the maltreatment determination and the disqualification must be
289.32 postmarked and sent to the investigating agency within 30 calendar days of the individual's
289.33 receipt of the maltreatment determination and notice of disqualification. If the request for
289.34 reconsideration is made by personal service, it must be received by the investigating agency
289.35 within 30 calendar days after the individual's receipt of the notice of disqualification.

290.1 Sec. 47. Laws 2024, chapter 80, article 2, section 6, subdivision 2, is amended to read:

290.2 Subd. 2. **Change in ownership.** (a) If the commissioner determines that there is a change
290.3 in ownership, the commissioner shall require submission of a new license application. This
290.4 subdivision does not apply to a licensed program or service located in a home where the
290.5 license holder resides. A change in ownership occurs when:

290.6 (1) except as provided in paragraph (b), the license holder sells or transfers 100 percent
290.7 of the property, stock, or assets;

290.8 (2) the license holder merges with another organization;

290.9 (3) the license holder consolidates with two or more organizations, resulting in the
290.10 creation of a new organization;

290.11 (4) there is a change to the federal tax identification number associated with the license
290.12 holder; or

290.13 (5) except as provided in paragraph (b), all controlling individuals ~~associated with~~ for
290.14 the original ~~application~~ license have changed.

290.15 (b) ~~Notwithstanding~~ For changes under paragraph (a), clauses (1) and (5) clause (1) or
290.16 (5), no change in ownership has occurred and a new license application is not required if
290.17 at least one controlling individual has been listed affiliated as a controlling individual for
290.18 the license for at least the previous 12 months immediately preceding the change.

290.19 **EFFECTIVE DATE.** This section is effective January 1, 2025.

290.20 Sec. 48. Laws 2024, chapter 80, article 2, section 6, subdivision 3, is amended to read:

290.21 Subd. 3. **Standard change of ownership process.** (a) When a change in ownership is
290.22 proposed and the party intends to assume operation without an interruption in service longer
290.23 than 60 days after acquiring the program or service, the license holder must provide the
290.24 commissioner with written notice of the proposed change on a form provided by the
290.25 commissioner at least ~~60~~ 90 days before the anticipated date of the change in ownership.
290.26 For purposes of this ~~subdivision and subdivision 4~~ section, "party" means the party that
290.27 intends to operate the service or program.

290.28 (b) The party must submit a license application under this chapter on the form and in
290.29 the manner prescribed by the commissioner at least ~~30~~ 90 days before the change in
290.30 ownership is anticipated to be complete and must include documentation to support the
290.31 upcoming change. The party must comply with background study requirements under chapter
290.32 245C and shall pay the application fee required under section 245A.10.

291.1 (c) The commissioner may streamline application procedures when the party is an existing
291.2 license holder under this chapter and is acquiring a program licensed under this chapter or
291.3 service in the same service class as one or more licensed programs or services the party
291.4 operates and those licenses are in substantial compliance. For purposes of this subdivision,
291.5 "substantial compliance" means within the previous 12 months the commissioner did not
291.6 (1) issue a sanction under section 245A.07 against a license held by the party, or (2) make
291.7 a license held by the party conditional according to section 245A.06.

291.8 (d) ~~Except when a temporary change in ownership license is issued pursuant to~~
291.9 ~~subdivision 4~~ While the standard change of ownership process is pending, the existing
291.10 license holder ~~is solely~~ remains responsible for operating the program according to applicable
291.11 laws and rules until a license under this chapter is issued to the party.

291.12 (e) If a licensing inspection of the program or service was conducted within the previous
291.13 12 months and the existing license holder's license record demonstrates substantial
291.14 compliance with the applicable licensing requirements, the commissioner may waive the
291.15 party's inspection required by section 245A.04, subdivision 4. The party must submit to the
291.16 commissioner (1) proof that the premises was inspected by a fire marshal or that the fire
291.17 marshal deemed that an inspection was not warranted, and (2) proof that the premises was
291.18 inspected for compliance with the building code or that no inspection was deemed warranted.

291.19 (f) If the party is seeking a license for a program or service that has an outstanding action
291.20 under section 245A.06 or 245A.07, the party must submit a letter as part of the application
291.21 process identifying how the party has or will come into full compliance with the licensing
291.22 requirements.

291.23 (g) The commissioner shall evaluate the party's application according to section 245A.04,
291.24 subdivision 6. If the commissioner determines that the party has remedied or demonstrates
291.25 the ability to remedy the outstanding actions under section 245A.06 or 245A.07 and has
291.26 determined that the program otherwise complies with all applicable laws and rules, the
291.27 commissioner shall issue a license or conditional license under this chapter. A conditional
291.28 license issued under this section is final and not subject to reconsideration under section
291.29 142B.16, subdivision 4. The conditional license remains in effect until the commissioner
291.30 determines that the grounds for the action are corrected or no longer exist.

291.31 (h) The commissioner may deny an application as provided in section 245A.05. An
291.32 applicant whose application was denied by the commissioner may appeal the denial according
291.33 to section 245A.05.

292.1 (i) This subdivision does not apply to a licensed program or service located in a home
292.2 where the license holder resides.

292.3 **EFFECTIVE DATE.** This section is effective January 1, 2025.

292.4 Sec. 49. Laws 2024, chapter 80, article 2, section 6, is amended by adding a subdivision
292.5 to read:

292.6 **Subd. 3a. Emergency change in ownership process.** (a) In the event of a death of a
292.7 license holder or sole controlling individual or a court order or other event that results in
292.8 the license holder being inaccessible or unable to operate the program or service, a party
292.9 may submit a request to the commissioner to allow the party to assume operation of the
292.10 program or service under an emergency change in ownership process to ensure persons
292.11 continue to receive services while the commissioner evaluates the party's license application.

292.12 (b) To request the emergency change of ownership process, the party must immediately:

292.13 (1) notify the commissioner of the event resulting in the inability of the license holder
292.14 to operate the program and of the party's intent to assume operations; and

292.15 (2) provide the commissioner with documentation that demonstrates the party has a legal
292.16 or legitimate ownership interest in the program or service if applicable and is able to operate
292.17 the program or service.

292.18 (c) If the commissioner approves the party to continue operating the program or service
292.19 under an emergency change in ownership process, the party must:

292.20 (1) request to be added as a controlling individual or license holder to the existing license;

292.21 (2) notify persons receiving services of the emergency change in ownership in a manner
292.22 approved by the commissioner;

292.23 (3) submit an application for a new license within 30 days of approval;

292.24 (4) comply with the background study requirements under chapter 245C; and

292.25 (5) pay the application fee required under section 142B.12.

292.26 (d) While the emergency change of ownership process is pending, a party approved
292.27 under this subdivision is responsible for operating the program under the existing license
292.28 according to applicable laws and rules until a new license under this chapter is issued.

292.29 (e) The provisions in subdivision 3, paragraphs (c), (g), and (h), apply to this subdivision.

292.30 (f) Once a party is issued a new license or has decided not to seek a new license, the
292.31 commissioner must close the existing license.

293.1 (g) This subdivision applies to any program or service licensed under this chapter.

293.2 **EFFECTIVE DATE.** This section is effective January 1, 2025.

293.3 Sec. 50. Laws 2024, chapter 80, article 2, section 6, is amended by adding a subdivision
293.4 to read:

293.5 Subd. 5. **Failure to comply.** If the commissioner finds that the applicant or license holder
293.6 has not fully complied with this section, the commissioner may impose a licensing sanction
293.7 under section 142B.15, 142B.16, or 142B.18.

293.8 **EFFECTIVE DATE.** This section is effective January 1, 2025.

293.9 Sec. 51. Laws 2024, chapter 80, article 2, section 10, subdivision 1, is amended to read:

293.10 Subdivision 1. **Sanctions; appeals; license.** (a) In addition to making a license conditional
293.11 under section 142B.16, the commissioner may suspend or revoke the license, impose a fine,
293.12 or secure an injunction against the continuing operation of the program of a license holder
293.13 who:

293.14 (1) does not comply with applicable law or rule;

293.15 (2) has nondisqualifying background study information, as described in section 245C.05,
293.16 subdivision 4, that reflects on the license holder's ability to safely provide care to foster
293.17 children; or

293.18 (3) has an individual living in the household where the licensed services are provided
293.19 or is otherwise subject to a background study, and the individual has nondisqualifying
293.20 background study information, as described in section 245C.05, subdivision 4, that reflects
293.21 on the license holder's ability to safely provide care to foster children.

293.22 When applying sanctions authorized under this section, the commissioner shall consider
293.23 the nature, chronicity, or severity of the violation of law or rule and the effect of the violation
293.24 on the health, safety, or rights of persons served by the program.

293.25 (b) If a license holder appeals the suspension or revocation of a license and the license
293.26 holder continues to operate the program pending a final order on the appeal, the commissioner
293.27 shall issue the license holder a temporary provisional license. Unless otherwise specified
293.28 by the commissioner, variances in effect on the date of the license sanction under appeal
293.29 continue under the temporary provisional license. The commissioner may include terms the
293.30 license holder must follow pending a final order on the appeal. If a license holder fails to
293.31 comply with applicable law or rule while operating under a temporary provisional license,

294.1 the commissioner may impose additional sanctions under this section and section 142B.16
294.2 and may terminate any prior variance. If a temporary provisional license is set to expire, a
294.3 new temporary provisional license shall be issued to the license holder upon payment of
294.4 any fee required under section 142B.12. The temporary provisional license shall expire on
294.5 the date the final order is issued. If the license holder prevails on the appeal, a new
294.6 nonprovisional license shall be issued for the remainder of the current license period.

294.7 (c) If a license holder is under investigation and the license issued under this chapter is
294.8 due to expire before completion of the investigation, the program shall be issued a new
294.9 license upon completion of the reapplication requirements and payment of any applicable
294.10 license fee. Upon completion of the investigation, a licensing sanction may be imposed
294.11 against the new license under this section or section 142B.16 or 142B.20.

294.12 (d) Failure to reapply or closure of a license issued under this chapter by the license
294.13 holder prior to the completion of any investigation shall not preclude the commissioner
294.14 from issuing a licensing sanction under this section or section 142B.16 at the conclusion of
294.15 the investigation.

294.16 **EFFECTIVE DATE.** This section is effective January 1, 2025.

294.17 Sec. 52. **REVISOR INSTRUCTION.**

294.18 The revisor of statutes shall renumber Minnesota Statutes, section 256D.21, as Minnesota
294.19 Statutes, section 261.004.

294.20 Sec. 53. **REPEALER.**

294.21 (a) Minnesota Statutes 2022, sections 256D.19, subdivisions 1 and 2; 256D.20,
294.22 subdivisions 1, 2, 3, and 4; and 256D.23, subdivisions 1, 2, and 3, are repealed.

294.23 (b) Minnesota Statutes 2022, section 245C.125, is repealed.

294.24 (c) Minnesota Statutes 2023 Supplement, section 245C.08, subdivision 2, is repealed.

294.25 (d) Laws 2024, chapter 80, article 2, section 6, subdivision 4, is repealed.

294.26 **EFFECTIVE DATE.** Paragraph (a) is effective the day following final enactment.

ARTICLE 10

OFFICE OF EMERGENCY MEDICAL SERVICES

295.1
295.2
295.3 Section 1. Minnesota Statutes 2022, section 144E.001, is amended by adding a subdivision
295.4 to read:

295.5 Subd. 16. **Director.** "Director" means the director of the Office of Emergency Medical
295.6 Services.

295.7 **EFFECTIVE DATE.** This section is effective January 1, 2025.

295.8 Sec. 2. Minnesota Statutes 2022, section 144E.001, is amended by adding a subdivision
295.9 to read:

295.10 Subd. 17. **Office.** "Office" means the Office of Emergency Medical Services.

295.11 **EFFECTIVE DATE.** This section is effective January 1, 2025.

295.12 Sec. 3. **[144E.011] OFFICE OF EMERGENCY MEDICAL SERVICES.**

295.13 Subdivision 1. **Establishment.** The Office of Emergency Medical Services is established
295.14 with the powers and duties established in law. In administering this chapter, the office must
295.15 promote the public health and welfare, protect the safety of the public, and effectively
295.16 regulate and support the operation of the emergency medical services system in this state.

295.17 Subd. 2. **Director.** The governor must appoint a director for the office with the advice
295.18 and consent of the senate. The director must be in the unclassified service and must serve
295.19 at the pleasure of the governor. The salary of the director shall be determined according to
295.20 section 15A.0815. The director shall direct the activities of the office.

295.21 Subd. 3. **Powers and duties.** The director has the following powers and duties:

295.22 (1) to administer and enforce this chapter and adopt rules as needed to implement this
295.23 chapter. Rules for which notice is published in the State Register before July 1, 2026, may
295.24 be adopted using the expedited rulemaking process in section 14.389;

295.25 (2) to license ambulance services in the state and regulate their operation;

295.26 (3) to establish and modify primary service areas;

295.27 (4) to designate an ambulance service as authorized to provide service in a primary
295.28 service area and to remove an ambulance service's authorization to provide service in a
295.29 primary service area;

295.30 (5) to register medical response units in the state and regulate their operation;

296.1 (6) to certify emergency medical technicians, advanced emergency medical technicians,
296.2 community emergency medical technicians, paramedics, and community paramedics and
296.3 to register emergency medical responders;

296.4 (7) to approve education programs for ambulance service personnel and emergency
296.5 medical responders and to administer qualifications for instructors of education programs;

296.6 (8) to administer grant programs related to emergency medical services;

296.7 (9) to report to the legislature, by February 15 each year, on the work of the office and
296.8 the advisory councils in the previous calendar year and with recommendations for any
296.9 needed policy changes related to emergency medical services, including but not limited to
296.10 improving access to emergency medical services, improving service delivery by ambulance
296.11 services and medical response units, and improving the effectiveness of the state's emergency
296.12 medical services system. The director must develop the reports and recommendations in
296.13 consultation with the office's deputy directors and advisory councils;

296.14 (10) to investigate complaints against and hold hearings regarding ambulance services,
296.15 ambulance service personnel, and emergency medical responders and to impose disciplinary
296.16 action or otherwise resolve complaints; and

296.17 (11) to perform other duties related to the provision of emergency medical services in
296.18 the state.

296.19 Subd. 4. **Employees.** The director may employ personnel in the classified service and
296.20 unclassified personnel as necessary to carry out the duties of this chapter.

296.21 Subd. 5. **Work plan.** The director must prepare a work plan to guide the work of the
296.22 office. The work plan must be updated biennially.

296.23 **EFFECTIVE DATE.** This section is effective January 1, 2025.

296.24 Sec. 4. **[144E.015] MEDICAL SERVICES DIVISION.**

296.25 A Medical Services Division is created in the Office of Emergency Medical Services.
296.26 The Medical Services Division shall be under the supervision of a deputy director of medical
296.27 services appointed by the director. The deputy director of medical services must be a
296.28 physician licensed under chapter 147. The deputy director, under the direction of the director,
296.29 shall enforce and coordinate the laws, rules, and policies assigned by the director, which
296.30 may include overseeing the clinical aspects of prehospital medical care and education
296.31 programs for emergency medical service personnel.

296.32 **EFFECTIVE DATE.** This section is effective January 1, 2025.

297.1 **Sec. 5. [144E.016] AMBULANCE SERVICES DIVISION.**

297.2 An Ambulance Services Division is created in the Office of Emergency Medical Services.
297.3 The Ambulance Services Division shall be under the supervision of a deputy director of
297.4 ambulance services appointed by the director. The deputy director, under the direction of
297.5 the director, shall enforce and coordinate the laws, rules, and policies assigned by the director,
297.6 which may include operating standards and licensing of ambulance services; registration
297.7 and operation of medical response units; establishment and modification of primary service
297.8 areas; authorization of ambulance services to provide service in a primary service area and
297.9 revocation of such authorization; coordination of ambulance services within regions and
297.10 across the state; and administration of grants.

297.11 **EFFECTIVE DATE.** This section is effective January 1, 2025.

297.12 **Sec. 6. [144E.017] EMERGENCY MEDICAL SERVICE PROVIDERS DIVISION.**

297.13 An Emergency Medical Service Providers Division is created in the Office of Emergency
297.14 Medical Services. The Emergency Medical Service Providers Division shall be under the
297.15 supervision of a deputy director of emergency medical service providers appointed by the
297.16 director. The deputy director, under the direction of the director, shall enforce and coordinate
297.17 the laws, rules, and policies assigned by the director, which may include certification and
297.18 registration of individual emergency medical service providers; overseeing worker safety,
297.19 worker well-being, and working conditions; implementation of education programs; and
297.20 administration of grants.

297.21 **EFFECTIVE DATE.** This section is effective January 1, 2025.

297.22 **Sec. 7. [144E.03] EMERGENCY MEDICAL SERVICES ADVISORY COUNCIL.**

297.23 Subdivision 1. **Establishment; membership.** The Emergency Medical Services Advisory
297.24 Council is established and consists of the following members:

297.25 (1) one emergency medical technician currently practicing with a licensed ambulance
297.26 service, appointed by the Minnesota Ambulance Association;

297.27 (2) one paramedic currently practicing with a licensed ambulance service or a medical
297.28 response unit, appointed jointly by the Minnesota Professional Fire Fighters Association
297.29 and the Minnesota Ambulance Association;

297.30 (3) one medical director of a licensed ambulance service, appointed by the National
297.31 Association of EMS Physicians, Minnesota Chapter;

298.1 (4) one firefighter currently serving as an emergency medical responder, appointed by
298.2 the Minnesota State Fire Chiefs Association;

298.3 (5) one registered nurse who is certified or currently practicing as a flight nurse, appointed
298.4 jointly by the regional emergency services boards of the designated regional emergency
298.5 medical services systems;

298.6 (6) one hospital administrator, appointed by the Minnesota Hospital Association;

298.7 (7) one social worker, appointed by the Board of Social Work;

298.8 (8) one member of a federally recognized Tribal Nation in Minnesota, appointed by the
298.9 Minnesota Indian Affairs Council;

298.10 (9) three public members, appointed by the governor. At least one of the public members
298.11 must reside outside the metropolitan counties listed in section 473.121, subdivision 4;

298.12 (10) one member with experience working as an employee organization representative
298.13 representing emergency medical service providers, appointed by an employee organization
298.14 representing emergency medical service providers;

298.15 (11) one member representing a local government, appointed by the Coalition of Greater
298.16 Minnesota Cities;

298.17 (12) one member representing a local government in the seven-county metropolitan area,
298.18 appointed by the League of Minnesota Cities;

298.19 (13) two members of the house of representatives and two members of the senate,
298.20 appointed according to subdivision 2; and

298.21 (14) the commissioner of health and commissioner of public safety or their designees
298.22 as ex officio members.

298.23 Subd. 2. **Legislative members.** The speaker of the house and the house minority leader
298.24 must each appoint one member of the house of representatives to serve on the advisory
298.25 council. The senate majority leader and the senate minority leader must each appoint one
298.26 member of the senate to serve on the advisory council. Legislative members appointed under
298.27 this subdivision serve until successors are appointed. Legislative members may receive per
298.28 diem compensation and reimbursement for expenses according to the rules of their respective
298.29 bodies.

298.30 Subd. 3. **Terms, compensation, removal, vacancies, and expiration.** Compensation
298.31 and reimbursement for expenses for members appointed under subdivision 1, clauses (1)
298.32 to (12); removal of members; filling of vacancies of members; and, except for initial

299.1 appointments, membership terms are governed by section 15.059. Notwithstanding section
299.2 15.059, subdivision 6, the advisory council does not expire.

299.3 Subd. 4. **Officers; meetings.** (a) The advisory council must elect a chair and vice-chair
299.4 from among its membership and may elect other officers as the advisory council deems
299.5 necessary.

299.6 (b) The advisory council must meet quarterly or at the call of the chair.

299.7 (c) Meetings of the advisory council are subject to chapter 13D.

299.8 Subd. 5. **Duties.** The advisory council must review and make recommendations to the
299.9 director and the deputy director of ambulance services on the administration of this chapter;
299.10 the regulation of ambulance services and medical response units; the operation of the
299.11 emergency medical services system in the state; and other topics as directed by the director.

299.12 **EFFECTIVE DATE.** This section is effective January 1, 2025.

299.13 Sec. 8. **[144E.035] EMERGENCY MEDICAL SERVICES PHYSICIAN ADVISORY**
299.14 **COUNCIL.**

299.15 Subdivision 1. **Establishment; membership.** The Emergency Medical Services Physician
299.16 Advisory Council is established and consists of the following members:

299.17 (1) eight physicians who meet the qualifications for medical directors in section 144E.265,
299.18 subdivision 1, with one physician appointed by each of the regional emergency services
299.19 boards of the designated regional emergency medical services systems;

299.20 (2) one physician who meets the qualifications for medical directors in section 144E.265,
299.21 subdivision 1, appointed by the Minnesota State Fire Chiefs Association;

299.22 (3) one physician who is board-certified in pediatrics, appointed by the Minnesota
299.23 Emergency Medical Services for Children program; and

299.24 (4) the medical director member of the Emergency Medical Services Advisory Council
299.25 appointed under section 144E.03, subdivision 1, clause (3).

299.26 Subd. 2. **Terms, compensation, removal, vacancies, and expiration.** Compensation
299.27 and reimbursement for expenses, removal of members, filling of vacancies of members,
299.28 and, except for initial appointments, membership terms are governed by section 15.059.
299.29 Notwithstanding section 15.059, subdivision 6, the advisory council shall not expire.

299.30 Subd. 3. **Officers; meetings.** (a) The advisory council must elect a chair and vice-chair
299.31 from among its membership and may elect other officers as it deems necessary.

300.1 (b) The advisory council must meet twice per year or upon the call of the chair.

300.2 (c) Meetings of the advisory council are subject to chapter 13D.

300.3 Subd. 4. **Duties.** The advisory council must:

300.4 (1) review and make recommendations to the director and deputy director of medical
300.5 services on clinical aspects of prehospital medical care. In doing so, the advisory council
300.6 must incorporate information from medical literature, advances in bedside clinical practice,
300.7 and advisory council member experience; and

300.8 (2) serve as subject matter experts for the director and deputy director of medical services
300.9 on evolving topics in clinical medicine, including but not limited to infectious disease,
300.10 pharmaceutical and equipment shortages, and implementation of new therapeutics.

300.11 **EFFECTIVE DATE.** This section is effective January 1, 2025.

300.12 Sec. 9. **[144E.04] LABOR AND EMERGENCY MEDICAL SERVICE PROVIDERS**
300.13 **ADVISORY COUNCIL.**

300.14 Subdivision 1. **Establishment; membership.** The Labor and Emergency Medical Service
300.15 Providers Advisory Council is established and consists of the following members:

300.16 (1) one emergency medical service provider of any type from each of the designated
300.17 regional emergency medical services systems, appointed by their respective regional
300.18 emergency services boards;

300.19 (2) one emergency medical technician instructor, appointed by an employee organization
300.20 representing emergency medical service providers;

300.21 (3) two members with experience working as an employee organization representative
300.22 representing emergency medical service providers, appointed by an employee organization
300.23 representing emergency medical service providers;

300.24 (4) one emergency medical service provider based in a fire department, appointed jointly
300.25 by the Minnesota State Fire Chiefs Association and the Minnesota Professional Fire Fighters
300.26 Association; and

300.27 (5) one emergency medical service provider not based in a fire department, appointed
300.28 by the League of Minnesota Cities.

