ARTICLE 3

HEALTH DEPARTMENT

Section 1. Minnesota Statutes 2020, section 62J.495, subdivision 1, is amended to read:

Subdivision 1. **Implementation.** The commissioner of health, in consultation with the e-Health Advisory Committee, shall develop uniform standards to be used for the interoperable electronic health records system for sharing and synchronizing patient data across systems. The standards must be compatible with federal efforts. The uniform standards must be developed by January 1, 2009, and updated on an ongoing basis. ~~The commissioner shall include an update on standards development as part of an annual report to the legislature.~~ Individual health care providers in private practice with no other providers and health care providers that do not accept reimbursement from a group purchaser, as defined in section 62J.03, subdivision 6, are excluded from the requirements of this section.

Sec. 2. Minnesota Statutes 2020, section 62J.495, subdivision 2, is amended to read:

Subd. 2. **E-Health Advisory Committee.** (a) The commissioner shall establish an e-Health Advisory Committee governed by section 15.059 to advise the commissioner on the following matters:

(1) assessment of the adoption and effective use of health information technology by the state, licensed health care providers and facilities, and local public health agencies;

(2) recommendations for implementing a statewide interoperable health information infrastructure, to include estimates of necessary resources, and for determining standards for clinical data exchange, clinical support programs, patient privacy requirements, and maintenance of the security and confidentiality of individual patient data;

(3) recommendations for encouraging use of innovative health care applications using information technology and systems to improve patient care and reduce the cost of care, including applications relating to disease management and personal health management that enable remote monitoring of patients' conditions, especially those with chronic conditions; and

(4) other related issues as requested by the commissioner.

(b) The members of the e-Health Advisory Committee shall include the commissioners, or commissioners' designees, of health, human services, administration, and commerce and additional members to be appointed by the commissioner to include persons representing Minnesota's local public health agencies, licensed hospitals and other licensed facilities and providers, private purchasers, the medical and nursing professions, health insurers and health plans, the state quality improvement organization, academic and research institutions, consumer advisory organizations with an interest and expertise in health information technology, and other stakeholders as identified by the commissioner to fulfill the requirements of section 3013, paragraph (g), of the HITECH Act.

ARTICLE 2

HEALTH DEPARTMENT

Section 1. Minnesota Statutes 2020, section 62J.495, subdivision 1, is amended to read:

Subdivision 1. **Implementation.** The commissioner of health, in consultation with the e-Health Advisory Committee, shall develop uniform standards to be used for the interoperable electronic health records system for sharing and synchronizing patient data across systems. The standards must be compatible with federal efforts. The uniform standards must be developed by January 1, 2009, and updated on an ongoing basis. ~~The commissioner shall include an update on standards development as part of an annual report to the legislature.~~ Individual health care providers in private practice with no other providers and health care providers that do not accept reimbursement from a group purchaser, as defined in section 62J.03, subdivision 6, are excluded from the requirements of this section.

Sec. 2. Minnesota Statutes 2020, section 62J.495, subdivision 2, is amended to read:

Subd. 2. **E-Health Advisory Committee.** (a) The commissioner shall establish an e-Health Advisory Committee governed by section 15.059 to advise the commissioner on the following matters:

(1) assessment of the adoption and effective use of health information technology by the state, licensed health care providers and facilities, and local public health agencies;

(2) recommendations for implementing a statewide interoperable health information infrastructure, to include estimates of necessary resources, and for determining standards for clinical data exchange, clinical support programs, patient privacy requirements, and maintenance of the security and confidentiality of individual patient data;

(3) recommendations for encouraging use of innovative health care applications using information technology and systems to improve patient care and reduce the cost of care, including applications relating to disease management and personal health management that enable remote monitoring of patients' conditions, especially those with chronic conditions; and

(4) other related issues as requested by the commissioner.

(b) The members of the e-Health Advisory Committee shall include the commissioners, or commissioners' designees, of health, human services, administration, and commerce and additional members to be appointed by the commissioner to include persons representing Minnesota's local public health agencies, licensed hospitals and other licensed facilities and providers, private purchasers, the medical and nursing professions, health insurers and health plans, the state quality improvement organization, academic and research institutions, consumer advisory organizations with an interest and expertise in health information technology, and other stakeholders as identified by the commissioner to fulfill the requirements of section 3013, paragraph (g), of the HITECH Act.

(c) ~~The commissioner shall prepare and issue an annual report not later than January 30 of each year outlining progress to date in implementing a statewide health information infrastructure and recommending action on policy and necessary resources to continue the promotion of adoption and effective use of health information technology.~~

~~(d)~~ This subdivision expires June 30, ~~2021~~ 2031.