300.29 Subd. 2. **Terms, compensation, removal, vacancies, and expiration.** Compensation
300.30 and reimbursement for expenses for members appointed under subdivision 1; removal of
300.31 members; filling of vacancies of members; and, except for initial appointments, membership

301.1 terms are governed by section 15.059. Notwithstanding section 15.059, subdivision 6, the
301.2 Labor and Emergency Medical Service Providers Advisory Council does not expire.

301.3 Subd. 3. **Officers; meetings.** (a) The Labor and Emergency Medical Service Providers
301.4 Advisory Council must elect a chair and vice-chair from among its membership and may
301.5 elect other officers as the advisory council deems necessary.

301.6 (b) The Labor and Emergency Medical Service Providers Advisory Council must meet
301.7 quarterly or at the call of the chair.

301.8 (c) Meetings of the Labor and Emergency Medical Service Providers Advisory Council
301.9 are subject to chapter 13D.

301.10 Subd. 4. **Duties.** The Labor and Emergency Medical Service Providers Advisory Council
301.11 must review and make recommendations to the director and deputy director of emergency
301.12 medical service providers on the laws, rules, and policies assigned to the Emergency Medical
301.13 Service Providers Division and other topics as directed by the director.

301.14 **EFFECTIVE DATE.** This section is effective January 1, 2025.

301.15 Sec. 10. Minnesota Statutes 2022, section 144E.16, subdivision 5, is amended to read:

301.16 **Subd. 5. Local government's powers.** (a) Local units of government may, with the
301.17 approval of the ~~board~~ director, establish standards for ambulance services which impose
301.18 additional requirements upon such services. Local units of government intending to impose
301.19 additional requirements shall consider whether any benefit accruing to the public health
301.20 would outweigh the costs associated with the additional requirements.

301.21 (b) Local units of government that desire to impose additional requirements shall, prior
301.22 to adoption of relevant ordinances, rules, or regulations, furnish the ~~board~~ director with a
301.23 copy of the proposed ordinances, rules, or regulations, along with information that
301.24 affirmatively substantiates that the proposed ordinances, rules, or regulations:

301.25 (1) will in no way conflict with the relevant rules of the ~~board~~ office;

301.26 (2) will establish additional requirements tending to protect the public health;

301.27 (3) will not diminish public access to ambulance services of acceptable quality; and

301.28 (4) will not interfere with the orderly development of regional systems of emergency
301.29 medical care.

301.30 (c) The ~~board~~ director shall base any decision to approve or disapprove local standards
301.31 upon whether or not the local unit of government in question has affirmatively substantiated

302.1 that the proposed ordinances, rules, or regulations meet the criteria specified in paragraph
302.2 (b).

302.3 **EFFECTIVE DATE.** This section is effective January 1, 2025.

302.4 Sec. 11. Minnesota Statutes 2022, section 144E.19, subdivision 3, is amended to read:

302.5 Subd. 3. **Temporary suspension.** (a) In addition to any other remedy provided by law,
302.6 the ~~board~~ director may temporarily suspend the license of a licensee after conducting a
302.7 preliminary inquiry to determine whether the ~~board~~ director believes that the licensee has
302.8 violated a statute or rule that the ~~board~~ director is empowered to enforce and determining
302.9 that the continued provision of service by the licensee would create an imminent risk to
302.10 public health or harm to others.

302.11 (b) A temporary suspension order prohibiting a licensee from providing ambulance
302.12 service shall give notice of the right to a preliminary hearing according to paragraph (d)
302.13 and shall state the reasons for the entry of the temporary suspension order.

302.14 (c) Service of a temporary suspension order is effective when the order is served on the
302.15 licensee personally or by certified mail, which is complete upon receipt, refusal, or return
302.16 for nondelivery to the most recent address provided to the ~~board~~ director for the licensee.

302.17 (d) At the time the ~~board~~ director issues a temporary suspension order, the ~~board~~ director
302.18 shall schedule a hearing, ~~to be held before a group of its members designated by the board,~~
302.19 that shall begin within 60 days after issuance of the temporary suspension order or within
302.20 15 working days of the date of the ~~board's~~ director's receipt of a request for a hearing from
302.21 a licensee, whichever is sooner. The hearing shall be on the sole issue of whether there is
302.22 a reasonable basis to continue, modify, or lift the temporary suspension. A hearing under
302.23 this paragraph is not subject to chapter 14.

302.24 (e) Evidence presented by the ~~board~~ director or licensee may be in the form of an affidavit.
302.25 The licensee or the licensee's designee may appear for oral argument.

302.26 (f) Within five working days of the hearing, the ~~board~~ director shall issue its order and,
302.27 if the suspension is continued, notify the licensee of the right to a contested case hearing
302.28 under chapter 14.

302.29 (g) If a licensee requests a contested case hearing within 30 days after receiving notice
302.30 under paragraph (f), the ~~board~~ director shall initiate a contested case hearing according to
302.31 chapter 14. The administrative law judge shall issue a report and recommendation within
302.32 30 days after the closing of the contested case hearing record. The ~~board~~ director shall issue
302.33 a final order within 30 days after receipt of the administrative law judge's report.

303.1 **EFFECTIVE DATE.** This section is effective January 1, 2025.

303.2 Sec. 12. Minnesota Statutes 2022, section 144E.27, subdivision 5, is amended to read:

303.3 Subd. 5. **Denial, suspension, revocation.** (a) The ~~board~~ director may deny, suspend,
303.4 revoke, place conditions on, or refuse to renew the registration of an individual who the
303.5 ~~board~~ director determines:

303.6 (1) violates sections 144E.001 to 144E.33 or the rules adopted under those sections, an
303.7 agreement for corrective action, or an order that the ~~board~~ director issued or is otherwise
303.8 empowered to enforce;

303.9 (2) misrepresents or falsifies information on an application form for registration;

303.10 (3) is convicted or pleads guilty or nolo contendere to any felony; any gross misdemeanor
303.11 relating to assault, sexual misconduct, theft, or the illegal use of drugs or alcohol; or any
303.12 misdemeanor relating to assault, sexual misconduct, theft, or the illegal use of drugs or
303.13 alcohol;

303.14 (4) is actually or potentially unable to provide emergency medical services with
303.15 reasonable skill and safety to patients by reason of illness, use of alcohol, drugs, chemicals,
303.16 or any other material, or as a result of any mental or physical condition;

303.17 (5) engages in unethical conduct, including, but not limited to, conduct likely to deceive,
303.18 defraud, or harm the public, or demonstrating a willful or careless disregard for the health,
303.19 welfare, or safety of the public;

303.20 (6) maltreats or abandons a patient;

303.21 (7) violates any state or federal controlled substance law;

303.22 (8) engages in unprofessional conduct or any other conduct which has the potential for
303.23 causing harm to the public, including any departure from or failure to conform to the
303.24 minimum standards of acceptable and prevailing practice without actual injury having to
303.25 be established;

303.26 (9) provides emergency medical services under lapsed or nonrenewed credentials;

303.27 (10) is subject to a denial, corrective, disciplinary, or other similar action in another
303.28 jurisdiction or by another regulatory authority;

303.29 (11) engages in conduct with a patient that is sexual or may reasonably be interpreted
303.30 by the patient as sexual, or in any verbal behavior that is seductive or sexually demeaning
303.31 to a patient; ~~or~~

304.1 (12) makes a false statement or knowingly provides false information to the ~~board~~
304.2 director, or fails to cooperate with an investigation of the ~~board~~ director as required by
304.3 section 144E.30; or

304.4 (13) fails to engage with the health professionals services program or diversion program
304.5 required under section 144E.287 after being referred to the program, violates the terms of
304.6 the program participation agreement, or leaves the program except upon fulfilling the terms
304.7 for successful completion of the program as set forth in the participation agreement.

304.8 (b) Before taking action under paragraph (a), the ~~board~~ director shall give notice to an
304.9 individual of the right to a contested case hearing under chapter 14. If an individual requests
304.10 a contested case hearing within 30 days after receiving notice, the ~~board~~ director shall initiate
304.11 a contested case hearing according to chapter 14.

304.12 (c) The administrative law judge shall issue a report and recommendation within 30
304.13 days after closing the contested case hearing record. The ~~board~~ director shall issue a final
304.14 order within 30 days after receipt of the administrative law judge's report.

304.15 (d) After six months from the ~~board's~~ director's decision to deny, revoke, place conditions
304.16 on, or refuse renewal of an individual's registration for disciplinary action, the individual
304.17 shall have the opportunity to apply to the ~~board~~ director for reinstatement.

304.18 **EFFECTIVE DATE.** This section is effective January 1, 2025.

304.19 Sec. 13. Minnesota Statutes 2022, section 144E.28, subdivision 5, is amended to read:

304.20 Subd. 5. **Denial, suspension, revocation.** (a) The ~~board~~ director may deny certification
304.21 or take any action authorized in subdivision 4 against an individual who the ~~board~~ director
304.22 determines:

304.23 (1) violates sections 144E.001 to 144E.33 or the rules adopted under those sections, or
304.24 an order that the ~~board~~ director issued or is otherwise authorized or empowered to enforce,
304.25 or agreement for corrective action;

304.26 (2) misrepresents or falsifies information on an application form for certification;

304.27 (3) is convicted or pleads guilty or nolo contendere to any felony; any gross misdemeanor
304.28 relating to assault, sexual misconduct, theft, or the illegal use of drugs or alcohol; or any
304.29 misdemeanor relating to assault, sexual misconduct, theft, or the illegal use of drugs or
304.30 alcohol;

305.1 (4) is actually or potentially unable to provide emergency medical services with
305.2 reasonable skill and safety to patients by reason of illness, use of alcohol, drugs, chemicals,
305.3 or any other material, or as a result of any mental or physical condition;

305.4 (5) engages in unethical conduct, including, but not limited to, conduct likely to deceive,
305.5 defraud, or harm the public or demonstrating a willful or careless disregard for the health,
305.6 welfare, or safety of the public;

305.7 (6) maltreats or abandons a patient;

305.8 (7) violates any state or federal controlled substance law;

305.9 (8) engages in unprofessional conduct or any other conduct which has the potential for
305.10 causing harm to the public, including any departure from or failure to conform to the
305.11 minimum standards of acceptable and prevailing practice without actual injury having to
305.12 be established;

305.13 (9) provides emergency medical services under lapsed or nonrenewed credentials;

305.14 (10) is subject to a denial, corrective, disciplinary, or other similar action in another
305.15 jurisdiction or by another regulatory authority;

305.16 (11) engages in conduct with a patient that is sexual or may reasonably be interpreted
305.17 by the patient as sexual, or in any verbal behavior that is seductive or sexually demeaning
305.18 to a patient; ~~or~~

305.19 (12) makes a false statement or knowingly provides false information to the ~~board~~ director
305.20 or fails to cooperate with an investigation of the ~~board~~ director as required by section
305.21 144E.30; or

305.22 (13) fails to engage with the health professionals services program or diversion program
305.23 required under section 144E.287 after being referred to the program, violates the terms of
305.24 the program participation agreement, or leaves the program except upon fulfilling the terms
305.25 for successful completion of the program as set forth in the participation agreement.

305.26 (b) Before taking action under paragraph (a), the ~~board~~ director shall give notice to an
305.27 individual of the right to a contested case hearing under chapter 14. If an individual requests
305.28 a contested case hearing within 30 days after receiving notice, the ~~board~~ director shall initiate
305.29 a contested case hearing according to chapter 14 and no disciplinary action shall be taken
305.30 at that time.

306.1 (c) The administrative law judge shall issue a report and recommendation within 30
306.2 days after closing the contested case hearing record. The ~~board~~ director shall issue a final
306.3 order within 30 days after receipt of the administrative law judge's report.

306.4 (d) After six months from the ~~board's~~ director's decision to deny, revoke, place conditions
306.5 on, or refuse renewal of an individual's certification for disciplinary action, the individual
306.6 shall have the opportunity to apply to the ~~board~~ director for reinstatement.

306.7 **EFFECTIVE DATE.** This section is effective January 1, 2025.

306.8 Sec. 14. Minnesota Statutes 2022, section 144E.28, subdivision 6, is amended to read:

306.9 Subd. 6. **Temporary suspension.** (a) In addition to any other remedy provided by law,
306.10 the ~~board~~ director may temporarily suspend the certification of an individual after conducting
306.11 a preliminary inquiry to determine whether the ~~board~~ director believes that the individual
306.12 has violated a statute or rule that the ~~board~~ director is empowered to enforce and determining
306.13 that the continued provision of service by the individual would create an imminent risk to
306.14 public health or harm to others.

306.15 (b) A temporary suspension order prohibiting an individual from providing emergency
306.16 medical care shall give notice of the right to a preliminary hearing according to paragraph
306.17 (d) and shall state the reasons for the entry of the temporary suspension order.

306.18 (c) Service of a temporary suspension order is effective when the order is served on the
306.19 individual personally or by certified mail, which is complete upon receipt, refusal, or return
306.20 for nondelivery to the most recent address provided to the ~~board~~ director for the individual.

306.21 (d) At the time the ~~board~~ director issues a temporary suspension order, the ~~board~~ director
306.22 shall schedule a hearing, ~~to be held before a group of its members designated by the board,~~
306.23 that shall begin within 60 days after issuance of the temporary suspension order or within
306.24 15 working days of the date of the ~~board's~~ director's receipt of a request for a hearing from
306.25 the individual, whichever is sooner. The hearing shall be on the sole issue of whether there
306.26 is a reasonable basis to continue, modify, or lift the temporary suspension. A hearing under
306.27 this paragraph is not subject to chapter 14.

306.28 (e) Evidence presented by the ~~board~~ director or the individual may be in the form of an
306.29 affidavit. The individual or individual's designee may appear for oral argument.

306.30 (f) Within five working days of the hearing, the ~~board~~ director shall issue its order and,
306.31 if the suspension is continued, notify the individual of the right to a contested case hearing
306.32 under chapter 14.

307.1 (g) If an individual requests a contested case hearing within 30 days of receiving notice
307.2 under paragraph (f), the ~~board~~ director shall initiate a contested case hearing according to
307.3 chapter 14. The administrative law judge shall issue a report and recommendation within
307.4 30 days after the closing of the contested case hearing record. The ~~board~~ director shall issue
307.5 a final order within 30 days after receipt of the administrative law judge's report.

307.6 **EFFECTIVE DATE.** This section is effective January 1, 2025.

307.7 Sec. 15. Minnesota Statutes 2022, section 144E.285, subdivision 6, is amended to read:

307.8 Subd. 6. **Temporary suspension.** (a) In addition to any other remedy provided by law,
307.9 the ~~board~~ director may temporarily suspend approval of the education program after
307.10 conducting a preliminary inquiry to determine whether the ~~board~~ director believes that the
307.11 education program has violated a statute or rule that the ~~board~~ director is empowered to
307.12 enforce and determining that the continued provision of service by the education program
307.13 would create an imminent risk to public health or harm to others.

307.14 (b) A temporary suspension order prohibiting the education program from providing
307.15 emergency medical care training shall give notice of the right to a preliminary hearing
307.16 according to paragraph (d) and shall state the reasons for the entry of the temporary
307.17 suspension order.

307.18 (c) Service of a temporary suspension order is effective when the order is served on the
307.19 education program personally or by certified mail, which is complete upon receipt, refusal,
307.20 or return for nondelivery to the most recent address provided to the ~~board~~ director for the
307.21 education program.

307.22 (d) At the time the ~~board~~ director issues a temporary suspension order, the ~~board~~ director
307.23 shall schedule a hearing, ~~to be held before a group of its members designated by the board,~~
307.24 that shall begin within 60 days after issuance of the temporary suspension order or within
307.25 15 working days of the date of the ~~board's~~ director's receipt of a request for a hearing from
307.26 the education program, whichever is sooner. The hearing shall be on the sole issue of whether
307.27 there is a reasonable basis to continue, modify, or lift the temporary suspension. A hearing
307.28 under this paragraph is not subject to chapter 14.

307.29 (e) Evidence presented by the ~~board~~ director or the individual may be in the form of an
307.30 affidavit. The education program or counsel of record may appear for oral argument.

307.31 (f) Within five working days of the hearing, the ~~board~~ director shall issue its order and,
307.32 if the suspension is continued, notify the education program of the right to a contested case
307.33 hearing under chapter 14.

308.1 (g) If an education program requests a contested case hearing within 30 days of receiving
308.2 notice under paragraph (f), the ~~board~~ director shall initiate a contested case hearing according
308.3 to chapter 14. The administrative law judge shall issue a report and recommendation within
308.4 30 days after the closing of the contested case hearing record. The ~~board~~ director shall issue
308.5 a final order within 30 days after receipt of the administrative law judge's report.

308.6 **EFFECTIVE DATE.** This section is effective January 1, 2025.

308.7 Sec. 16. Minnesota Statutes 2022, section 144E.287, is amended to read:

308.8 **144E.287 DIVERSION PROGRAM.**

308.9 The ~~board~~ director shall either conduct a health professionals ~~service~~ services program
308.10 ~~under sections 214.31 to 214.37~~ or contract for a diversion program ~~under section 214.28~~
308.11 for professionals regulated ~~by the board~~ under this chapter who are unable to perform their
308.12 duties with reasonable skill and safety by reason of illness, use of alcohol, drugs, chemicals,
308.13 or any other materials, or as a result of any mental, physical, or psychological condition.

308.14 **EFFECTIVE DATE.** This section is effective January 1, 2025.

308.15 Sec. 17. Minnesota Statutes 2022, section 144E.305, subdivision 3, is amended to read:

308.16 Subd. 3. **Immunity.** (a) An individual, licensee, health care facility, business, or
308.17 organization is immune from civil liability or criminal prosecution for submitting in good
308.18 faith a report to the ~~board~~ director under subdivision 1 or 2 or for otherwise reporting in
308.19 good faith to the ~~board~~ director violations or alleged violations of sections 144E.001 to
308.20 144E.33. Reports are classified as confidential data on individuals or protected nonpublic
308.21 data under section 13.02 while an investigation is active. Except for the ~~board's~~ director's
308.22 final determination, all communications or information received by or disclosed to the ~~board~~
308.23 director relating to disciplinary matters of any person or entity subject to the ~~board's~~ director's
308.24 regulatory jurisdiction are confidential and privileged and any disciplinary hearing shall be
308.25 closed to the public.

308.26 (b) ~~Members of the board~~ The director, persons employed by the ~~board~~ director, persons
308.27 engaged in the investigation of violations and in the preparation and management of charges
308.28 of violations of sections 144E.001 to 144E.33 on behalf of the ~~board~~ director, and persons
308.29 participating in the investigation regarding charges of violations are immune from civil
308.30 liability and criminal prosecution for any actions, transactions, or publications, made in
308.31 good faith, in the execution of, or relating to, their duties under sections 144E.001 to 144E.33.

309.1 ~~(e) For purposes of this section, a member of the board is considered a state employee~~
309.2 ~~under section 3.736, subdivision 9.~~

309.3 **EFFECTIVE DATE.** This section is effective January 1, 2025.

309.4 Sec. 18. **INITIAL MEMBERS AND FIRST MEETING; EMERGENCY MEDICAL**
309.5 **SERVICES ADVISORY COUNCIL.**

309.6 (a) Initial appointments of members to the Emergency Medical Services Advisory
309.7 Council must be made by January 1, 2025. The terms of initial appointees shall be determined
309.8 by lot by the secretary of state and shall be as follows:

309.9 (1) eight members shall serve two-year terms; and

309.10 (2) eight members shall serve three-year terms.

309.11 (b) The medical director appointee must convene the first meeting of the Emergency
309.12 Medical Services Advisory Council by February 1, 2025.

309.13 Sec. 19. **INITIAL MEMBERS AND FIRST MEETING; EMERGENCY MEDICAL**
309.14 **SERVICES PHYSICIAN ADVISORY COUNCIL.**

309.15 (a) Initial appointments of members to the Emergency Medical Services Physician
309.16 Advisory Council must be made by January 1, 2025. The terms of initial appointees shall
309.17 be determined by lot by the secretary of state and shall be as follows:

309.18 (1) five members shall serve two-year terms;

309.19 (2) five members shall serve three-year terms; and

309.20 (3) the term for the medical director appointee to the Emergency Medical Services
309.21 Physician Advisory Council shall coincide with that member's term on the Emergency
309.22 Medical Services Advisory Council.

309.23 (b) The medical director appointee must convene the first meeting of the Emergency
309.24 Medical Services Physician Advisory Council by February 1, 2025.

309.25 Sec. 20. **INITIAL MEMBERS AND FIRST MEETING; LABOR AND EMERGENCY**
309.26 **MEDICAL SERVICE PROVIDERS ADVISORY COUNCIL.**

309.27 (a) Initial appointments of members to the Labor and Emergency Medical Service
309.28 Providers Advisory Council must be made by January 1, 2025. The terms of initial appointees
309.29 shall be determined by lot by the secretary of state and shall be as follows:

309.30 (1) six members shall serve two-year terms; and

310.1 (2) seven members shall serve three-year terms.

310.2 (b) The emergency medical technician instructor appointee must convene the first meeting
310.3 of the Labor and Emergency Medical Service Providers Advisory Council by February 1,
310.4 2025.

310.5 Sec. 21. **TRANSITION.**

310.6 Subdivision 1. **Appointment of director; operation of office.** No later than October
310.7 1, 2024, the governor shall appoint a director-designee of the Office of Emergency Medical
310.8 Services. The individual appointed as the director-designee of the Office of Emergency
310.9 Medical Services shall become the governor's appointee as director of the Office of
310.10 Emergency Medical Services on January 1, 2025. Effective January 1, 2025, the
310.11 responsibilities to regulate emergency medical services in the state under Minnesota Statutes,
310.12 chapter 144E, and Minnesota Rules, chapter 4690, are transferred from the Emergency
310.13 Medical Services Regulatory Board to the Office of Emergency Medical Services and the
310.14 director of the Office of Emergency Medical Services.

310.15 Subd. 2. **Transfer of responsibilities.** Minnesota Statutes, section 15.039, applies to
310.16 the transfer of responsibilities from the Emergency Medical Services Regulatory Board to
310.17 the Office of Emergency Medical Services required by this act. The commissioner of
310.18 administration, with the approval of the governor, may issue reorganization orders under
310.19 Minnesota Statutes, section 16B.37, as necessary to carry out the transfer of responsibilities
310.20 required by this act. The provision of Minnesota Statutes, section 16B.37, subdivision 1,
310.21 which states that transfers under that section may be made only to an agency that has been
310.22 in existence for at least one year, does not apply to transfers in this act to the Office of
310.23 Emergency Medical Services.

310.24 Sec. 22. **REVISOR INSTRUCTION.**

310.25 (a) In Minnesota Statutes, chapter 144E, the revisor of statutes shall replace "board"
310.26 with "director"; "board's" with "director's"; "Emergency Medical Services Regulatory Board"
310.27 or "Minnesota Emergency Medical Services Regulatory Board" with "director"; and
310.28 "board-approved" with "director-approved," except that:

310.29 (1) in Minnesota Statutes, section 144E.11, the revisor of statutes shall not modify the
310.30 term "county board," "community health board," or "community health boards";

311.1 (2) in Minnesota Statutes, sections 144E.40, subdivision 2; 144E.42, subdivision 2;
311.2 144E.44; and 144E.45, subdivision 2, the revisor of statutes shall not modify the term "State
311.3 Board of Investment"; and

311.4 (3) in Minnesota Statutes, sections 144E.50 and 144E.52, the revisor of statutes shall
311.5 not modify the term "regional emergency medical services board," "regional board," "regional
311.6 emergency medical services board's," or "regional boards."

311.7 (b) In the following sections of Minnesota Statutes, the revisor of statutes shall replace
311.8 "Emergency Medical Services Regulatory Board" with "director of the Office of Emergency
311.9 Medical Services": sections 13.717, subdivision 10; 62J.49, subdivision 2; 144.604; 144.608;
311.10 147.09; 156.12, subdivision 2; 169.686, subdivision 3; and 299A.41, subdivision 4.

311.11 (c) In the following sections of Minnesota Statutes, the revisor of statutes shall replace
311.12 "Emergency Medical Services Regulatory Board" with "Office of Emergency Medical
311.13 Services": sections 144.603 and 161.045, subdivision 3.

311.14 (d) In making the changes specified in this section, the revisor of statutes may make
311.15 technical and other necessary changes to sentence structure to preserve the meaning of the
311.16 text.

311.17 Sec. 23. **REPEALER.**

311.18 Minnesota Statutes 2022, sections 144E.001, subdivision 5; 144E.01; 144E.123,
311.19 subdivision 5; and 144E.50, subdivision 3, are repealed.

311.20 **EFFECTIVE DATE.** This section is effective January 1, 2025.

311.21 **ARTICLE 11**

311.22 **EMERGENCY MEDICAL SERVICES CONFORMING CHANGES**

311.23 Section 1. Minnesota Statutes 2023 Supplement, section 15A.0815, subdivision 2, is
311.24 amended to read:

311.25 Subd. 2. **Agency head salaries.** The salary for a position listed in this subdivision shall
311.26 be determined by the Compensation Council under section 15A.082. The commissioner of
311.27 management and budget must publish the salaries on the department's website. This
311.28 subdivision applies to the following positions:

311.29 Commissioner of administration;

311.30 Commissioner of agriculture;

311.31 Commissioner of education;

- 312.1 Commissioner of children, youth, and families;
- 312.2 Commissioner of commerce;
- 312.3 Commissioner of corrections;
- 312.4 Commissioner of health;
- 312.5 Commissioner, Minnesota Office of Higher Education;
- 312.6 Commissioner, Minnesota IT Services;
- 312.7 Commissioner, Housing Finance Agency;
- 312.8 Commissioner of human rights;
- 312.9 Commissioner of human services;
- 312.10 Commissioner of labor and industry;
- 312.11 Commissioner of management and budget;
- 312.12 Commissioner of natural resources;
- 312.13 Commissioner, Pollution Control Agency;
- 312.14 Commissioner of public safety;
- 312.15 Commissioner of revenue;
- 312.16 Commissioner of employment and economic development;
- 312.17 Commissioner of transportation;
- 312.18 Commissioner of veterans affairs;
- 312.19 Executive director of the Gambling Control Board;
- 312.20 Executive director of the Minnesota State Lottery;
- 312.21 Commissioner of Iron Range resources and rehabilitation;
- 312.22 Commissioner, Bureau of Mediation Services;
- 312.23 Ombudsman for mental health and developmental disabilities;
- 312.24 Ombudsperson for corrections;
- 312.25 Chair, Metropolitan Council;
- 312.26 Chair, Metropolitan Airports Commission;
- 312.27 School trust lands director;

313.1 Executive director of pari-mutuel racing; ~~and~~
 313.2 Commissioner, Public Utilities Commission; and
 313.3 Director of the Office of Emergency Medical Services.

313.4 **EFFECTIVE DATE.** This section is effective January 1, 2025.

313.5 Sec. 2. Minnesota Statutes 2023 Supplement, section 43A.08, subdivision 1a, is amended
 313.6 to read:

313.7 Subd. 1a. **Additional unclassified positions.** Appointing authorities for the following
 313.8 agencies may designate additional unclassified positions according to this subdivision: the
 313.9 Departments of Administration; Agriculture; Children, Youth, and Families; Commerce;
 313.10 Corrections; Direct Care and Treatment; Education; Employment and Economic
 313.11 Development; Explore Minnesota Tourism; Management and Budget; Health; Human
 313.12 Rights; Human Services; Labor and Industry; Natural Resources; Public Safety; Revenue;
 313.13 Transportation; and Veterans Affairs; the Housing Finance and Pollution Control Agencies;
 313.14 the State Lottery; the State Board of Investment; the Office of Administrative Hearings; the
 313.15 Department of Information Technology Services; the Offices of the Attorney General,
 313.16 Secretary of State, and State Auditor; the Minnesota State Colleges and Universities; the
 313.17 Minnesota Office of Higher Education; the Perpich Center for Arts Education; ~~and~~ the
 313.18 Minnesota Zoological Board; and the Office of Emergency Medical Services.

313.19 A position designated by an appointing authority according to this subdivision must
 313.20 meet the following standards and criteria:

313.21 (1) the designation of the position would not be contrary to other law relating specifically
 313.22 to that agency;

313.23 (2) the person occupying the position would report directly to the agency head or deputy
 313.24 agency head and would be designated as part of the agency head's management team;

313.25 (3) the duties of the position would involve significant discretion and substantial
 313.26 involvement in the development, interpretation, and implementation of agency policy;

313.27 (4) the duties of the position would not require primarily personnel, accounting, or other
 313.28 technical expertise where continuity in the position would be important;

313.29 (5) there would be a need for the person occupying the position to be accountable to,
 313.30 loyal to, and compatible with, the governor and the agency head, the employing statutory
 313.31 board or commission, or the employing constitutional officer;

314.1 (6) the position would be at the level of division or bureau director or assistant to the
314.2 agency head; and

314.3 (7) the commissioner has approved the designation as being consistent with the standards
314.4 and criteria in this subdivision.

314.5 **EFFECTIVE DATE.** This section is effective January 1, 2025.

314.6 Sec. 3. Minnesota Statutes 2022, section 62J.49, subdivision 1, is amended to read:

314.7 Subdivision 1. **Establishment.** The director of the Office of Emergency Medical Services
314.8 ~~Regulatory Board~~ established under chapter ~~144~~ 144E shall establish a financial data
314.9 collection system for all ambulance services licensed in this state. To establish the financial
314.10 database, the ~~Emergency Medical Services Regulatory Board~~ director may contract with
314.11 an entity that has experience in ambulance service financial data collection.

314.12 **EFFECTIVE DATE.** This section is effective January 1, 2025.

314.13 Sec. 4. Minnesota Statutes 2023 Supplement, section 152.126, subdivision 6, is amended
314.14 to read:

314.15 Subd. 6. **Access to reporting system data.** (a) Except as indicated in this subdivision,
314.16 the data submitted to the board under subdivision 4 is private data on individuals as defined
314.17 in section 13.02, subdivision 12, and not subject to public disclosure.

314.18 (b) Except as specified in subdivision 5, the following persons shall be considered
314.19 permissible users and may access the data submitted under subdivision 4 in the same or
314.20 similar manner, and for the same or similar purposes, as those persons who are authorized
314.21 to access similar private data on individuals under federal and state law:

314.22 (1) a prescriber or an agent or employee of the prescriber to whom the prescriber has
314.23 delegated the task of accessing the data, to the extent the information relates specifically to
314.24 a current patient, to whom the prescriber is:

314.25 (i) prescribing or considering prescribing any controlled substance;

314.26 (ii) providing emergency medical treatment for which access to the data may be necessary;

314.27 (iii) providing care, and the prescriber has reason to believe, based on clinically valid
314.28 indications, that the patient is potentially abusing a controlled substance; or

314.29 (iv) providing other medical treatment for which access to the data may be necessary
314.30 for a clinically valid purpose and the patient has consented to access to the submitted data,

315.1 and with the provision that the prescriber remains responsible for the use or misuse of data
315.2 accessed by a delegated agent or employee;

315.3 (2) a dispenser or an agent or employee of the dispenser to whom the dispenser has
315.4 delegated the task of accessing the data, to the extent the information relates specifically to
315.5 a current patient to whom that dispenser is dispensing or considering dispensing any
315.6 controlled substance and with the provision that the dispenser remains responsible for the
315.7 use or misuse of data accessed by a delegated agent or employee;

315.8 (3) a licensed dispensing practitioner or licensed pharmacist to the extent necessary to
315.9 determine whether corrections made to the data reported under subdivision 4 are accurate;

315.10 (4) a licensed pharmacist who is providing pharmaceutical care for which access to the
315.11 data may be necessary to the extent that the information relates specifically to a current
315.12 patient for whom the pharmacist is providing pharmaceutical care: (i) if the patient has
315.13 consented to access to the submitted data; or (ii) if the pharmacist is consulted by a prescriber
315.14 who is requesting data in accordance with clause (1);

315.15 (5) an individual who is the recipient of a controlled substance prescription for which
315.16 data was submitted under subdivision 4, or a guardian of the individual, parent or guardian
315.17 of a minor, or health care agent of the individual acting under a health care directive under
315.18 chapter 145C. For purposes of this clause, access by individuals includes persons in the
315.19 definition of an individual under section 13.02;

315.20 (6) personnel or designees of a health-related licensing board listed in section 214.01,
315.21 subdivision 2, or of the Office of Emergency Medical Services Regulatory Board, assigned
315.22 to conduct a bona fide investigation of a complaint received by that board or office that
315.23 alleges that a specific licensee is impaired by use of a drug for which data is collected under
315.24 subdivision 4, has engaged in activity that would constitute a crime as defined in section
315.25 152.025, or has engaged in the behavior specified in subdivision 5, paragraph (a);

315.26 (7) personnel of the board engaged in the collection, review, and analysis of controlled
315.27 substance prescription information as part of the assigned duties and responsibilities under
315.28 this section;

315.29 (8) authorized personnel under contract with the board, or under contract with the state
315.30 of Minnesota and approved by the board, who are engaged in the design, evaluation,
315.31 implementation, operation, or maintenance of the prescription monitoring program as part
315.32 of the assigned duties and responsibilities of their employment, provided that access to data
315.33 is limited to the minimum amount necessary to carry out such duties and responsibilities,

316.1 and subject to the requirement of de-identification and time limit on retention of data specified
316.2 in subdivision 5, paragraphs (d) and (e);

316.3 (9) federal, state, and local law enforcement authorities acting pursuant to a valid search
316.4 warrant;

316.5 (10) personnel of the Minnesota health care programs assigned to use the data collected
316.6 under this section to identify and manage recipients whose usage of controlled substances
316.7 may warrant restriction to a single primary care provider, a single outpatient pharmacy, and
316.8 a single hospital;

316.9 (11) personnel of the Department of Human Services assigned to access the data pursuant
316.10 to paragraph (k);

316.11 (12) personnel of the health professionals services program established under section
316.12 214.31, to the extent that the information relates specifically to an individual who is currently
316.13 enrolled in and being monitored by the program, and the individual consents to access to
316.14 that information. The health professionals services program personnel shall not provide this
316.15 data to a health-related licensing board ~~or the Emergency Medical Services Regulatory~~
316.16 ~~Board~~, except as permitted under section 214.33, subdivision 3;

316.17 (13) personnel or designees of a health-related licensing board other than the Board of
316.18 Pharmacy listed in section 214.01, subdivision 2, assigned to conduct a bona fide
316.19 investigation of a complaint received by that board that alleges that a specific licensee is
316.20 inappropriately prescribing controlled substances as defined in this section. For the purposes
316.21 of this clause, the health-related licensing board may also obtain utilization data; and

316.22 (14) personnel of the board specifically assigned to conduct a bona fide investigation
316.23 of a specific licensee or registrant. For the purposes of this clause, the board may also obtain
316.24 utilization data.

316.25 (c) By July 1, 2017, every prescriber licensed by a health-related licensing board listed
316.26 in section 214.01, subdivision 2, practicing within this state who is authorized to prescribe
316.27 controlled substances for humans and who holds a current registration issued by the federal
316.28 Drug Enforcement Administration, and every pharmacist licensed by the board and practicing
316.29 within the state, shall register and maintain a user account with the prescription monitoring
316.30 program. Data submitted by a prescriber, pharmacist, or their delegate during the registration
316.31 application process, other than their name, license number, and license type, is classified
316.32 as private pursuant to section 13.02, subdivision 12.

317.1 (d) Notwithstanding paragraph (b), beginning January 1, 2021, a prescriber or an agent
317.2 or employee of the prescriber to whom the prescriber has delegated the task of accessing
317.3 the data, must access the data submitted under subdivision 4 to the extent the information
317.4 relates specifically to the patient:

317.5 (1) before the prescriber issues an initial prescription order for a Schedules II through
317.6 IV opiate controlled substance to the patient; and

317.7 (2) at least once every three months for patients receiving an opiate for treatment of
317.8 chronic pain or participating in medically assisted treatment for an opioid addiction.

317.9 (e) Paragraph (d) does not apply if:

317.10 (1) the patient is receiving palliative care, or hospice or other end-of-life care;

317.11 (2) the patient is being treated for pain due to cancer or the treatment of cancer;

317.12 (3) the prescription order is for a number of doses that is intended to last the patient five
317.13 days or less and is not subject to a refill;

317.14 (4) the prescriber and patient have a current or ongoing provider/patient relationship of
317.15 a duration longer than one year;

317.16 (5) the prescription order is issued within 14 days following surgery or three days
317.17 following oral surgery or follows the prescribing protocols established under the opioid
317.18 prescribing improvement program under section 256B.0638;

317.19 (6) the controlled substance is prescribed or administered to a patient who is admitted
317.20 to an inpatient hospital;

317.21 (7) the controlled substance is lawfully administered by injection, ingestion, or any other
317.22 means to the patient by the prescriber, a pharmacist, or by the patient at the direction of a
317.23 prescriber and in the presence of the prescriber or pharmacist;

317.24 (8) due to a medical emergency, it is not possible for the prescriber to review the data
317.25 before the prescriber issues the prescription order for the patient; or

317.26 (9) the prescriber is unable to access the data due to operational or other technological
317.27 failure of the program so long as the prescriber reports the failure to the board.

317.28 (f) Only permissible users identified in paragraph (b), clauses (1), (2), (3), (4), (7), (8),
317.29 (10), and (11), may directly access the data electronically. No other permissible users may
317.30 directly access the data electronically. If the data is directly accessed electronically, the
317.31 permissible user shall implement and maintain a comprehensive information security program
317.32 that contains administrative, technical, and physical safeguards that are appropriate to the

318.1 user's size and complexity, and the sensitivity of the personal information obtained. The
318.2 permissible user shall identify reasonably foreseeable internal and external risks to the
318.3 security, confidentiality, and integrity of personal information that could result in the
318.4 unauthorized disclosure, misuse, or other compromise of the information and assess the
318.5 sufficiency of any safeguards in place to control the risks.

318.6 (g) The board shall not release data submitted under subdivision 4 unless it is provided
318.7 with evidence, satisfactory to the board, that the person requesting the information is entitled
318.8 to receive the data.

318.9 (h) The board shall maintain a log of all persons who access the data for a period of at
318.10 least three years and shall ensure that any permissible user complies with paragraph (c)
318.11 prior to attaining direct access to the data.

318.12 (i) Section 13.05, subdivision 6, shall apply to any contract the board enters into pursuant
318.13 to subdivision 2. A vendor shall not use data collected under this section for any purpose
318.14 not specified in this section.

318.15 (j) The board may participate in an interstate prescription monitoring program data
318.16 exchange system provided that permissible users in other states have access to the data only
318.17 as allowed under this section, and that section 13.05, subdivision 6, applies to any contract
318.18 or memorandum of understanding that the board enters into under this paragraph.

318.19 (k) With available appropriations, the commissioner of human services shall establish
318.20 and implement a system through which the Department of Human Services shall routinely
318.21 access the data for the purpose of determining whether any client enrolled in an opioid
318.22 treatment program licensed according to chapter 245A has been prescribed or dispensed a
318.23 controlled substance in addition to that administered or dispensed by the opioid treatment
318.24 program. When the commissioner determines there have been multiple prescribers or multiple
318.25 prescriptions of controlled substances, the commissioner shall:

318.26 (1) inform the medical director of the opioid treatment program only that the
318.27 commissioner determined the existence of multiple prescribers or multiple prescriptions of
318.28 controlled substances; and

318.29 (2) direct the medical director of the opioid treatment program to access the data directly,
318.30 review the effect of the multiple prescribers or multiple prescriptions, and document the
318.31 review.

319.1 If determined necessary, the commissioner of human services shall seek a federal waiver
319.2 of, or exception to, any applicable provision of Code of Federal Regulations, title 42, section
319.3 2.34, paragraph (c), prior to implementing this paragraph.

319.4 (l) The board shall review the data submitted under subdivision 4 on at least a quarterly
319.5 basis and shall establish criteria, in consultation with the advisory task force, for referring
319.6 information about a patient to prescribers and dispensers who prescribed or dispensed the
319.7 prescriptions in question if the criteria are met.

319.8 (m) The board shall conduct random audits, on at least a quarterly basis, of electronic
319.9 access by permissible users, as identified in paragraph (b), clauses (1), (2), (3), (4), (7), (8),
319.10 (10), and (11), to the data in subdivision 4, to ensure compliance with permissible use as
319.11 defined in this section. A permissible user whose account has been selected for a random
319.12 audit shall respond to an inquiry by the board, no later than 30 days after receipt of notice
319.13 that an audit is being conducted. Failure to respond may result in deactivation of access to
319.14 the electronic system and referral to the appropriate health licensing board, or the
319.15 commissioner of human services, for further action. The board shall report the results of
319.16 random audits to the chairs and ranking minority members of the legislative committees
319.17 with jurisdiction over health and human services policy and finance and government data
319.18 practices.

319.19 (n) A permissible user who has delegated the task of accessing the data in subdivision
319.20 4 to an agent or employee shall audit the use of the electronic system by delegated agents
319.21 or employees on at least a quarterly basis to ensure compliance with permissible use as
319.22 defined in this section. When a delegated agent or employee has been identified as
319.23 inappropriately accessing data, the permissible user must immediately remove access for
319.24 that individual and notify the board within seven days. The board shall notify all permissible
319.25 users associated with the delegated agent or employee of the alleged violation.

319.26 (o) A permissible user who delegates access to the data submitted under subdivision 4
319.27 to an agent or employee shall terminate that individual's access to the data within three
319.28 business days of the agent or employee leaving employment with the permissible user. The
319.29 board may conduct random audits to determine compliance with this requirement.

319.30 **EFFECTIVE DATE.** This section is effective January 1, 2025.

320.1 Sec. 5. Minnesota Statutes 2022, section 214.025, is amended to read:

320.2 **214.025 COUNCIL OF HEALTH BOARDS.**

320.3 The health-related licensing boards may establish a Council of Health Boards consisting
320.4 of representatives of the health-related licensing boards ~~and the Emergency Medical Services~~
320.5 ~~Regulatory Board~~. When reviewing legislation or legislative proposals relating to the
320.6 regulation of health occupations, the council shall include the commissioner of health or a
320.7 designee and the director of the Office of Emergency Medical Services or a designee.

320.8 **EFFECTIVE DATE.** This section is effective January 1, 2025.

320.9 Sec. 6. Minnesota Statutes 2022, section 214.04, subdivision 2a, is amended to read:

320.10 Subd. 2a. **Performance of executive directors.** The governor may request that a
320.11 health-related licensing board ~~or the Emergency Medical Services Regulatory Board~~ review
320.12 the performance of the board's executive director. Upon receipt of the request, the board
320.13 must respond by establishing a performance improvement plan or taking disciplinary or
320.14 other corrective action, including dismissal. The board shall include the governor's
320.15 representative as a voting member of the board in the board's discussions and decisions
320.16 regarding the governor's request. The board shall report to the governor on action taken by
320.17 the board, including an explanation if no action is deemed necessary.

320.18 **EFFECTIVE DATE.** This section is effective January 1, 2025.

320.19 Sec. 7. Minnesota Statutes 2022, section 214.29, is amended to read:

320.20 **214.29 PROGRAM REQUIRED.**

320.21 Each health-related licensing board, ~~including the Emergency Medical Services~~
320.22 ~~Regulatory Board under chapter 144E~~, shall either conduct a health professionals service
320.23 program under sections 214.31 to 214.37 or contract for a diversion program under section
320.24 214.28.

320.25 **EFFECTIVE DATE.** This section is effective January 1, 2025.

320.26 Sec. 8. Minnesota Statutes 2022, section 214.31, is amended to read:

320.27 **214.31 AUTHORITY.**

320.28 Two or more of the health-related licensing boards listed in section 214.01, subdivision
320.29 2, may jointly conduct a health professionals services program to protect the public from
320.30 persons regulated by the boards who are unable to practice with reasonable skill and safety

321.1 by reason of illness, use of alcohol, drugs, chemicals, or any other materials, or as a result
 321.2 of any mental, physical, or psychological condition. The program does not affect a board's
 321.3 authority to discipline violations of a board's practice act. ~~For purposes of sections 214.31~~
 321.4 ~~to 214.37, the emergency medical services regulatory board shall be included in the definition~~
 321.5 ~~of a health-related licensing board under chapter 144E.~~

321.6 **EFFECTIVE DATE.** This section is effective January 1, 2025.

321.7 Sec. 9. Minnesota Statutes 2022, section 214.355, is amended to read:

321.8 **214.355 GROUNDS FOR DISCIPLINARY ACTION.**

321.9 Each health-related licensing board, ~~including the Emergency Medical Services~~
 321.10 ~~Regulatory Board under chapter 144E,~~ shall consider it grounds for disciplinary action if a
 321.11 regulated person violates the terms of the health professionals services program participation
 321.12 agreement or leaves the program except upon fulfilling the terms for successful completion
 321.13 of the program as set forth in the participation agreement.

321.14 **EFFECTIVE DATE.** This section is effective January 1, 2025.

321.15 **ARTICLE 12**

321.16 **AMBULANCE SERVICE PERSONNEL AND EMERGENCY MEDICAL**
 321.17 **RESPONDERS**

321.18 Section 1. Minnesota Statutes 2022, section 144E.001, subdivision 3a, is amended to read:

321.19 Subd. 3a. **Ambulance service personnel.** "Ambulance service personnel" means
 321.20 individuals who are authorized by a licensed ambulance service to provide emergency care
 321.21 for the ambulance service and are:

321.22 (1) EMTs, AEMTs, or paramedics;

321.23 (2) Minnesota registered nurses who are: (i) EMTs, are currently practicing nursing, and
 321.24 ~~have passed a paramedic practical skills test, as approved by the board and administered by~~
 321.25 ~~an educational program approved by the board~~ been approved by the ambulance service
 321.26 medical director; (ii) on the roster of an ambulance service on or before January 1, 2000;
 321.27 ~~or~~ (iii) after petitioning the board, deemed by the board to have training and skills equivalent
 321.28 to an EMT, as determined on a case-by-case basis; or (iv) certified as a certified flight
 321.29 registered nurse or certified emergency nurse; or

321.30 (3) Minnesota licensed physician assistants who are: (i) EMTs, are currently practicing
 321.31 as physician assistants, and ~~have passed a paramedic practical skills test, as approved by~~
 321.32 ~~the board and administered by an educational program approved by the board~~ been approved

322.1 by the ambulance service medical director; (ii) on the roster of an ambulance service on or
 322.2 before January 1, 2000; or (iii) after petitioning the board, deemed by the board to have
 322.3 training and skills equivalent to an EMT, as determined on a case-by-case basis.

322.4 Sec. 2. Minnesota Statutes 2023 Supplement, section 144E.101, subdivision 6, is amended
 322.5 to read:

322.6 Subd. 6. **Basic life support.** (a) Except as provided in ~~paragraph (f)~~ subdivision 6a, a
 322.7 basic life-support ambulance shall be staffed by at least ~~two EMTs, one of whom must~~
 322.8 ~~accompany the patient and provide a level of care so as to ensure that:~~

322.9 (1) one individual who is:

322.10 (i) certified as an EMT;

322.11 (ii) a Minnesota registered nurse who meets the qualification requirements in section
 322.12 144E.001, subdivision 3a, clause (2); or

322.13 (iii) a Minnesota licensed physician assistant who meets the qualification requirements
 322.14 in section 144E.001, subdivision 3a, clause (3); and

322.15 (2) one individual to drive the ambulance who:

322.16 (i) either meets one of the qualification requirements in clause (1) or is a registered
 322.17 emergency medical responder driver; and

322.18 (ii) satisfies the requirements in subdivision 10.

322.19 (b) An individual who meets one of the qualification requirements in paragraph (a),
 322.20 clause (1), must accompany the patient and provide a level of care so as to ensure that:

322.21 (1) life-threatening situations and potentially serious injuries are recognized;

322.22 (2) patients are protected from additional hazards;

322.23 (3) basic treatment to reduce the seriousness of emergency situations is administered;

322.24 and

322.25 (4) patients are transported to an appropriate medical facility for treatment.

322.26 ~~(b)~~ (c) A basic life-support service shall provide basic airway management.

322.27 ~~(e)~~ (d) A basic life-support service shall provide automatic defibrillation.

322.28 ~~(d)~~ (e) A basic life-support service shall administer opiate antagonists consistent with
 322.29 protocols established by the service's medical director.

323.1 ~~(e)~~ (f) A basic life-support service licensee's medical director may authorize ambulance
 323.2 service personnel to perform intravenous infusion and use equipment that is within the
 323.3 licensure level of the ambulance service. Ambulance service personnel must be properly
 323.4 trained. Documentation of authorization for use, guidelines for use, continuing education,
 323.5 and skill verification must be maintained in the licensee's files.

323.6 ~~(f)~~ ~~For emergency ambulance calls and interfacility transfers, an ambulance service may~~
 323.7 ~~staff its basic life-support ambulances with one EMT, who must accompany the patient,~~
 323.8 ~~and one registered emergency medical responder driver. For purposes of this paragraph,~~
 323.9 ~~"ambulance service" means either an ambulance service whose primary service area is~~
 323.10 ~~mainly located outside the metropolitan counties listed in section 473.121, subdivision 4,~~
 323.11 ~~and outside the cities of Duluth, Mankato, Moorhead, Rochester, and St. Cloud; or an~~
 323.12 ~~ambulance service based in a community with a population of less than 2,500.~~

323.13 Sec. 3. Minnesota Statutes 2022, section 144E.101, is amended by adding a subdivision
 323.14 to read:

323.15 Subd. 6a. Variance; staffing of basic life-support ambulance. (a) Upon application
 323.16 from an ambulance service that includes evidence demonstrating hardship, the board may
 323.17 grant a variance from the staff requirements in subdivision 6, paragraph (a), and may
 323.18 authorize a basic life-support ambulance to be staffed, for all emergency calls and interfacility
 323.19 transfers, with one individual who meets the qualification requirements in paragraph (b) to
 323.20 drive the ambulance and one individual who meets one of the qualification requirements in
 323.21 subdivision 6, paragraph (a), clause (1), and who must accompany the patient. The variance
 323.22 applies to basic life-support ambulances until the ambulance service renews its license.
 323.23 When the variance expires, the ambulance service may apply for a new variance under this
 323.24 subdivision.

323.25 (b) In order to drive an ambulance under a variance granted under this subdivision, an
 323.26 individual must:

323.27 (1) hold a valid driver's license from any state;

323.28 (2) have attended an emergency vehicle driving course approved by the ambulance
 323.29 service;

323.30 (3) have completed a course on cardiopulmonary resuscitation approved by the ambulance
 323.31 service; and

323.32 (4) register with the board according to a process established by the board.

324.1 (c) If an individual serving as a driver under this subdivision commits or has a record
324.2 of committing an act listed in section 144E.27, subdivision 5, paragraph (a), the board may
324.3 temporarily suspend or prohibit the individual from driving an ambulance or place conditions
324.4 on the individual's ability to drive an ambulance using the procedures and authority in
324.5 section 144E.27, subdivisions 5 and 6.

324.6 Sec. 4. Minnesota Statutes 2023 Supplement, section 144E.101, subdivision 7, as amended
324.7 by Laws 2024, chapter 85, section 32, is amended to read:

324.8 Subd. 7. **Advanced life support.** (a) Except as provided in paragraphs (f) and (g), an
324.9 advanced life-support ambulance shall be staffed by at least:

324.10 (1) one EMT or one AEMT and one paramedic;

324.11 (2) one EMT or one AEMT and one registered nurse who: (i) is an EMT or an AEMT,
324.12 is currently practicing nursing, and ~~has passed a paramedic practical skills test approved by~~
324.13 ~~the board and administered by an education program~~ has been approved by the ambulance
324.14 service medical director; or (ii) is certified as a certified flight registered nurse or certified
324.15 emergency nurse; or

324.16 (3) one EMT or one AEMT and one physician assistant who is an EMT or an AEMT,
324.17 is currently practicing as a physician assistant, and ~~has passed a paramedic practical skills~~
324.18 ~~test approved by the board and administered by an education program~~ has been approved
324.19 by the ambulance service medical director.

324.20 (b) An advanced life-support service shall provide basic life support, as specified under
324.21 subdivision 6, paragraph ~~(a)~~ (b), advanced airway management, manual defibrillation,
324.22 administration of intravenous fluids and pharmaceuticals, and administration of opiate
324.23 antagonists.

324.24 (c) In addition to providing advanced life support, an advanced life-support service may
324.25 staff additional ambulances to provide basic life support according to subdivision 6 and
324.26 section 144E.103, subdivision 1.

324.27 (d) An ambulance service providing advanced life support shall have a written agreement
324.28 with its medical director to ensure medical control for patient care 24 hours a day, seven
324.29 days a week. The terms of the agreement shall include a written policy on the administration
324.30 of medical control for the service. The policy shall address the following issues:

324.31 (1) two-way communication for physician direction of ambulance service personnel;

324.32 (2) patient triage, treatment, and transport;

325.1 (3) use of standing orders; and

325.2 (4) the means by which medical control will be provided 24 hours a day.

325.3 The agreement shall be signed by the licensee's medical director and the licensee or the
325.4 licensee's designee and maintained in the files of the licensee.

325.5 (e) When an ambulance service provides advanced life support, the authority of a
325.6 paramedic, Minnesota registered nurse-EMT, or Minnesota registered physician
325.7 assistant-EMT to determine the delivery of patient care prevails over the authority of an
325.8 EMT.

325.9 (f) Upon application from an ambulance service that includes evidence demonstrating
325.10 hardship, the board may grant a variance from the staff requirements in paragraph (a), clause
325.11 (1), and may authorize an advanced life-support ambulance to be staffed by a registered
325.12 emergency medical responder driver with a paramedic for all emergency calls and interfacility
325.13 transfers. The variance shall apply to advanced life-support ambulance services until the
325.14 ambulance service renews its license. When the variance expires, an ambulance service
325.15 may apply for a new variance under this paragraph. ~~This paragraph applies only to an
325.16 ambulance service whose primary service area is mainly located outside the metropolitan
325.17 counties listed in section 473.121, subdivision 4, and outside the cities of Duluth, Mankato,
325.18 Moorhead, Rochester, and St. Cloud, or an ambulance service based in a community with
325.19 a population of less than 1,000 persons.~~

325.20 (g) After an initial emergency ambulance call, each subsequent emergency ambulance
325.21 response, until the initial ambulance is again available, and interfacility transfers, may be
325.22 staffed by one registered emergency medical responder driver and an EMT or paramedic.
325.23 ~~This paragraph applies only to an ambulance service whose primary service area is mainly
325.24 located outside the metropolitan counties listed in section 473.121, subdivision 4, and outside
325.25 the cities of Duluth, Mankato, Moorhead, Rochester, and St. Cloud, or an ambulance service
325.26 based in a community with a population of less than 1,000 persons.~~

325.27 (h) An individual who staffs an advanced life-support ambulance as a driver must also
325.28 meet the requirements in subdivision 10.

325.29 Sec. 5. Minnesota Statutes 2022, section 144E.27, subdivision 3, is amended to read:

325.30 Subd. 3. **Renewal.** (a) The board may renew the registration of an emergency medical
325.31 responder who:

325.32 (1) successfully completes a board-approved refresher course; ~~and~~

326.1 (2) successfully completes a course in cardiopulmonary resuscitation approved by the
 326.2 board or by the licensee's medical director. This course may be a component of a
 326.3 board-approved refresher course; and

326.4 ~~(2)~~ (3) submits a completed renewal application to the board before the registration
 326.5 expiration date.

326.6 (b) The board may renew the lapsed registration of an emergency medical responder
 326.7 who:

326.8 (1) successfully completes a board-approved refresher course; ~~and~~

326.9 (2) successfully completes a course in cardiopulmonary resuscitation approved by the
 326.10 board or by the licensee's medical director. This course may be a component of a
 326.11 board-approved refresher course; and

326.12 ~~(2)~~ (3) submits a completed renewal application to the board within ~~12~~ 48 months after
 326.13 the registration expiration date.

326.14 Sec. 6. Minnesota Statutes 2022, section 144E.27, subdivision 5, is amended to read:

326.15 Subd. 5. **Denial, suspension, revocation; emergency medical responders and**
 326.16 **drivers.** (a) This subdivision applies to individuals seeking registration or registered as an
 326.17 emergency medical responder and to individuals seeking registration or registered as a driver
 326.18 of a basic life-support ambulance under section 144E.101, subdivision 6a. The board may
 326.19 deny, suspend, revoke, place conditions on, or refuse to renew the registration of an individual
 326.20 who the board determines:

326.21 (1) violates sections 144E.001 to 144E.33 or the rules adopted under those sections, an
 326.22 agreement for corrective action, or an order that the board issued or is otherwise empowered
 326.23 to enforce;

326.24 (2) misrepresents or falsifies information on an application form for registration;

326.25 (3) is convicted or pleads guilty or nolo contendere to any felony; any gross misdemeanor
 326.26 relating to assault, sexual misconduct, theft, or the illegal use of drugs or alcohol; or any
 326.27 misdemeanor relating to assault, sexual misconduct, theft, or the illegal use of drugs or
 326.28 alcohol;

326.29 (4) is actually or potentially unable to provide emergency medical services or drive an
 326.30 ambulance with reasonable skill and safety to patients by reason of illness, use of alcohol,
 326.31 drugs, chemicals, or any other material, or as a result of any mental or physical condition;

327.1 (5) engages in unethical conduct, including, but not limited to, conduct likely to deceive,
327.2 defraud, or harm the public, or demonstrating a willful or careless disregard for the health,
327.3 welfare, or safety of the public;

327.4 (6) maltreats or abandons a patient;

327.5 (7) violates any state or federal controlled substance law;

327.6 (8) engages in unprofessional conduct or any other conduct which has the potential for
327.7 causing harm to the public, including any departure from or failure to conform to the
327.8 minimum standards of acceptable and prevailing practice without actual injury having to
327.9 be established;

327.10 (9) for emergency medical responders, provides emergency medical services under
327.11 lapsed or nonrenewed credentials;

327.12 (10) is subject to a denial, corrective, disciplinary, or other similar action in another
327.13 jurisdiction or by another regulatory authority;

327.14 (11) engages in conduct with a patient that is sexual or may reasonably be interpreted
327.15 by the patient as sexual, or in any verbal behavior that is seductive or sexually demeaning
327.16 to a patient; or

327.17 (12) makes a false statement or knowingly provides false information to the board, or
327.18 fails to cooperate with an investigation of the board as required by section 144E.30.

327.19 (b) Before taking action under paragraph (a), the board shall give notice to an individual
327.20 of the right to a contested case hearing under chapter 14. If an individual requests a contested
327.21 case hearing within 30 days after receiving notice, the board shall initiate a contested case
327.22 hearing according to chapter 14.

327.23 (c) The administrative law judge shall issue a report and recommendation within 30
327.24 days after closing the contested case hearing record. The board shall issue a final order
327.25 within 30 days after receipt of the administrative law judge's report.

327.26 (d) After six months from the board's decision to deny, revoke, place conditions on, or
327.27 refuse renewal of an individual's registration for disciplinary action, the individual shall
327.28 have the opportunity to apply to the board for reinstatement.

327.29 Sec. 7. Minnesota Statutes 2022, section 144E.27, subdivision 6, is amended to read:

327.30 Subd. 6. **Temporary suspension; emergency medical responders and drivers**. (a)
327.31 This subdivision applies to emergency medical responders registered under this section and
327.32 to individuals registered as drivers of basic life-support ambulances under section 144E.101,

328.1 subdivision 6a. In addition to any other remedy provided by law, the board may temporarily
328.2 suspend the registration of an individual after conducting a preliminary inquiry to determine
328.3 whether the board believes that the individual has violated a statute or rule that the board
328.4 is empowered to enforce and determining that the continued provision of service by the
328.5 individual would create an imminent risk to public health or harm to others.

328.6 (b) A temporary suspension order prohibiting an individual from providing emergency
328.7 medical care or from driving a basic life-support ambulance shall give notice of the right
328.8 to a preliminary hearing according to paragraph (d) and shall state the reasons for the entry
328.9 of the temporary suspension order.

328.10 (c) Service of a temporary suspension order is effective when the order is served on the
328.11 individual personally or by certified mail, which is complete upon receipt, refusal, or return
328.12 for nondelivery to the most recent address provided to the board for the individual.

328.13 (d) At the time the board issues a temporary suspension order, the board shall schedule
328.14 a hearing, to be held before a group of its members designated by the board, that shall begin
328.15 within 60 days after issuance of the temporary suspension order or within 15 working days
328.16 of the date of the board's receipt of a request for a hearing from the individual, whichever
328.17 is sooner. The hearing shall be on the sole issue of whether there is a reasonable basis to
328.18 continue, modify, or lift the temporary suspension. A hearing under this paragraph is not
328.19 subject to chapter 14.

328.20 (e) Evidence presented by the board or the individual may be in the form of an affidavit.
328.21 The individual or the individual's designee may appear for oral argument.

328.22 (f) Within five working days of the hearing, the board shall issue its order and, if the
328.23 suspension is continued, notify the individual of the right to a contested case hearing under
328.24 chapter 14.

328.25 (g) If an individual requests a contested case hearing within 30 days after receiving
328.26 notice under paragraph (f), the board shall initiate a contested case hearing according to
328.27 chapter 14. The administrative law judge shall issue a report and recommendation within
328.28 30 days after the closing of the contested case hearing record. The board shall issue a final
328.29 order within 30 days after receipt of the administrative law judge's report.

328.30 Sec. 8. Minnesota Statutes 2022, section 144E.28, subdivision 3, is amended to read:

328.31 Subd. 3. **Reciprocity.** The board may certify an individual who possesses a current
328.32 National Registry of Emergency Medical Technicians registration certification from another
328.33 jurisdiction if the individual submits a board-approved application form. The board

329.1 certification classification shall be the same as the National Registry's classification.

329.2 Certification shall be for the duration of the applicant's ~~registration~~ certification period in
329.3 another jurisdiction, not to exceed two years.

329.4 Sec. 9. Minnesota Statutes 2022, section 144E.28, subdivision 8, is amended to read:

329.5 Subd. 8. **Reinstatement.** (a) Within four years of a certification expiration date, a person
329.6 whose certification has expired under subdivision 7, paragraph (d), may have the certification
329.7 reinstated upon submission of:

329.8 (1) evidence to the board of training equivalent to the continuing education requirements
329.9 of subdivision 7 or, for community paramedics, evidence to the board of training equivalent
329.10 to the continuing education requirements of subdivision 9, paragraph (c); and

329.11 (2) a board-approved application form.

329.12 (b) If more than four years have passed since a certificate expiration date, an applicant
329.13 must complete the initial certification process required under subdivision 1.

329.14 (c) Beginning July 1, 2024, through December 31, 2025, and notwithstanding paragraph
329.15 (b), a person whose certification as an EMT, AEMT, paramedic, or community paramedic
329.16 expired more than four years ago but less than ten years ago may have the certification
329.17 reinstated upon submission of:

329.18 (1) evidence to the board of the training required under paragraph (a), clause (1). This
329.19 training must have been completed within the 24 months prior to the date of the application
329.20 for reinstatement;

329.21 (2) a board-approved application form; and

329.22 (3) a recommendation from an ambulance service medical director.

329.23 This paragraph expires December 31, 2025.

329.24 Sec. 10. Minnesota Statutes 2022, section 144E.285, subdivision 1, is amended to read:

329.25 Subdivision 1. **Approval required.** (a) All education programs for an EMR, EMT,
329.26 AEMT, or paramedic must be approved by the board.

329.27 (b) To be approved by the board, an education program must:

329.28 (1) submit an application prescribed by the board that includes:

329.29 (i) ~~type and length~~ type and length of course to be offered;

- 330.1 (ii) names, addresses, and qualifications of the program medical director, program
330.2 education coordinator, and instructors;
- 330.3 ~~(iii) names and addresses of clinical sites, including a contact person and telephone~~
330.4 ~~number;~~
- 330.5 ~~(iv)~~ (iii) admission criteria for students; and
- 330.6 ~~(v)~~ (iv) materials and equipment to be used;
- 330.7 (2) for each course, implement the most current version of the United States Department
330.8 of Transportation EMS Education Standards, or its equivalent as determined by the board
330.9 applicable to EMR, EMT, AEMT, or paramedic education;
- 330.10 (3) have a program medical director and a program coordinator;
- 330.11 (4) utilize instructors who meet the requirements of section 144E.283 for teaching at
330.12 least 50 percent of the course content. The remaining 50 percent of the course may be taught
330.13 by guest lecturers approved by the education program coordinator or medical director;
- 330.14 ~~(5) have at least one instructor for every ten students at the practical skill stations;~~
- 330.15 ~~(6) maintain a written agreement with a licensed hospital or licensed ambulance service~~
330.16 ~~designating a clinical training site;~~
- 330.17 ~~(7)~~ (5) retain documentation of program approval by the board, course outline, and
330.18 student information;
- 330.19 ~~(8)~~ (6) notify the board of the starting date of a course prior to the beginning of a course;
330.20 and
- 330.21 ~~(9)~~ (7) submit the appropriate fee as required under section 144E.29; and.
- 330.22 ~~(10) maintain a minimum average yearly pass rate as set by the board on an annual basis.~~
330.23 ~~The pass rate will be determined by the percent of candidates who pass the exam on the~~
330.24 ~~first attempt. An education program not meeting this yearly standard shall be placed on~~
330.25 ~~probation and shall be on a performance improvement plan approved by the board until~~
330.26 ~~meeting the pass rate standard. While on probation, the education program may continue~~
330.27 ~~providing classes if meeting the terms of the performance improvement plan as determined~~
330.28 ~~by the board. If an education program having probation status fails to meet the pass rate~~
330.29 ~~standard after two years in which an EMT initial course has been taught, the board may~~
330.30 ~~take disciplinary action under subdivision 5.~~

331.1 Sec. 11. Minnesota Statutes 2022, section 144E.285, is amended by adding a subdivision
331.2 to read:

331.3 Subd. 1a. **EMR education program requirements.** The National EMS Education
331.4 Standards established by the National Highway Traffic Safety Administration of the United
331.5 States Department of Transportation specify the minimum requirements for knowledge and
331.6 skills for emergency medical responders. An education program applying for approval to
331.7 teach EMRs must comply with the requirements under subdivision 1, paragraph (b). A
331.8 medical director of an emergency medical responder group may establish additional
331.9 knowledge and skill requirements for EMRs.

331.10 Sec. 12. Minnesota Statutes 2022, section 144E.285, is amended by adding a subdivision
331.11 to read:

331.12 Subd. 1b. **EMT education program requirements.** In addition to the requirements
331.13 under subdivision 1, paragraph (b), an education program applying for approval to teach
331.14 EMTs must:

331.15 (1) include in the application prescribed by the board the names and addresses of clinical
331.16 sites, including a contact person and telephone number;

331.17 (2) maintain a written agreement with at least one clinical training site that is of a type
331.18 recognized by the National EMS Education Standards established by the National Highway
331.19 Traffic Safety Administration; and

331.20 (3) maintain a minimum average yearly pass rate as set by the board. An education
331.21 program not meeting this standard must be placed on probation and must comply with a
331.22 performance improvement plan approved by the board until the program meets the pass-rate
331.23 standard. While on probation, the education program may continue to provide classes if the
331.24 program meets the terms of the performance improvement plan, as determined by the board.
331.25 If an education program that is on probation status fails to meet the pass-rate standard after
331.26 two years in which an EMT initial course has been taught, the board may take disciplinary
331.27 action under subdivision 5.

331.28 Sec. 13. Minnesota Statutes 2022, section 144E.285, subdivision 2, is amended to read:

331.29 Subd. 2. **AEMT and paramedic education program requirements.** (a) In addition to
331.30 the requirements under subdivision 1, paragraph (b), an education program applying for
331.31 approval to teach AEMTs and paramedics must:

332.1 (1) be administered by an educational institution accredited by the Commission of
332.2 Accreditation of Allied Health Education Programs (CAAHEP);

332.3 (2) include in the application prescribed by the board the names and addresses of clinical
332.4 sites, including a contact person and telephone number; and

332.5 (3) maintain a written agreement with a licensed hospital or licensed ambulance service
332.6 designating a clinical training site.

332.7 (b) An AEMT and paramedic education program that is administered by an educational
332.8 institution not accredited by CAAHEP, but that is in the process of completing the
332.9 accreditation process, may be granted provisional approval by the board upon verification
332.10 of submission of its self-study report and the appropriate review fee to CAAHEP.

332.11 (c) An educational institution that discontinues its participation in the accreditation
332.12 process must notify the board immediately and provisional approval shall be withdrawn.

332.13 ~~(d) This subdivision does not apply to a paramedic education program when the program~~
332.14 ~~is operated by an advanced life support ambulance service licensed by the Emergency~~
332.15 ~~Medical Services Regulatory Board under this chapter, and the ambulance service meets~~
332.16 ~~the following criteria:~~

332.17 ~~(1) covers a rural primary service area that does not contain a hospital within the primary~~
332.18 ~~service area or contains a hospital within the primary service area that has been designated~~
332.19 ~~as a critical access hospital under section 144.1483, clause (9);~~

332.20 ~~(2) has tax-exempt status in accordance with the Internal Revenue Code, section~~
332.21 ~~501(c)(3);~~

332.22 ~~(3) received approval before 1991 from the commissioner of health to operate a paramedic~~
332.23 ~~education program;~~

332.24 ~~(4) operates an AEMT and paramedic education program exclusively to train paramedics~~
332.25 ~~for the local ambulance service; and~~

332.26 ~~(5) limits enrollment in the AEMT and paramedic program to five candidates per~~
332.27 ~~biennium.~~

332.28 Sec. 14. Minnesota Statutes 2022, section 144E.285, subdivision 4, is amended to read:

332.29 Subd. 4. **Reapproval.** An education program shall apply to the board for reapproval at
332.30 least ~~three months~~ 30 days prior to the expiration date of its approval and must:

333.1 (1) submit an application prescribed by the board specifying any changes from the
 333.2 information provided for prior approval and any other information requested by the board
 333.3 to clarify incomplete or ambiguous information presented in the application; ~~and~~

333.4 (2) comply with the requirements under subdivision 1, paragraph (b), clauses (2) to ~~(10)~~.
 333.5 (7);

333.6 (3) be subject to a site visit by the board;

333.7 (4) for education programs that teach EMRs, comply with the requirements in subdivision
 333.8 1a;

333.9 (5) for education programs that teach EMTs, comply with the requirements in subdivision
 333.10 1b; and

333.11 (6) for education programs that teach AEMTs and paramedics, comply with the
 333.12 requirements in subdivision 2 and maintain accreditation with CAAHEP.

333.13 Sec. 15. **REPEALER.**

333.14 Minnesota Statutes 2022, section 144E.27, subdivisions 1 and 1a, are repealed.

333.15 **ARTICLE 13**

333.16 **MISCELLANEOUS**

333.17 Section 1. Minnesota Statutes 2022, section 16A.055, subdivision 1a, is amended to read:

333.18 Subd. 1a. ~~Additional duties~~ **Program evaluation and organizational development**
 333.19 **services.** The commissioner may assist state agencies by providing analytical, statistical,
 333.20 program evaluation using experimental or quasi-experimental design, and organizational
 333.21 development services to state agencies in order to assist the agency to achieve the agency's
 333.22 mission and to operate efficiently and effectively. For purposes of this section, "experimental
 333.23 design" means a method of evaluating the impact of a service that uses random assignment
 333.24 to assign participants into groups that respectively receive the studied service and those that
 333.25 receive service as usual, so that any difference in outcomes found at the end of the evaluation
 333.26 can be attributed to the studied service; and "quasi-experimental design" means a method
 333.27 of evaluating the impact of a service that uses strategies other than random assignment to
 333.28 establish statistically similar groups that respectively receive the service and those that
 333.29 receive service as usual, so that any difference in outcomes found at the end of the evaluation
 333.30 can be attributed to the studied service.

334.1 Sec. 2. Minnesota Statutes 2022, section 16A.055, is amended by adding a subdivision to
334.2 read:

334.3 Subd. 1b. Consultation to develop performance measures for grants. (a) The
334.4 commissioner must, in consultation with the commissioners of health, human services, and
334.5 children, youth, and families, develop an ongoing consultation schedule to create, review,
334.6 and revise, as necessary, performance measures, data collection, and program evaluation
334.7 plans for all state-funded grants administered by the commissioners of health, human
334.8 services, and children, youth, and families that distribute at least \$1,000,000 annually.

334.9 (b) Following the development of the ongoing consultation schedule under paragraph
334.10 (a), the commissioner and the commissioner of the administering agency must conduct a
334.11 grant program consultation in accordance with the ongoing consultation schedule. Each
334.12 grant program consultation must include a review of performance measures, data collection,
334.13 program evaluation plans, and reporting for each grant program. Following each consultation,
334.14 the commissioner and the commissioner of the administering agency may revise evaluation
334.15 metrics of a grant program. The commissioner may provide continuing support to the grant
334.16 program in accordance with subdivision 1a.

334.17 Sec. 3. [137.095] EVIDENCE IN SUPPORT OF APPROPRIATION.

334.18 Subdivision 1. Written report. Prior to the introduction of a bill proposing to appropriate
334.19 money to the Board of Regents of the University of Minnesota to benefit the University of
334.20 Minnesota's health sciences schools and colleges, the proponents of the bill are requested
334.21 to submit a written report to the chairs and ranking minority members of the legislative
334.22 committees with jurisdiction over higher education and health and human services policy
334.23 and finance setting out the information described in subdivision 2. The University of
334.24 Minnesota's health sciences schools and colleges are medicine, nursing, public health,
334.25 pharmacy, dentistry, and veterinary medicine.

334.26 Subd. 2. Contents of report. (a) The report requested under this section must include
334.27 the following information as specifically as possible:

334.28 (1) the dollar amount requested;

334.29 (2) how the requested dollar amount was calculated;

334.30 (3) the necessity for the appropriation's purpose to be funded by public funds;

334.31 (4) University of Minnesota budgeting considerations and decisions impacting the
334.32 necessity analysis required by clause (3);

335.1 (5) all goals, outcomes, and purposes of the appropriation;

335.2 (6) performance measures as defined by the University of Minnesota that the University
335.3 of Minnesota will utilize to ensure the funds are dedicated to the successful achievement
335.4 of the identified goals, outcomes, and purposes; and

335.5 (7) the extent to which the appropriation advances recruitment from, and training for
335.6 and retention of, health professionals from and in greater Minnesota and from underserved
335.7 communities in metropolitan areas.

335.8 (b) This subdivision only applies when the Board of Regents of the University of
335.9 Minnesota approves a legislative funding request for the University of Minnesota's health
335.10 sciences schools and colleges.

335.11 Subd. 3. **Certifications for academic health.** A report submitted under this section
335.12 must include, in addition to the information listed in subdivision 2, a certification, by the
335.13 University of Minnesota Vice President and Budget Director, that:

335.14 (1) the appropriation will not be used to cover academic health clinical revenue deficits;

335.15 (2) the goals, outcomes, and purposes of the appropriation are aligned with state goals
335.16 for population health improvement; and

335.17 (3) the appropriation is aligned with the University of Minnesota's strategic plan for its
335.18 health sciences schools and colleges, including but not limited to shared goals and strategies
335.19 for the health professional schools.

335.20 Subd. 4. **Right to request.** The chair of a standing committee in either house of the
335.21 legislature may request and obtain the reports submitted pursuant to this section from the
335.22 chair of a legislative committee with jurisdiction over higher education or health and human
335.23 services policy and finance.

335.24 Sec. 4. Minnesota Statutes 2023 Supplement, section 142A.03, is amended by adding a
335.25 subdivision to read:

335.26 Subd. 2a. **Grant consultation.** The commissioner must consult with the commissioner
335.27 of management and budget to create, review, and revise grant program performance measures
335.28 and to evaluate grant programs administered by the commissioner in accordance with section
335.29 16A.055, subdivisions 1a and 1b.

336.1 Sec. 5. Minnesota Statutes 2022, section 144.05, is amended by adding a subdivision to
336.2 read:

336.3 Subd. 8. Grant consultation. The commissioner must consult with the commissioner
336.4 of management and budget to create, review, and revise grant program performance measures
336.5 and to evaluate grant programs administered by the commissioner in accordance with section
336.6 16A.055, subdivisions 1a and 1b.

336.7 Sec. 6. Minnesota Statutes 2022, section 144.292, subdivision 6, is amended to read:

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

336.10 (b) When a provider or its representative makes copies of patient records upon a patient's
336.11 request under this section, the provider or its representative may charge the patient or the
336.12 patient's representative no more than ~~75 cents per page, plus \$10 for time spent retrieving~~
336.13 ~~and copying the records, unless other law or a rule or contract provide for a lower maximum~~
336.14 ~~charge. This limitation does not apply to x-rays. The provider may charge a patient no more~~
336.15 ~~than the actual cost of reproducing x-rays, plus no more than \$10 for the time spent retrieving~~
336.16 ~~and copying the x-rays~~ the following amount, unless other law or a rule or contract provide
336.17 for a lower maximum charge:

336.18 (1) for paper copies, \$1 per page, plus \$10 for time spent retrieving and copying the
336.19 records;

336.20 (2) for x-rays, a total of \$30 for retrieving and reproducing x-rays; and

336.21 (3) for electronic copies, a total of \$20 for retrieving the records.

336.22 ~~(c) The respective maximum charges of 75 cents per page and \$10 for time provided in~~
336.23 ~~this subdivision are in effect for calendar year 1992 and may be adjusted annually each~~
336.24 ~~calendar year as provided in this subdivision. The permissible maximum charges shall~~
336.25 ~~change each year by an amount that reflects the change, as compared to the previous year,~~
336.26 ~~in the Consumer Price Index for all Urban Consumers, Minneapolis-St. Paul (CPI-U),~~
336.27 ~~published by the Department of Labor. For any copies of paper records provided under~~
336.28 ~~paragraph (b), clause (1), a provider or the provider's representative may not charge more~~
336.29 than a total of:

336.30 (1) \$10 if there are no records available;

336.31 (2) \$30 for copies of records of up to 25 pages;

336.32 (3) \$50 for copies of records of up to 100 pages;

337.1 (4) \$50, plus an additional 20 cents per page for pages 101 and above; or

337.2 (5) \$500 for any request.

337.3 (d) A provider or its representative may charge ~~the~~ a \$10 retrieval fee, but must not
 337.4 charge a per page fee or x-ray fee to provide copies of records requested by a patient or the
 337.5 patient's authorized representative if the request for copies of records is for purposes of
 337.6 appealing a denial of Social Security disability income or Social Security disability benefits
 337.7 under title II or title XVI of the Social Security Act; ~~except that no fee shall be charged to~~
 337.8 ~~a patient who is receiving public assistance, or to a patient who is represented by an attorney~~
 337.9 ~~on behalf of a civil legal services program or a volunteer attorney program based on~~
 337.10 ~~indigency.~~ Notwithstanding the foregoing, a provider or its representative must not charge
 337.11 a fee, including a retrieval fee, to provide copies of records requested by a patient or the
 337.12 patient's authorized representative if the request for copies of records is for purposes of
 337.13 appealing a denial of Social Security disability income or Social Security disability benefits
 337.14 under title II or title XVI of the Social Security Act when the patient is receiving public
 337.15 assistance, represented by an attorney on behalf of a civil legal services program, or
 337.16 represented by a volunteer attorney program based on indigency. The patient or the patient's
 337.17 representative must submit one of the following to show that they are entitled to receive
 337.18 records without charge under this paragraph:

337.19 (1) a public assistance statement from the county or state administering assistance;

337.20 (2) a request for records on the letterhead of the civil legal services program or volunteer
 337.21 attorney program based on indigency; or

337.22 (3) a benefits statement from the Social Security Administration.

337.23 For the purpose of further appeals, a patient may receive no more than two medical record
 337.24 updates without charge, but only for medical record information previously not provided.

337.25 For purposes of this paragraph, a patient's authorized representative does not include units
 337.26 of state government engaged in the adjudication of Social Security disability claims.

337.27 **EFFECTIVE DATE.** This section is effective January 1, 2025.

337.28 **Sec. 7. [144.2925] CONSTRUCTION.**

337.29 Sections 144.291 to 144.298 must be construed to protect the privacy of a patient's health
 337.30 records in a more stringent manner than provided in Code of Federal Regulations, title 45,
 337.31 part 164. For purposes of this section, "more stringent" has the meaning given to that term
 337.32 in Code of Federal Regulations, title 45, section 160.202, with respect to a use or disclosure

338.1 or the need for express legal permission from an individual to disclose individually
338.2 identifiable health information.

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

338.4 Sec. 8. Minnesota Statutes 2022, section 144.293, subdivision 2, is amended to read:

338.5 Subd. 2. **Patient consent to release of records.** A provider, or a person who receives
338.6 health records from a provider, may not release a patient's health records to a person without:

338.7 (1) a signed and dated consent from the patient or the patient's legally authorized
338.8 representative authorizing the release;

338.9 (2) specific authorization in Minnesota law; or

338.10 (3) a representation from a provider that holds a signed and dated consent from the
338.11 patient authorizing the release.

338.12 **EFFECTIVE DATE.** This section is effective the day following final enactment and
338.13 applies to health records released on or after that date.

338.14 Sec. 9. Minnesota Statutes 2022, section 144.293, subdivision 4, is amended to read:

338.15 Subd. 4. **Duration of consent.** Except as provided in this section, a consent is valid for
338.16 one year or for a period specified in the consent or for a different period provided by
338.17 Minnesota law.

338.18 **EFFECTIVE DATE.** This section is effective the day following final enactment and
338.19 applies to health records released on or after that date.

338.20 Sec. 10. Minnesota Statutes 2022, section 144.293, subdivision 9, is amended to read:

338.21 Subd. 9. **Documentation of release.** (a) In cases where a provider releases health records
338.22 without patient consent as authorized by Minnesota law, the release must be documented
338.23 in the patient's health record. In the case of a release under section 144.294, subdivision 2,
338.24 the documentation must include the date and circumstances under which the release was
338.25 made, the person or agency to whom the release was made, and the records that were released.

338.26 (b) When a health record is released using a representation from a provider that holds a
338.27 consent from the patient, the releasing provider shall document:

338.28 (1) the provider requesting the health records;

338.29 (2) the identity of the patient;

339.1 (3) the health records requested; and

339.2 (4) the date the health records were requested.

339.3 **EFFECTIVE DATE.** This section is effective the day following final enactment and
339.4 applies to health records released on or after that date.

339.5 Sec. 11. Minnesota Statutes 2022, section 144.293, subdivision 10, is amended to read:

339.6 Subd. 10. **Warranties regarding consents, requests, and disclosures.** (a) When
339.7 requesting health records using consent, a person warrants that the consent:

339.8 (1) contains no information known to the person to be false; and

339.9 (2) accurately states the patient's desire to have health records disclosed or that there is
339.10 specific authorization in Minnesota law.

339.11 (b) When requesting health records using consent, or a representation of holding a
339.12 consent, a provider warrants that the request:

339.13 (1) contains no information known to the provider to be false;

339.14 (2) accurately states the patient's desire to have health records disclosed or that there is
339.15 specific authorization in Minnesota law; and

339.16 (3) does not exceed any limits imposed by the patient in the consent.

339.17 (c) When disclosing health records, a person releasing health records warrants that the
339.18 person:

339.19 (1) has complied with the requirements of this section regarding disclosure of health
339.20 records;

339.21 (2) knows of no information related to the request that is false; and

339.22 (3) has complied with the limits set by the patient in the consent.

339.23 **EFFECTIVE DATE.** This section is effective the day following final enactment and
339.24 applies to health records released on or after that date.

339.25 Sec. 12. Minnesota Statutes 2023 Supplement, section 245.991, subdivision 1, is amended
339.26 to read:

339.27 Subdivision 1. **Establishment.** The commissioner of human services must establish the
339.28 projects for assistance in transition from homelessness program to prevent or end
339.29 homelessness for people with serious mental illness, substance use disorder, or co-occurring

340.1 substance use disorder and ensure the commissioner achieves the goals of the housing
340.2 mission statement in section 245.461, subdivision 4.

340.3 Sec. 13. Minnesota Statutes 2023 Supplement, section 245C.31, subdivision 1, is amended
340.4 to read:

340.5 Subdivision 1. **Board determines disciplinary or corrective action.** (a) The
340.6 commissioner shall notify a health-related licensing board as defined in section 214.01,
340.7 subdivision 2, if the commissioner determines that an individual who is licensed by the
340.8 health-related licensing board and who is included on the board's roster list provided in
340.9 accordance with subdivision 3a is responsible for substantiated maltreatment under section
340.10 626.557 or chapter 260E, in accordance with subdivision 2. ~~Upon receiving notification~~
340.11 Except as provided in paragraph (b), the health-related licensing board shall make a
340.12 determination as to whether to impose disciplinary or corrective action under chapter 214,
340.13 rather than the commissioner making the decision regarding disqualification.

340.14 (b) The prohibition on disqualification in paragraph (a) does not apply to a background
340.15 study of an individual regulated by a health-related licensing board if the individual's study
340.16 is related to child foster care, adult foster care, or family child care licensure.

340.17 Sec. 14. Minnesota Statutes 2022, section 256.01, is amended by adding a subdivision to
340.18 read:

340.19 Subd. 2c. **Grant consultation.** The commissioner must consult with the commissioner
340.20 of management and budget to create, review, and revise grant program performance measures
340.21 and to evaluate grant programs administered by the commissioner in accordance with section
340.22 16A.055, subdivisions 1a and 1b.

340.23 Sec. 15. Minnesota Statutes 2022, section 256.01, subdivision 41, is amended to read:

340.24 Subd. 41. **Reports on interagency agreements and intra-agency transfers.** (a)
340.25 Beginning October 31, 2024, and annually thereafter, the commissioner of human services
340.26 shall provide ~~quarterly reports~~ a report to the chairs and ranking minority members of the
340.27 legislative committees with jurisdiction over health and human services policy and finance
340.28 on:

340.29 (1) interagency agreements or service-level agreements and any renewals or extensions
340.30 of existing interagency or service-level agreements with a state department under section
340.31 15.01, state agency under section 15.012, or the Department of Information Technology

341.1 Services, with a value of more than \$100,000, or related agreements with the same department
341.2 or agency with a cumulative value of more than \$100,000; and

341.3 (2) transfers of appropriations of more than \$100,000 between accounts within or between
341.4 agencies.

341.5 The report must include the statutory citation authorizing the agreement, transfer or dollar
341.6 amount, purpose, and effective date of the agreement, the duration of the agreement, and a
341.7 copy of the agreement.

341.8 (b) This subdivision expires December 31, 2034.

341.9 Sec. 16. Minnesota Statutes 2022, section 256B.795, is amended to read:

341.10 **256B.795 MATERNAL AND INFANT HEALTH REPORT.**

341.11 (a) The commissioner of human services, in consultation with the commissioner of
341.12 health, shall submit a biennial report beginning April 15, 2022, to the chairs and ranking
341.13 minority members of the legislative committees with jurisdiction over health policy and
341.14 finance on the effectiveness of state maternal and infant health policies and programs
341.15 addressing health disparities in prenatal and postpartum health outcomes. For each reporting
341.16 period, the commissioner shall determine the number of women enrolled in the medical
341.17 assistance program who are pregnant or are in the 12-month postpartum period of eligibility
341.18 and the percentage of women in that group who, during each reporting period:

341.19 (1) received prenatal services;

341.20 (2) received doula services;

341.21 (3) gave birth by primary cesarean section;

341.22 (4) gave birth to an infant who received care in the neonatal intensive care unit;

341.23 (5) gave birth to an infant who was premature or who had a low birth weight;

341.24 (6) experienced postpartum hemorrhage;

341.25 (7) received postpartum care within six weeks of giving birth; and

341.26 (8) received a prenatal and postpartum follow-up home visit from a public health nurse.

341.27 (b) These measurements must be determined through an analysis of the utilization data
341.28 from claims submitted during each reporting period and by any other appropriate means.

341.29 The measurements for each metric must be determined in the aggregate stratified by race
341.30 and ethnicity.

342.1 (c) The commissioner shall establish a baseline for the metrics described in paragraph
 342.2 (a) using calendar year 2017. The initial report due April 15, 2022, must contain the baseline
 342.3 metrics and the metrics data for calendar years 2019 and 2020. The following reports due
 342.4 biennially thereafter must contain the metrics for the preceding two calendar years.

342.5 (d) This section expires December 31, 2034.

342.6 Sec. 17. Minnesota Statutes 2022, section 256K.45, subdivision 2, is amended to read:

342.7 Subd. 2. **Homeless youth report.** (a) The commissioner shall prepare a biennial report,
 342.8 beginning ~~in February 2015~~ February 1, 2025, which provides meaningful information to
 342.9 the chairs and ranking minority members of the legislative committees having with
 342.10 jurisdiction over ~~the issue of~~ homeless youth, that includes, but is not limited to: (1) a list
 342.11 of the areas of the state with the greatest need for services and housing for homeless youth,
 342.12 and the level and nature of the needs identified; (2) details about grants made, including
 342.13 shelter-linked youth mental health grants under section 256K.46; (3) the distribution of
 342.14 funds throughout the state based on population need; (4) follow-up information, if available,
 342.15 on the status of homeless youth and whether they have stable housing two years after services
 342.16 are provided; and (5) any other outcomes for populations served to determine the
 342.17 effectiveness of the programs and use of funding.

342.18 (b) This subdivision expires December 31, 2034.

342.19 Sec. 18. Minnesota Statutes 2023 Supplement, section 260.761, is amended by adding a
 342.20 subdivision to read:

342.21 Subd. 8. **Missing child notification.** A child-placing agency or individual petitioner
 342.22 shall notify an Indian child's Tribe or Tribes by telephone and by email or facsimile
 342.23 immediately but no later than 24 hours after receiving information on a missing child as
 342.24 defined under section 260C.212, subdivision 13, paragraph (a).

342.25 Sec. 19. 2024 H.F. No. 5237, article 22, section 2, subdivision 4, if enacted, is amended
 342.26 to read:

342.27 Subd. 4. **Central Office; Health Care** (3,216,000) 3,216,000

342.28 The appropriation in fiscal year 2025 is a
 342.29 onetime appropriation.

343.1 Sec. 20. 2024 H.F. No. 5237, article 22, section 2, subdivision 5, if enacted, is amended
343.2 to read:

343.3 **Subd. 5. Central Office; Behavioral Health, Deaf**
343.4 **and Hard-of-Hearing, and Housing Services** (136,000) 136,000

343.5 The appropriation in fiscal year 2025 is a
343.6 onetime appropriation.

343.7 **Extended Availability.** \$136,000 of the
343.8 general fund appropriation in fiscal year 2025
343.9 is available until June 30, 2027.

343.10 Sec. 21. **ANNUAL REPORT TO LEGISLATURE; USE OF APPROPRIATION**
343.11 **FUNDS.**

343.12 By January 15, 2025, and every year thereafter, the Board of Regents of the University
343.13 of Minnesota must submit a report to the chairs and ranking minority members of the
343.14 legislative committees with primary jurisdiction over higher education and health and human
343.15 services policy and finance on the use of all appropriations for the benefit of the University
343.16 of Minnesota's health sciences schools and colleges, including:

343.17 (1) changes to the University of Minnesota's anticipated uses of each appropriation;

343.18 (2) the results of the performance measures required by Minnesota Statutes, section
343.19 137.095, subdivision 2, clause (6); and

343.20 (3) current and anticipated achievement of the goals, outcomes, and purposes of each
343.21 appropriation.

343.22 Sec. 22. **DIRECTION TO COMMISSIONER OF HEALTH; HEALTH**
343.23 **PROFESSIONS WORKFORCE ADVISORY COUNCIL.**

343.24 Subdivision 1. Health professions workforce advisory council. The commissioner of
343.25 health, in consultation with the University of Minnesota and the Minnesota State HealthForce
343.26 Center of Excellence, shall provide recommendations to the legislature for the creation of
343.27 a health professions workforce advisory council to:

343.28 (1) research and advise the legislature and the Minnesota Office of Higher Education
343.29 on the status of the health workforce who are in training and on the need for additional or
343.30 different training opportunities;

- 344.1 (2) provide information and analysis on health workforce needs and trends, upon request,
344.2 to the legislature, any state department, or any other entity the advisory council deems
344.3 appropriate;
- 344.4 (3) review and comment on legislation relevant to Minnesota's health workforce; and
- 344.5 (4) study and provide recommendations regarding the following:
- 344.6 (i) health workforce supply, including:
- 344.7 (A) employment trends and demand;
- 344.8 (B) strategies that entities in Minnesota are using or may use to address health workforce
344.9 shortages, recruitment, and retention; and
- 344.10 (C) future investments to increase the supply of health care professionals, with particular
344.11 focus on critical areas of need within Minnesota;
- 344.12 (ii) options for training and educating the health workforce, including:
- 344.13 (A) increasing the diversity of health professions workers to reflect Minnesota's
344.14 communities;
- 344.15 (B) addressing the maldistribution of primary, mental health, nursing, and dental providers
344.16 in greater Minnesota and in underserved communities in metropolitan areas;
- 344.17 (C) increasing interprofessional training and clinical practice;
- 344.18 (D) addressing the need for increased quality faculty to train an increased workforce;
344.19 and
- 344.20 (E) developing advancement paths or career ladders for health care professionals;
- 344.21 (iii) increasing funding for strategies to diversify and address gaps in the health workforce,
344.22 including:
- 344.23 (A) increasing access to financing for graduate medical education;
- 344.24 (B) expanding pathway programs to increase awareness of the health care professions
344.25 among high school, undergraduate, and community college students and engaging the current
344.26 health workforce in those programs;
- 344.27 (C) reducing or eliminating tuition for entry-level health care positions that offer
344.28 opportunities for future advancement in high-demand settings and expanding other existing
344.29 financial support programs such as loan forgiveness and scholarship programs;

345.1 (D) incentivizing recruitment from greater Minnesota and recruitment and retention for
345.2 providers practicing in greater Minnesota and in underserved communities in metropolitan
345.3 areas; and

345.4 (E) expanding existing programs, or investing in new programs, that provide wraparound
345.5 support services to the existing health care workforce, especially people of color and
345.6 professionals from other underrepresented identities, to acquire training and advance within
345.7 the health care workforce; and

345.8 (iv) other Minnesota health workforce priorities as determined by the advisory council.

345.9 Subd. 2. Report to the legislature. On or before February 1, 2025, the commissioner
345.10 of health shall submit a report to the chairs and ranking minority members of the legislative
345.11 committees with jurisdiction over health and human services and higher education finance
345.12 and policy with recommendations for the creation of a health professions workforce advisory
345.13 council as described in subdivision 1. The report must include recommendations regarding:

345.14 (1) membership of the advisory council;

345.15 (2) funding sources and estimated costs for the advisory council;

345.16 (3) existing sources of workforce data for the advisory council to perform its duties;

345.17 (4) necessity for and options to obtain new data for the advisory council to perform its
345.18 duties;

345.19 (5) additional duties of the advisory council;

345.20 (6) proposed legislation to establish the advisory council;

345.21 (7) similar health workforce advisory councils in other states; and

345.22 (8) advisory council reporting requirements.

345.23 Sec. 23. REQUEST FOR INFORMATION; EVALUATION OF STATEWIDE
345.24 HEALTH CARE NEEDS AND CAPACITY AND PROJECTIONS OF FUTURE
345.25 HEALTH CARE NEEDS.

345.26 (a) By November 1, 2024, the commissioner of health must publish a request for
345.27 information to assist the commissioner in a future comprehensive evaluation of current
345.28 health care needs and capacity in the state and projections of future health care needs in the
345.29 state based on population and provider characteristics. The request for information:

346.1 (1) must provide guidance on defining the scope of the study and assist in answering
 346.2 methodological questions that will inform the development of a request for proposals to
 346.3 contract for performance of the study; and

346.4 (2) may address topics that include but are not limited to how to define health care
 346.5 capacity, expectations for capacity by geography or service type, how to consider health
 346.6 centers that have areas of particular expertise or services that generally have a higher margin,
 346.7 how hospital-based services should be considered as compared with evolving
 346.8 nonhospital-based services, the role of technology in service delivery, health care workforce
 346.9 supply issues, and other issues related to data or methods.

346.10 (b) By February 1, 2025, the commissioner must submit a report to the chairs and ranking
 346.11 minority members of the legislative committees with jurisdiction over health care, with the
 346.12 results of the request for information and recommendations regarding conducting a
 346.13 comprehensive evaluation of current health care needs and capacity in the state and
 346.14 projections of future health care needs in the state.

346.15 Sec. 24. **REPEALER.**

346.16 Minnesota Statutes 2022, section 256B.79, subdivision 6, is repealed.

346.17 **ARTICLE 14**

346.18 **APPROPRIATIONS**

346.19 Section 1. **HEALTH AND HUMAN SERVICES APPROPRIATIONS.**

346.20 The sums shown in the columns marked "Appropriations" are added to or, if shown in
 346.21 parentheses, subtracted from the appropriations in Laws 2023, chapter 61, article 9; Laws
 346.22 2023, chapter 70, article 20; and Laws 2023, chapter 74, section 6, to the agencies and for
 346.23 the purposes specified in this article. The appropriations are from the general fund or other
 346.24 named fund and are available for the fiscal years indicated for each purpose. The figures
 346.25 "2024" and "2025" used in this article mean that the addition to or subtraction from the
 346.26 appropriation listed under them is available for the fiscal year ending June 30, 2024, or June
 346.27 30, 2025, respectively. Base adjustments mean the addition to or subtraction from the base
 346.28 level adjustment set in Laws 2023, chapter 61, article 9; Laws 2023, chapter 70, article 20;
 346.29 and Laws 2023, chapter 74, section 6. Supplemental appropriations and reductions to
 346.30 appropriations for the fiscal year ending June 30, 2024, are effective the day following final
 346.31 enactment unless a different effective date is explicit.

346.32
 346.33

APPROPRIATIONS
Available for the Year

		<u>Ending June 30</u>	
		<u>2024</u>	<u>2025</u>
347.1			
347.2			
347.3	<u>Sec. 2. COMMISSIONER OF HUMAN</u>		
347.4	<u>SERVICES</u>		
347.5	<u>Subdivision 1. Total Appropriation</u>	<u>\$ (22,695,000)</u>	<u>\$ 23,032,000</u>
347.6	<u>Appropriations by Fund</u>		
347.7	<u>2024</u>	<u>2025</u>	
347.8	<u>General</u>	<u>(22,695,000)</u>	<u>23,132,000</u>
347.9	<u>Health Care Access</u>	<u>-0-</u>	<u>(100,000)</u>
347.10	<u>The amounts that may be spent for each</u>		
347.11	<u>purpose are specified in the following</u>		
347.12	<u>subdivisions.</u>		
347.13	<u>Subd. 2. Central Office; Operations</u>	<u>-0-</u>	<u>(1,907,000)</u>
347.14	<u>Base Level Adjustment.</u> <u>The general fund</u>		
347.15	<u>base is increased by \$239,000 in fiscal year</u>		
347.16	<u>2026 and increased by \$181,000 in fiscal year</u>		
347.17	<u>2027.</u>		
347.18	<u>Subd. 3. Central Office; Health Care</u>		
347.19	<u>Appropriations by Fund</u>		
347.20	<u>General</u>	<u>-0-</u>	<u>540,000</u>
347.21	<u>Health Care Access</u>	<u>(1,000,000)</u>	<u>-0-</u>
347.22	<u>Base Level Adjustment.</u> <u>The general fund</u>		
347.23	<u>base is increased by \$1,063,000 in fiscal year</u>		
347.24	<u>2026 and increased by \$1,063,000 in fiscal</u>		
347.25	<u>year 2027.</u>		
347.26	<u>Subd. 4. Central Office; Behavioral Health, Deaf</u>		
347.27	<u>and Hard-of-Hearing, and Housing Services</u>	<u>-0-</u>	<u>2,036,000</u>
347.28	<u>(a) The appropriation in fiscal year 2025 is a</u>		
347.29	<u>onetime appropriation.</u>		
347.30	<u>(b) Medical Assistance Mental Health</u>		
347.31	<u>Benefit Development.</u> <u>\$1,227,000 in fiscal</u>		
347.32	<u>year 2025 is to: (1) conduct an analysis to</u>		
347.33	<u>identify existing or pending Medicaid</u>		
347.34	<u>Clubhouse benefits in other states, federal</u>		

348.1 authorities used, populations served, service
 348.2 and reimbursement design, and accreditation
 348.3 standards; (2) consult with providers,
 348.4 advocates, Tribal Nations, counties, people
 348.5 with lived experience as or with a child in a
 348.6 mental health crisis, and other interested
 348.7 community members to develop a covered
 348.8 benefit under medical assistance to provide
 348.9 residential mental health crisis stabilization
 348.10 for children; and (3) develop a First Episode
 348.11 Psychosis Coordinated Specialty Care
 348.12 (FEP-CSC) medical assistance benefit. This
 348.13 is a onetime appropriation and is available
 348.14 until June 30, 2027.

348.15 **Subd. 5. Forecasted Programs; MinnesotaCare** -0- 343,000

348.16 (a) This appropriation is from the health care
 348.17 access fund.

348.18 **(b) Base Level Adjustment.** The health care
 348.19 access fund base is increased by \$1,165,000
 348.20 in fiscal year 2026 and increased by
 348.21 \$1,713,000 in fiscal year 2027.

348.22 **Subd. 6. Forecasted Programs; Medical**
 348.23 **Assistance**

348.24	<u>Appropriations by Fund</u>		
348.25	<u>General</u>	-0-	<u>6,527,000</u>
348.26	<u>Health Care Access</u>	1,000,000	<u>(443,000)</u>

348.27 **(a) Additional Payment for Behavioral**
 348.28 **Health Services Provided by Hospitals.**
 348.29 \$5,814,000 in fiscal year 2025 is from the
 348.30 general fund for behavioral health services
 348.31 provided by hospitals under Minnesota
 348.32 Statutes, section 256.969, subdivision 2b,
 348.33 paragraph (a), clause (4). The increase in
 348.34 payments shall be made by increasing the
 348.35 adjustment under Minnesota Statutes, section

349.1 256.969, subdivision 2b, paragraph (e), clause
349.2 (2).

349.3 (b) Base Level Adjustment. The health care
349.4 access fund base is decreased by \$1,265,000
349.5 in fiscal year 2026 and decreased by
349.6 \$1,813,000 in fiscal year 2027.

349.7 Subd. 7. Forecasted Programs; Behavioral
349.8 Health Fund -0- 127,000

349.9 Subd. 8. Grant Programs; Adult Mental Health
349.10 Grants (22,695,000) 14,568,000

349.11 (a) Youable Emotional Health. \$300,000 in
349.12 fiscal year 2025 is for a grant to Youable
349.13 Emotional Health for day treatment
349.14 transportation costs on nonschool days, student
349.15 nutrition, and student learning experiences
349.16 such as technology, arts, and outdoor activity.

349.17 This is a onetime appropriation.
349.18 Notwithstanding Minnesota Statutes, section
349.19 16B.98, subdivision 14, the amount for
349.20 administrative costs under this paragraph is
349.21 \$0.

349.22 (b) Comunidades Latinas Unidas En
349.23 Servicio Certified Community Behavioral
349.24 Health Clinic Services. \$1,500,000 in fiscal
349.25 year 2025 is for a payment to Comunidades
349.26 Latinas Unidas En Servicio (CLUES) to
349.27 provide comprehensive integrated health care
349.28 through the certified community behavioral
349.29 health clinic (CCBHC) model of service
349.30 delivery as required under Minnesota Statutes,
349.31 section 245.735. Funds must be used to
349.32 provide evidence-based services under the
349.33 CCBHC service model and must not be used
349.34 to supplant available medical assistance
349.35 funding. By June 30, 2026, CLUES must

350.1 report to the commissioner of human services
 350.2 on:
 350.3 (1) the number of people served;
 350.4 (2) outcomes for people served; and
 350.5 (3) whether the funding reduced behavioral
 350.6 health racial and ethnic disparities.

350.7 This is a onetime appropriation and is
 350.8 available until June 30, 2026. Notwithstanding
 350.9 Minnesota Statutes, section 16B.98,
 350.10 subdivision 14, the amount for administrative
 350.11 costs under this paragraph is \$0.

350.12 **(c) Grant to PFund Foundation. \$1,000,000**
 350.13 in fiscal year 2025 is for a payment to the
 350.14 PFund Foundation for grants in Minnesota to
 350.15 support the medical, mental health, and social
 350.16 service needs of LGBTQIA2S+ individuals.

350.17 This is a onetime appropriation.

350.18 **(d) Adult Mental Health Initiative**
 350.19 **Appropriation Cancellation and**
 350.20 **Appropriation. \$11,768,000 of the fiscal year**
 350.21 **2024 appropriation for the adult mental health**
 350.22 **initiative is canceled and \$11,768,000 in fiscal**
 350.23 **year 2025 is for the adult mental health**
 350.24 **initiative. This is a onetime appropriation.**

350.25 **Subd. 9. Grant Programs; Child Mental Health**
 350.26 **Grants**

-0-

7,350,000

350.27 **(a) School-Linked Behavioral Health**
 350.28 **Grants. \$3,000,000 in fiscal year 2025 is for**
 350.29 **school-linked behavioral health grants under**
 350.30 **Minnesota Statutes, section 245.4901. This is**
 350.31 **a onetime appropriation and is available until**
 350.32 **June 30, 2027. Notwithstanding Minnesota**
 350.33 **Statutes, section 16B.98, subdivision 14, the**

351.1 amount for administrative costs under this
351.2 paragraph is \$0.

351.3 (b) **Respite Care Services.** \$2,650,000 in
351.4 fiscal year 2025 is for respite care services
351.5 under Minnesota Statutes, section 245.4889,
351.6 subdivision 1, paragraph (b), clause (3). This
351.7 is a onetime appropriation and is available
351.8 until June 30, 2027. Notwithstanding
351.9 Minnesota Statutes, section 16B.98,
351.10 subdivision 14, the amount for administrative
351.11 costs under this paragraph is \$515,000.

351.12 (c) **Grant to Volunteers of America.**
351.13 \$1,700,000 in fiscal year 2025 is for a grant
351.14 to Volunteers of America for program
351.15 consolidation, workforce training, and the
351.16 development of a trauma-informed locked
351.17 setting environment. This is a onetime
351.18 appropriation and is available until June 30,
351.19 2027. Notwithstanding Minnesota Statutes,
351.20 section 16B.98, subdivision 14, the amount
351.21 for administrative costs under this paragraph
351.22 is \$0.

351.23 Subd. 10. **Direct Care and Treatment; Mental**
351.24 **Health and Substance Abuse**

-0- (6,109,000)

351.25 **Base Level Adjustments.** The general fund
351.26 base is decreased by \$7,566,000 in fiscal year
351.27 2026 and decreased by \$7,566,000 in fiscal
351.28 year 2027.

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

351.30 Sec. 3. **COMMISSIONER OF HEALTH**

351.31 Subdivision 1. **Total Appropriation** \$ (2,690,000) \$ (251,000)

351.32 Appropriations by Fund

351.33 2024 2025

352.1	<u>General</u>	<u>(2,694,000)</u>	<u>2,485,000</u>
352.2	<u>State Government</u>		
352.3	<u>Special Revenue</u>	<u>4,000</u>	<u>(2,736,000)</u>

352.4 The amount that may be spent for each
 352.5 purpose is specified in the following
 352.6 subdivisions.

352.7	<u>Subd. 2. Health Improvement</u>	<u>(2,694,000)</u>	<u>2,075,000</u>
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352.8 (a) Stillbirth Prevention Grant. \$210,000 in
 352.9 fiscal year 2025 is for a grant to Healthy Birth
 352.10 Day, Inc., to operate a stillbirth prevention
 352.11 through tracking fetal movement pilot
 352.12 program. This is a onetime appropriation and
 352.13 is available until June 30, 2028. In accordance
 352.14 with Minnesota Statutes, section 16B.98,
 352.15 subdivision 14, the commissioner may use
 352.16 \$10,000 of this appropriation for
 352.17 administrative costs.

352.18 **(b) Grant to Chosen Vessels Midwifery**
 352.19 **Services. \$263,000 in fiscal year 2025 is for**
 352.20 **a grant to Chosen Vessels Midwifery Services**
 352.21 **for a program to provide education, support,**
 352.22 **and encouragement for African American**
 352.23 **mothers to breastfeed their infants for the first**
 352.24 **year of life or longer. Chosen Vessel**
 352.25 **Midwifery Services must combine the midwife**
 352.26 **model of care with the cultural tradition of**
 352.27 **mutual aid to inspire African American**
 352.28 **women to breastfeed their infants and to**
 352.29 **provide support to those who do. This is a**
 352.30 **onetime appropriation and is available until**
 352.31 **June 30, 2026. In accordance with Minnesota**
 352.32 **Statutes, section 16B.98, subdivision 14, the**
 352.33 **commissioner may use \$13,000 of this**
 352.34 **appropriation for administrative costs.**

353.1 **(c) American Indian Birth Center Planning**
353.2 **Grant.** \$368,000 in fiscal year 2025 is for a
353.3 grant to the Birth Justice Collaborative to plan
353.4 for and engage the community in the
353.5 development of an American Indian-focused
353.6 birth center to improve access to culturally
353.7 centered prenatal and postpartum care with
353.8 the goal of improving maternal and child
353.9 health outcomes. The Birth Justice
353.10 Collaborative must report to the commissioner
353.11 on the plan to develop an American
353.12 Indian-focused birth center. This is a onetime
353.13 appropriation. In accordance with Minnesota
353.14 Statutes, section 16B.98, subdivision 14, the
353.15 commissioner may use \$18,000 of this
353.16 appropriation for administrative costs.

353.17 **(d) Grant to Birth Justice Collaborative for**
353.18 **African American-Focused Homeplace**
353.19 **Model.** \$263,000 in fiscal year 2025 is for a
353.20 grant to the Birth Justice Collaborative for
353.21 planning and community engagement to
353.22 develop a replicable African
353.23 American-focused Homeplace model. The
353.24 model's purpose must be to improve access to
353.25 culturally centered healing and care during
353.26 pregnancy and the postpartum period, with
353.27 the goal of improving maternal and child
353.28 health outcomes. The Birth Justice
353.29 Collaborative must report to the commissioner
353.30 on the needs of and plan to develop an African
353.31 American-focused Homeplace model in
353.32 Hennepin County. The report must outline
353.33 potential state and public partnerships and
353.34 financing strategies and must provide a
353.35 timeline for development. This is a onetime
353.36 appropriation. In accordance with Minnesota

354.1 Statutes, section 16B.98, subdivision 14, the
 354.2 commissioner may use \$13,000 of this
 354.3 appropriation for administrative costs.

354.4 **(e) Request for Information; Evaluation of**
 354.5 **Statewide Health Care Needs and Capacity.**
 354.6 \$250,000 in fiscal year 2025 is for a request
 354.7 for information for a future evaluation of
 354.8 statewide health care needs and capacity and
 354.9 projections of future health care needs. This
 354.10 is a onetime appropriation.

354.11 **(f) Reports on Prior Authorization**
 354.12 **Requests.** \$191,000 in fiscal year 2025 is for
 354.13 the purposes of Minnesota Statutes, section
 354.14 62M.19. This appropriation is available until
 354.15 June 30, 2027. The base for this appropriation
 354.16 is \$21,000 in fiscal year 2026 and \$22,000 in
 354.17 fiscal year 2027.

354.18 **(g) Base Level Adjustment.** The general fund
 354.19 base is increased by \$247,000 in fiscal year
 354.20 2026 and increased by \$318,000 in fiscal year
 354.21 2027.

354.22 **Subd. 3. Health Protection**

354.23	<u>Appropriations by Fund</u>		
354.24	<u>General</u>	<u>-0-</u>	<u>410,000</u>
354.25	<u>State Government</u>		
354.26	<u>Special Revenue</u>	<u>4,000</u>	<u>(2,736,000)</u>

354.27 **(a) Translation of Competency Evaluation**
 354.28 **for Nursing Assistant Registry.** \$20,000 in
 354.29 fiscal year 2025 is from the general fund for
 354.30 translation of competency evaluation materials
 354.31 for the nursing assistant registry. This is a
 354.32 onetime appropriation.

354.33 **(b) Hospital Closure, Relocation, or Service**
 354.34 **Cessation.** \$9,000 in fiscal year 2025 is from

355.1 the general fund for activities under Minnesota
 355.2 Statutes, section 144.555.

355.3 **(c) Natural Organic Reduction.** \$140,000 in
 355.4 fiscal year 2025 is from the state government
 355.5 special revenue fund for the licensure of
 355.6 natural organic reduction facilities. The base
 355.7 for this appropriation is \$85,000 in fiscal year
 355.8 2026 and \$16,000 in fiscal year 2027.

355.9 **(d) Groundwater Thermal Exchange Device**
 355.10 **Permitting.** \$4,000 in fiscal year 2024 and
 355.11 \$4,000 in fiscal year 2025 are from the state
 355.12 government special revenue fund for costs
 355.13 related to issuing permits for groundwater
 355.14 thermal exchange devices.

355.15 **(e) Base Level Adjustment.** The general fund
 355.16 base is increased by \$390,000 in fiscal year
 355.17 2026 and increased by \$185,000 in fiscal year
 355.18 2027. The state government special revenue
 355.19 fund base is decreased by \$2,791,000 in fiscal
 355.20 year 2026 and decreased by \$2,860,000 in
 355.21 fiscal year 2027.

355.22 **Sec. 4. BOARD OF PHARMACY**

355.23	<u>Appropriations by Fund</u>		
355.24	<u>General</u>	<u>1,500,000</u>	<u>-0-</u>
355.25	<u>State Government</u>		
355.26	<u>Special Revenue</u>	<u>-0-</u>	<u>27,000</u>

355.27 **(a) Legal Costs.** \$1,500,000 in fiscal year
 355.28 2024 is from the general fund for legal costs.
 355.29 This is a onetime appropriation.

355.30 **(b) Base Level Adjustment.** The state
 355.31 government special revenue fund base is
 355.32 increased by \$27,000 in fiscal year 2026 and
 355.33 increased by \$27,000 in fiscal year 2027.

356.1 **Sec. 5. RARE DISEASE ADVISORY**
 356.2 **COUNCIL** \$ -0- \$ 342,000

356.3 This is a onetime appropriation and is
 356.4 available until June 30, 2027.

356.5 **Sec. 6. COMMISSIONER OF MANAGEMENT**
 356.6 **AND BUDGET**

356.7	<u>Appropriations by Fund</u>		
356.8		<u>2024</u>	<u>2025</u>
356.9	<u>General</u>	<u>-0-</u>	<u>(232,000)</u>
356.10	<u>Health Care Access</u>	<u>-0-</u>	<u>100,000</u>

356.11 (a) **Insulin safety net program.** \$100,000 in
 356.12 fiscal year 2025 is from the health care access
 356.13 fund for the insulin safety net program in
 356.14 Minnesota Statutes, section 151.74.

356.15 (b) **Transfer.** The commissioner must transfer
 356.16 from the health care access fund to the insulin
 356.17 safety net program account in the special
 356.18 revenue fund the amount certified by the
 356.19 commissioner of administration under
 356.20 Minnesota Statutes, section 151.741,
 356.21 subdivision 5, paragraph (b), estimated to be
 356.22 \$100,000 in fiscal year 2025, for
 356.23 reimbursement to manufacturers for insulin
 356.24 dispensed under the insulin safety net program
 356.25 in Minnesota Statutes, section 151.74. The
 356.26 base for this transfer is estimated to be
 356.27 \$100,000 in fiscal year 2026 and \$100,000 in
 356.28 fiscal year 2027.

356.29 (c) **Base Level Adjustment.** The health care
 356.30 access fund base is increased by \$100,000 in
 356.31 fiscal year 2026 and increased by \$100,000 in
 356.32 fiscal year 2027.

356.33 **Sec. 7. BOARD OF DIRECTORS OF MNSURE** \$ -0- \$ 2,330,000

357.1 (a) Information Technology to Implement
 357.2 Federal Deferred Action for Childhood
 357.3 Arrivals Regulatory Requirements.
 357.4 \$2,330,000 in fiscal year 2025 is for
 357.5 information technology to implement federal
 357.6 Deferred Action for Childhood Arrivals
 357.7 regulatory requirements. This is a onetime
 357.8 appropriation and is available until June 30,
 357.9 2027.

357.10 (b) Transfer to Enterprise Account. The
 357.11 Board of Directors of MNsure must transfer
 357.12 \$2,330,000 in fiscal year 2025 from the
 357.13 general fund to the enterprise account under
 357.14 Minnesota Statutes, section 62V.07. This is a
 357.15 onetime transfer.

357.16 Sec. 8. COMMISSIONER OF COMMERCE \$ -0- \$ 149,000

357.17 (a) Defrayal of Costs for Mandated
 357.18 Coverage of Orthotic and Prosthetic
 357.19 Devices. The general fund base is increased
 357.20 by \$558,000 in fiscal year 2026 and increased
 357.21 by \$539,000 in fiscal year 2027. The base
 357.22 includes \$520,000 in fiscal year 2026 and
 357.23 \$540,000 in fiscal year 2027 for the estimated
 357.24 amount of defrayal costs for mandated
 357.25 coverage of orthotic and prosthetic devices
 357.26 and \$38,000 in fiscal year 2026 and \$19,000
 357.27 in fiscal year 2027 for administrative costs to
 357.28 implement mandated coverage of orthotic and
 357.29 prosthetic devices.

357.30 (b) Defrayal of Costs for Mandated
 357.31 Coverage of Abortions and
 357.32 Abortion-Related Services. The general fund
 357.33 base is increased by \$338,000 in fiscal year
 357.34 2026 and increased by \$319,000 in fiscal year
 357.35 2027. The base includes \$300,000 in fiscal

359.1 year 2025 is for review and related
359.2 investigatory and enforcement actions for
359.3 conversion transactions under Minnesota
359.4 Statutes, sections 145D.30 to 145D.37.

359.5 (b) **Base Level Adjustment.** The general fund
359.6 base is increased by \$53,000 in fiscal year
359.7 2026 and increased by \$53,000 in fiscal year
359.8 2027.

359.9 Sec. 10. Laws 2023, chapter 22, section 4, subdivision 2, is amended to read:

359.10 Subd. 2. **Grants to navigators.**

359.11 (a) \$1,936,000 in fiscal year 2024 is
359.12 appropriated from the health care access fund
359.13 to the commissioner of human services for
359.14 grants to organizations with a MNsure grant
359.15 services navigator assister contract in good
359.16 standing as of the date of enactment. The grant
359.17 payment to each organization must be in
359.18 proportion to the number of medical assistance
359.19 and MinnesotaCare enrollees each
359.20 organization assisted that resulted in a
359.21 successful enrollment in the second quarter of
359.22 fiscal years 2020 and 2023, as determined by
359.23 MNsure's navigator payment process. This is
359.24 a onetime appropriation and is available until
359.25 June 30, 2025.

359.26 (b) \$3,000,000 in fiscal year 2024 is
359.27 appropriated from the health care access fund
359.28 to the commissioner of human services for
359.29 grants to organizations with a MNsure grant
359.30 services navigator assister contract for
359.31 successful enrollments in medical assistance
359.32 and MinnesotaCare. This is a onetime
359.33 appropriation and is available until June 30,
359.34 2025.

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

360.2 Sec. 11. Laws 2023, chapter 57, article 1, section 6, is amended to read:

360.3 Sec. 6. **PREMIUM SECURITY ACCOUNT TRANSFER; OUT.**

360.4 ~~\$275,775,000~~ \$284,605,000 in fiscal year 2026 is transferred from the premium security
360.5 plan account under Minnesota Statutes, section 62E.25, subdivision 1, to the general fund.
360.6 This is a onetime transfer.

360.7 Sec. 12. Laws 2023, chapter 70, article 20, section 2, subdivision 5, is amended to read:

360.8 Subd. 5. **Central Office; Health Care**

360.9	Appropriations by Fund		
360.10	General	35,807,000	31,349,000
360.11	Health Care Access	30,668,000	50,168,000

360.12 (a) **Medical assistance and MinnesotaCare**
360.13 **accessibility improvements.** \$4,000,000 in
360.14 fiscal year 2024 is from the general fund for
360.15 interactive voice response upgrades and
360.16 translation services for medical assistance and
360.17 MinnesotaCare enrollees with limited English
360.18 proficiency. This appropriation is available
360.19 until June 30, 2025.

360.20 (b) **Transforming service delivery.** \$155,000
360.21 in fiscal year 2024 and \$180,000 in fiscal year
360.22 2025 are from the general fund for
360.23 transforming service delivery projects.

360.24 (c) **Improving the Minnesota eligibility**
360.25 **technology system functionality.** \$1,604,000
360.26 in fiscal year 2024 and \$711,000 in fiscal year
360.27 2025 are from the general fund for improving
360.28 the Minnesota eligibility technology system
360.29 functionality. The base for this appropriation
360.30 is \$1,421,000 in fiscal year 2026 and \$0 in
360.31 fiscal year 2027.

361.1 **(d) Actuarial and economic analyses.**
361.2 \$2,500,000 is from the health care access fund
361.3 for actuarial and economic analyses and to
361.4 prepare and submit a state innovation waiver
361.5 under section 1332 of the federal Affordable
361.6 Care Act for a Minnesota public option health
361.7 care plan. This is a onetime appropriation and
361.8 is available until June 30, 2025.

361.9 **(e) Contingent appropriation for Minnesota**
361.10 **public option health care plan. ~~\$22,000,000~~**
361.11 **\$21,000,000** in fiscal year 2025 is from the
361.12 health care access fund to implement a
361.13 Minnesota public option health care plan. This
361.14 is a onetime appropriation and is available
361.15 upon approval of a state innovation waiver
361.16 under section 1332 of the federal Affordable
361.17 Care Act. This appropriation is available until
361.18 June 30, 2027.

361.19 **(f) Carryforward authority.** Notwithstanding
361.20 Minnesota Statutes, section 16A.28,
361.21 subdivision 3, \$2,367,000 of the appropriation
361.22 in fiscal year 2024 is available until June 30,
361.23 2027.

361.24 **(g) Base level adjustment.** The general fund
361.25 base is \$32,315,000 in fiscal year 2026 and
361.26 \$27,536,000 in fiscal year 2027. The health
361.27 care access fund base is \$28,168,000 in fiscal
361.28 year 2026 and \$28,168,000 in fiscal year 2027.

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

362.1 Sec. 13. Laws 2023, chapter 70, article 20, section 2, subdivision 31, as amended by Laws
362.2 2023, chapter 75, section 12, is amended to read:

362.3 Subd. 31. **Direct Care and Treatment - Mental**
362.4 **Health and Substance Abuse** -0- 6,109,000

362.5 ~~(a) Keeping Nurses at the Bedside Act;~~
362.6 ~~contingent appropriation. The appropriation~~
362.7 ~~in this subdivision is contingent upon~~
362.8 ~~legislative enactment by the 93rd Legislature~~
362.9 ~~of provisions substantially similar to 2023 S.F.~~
362.10 ~~No. 1561, the second engrossment, article 2.~~

362.11 ~~(b) Base level adjustment.~~ The general fund
362.12 base is increased by \$7,566,000 in fiscal year
362.13 2026 and increased by \$7,566,000 in fiscal
362.14 year 2027.

362.15 Sec. 14. Laws 2023, chapter 70, article 20, section 3, subdivision 2, is amended to read:

362.16 Subd. 2. **Health Improvement**

362.17	Appropriations by Fund		
362.18	General	229,600,000	210,030,000
362.19	State Government		
362.20	Special Revenue	12,392,000	12,682,000
362.21	Health Care Access	49,051,000	53,290,000
362.22	Federal TANF	11,713,000	11,713,000

362.23 (a) **Studies of telehealth expansion and**
362.24 **payment parity.** \$1,200,000 in fiscal year
362.25 2024 is from the general fund for studies of
362.26 telehealth expansion and payment parity. This
362.27 is a onetime appropriation and is available
362.28 until June 30, 2025.

362.29 (b) **Advancing equity through capacity**
362.30 **building and resource allocation grant**
362.31 **program.** \$916,000 in fiscal year 2024 and
362.32 \$916,000 in fiscal year 2025 are from the
362.33 general fund for grants under Minnesota

363.1 Statutes, section 144.9821. This is a onetime
363.2 appropriation.

363.3 **(c) Grant to Minnesota Community Health**
363.4 **Worker Alliance.** \$971,000 in fiscal year
363.5 2024 and \$971,000 in fiscal year 2025 are
363.6 from the general fund for Minnesota Statutes,
363.7 section 144.1462.

363.8 **(d) Community solutions for healthy child**
363.9 **development grants.** \$2,730,000 in fiscal year
363.10 2024 and \$2,730,000 in fiscal year 2025 are
363.11 from the general fund for grants under
363.12 Minnesota Statutes, section 145.9257. The
363.13 base for this appropriation is \$2,415,000 in
363.14 fiscal year 2026 and \$2,415,000 in fiscal year
363.15 2027.

363.16 **(e) Comprehensive Overdose and Morbidity**
363.17 **Prevention Act.** \$9,794,000 in fiscal year
363.18 2024 and \$10,458,000 in fiscal year 2025 are
363.19 from the general fund for comprehensive
363.20 overdose and morbidity prevention strategies
363.21 under Minnesota Statutes, section 144.0528.
363.22 The base for this appropriation is \$10,476,000
363.23 in fiscal year 2026 and \$10,476,000 in fiscal
363.24 year 2027.

363.25 **(f) Emergency preparedness and response.**
363.26 \$10,486,000 in fiscal year 2024 and
363.27 \$14,314,000 in fiscal year 2025 are from the
363.28 general fund for public health emergency
363.29 preparedness and response, the sustainability
363.30 of the strategic stockpile, and COVID-19
363.31 pandemic response transition. The base for
363.32 this appropriation is \$11,438,000 in fiscal year
363.33 2026 and \$11,362,000 in fiscal year 2027.

364.1 **(g) Healthy Beginnings, Healthy Families.**
364.2 (1) \$8,440,000 in fiscal year 2024 and
364.3 \$7,305,000 in fiscal year 2025 are from the
364.4 general fund for grants under Minnesota
364.5 Statutes, sections 145.9571 to 145.9576. The
364.6 base for this appropriation is \$1,500,000 in
364.7 fiscal year 2026 and \$1,500,000 in fiscal year
364.8 2027. (2) Of the amount in clause (1),
364.9 \$400,000 in fiscal year 2024 is to support the
364.10 transition from implementation of activities
364.11 under Minnesota Statutes, section 145.4235,
364.12 to implementation of activities under
364.13 Minnesota Statutes, sections 145.9571 to
364.14 145.9576. The commissioner shall award four
364.15 sole-source grants of \$100,000 each to Face
364.16 to Face, Cradle of Hope, Division of Indian
364.17 Work, and Minnesota Prison Doula Project.
364.18 The amount in this clause is a onetime
364.19 appropriation.

364.20 **(h) Help Me Connect.** \$463,000 in fiscal year
364.21 2024 and \$921,000 in fiscal year 2025 are
364.22 from the general fund for the Help Me
364.23 Connect program under Minnesota Statutes,
364.24 section 145.988.

364.25 **(i) Home visiting.** \$2,000,000 in fiscal year
364.26 2024 and \$2,000,000 in fiscal year 2025 are
364.27 from the general fund for home visiting under
364.28 Minnesota Statutes, section 145.87, to provide
364.29 home visiting to priority populations under
364.30 Minnesota Statutes, section 145.87,
364.31 subdivision 1, paragraph (e).

364.32 **(j) No Surprises Act enforcement.**
364.33 \$1,210,000 in fiscal year 2024 and \$1,090,000
364.34 in fiscal year 2025 are from the general fund
364.35 for implementation of the federal No Surprises

365.1 Act under Minnesota Statutes, section
365.2 62Q.021, and an assessment of the feasibility
365.3 of a statewide provider directory. The general
365.4 fund base for this appropriation is \$855,000
365.5 in fiscal year 2026 and \$855,000 in fiscal year
365.6 2027.

365.7 **(k) Office of African American Health.**
365.8 \$1,000,000 in fiscal year 2024 and \$1,000,000
365.9 in fiscal year 2025 are from the general fund
365.10 for grants under the authority of the Office of
365.11 African American Health under Minnesota
365.12 Statutes, section 144.0756.

365.13 **(l) Office of American Indian Health.**
365.14 \$1,000,000 in fiscal year 2024 and \$1,000,000
365.15 in fiscal year 2025 are from the general fund
365.16 for grants under the authority of the Office of
365.17 American Indian Health under Minnesota
365.18 Statutes, section 144.0757.

365.19 **(m) Public health system transformation**
365.20 **grants.** (1) \$9,844,000 in fiscal year 2024 and
365.21 \$9,844,000 in fiscal year 2025 are from the
365.22 general fund for grants under Minnesota
365.23 Statutes, section 145A.131, subdivision 1,
365.24 paragraph (f).

365.25 (2) \$535,000 in fiscal year 2024 and \$535,000
365.26 in fiscal year 2025 are from the general fund
365.27 for grants under Minnesota Statutes, section
365.28 145A.14, subdivision 2b.

365.29 (3) \$321,000 in fiscal year 2024 and \$321,000
365.30 in fiscal year 2025 are from the general fund
365.31 for grants under Minnesota Statutes, section
365.32 144.0759.

365.33 **(n) Health care workforce.** (1) \$1,010,000
365.34 in fiscal year 2024 and \$2,550,000 in fiscal

366.1 year 2025 are from the health care access fund
366.2 for rural training tracks and rural clinicals
366.3 grants under Minnesota Statutes, sections
366.4 144.1505 and 144.1507. The base for this
366.5 appropriation is \$4,060,000 in fiscal year 2026
366.6 and \$3,600,000 in fiscal year 2027.

366.7 (2) \$420,000 in fiscal year 2024 and \$420,000
366.8 in fiscal year 2025 are from the health care
366.9 access fund for immigrant international
366.10 medical graduate training grants under
366.11 Minnesota Statutes, section 144.1911.

366.12 (3) \$5,654,000 in fiscal year 2024 and
366.13 \$5,550,000 in fiscal year 2025 are from the
366.14 health care access fund for site-based clinical
366.15 training grants under Minnesota Statutes,
366.16 section 144.1508. The base for this
366.17 appropriation is \$4,657,000 in fiscal year 2026
366.18 and \$3,451,000 in fiscal year 2027.

366.19 (4) \$1,000,000 in fiscal year 2024 and
366.20 \$1,000,000 in fiscal year 2025 are from the
366.21 health care access fund for mental health for
366.22 health care professional grants. This is a
366.23 onetime appropriation and is available until
366.24 June 30, 2027.

366.25 (5) \$502,000 in fiscal year 2024 and \$502,000
366.26 in fiscal year 2025 are from the health care
366.27 access fund for workforce research and data
366.28 analysis of shortages, maldistribution of health
366.29 care providers in Minnesota, and the factors
366.30 that influence decisions of health care
366.31 providers to practice in rural areas of
366.32 Minnesota.

366.33 (o) **School health.** \$800,000 in fiscal year
366.34 2024 and \$1,300,000 in fiscal year 2025 are

367.1 from the general fund for grants under
367.2 Minnesota Statutes, section 145.903. The base
367.3 for this appropriation is \$2,300,000 in fiscal
367.4 year 2026 and \$2,300,000 in fiscal year 2027.

367.5 **(p) Long COVID.** \$3,146,000 in fiscal year
367.6 2024 and \$3,146,000 in fiscal year 2025 are
367.7 from the general fund for grants and to
367.8 implement Minnesota Statutes, section
367.9 145.361.

367.10 **(q) Workplace safety grants.** \$4,400,000 in
367.11 fiscal year 2024 is from the general fund for
367.12 grants to health care entities to improve
367.13 employee safety or security. This is a onetime
367.14 appropriation and is available until June 30,
367.15 2027. The commissioner may use up to ten
367.16 percent of this appropriation for
367.17 administration.

367.18 **(r) Clinical dental education innovation**
367.19 **grants.** \$1,122,000 in fiscal year 2024 and
367.20 \$1,122,000 in fiscal year 2025 are from the
367.21 general fund for clinical dental education
367.22 innovation grants under Minnesota Statutes,
367.23 section 144.1913.

367.24 **(s) Emmett Louis Till Victims Recovery**
367.25 **Program.** \$500,000 in fiscal year 2024 is from
367.26 the general fund for a grant to the Emmett
367.27 Louis Till Victims Recovery Program. The
367.28 commissioner must not use any of this
367.29 appropriation for administration. This is a
367.30 onetime appropriation and is available until
367.31 June 30, 2025.

367.32 **(t) Center for health care affordability.**
367.33 \$2,752,000 in fiscal year 2024 and \$3,989,000
367.34 in fiscal year 2025 are from the general fund

368.1 to establish a center for health care
368.2 affordability and to implement Minnesota
368.3 Statutes, section 62J.312. The general fund
368.4 base for this appropriation is \$3,988,000 in
368.5 fiscal year 2026 and \$3,988,000 in fiscal year
368.6 2027.

368.7 **(u) Federally qualified health centers**
368.8 **apprenticeship program.** \$690,000 in fiscal
368.9 year 2024 and \$690,000 in fiscal year 2025
368.10 are from the general fund for grants under
368.11 Minnesota Statutes, section 145.9272.

368.12 **(v) Alzheimer's public information**
368.13 **program.** \$80,000 in fiscal year 2024 and
368.14 \$80,000 in fiscal year 2025 are from the
368.15 general fund for grants to community-based
368.16 organizations to co-create culturally specific
368.17 messages to targeted communities and to
368.18 promote public awareness materials online
368.19 through diverse media channels.

368.20 ~~(w) **Keeping Nurses at the Bedside Act;**~~
368.21 ~~**contingent appropriation Nurse and Patient**~~
368.22 ~~**Safety Act.** The appropriations in this~~
368.23 ~~paragraph are contingent upon legislative~~
368.24 ~~enactment of 2023 Senate File 1384 by the~~
368.25 ~~93rd Legislature. The appropriations in this~~
368.26 ~~paragraph are available until June 30, 2027.~~

368.27 (1) \$5,317,000 in fiscal year 2024 and
368.28 \$5,317,000 in fiscal year 2025 are from the
368.29 general fund for loan forgiveness under
368.30 Minnesota Statutes, section 144.1501, for
368.31 eligible nurses who have agreed to work as
368.32 hospital nurses in accordance with Minnesota
368.33 Statutes, section 144.1501, subdivision 2,
368.34 paragraph (a), clause (7).

369.1 (2) \$66,000 in fiscal year 2024 and \$66,000
369.2 in fiscal year 2025 are from the general fund
369.3 for loan forgiveness under Minnesota Statutes,
369.4 section 144.1501, for eligible nurses who have
369.5 agreed to teach in accordance with Minnesota
369.6 Statutes, section 144.1501, subdivision 2,
369.7 paragraph (a), clause (3).

369.8 ~~(3) \$545,000 in fiscal year 2024 and \$879,000~~
369.9 ~~in fiscal year 2025 are from the general fund~~
369.10 ~~to administer Minnesota Statutes, section~~
369.11 ~~144.7057; to perform the evaluation duties~~
369.12 ~~described in Minnesota Statutes, section~~
369.13 ~~144.7058; to continue prevention of violence~~
369.14 ~~in health care program activities; to analyze~~
369.15 ~~potential links between adverse events and~~
369.16 ~~understaffing; to convene stakeholder groups~~
369.17 ~~and create a best practices toolkit; and for a~~
369.18 ~~report on the current status of the state's~~
369.19 ~~nursing workforce employed by hospitals. The~~
369.20 ~~base for this appropriation is \$624,000 in fiscal~~
369.21 ~~year 2026 and \$454,000 in fiscal year 2027.~~

369.22 **(x) Supporting healthy development of**
369.23 **babies.** \$260,000 in fiscal year 2024 and
369.24 \$260,000 in fiscal year 2025 are from the
369.25 general fund for a grant to the Amherst H.
369.26 Wilder Foundation for the African American
369.27 Babies Coalition initiative. The base for this
369.28 appropriation is \$520,000 in fiscal year 2026
369.29 and \$0 in fiscal year 2027. Any appropriation
369.30 in fiscal year 2026 is available until June 30,
369.31 2027. This paragraph expires on June 30,
369.32 2027.

369.33 **(y) Health professional education loan**
369.34 **forgiveness.** \$2,780,000 in fiscal year 2024
369.35 is from the general fund for eligible mental

370.1 health professional loan forgiveness under
370.2 Minnesota Statutes, section 144.1501. This is
370.3 a onetime appropriation. The commissioner
370.4 may use up to ten percent of this appropriation
370.5 for administration.

370.6 **(z) Primary care residency expansion grant**
370.7 **program.** \$400,000 in fiscal year 2024 and
370.8 \$400,000 in fiscal year 2025 are from the
370.9 general fund for a psychiatry resident under
370.10 Minnesota Statutes, section 144.1506.

370.11 **(aa) Pediatric primary care mental health**
370.12 **training grant program.** \$1,000,000 in fiscal
370.13 year 2024 and \$1,000,000 in fiscal year 2025
370.14 are from the general fund for grants under
370.15 Minnesota Statutes, section 144.1509. The
370.16 commissioner may use up to ten percent of
370.17 this appropriation for administration.

370.18 **(bb) Mental health cultural community**
370.19 **continuing education grant program.**
370.20 \$500,000 in fiscal year 2024 and \$500,000 in
370.21 fiscal year 2025 are from the general fund for
370.22 grants under Minnesota Statutes, section
370.23 144.1511. The commissioner may use up to
370.24 ten percent of this appropriation for
370.25 administration.

370.26 **(cc) Labor trafficking services grant**
370.27 **program.** \$500,000 in fiscal year 2024 and
370.28 \$500,000 in fiscal year 2025 are from the
370.29 general fund for grants under Minnesota
370.30 Statutes, section 144.3885.

370.31 **(dd) Palliative Care Advisory Council.**
370.32 ~~\$40,000~~ \$44,000 in fiscal year 2024 and
370.33 ~~\$40,000~~ \$44,000 in fiscal year 2025 are from

371.1 the general fund for ~~grants under~~ Minnesota
371.2 Statutes, section 144.059.

371.3 **(ee) Analysis of a universal health care**
371.4 **financing system.** \$1,815,000 in fiscal year
371.5 2024 and \$580,000 in fiscal year 2025 are
371.6 from the general fund to the commissioner to
371.7 contract for an analysis of the benefits and
371.8 costs of a legislative proposal for a universal
371.9 health care financing system and a similar
371.10 analysis of the current health care financing
371.11 system. The base for this appropriation is
371.12 \$580,000 in fiscal year 2026 and \$0 in fiscal
371.13 year 2027. This appropriation is available until
371.14 June 30, 2027.

371.15 **(ff) Charitable assets public interest review.**
371.16 (1) The appropriations under this paragraph
371.17 are contingent upon legislative enactment of
371.18 2023 House File 402 by the 93rd Legislature.

371.19 (2) \$1,584,000 in fiscal year 2024 and
371.20 \$769,000 in fiscal year 2025 are from the
371.21 general fund to review certain health care
371.22 entity transactions; to conduct analyses of the
371.23 impacts of health care transactions on health
371.24 care cost, quality, and competition; and to
371.25 issue public reports on health care transactions
371.26 in Minnesota and their impacts. The base for
371.27 this appropriation is \$710,000 in fiscal year
371.28 2026 and \$710,000 in fiscal year 2027.

371.29 **(gg) Study of the development of a statewide**
371.30 **registry for provider orders for**
371.31 **life-sustaining treatment.** ~~\$365,000~~ \$225,000
371.32 in fiscal year 2024 ~~and \$365,000 in fiscal year~~
371.33 ~~2025 are~~ is from the general fund for a study
371.34 of the development of a statewide registry for

372.1 provider orders for life-sustaining treatment.
372.2 This is a onetime appropriation.

372.3 **(hh) Task Force on Pregnancy Health and**
372.4 **Substance Use Disorders.** \$199,000 in fiscal
372.5 year 2024 and \$100,000 in fiscal year 2025
372.6 are from the general fund for the Task Force
372.7 on Pregnancy Health and Substance Use
372.8 Disorders. This is a onetime appropriation and
372.9 is available until June 30, 2025.

372.10 **(ii) 988 Suicide and crisis lifeline.** \$4,000,000
372.11 in fiscal year 2024 is from the general fund
372.12 for 988 national suicide prevention lifeline
372.13 grants under Minnesota Statutes, section
372.14 145.561. This is a onetime appropriation.

372.15 **(jj) Equitable Health Care Task Force.**
372.16 \$779,000 in fiscal year 2024 and \$749,000 in
372.17 fiscal year 2025 are from the general fund for
372.18 the Equitable Health Care Task Force. This is
372.19 a onetime appropriation.

372.20 **(kk) Psychedelic Medicine Task Force.**
372.21 \$338,000 in fiscal year 2024 and \$171,000 in
372.22 fiscal year 2025 are from the general fund for
372.23 the Psychedelic Medicine Task Force. This is
372.24 a onetime appropriation.

372.25 **(ll) Medical education and research costs.**
372.26 \$300,000 in fiscal year 2024 and \$300,000 in
372.27 fiscal year 2025 are from the general fund for
372.28 the medical education and research costs
372.29 program under Minnesota Statutes, section
372.30 62J.692.

372.31 **(mm) Special Guerilla Unit Veterans grant**
372.32 **program.** \$250,000 in fiscal year 2024 and
372.33 \$250,000 in fiscal year 2025 are from the
372.34 general fund for a grant to the Special

373.1 Guerrilla Units Veterans and Families of the
373.2 United States of America to offer
373.3 programming and culturally specific and
373.4 specialized assistance to support the health
373.5 and well-being of Special Guerilla Unit
373.6 Veterans. The base for this appropriation is
373.7 \$500,000 in fiscal year 2026 and \$0 in fiscal
373.8 year 2027. Any amount appropriated in fiscal
373.9 year 2026 is available until June 30, 2027.

373.10 This paragraph expires June 30, 2027.

373.11 **(nn) Safe harbor regional navigator.**

373.12 \$300,000 in fiscal year 2024 and \$300,000 in
373.13 fiscal year 2025 are for a regional navigator
373.14 in northwestern Minnesota. The commissioner
373.15 may use up to ten percent of this appropriation
373.16 for administration.

373.17 **(oo) Network adequacy.** \$798,000 in fiscal
373.18 year 2024 and \$491,000 in fiscal year 2025
373.19 are from the general fund for reviews of
373.20 provider networks under Minnesota Statutes,
373.21 section 62K.10, to determine network
373.22 adequacy.

373.23 **(pp) Grant to Minnesota Alliance for**
373.24 **Volunteer Advancement.** \$278,000 in fiscal
373.25 year 2024 is from the general fund for a grant
373.26 to the Minnesota Alliance for Volunteer
373.27 Advancement to administer needs-based
373.28 volunteerism subgrants targeting
373.29 underresourced nonprofit organizations in
373.30 greater Minnesota. Subgrants must be used to
373.31 support the ongoing efforts of selected
373.32 organizations to address and minimize
373.33 disparities in access to human services through
373.34 increased volunteerism. Subgrant applicants
373.35 must demonstrate that the populations to be

374.1 served by the subgrantee are underserved or
374.2 suffer from or are at risk of homelessness,
374.3 hunger, poverty, lack of access to health care,
374.4 or deficits in education. The Minnesota
374.5 Alliance for Volunteer Advancement must
374.6 give priority to organizations that are serving
374.7 the needs of vulnerable populations. This is a
374.8 onetime appropriation and is available until
374.9 June 30, 2025.

374.10 ~~(pp)~~ (qq)(1) **TANF Appropriations.** TANF
374.11 funds must be used as follows:

374.12 (i) \$3,579,000 in fiscal year 2024 and
374.13 \$3,579,000 in fiscal year 2025 are from the
374.14 TANF fund for home visiting and nutritional
374.15 services listed under Minnesota Statutes,
374.16 section 145.882, subdivision 7, clauses (6) and
374.17 (7). Funds must be distributed to community
374.18 health boards according to Minnesota Statutes,
374.19 section 145A.131, subdivision 1;

374.20 (ii) \$2,000,000 in fiscal year 2024 and
374.21 \$2,000,000 in fiscal year 2025 are from the
374.22 TANF fund for decreasing racial and ethnic
374.23 disparities in infant mortality rates under
374.24 Minnesota Statutes, section 145.928,
374.25 subdivision 7;

374.26 (iii) \$4,978,000 in fiscal year 2024 and
374.27 \$4,978,000 in fiscal year 2025 are from the
374.28 TANF fund for the family home visiting grant
374.29 program under Minnesota Statutes, section
374.30 145A.17. \$4,000,000 of the funding in fiscal
374.31 year 2024 and \$4,000,000 in fiscal year 2025
374.32 must be distributed to community health
374.33 boards under Minnesota Statutes, section
374.34 145A.131, subdivision 1. \$978,000 of the
374.35 funding in fiscal year 2024 and \$978,000 in

375.1 fiscal year 2025 must be distributed to Tribal
 375.2 governments under Minnesota Statutes, section
 375.3 145A.14, subdivision 2a;

375.4 (iv) \$1,156,000 in fiscal year 2024 and
 375.5 \$1,156,000 in fiscal year 2025 are from the
 375.6 TANF fund for sexual and reproductive health
 375.7 services grants under Minnesota Statutes,
 375.8 section 145.925; and

375.9 (v) the commissioner may use up to 6.23
 375.10 percent of the funds appropriated from the
 375.11 TANF fund each fiscal year to conduct the
 375.12 ongoing evaluations required under Minnesota
 375.13 Statutes, section 145A.17, subdivision 7, and
 375.14 training and technical assistance as required
 375.15 under Minnesota Statutes, section 145A.17,
 375.16 subdivisions 4 and 5.

375.17 (2) **TANF Carryforward.** Any unexpended
 375.18 balance of the TANF appropriation in the first
 375.19 year does not cancel but is available in the
 375.20 second year.

375.21 ~~(qq)~~ **(rr) Base level adjustments.** The general
 375.22 fund base is \$197,644,000 in fiscal year 2026
 375.23 and \$195,714,000 in fiscal year 2027. The
 375.24 health care access fund base is \$53,354,000
 375.25 in fiscal year 2026 and \$50,962,000 in fiscal
 375.26 year 2027.

375.27 **EFFECTIVE DATE.** This section is effective the day following final enactment, except
 375.28 paragraph (pp) is effective retroactively from July 1, 2023.

375.29 Sec. 15. Laws 2023, chapter 70, article 20, section 12, as amended by Laws 2023, chapter
 375.30 75, section 13, is amended to read:

375.31 **Sec. 12. COMMISSIONER OF**
 375.32 **MANAGEMENT AND BUDGET** \$ 12,932,000 \$ 3,412,000

376.1 (a) **Outcomes and evaluation consultation.**
 376.2 \$450,000 in fiscal year 2024 and \$450,000 in
 376.3 fiscal year 2025 are for outcomes and
 376.4 evaluation consultation requirements.

376.5 (b) **Department of Children, Youth, and**
 376.6 **Families.** \$11,931,000 in fiscal year 2024 and
 376.7 \$2,066,000 in fiscal year 2025 are to establish
 376.8 the Department of Children, Youth, and
 376.9 Families. This is a onetime appropriation.

376.10 ~~(e) **Keeping Nurses at the Bedside Act**~~
 376.11 ~~**impact evaluation; contingent**~~
 376.12 ~~**appropriation.** \$232,000 in fiscal year 2025~~
 376.13 ~~is for the Keeping Nurses at the Bedside Act~~
 376.14 ~~impact evaluation. This appropriation is~~
 376.15 ~~contingent upon legislative enactment by the~~
 376.16 ~~93rd Legislature of a provision substantially~~
 376.17 ~~similar to the impact evaluation provision in~~
 376.18 ~~2023 S.F. No. 2995, the third engrossment,~~
 376.19 ~~article 3, section 22. This is a onetime~~
 376.20 ~~appropriation and is available until June 30,~~
 376.21 ~~2029.~~

376.22 ~~(d)~~ (c) **Health care subcabinet.** \$551,000 in
 376.23 fiscal year 2024 and \$664,000 in fiscal year
 376.24 2025 are to hire an executive director for the
 376.25 health care subcabinet and to provide staffing
 376.26 and administrative support for the health care
 376.27 subcabinet.

376.28 ~~(e)~~ (d) **Base level adjustment.** The general
 376.29 fund base is \$1,114,000 in fiscal year 2026
 376.30 and \$1,114,000 in fiscal year 2027.

376.31 Sec. 16. **APPROPRIATIONS GIVEN EFFECT ONCE.**

376.32 If an appropriation or transfer in this article is enacted more than once during the 2024
 376.33 regular session, the appropriation or transfer must be given effect once.

377.1 **Sec. 17. EXPIRATION OF UNCODIFIED LANGUAGE.**

377.2 All uncodified language contained in this article expires on June 30, 2025, unless a
 377.3 different expiration date is explicit."

377.4 Delete the title and insert:

377.5 "A bill for an act

377.6 relating to state government; modifying provisions governing the Department of
 377.7 Human Services, human services health care policy, health care finance, and
 377.8 licensing policy; modifying provisions governing the Department of Health, health
 377.9 policy, health insurance, and health care; modifying provisions governing pharmacy
 377.10 practice and behavioral health; establishing an Office of Emergency Medical
 377.11 Services and making conforming changes, specifying and transferring office duties,
 377.12 establishing advisory councils, and modifying provisions relating to ambulance
 377.13 service personnel and emergency medical responders; establishing consultation
 377.14 and report requirements for certain state-funded grants and appropriations;
 377.15 modifying health record copy charges; establishing expirations of certain reports;
 377.16 making technical changes; requiring reports, information, and recommendations;
 377.17 appropriating money; amending Minnesota Statutes 2022, sections 16A.055,
 377.18 subdivision 1a, by adding a subdivision; 43A.24, by adding a subdivision;
 377.19 62A.0411; 62A.15, subdivision 4, by adding a subdivision; 62A.28, subdivision
 377.20 2; 62D.02, subdivision 7; 62D.04, subdivision 5; 62D.12, subdivision 19; 62D.14,
 377.21 subdivision 1; 62D.20, subdivision 1; 62D.22, subdivision 5, by adding a
 377.22 subdivision; 62J.49, subdivision 1; 62J.61, subdivision 5; 62M.01, subdivision 3;
 377.23 62M.02, subdivisions 1a, 5, 11, 12, 21, by adding a subdivision; 62M.04,
 377.24 subdivision 1; 62M.05, subdivision 3a; 62M.07, subdivisions 2, 4, by adding a
 377.25 subdivision; 62M.10, subdivisions 7, 8; 62M.17, subdivision 2; 62Q.097, by adding
 377.26 a subdivision; 62Q.14; 62Q.19, subdivisions 3, 5, by adding a subdivision; 62Q.73,
 377.27 subdivision 2; 62V.05, subdivision 12; 62V.08; 62V.11, subdivision 4; 103I.621,
 377.28 subdivisions 1, 2; 144.05, subdivisions 6, 7, by adding a subdivision; 144.058;
 377.29 144.0724, subdivisions 2, 3a, 4, 6, 7, 8, 9, 11; 144.1464, subdivisions 1, 2, 3;
 377.30 144.1501, subdivision 5; 144.1911, subdivision 2; 144.212, by adding a subdivision;
 377.31 144.216, subdivision 2, by adding subdivisions; 144.218, by adding a subdivision;
 377.32 144.292, subdivision 6; 144.293, subdivisions 2, 4, 9, 10; 144.493, by adding a
 377.33 subdivision; 144.494, subdivision 2; 144.551, subdivision 1; 144.555, subdivisions
 377.34 1a, 1b, 2, by adding subdivisions; 144.605, by adding a subdivision; 144.7067,
 377.35 subdivision 2; 144.99, subdivision 3; 144A.10, subdivisions 15, 16; 144A.471, by
 377.36 adding a subdivision; 144A.474, subdivision 13; 144A.61, subdivision 3a; 144A.70,
 377.37 subdivisions 3, 5, 6, 7; 144A.71, subdivision 2, by adding a subdivision; 144A.72,
 377.38 subdivision 1; 144A.73; 144E.001, subdivision 3a, by adding subdivisions;
 377.39 144E.101, by adding a subdivision; 144E.16, subdivisions 5, 7; 144E.19,
 377.40 subdivision 3; 144E.27, subdivisions 3, 5, 6; 144E.28, subdivisions 3, 5, 6, 8;
 377.41 144E.285, subdivisions 1, 2, 4, 6, by adding subdivisions; 144E.287; 144E.305,
 377.42 subdivision 3; 144G.08, subdivision 29; 144G.10, by adding a subdivision;
 377.43 144G.16, subdivision 6; 146B.03, subdivision 7a; 146B.10, subdivisions 1, 3;
 377.44 149A.02, subdivisions 3, 3b, 16, 23, 26a, 27, 35, 37c, by adding subdivisions;
 377.45 149A.03; 149A.65; 149A.70, subdivisions 1, 2, 3, 5; 149A.71, subdivisions 2, 4;
 377.46 149A.72, subdivisions 3, 9; 149A.73, subdivision 1; 149A.74, subdivision 1;
 377.47 149A.93, subdivision 3; 149A.94, subdivisions 1, 3, 4; 149A.97, subdivision 2;
 377.48 151.01, subdivisions 23, 27; 151.065, by adding subdivisions; 151.066, subdivisions
 377.49 1, 2, 3; 151.212, by adding a subdivision; 151.37, by adding a subdivision; 151.74,
 377.50 subdivision 6; 214.025; 214.04, subdivision 2a; 214.29; 214.31; 214.355; 245.462,
 377.51 subdivision 6; 245.4663, subdivision 2; 245A.043, subdivisions 2, 4, by adding
 377.52 subdivisions; 245A.07, subdivision 6; 245C.05, subdivision 5; 245C.10, subdivision
 377.53 18; 245C.14, subdivision 1, by adding a subdivision; 245C.15, subdivisions 3, 4;
 377.54 245C.22, subdivision 4; 245C.24, subdivisions 2, 5; 245C.30, by adding a

378.1 subdivision; 245F.09, subdivision 2; 245F.14, by adding a subdivision; 245F.17;
378.2 245G.07, subdivision 4; 245G.08, subdivisions 5, 6; 245G.10, by adding a
378.3 subdivision; 245G.22, subdivisions 6, 7; 245I.02, subdivisions 17, 19; 245I.04,
378.4 subdivision 6; 245I.10, subdivision 9; 245I.11, subdivision 1, by adding a
378.5 subdivision; 245I.20, subdivision 4; 245I.23, subdivision 14; 256.01, subdivision
378.6 41, by adding a subdivision; 256.9657, subdivision 8, by adding a subdivision;
378.7 256.969, by adding subdivisions; 256B.035; 256B.056, subdivisions 1a, 10;
378.8 256B.0622, subdivisions 2a, 3a, 7a, 7d; 256B.0623, subdivision 5; 256B.0625,
378.9 subdivisions 10, 12, 32, 39, by adding subdivisions; 256B.0757, subdivisions 4a,
378.10 4d; 256B.0943, subdivisions 3, 12; 256B.0947, subdivision 5; 256B.69, subdivision
378.11 2; 256B.76, subdivision 6; 256B.795; 256I.04, subdivision 2f; 256K.45, subdivision
378.12 2; 256L.12, subdivision 7; 256R.02, subdivision 20; 259.52, subdivisions 2, 4;
378.13 260E.33, subdivision 2, as amended; 317A.811, subdivision 1; 524.3-801, as
378.14 amended; Minnesota Statutes 2023 Supplement, sections 15A.0815, subdivision
378.15 2; 43A.08, subdivision 1a; 62J.84, subdivision 10; 62Q.46, subdivision 1; 62Q.473,
378.16 by adding subdivisions; 142A.03, by adding a subdivision; 144.0526, subdivision
378.17 1; 144.1501, subdivision 2; 144.1505, subdivision 2; 144.651, subdivision 10a;
378.18 144A.4791, subdivision 10; 144E.101, subdivisions 6, 7, as amended; 145.561,
378.19 subdivision 4; 145D.01, subdivision 1; 151.555, subdivisions 1, 4, 5, 6, 7, 8, 9,
378.20 11, 12; 151.74, subdivision 3; 152.126, subdivision 6; 245.4889, subdivision 1;
378.21 245.735, subdivision 3; 245.991, subdivision 1; 245A.03, subdivision 2, as
378.22 amended; 245A.043, subdivision 3; 245A.07, subdivision 1, as amended; 245A.11,
378.23 subdivision 7; 245A.16, subdivision 1, as amended; 245A.211, subdivision 4;
378.24 245A.242, subdivision 2; 245C.02, subdivision 13e; 245C.08, subdivision 1;
378.25 245C.15, subdivisions 2, 4a; 245C.31, subdivision 1; 245G.22, subdivisions 2, 17;
378.26 254B.04, subdivision 1a; 256.0471, subdivision 1, as amended; 256.9631; 256.969,
378.27 subdivision 2b; 256B.0622, subdivisions 7b, 8; 256B.0625, subdivisions 3a, 5m,
378.28 9, 13e, as amended, 13f, 13k, 16; 256B.064, subdivision 4; 256B.0671, subdivisions
378.29 3, 5; 256B.0701, subdivision 6; 256B.0947, subdivision 7; 256B.764; 256D.01,
378.30 subdivision 1a; 256I.05, subdivisions 1a, 11; 256L.03, subdivision 1; 256L.04,
378.31 subdivision 10; 260.761, by adding a subdivision; 2024 H.F. No. 5237, article 22,
378.32 section 2, subdivisions 4, if enacted, 5, if enacted; Laws 2020, chapter 73, section
378.33 8; Laws 2023, chapter 22, section 4, subdivision 2; Laws 2023, chapter 57, article
378.34 1, section 6; Laws 2023, chapter 70, article 1, section 35; article 20, sections 2,
378.35 subdivisions 5, 31; 3, subdivision 2; 12, as amended; Laws 2024, chapter 80, article
378.36 2, sections 6, subdivisions 2, 3, by adding subdivisions; 10, subdivision 1; proposing
378.37 coding for new law in Minnesota Statutes, chapters 62A; 62C; 62D; 62J; 62M;
378.38 62Q; 137; 144; 144A; 144E; 145D; 149A; 151; 214; 245C; 256B; repealing
378.39 Minnesota Statutes 2022, sections 62A.041, subdivision 3; 144.218, subdivision
378.40 3; 144.497; 144E.001, subdivision 5; 144E.01; 144E.123, subdivision 5; 144E.27,
378.41 subdivisions 1, 1a; 144E.50, subdivision 3; 151.74, subdivision 16; 245C.125;
378.42 256B.79, subdivision 6; 256D.19, subdivisions 1, 2; 256D.20, subdivisions 1, 2,
378.43 3, 4; 256D.23, subdivisions 1, 2, 3; 256R.02, subdivision 46; Minnesota Statutes
378.44 2023 Supplement, sections 62J.312, subdivision 6; 62Q.522, subdivisions 3, 4;
378.45 245C.08, subdivision 2; Laws 2024, chapter 80, article 2, section 6, subdivision
378.46 4."