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

Sec. 3. Minnesota Statutes 2020, section 62J.495, subdivision 3, is amended to read:

Subd. 3. **Interoperable electronic health record requirements.** (a) Hospitals and health care providers must meet the following criteria when implementing an interoperable electronic health records system within their hospital system or clinical practice setting.

(b) The electronic health record must be a qualified electronic health record.

(c) The electronic health record must be certified by the Office of the National Coordinator pursuant to the HITECH Act. This criterion only applies to hospitals and health care providers if a certified electronic health record product for the provider's particular practice setting is available. This criterion shall be considered met if a hospital or health care provider is using an electronic health records system that has been certified within the last three years, even if a more current version of the system has been certified within the three-year period.

(d) The electronic health record must meet the standards established according to section 3004 of the HITECH Act as applicable.

(e) The electronic health record must have the ability to generate information on clinical quality measures and other measures reported under sections 4101, 4102, and 4201 of the HITECH Act.

(f) The electronic health record system must be connected to a state-certified health information organization either directly or through a connection facilitated by a ~~state-certified~~ health data intermediary as defined in section 62J.498.

(g) A health care provider who is a prescriber or dispenser of legend drugs must have an electronic health record system that meets the requirements of section 62J.497.

Sec. 4. Minnesota Statutes 2020, section 62J.495, subdivision 4, is amended to read:

Subd. 4. **Coordination with national HIT activities.** (a) The commissioner, in consultation with the e-Health Advisory Committee, shall update the statewide implementation plan required under subdivision 2 and released June 2008, to be consistent with the updated federal ~~HIT Strategic Plan released by the Office of the National Coordinator in accordance with section 3001 of the HITECH Act. The statewide plan shall meet the requirements for a plan required under section 3013 of the HITECH Act~~ plans.

(c) ~~The commissioner shall prepare and issue an annual report not later than January 30 of each year outlining progress to date in implementing a statewide health information infrastructure and recommending action on policy and necessary resources to continue the promotion of adoption and effective use of health information technology.~~

~~(d)~~ This subdivision expires June 30, 2021.

Sec. 3. Minnesota Statutes 2020, section 62J.495, subdivision 3, is amended to read:

Subd. 3. **Interoperable electronic health record requirements.** (a) Hospitals and health care providers must meet the following criteria when implementing an interoperable electronic health records system within their hospital system or clinical practice setting.

(b) The electronic health record must be a qualified electronic health record.

(c) The electronic health record must be certified by the Office of the National Coordinator pursuant to the HITECH Act. This criterion only applies to hospitals and health care providers if a certified electronic health record product for the provider's particular practice setting is available. This criterion shall be considered met if a hospital or health care provider is using an electronic health records system that has been certified within the last three years, even if a more current version of the system has been certified within the three-year period.

(d) The electronic health record must meet the standards established according to section 3004 of the HITECH Act as applicable.

(e) The electronic health record must have the ability to generate information on clinical quality measures and other measures reported under sections 4101, 4102, and 4201 of the HITECH Act.

(f) The electronic health record system must be connected to a state-certified health information organization either directly or through a connection facilitated by a ~~state-certified~~ health data intermediary as defined in section 62J.498.

(g) A health care provider who is a prescriber or dispenser of legend drugs must have an electronic health record system that meets the requirements of section 62J.497.

Sec. 4. Minnesota Statutes 2020, section 62J.495, subdivision 4, is amended to read:

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(b) The commissioner, in consultation with the e-Health Advisory Committee, shall work to ensure coordination between state, regional, and national efforts to support and accelerate efforts to effectively use health information technology to improve the quality and coordination of health care and the continuity of patient care among health care providers, to reduce medical errors, to improve population health, to reduce health disparities, and to reduce chronic disease. The commissioner's coordination efforts shall include but not be limited to:

~~(1) assisting in the development and support of health information technology regional extension centers established under section 3012(e) of the HITECH Act to provide technical assistance and disseminate best practices;~~

~~(2) providing supplemental information to the best practices gathered by regional centers to ensure that the information is relayed in a meaningful way to the Minnesota health care community;~~

~~(3)~~ (1) providing financial and technical support to Minnesota health care providers to encourage implementation of admission, discharge and transfer alerts, and care summary document exchange transactions and to evaluate the impact of health information technology on cost and quality of care. Communications about available financial and technical support shall include clear information about the interoperable health record requirements in subdivision 1, including a separate statement in bold-face type clarifying the exceptions to those requirements;

~~(4)~~ (2) providing educational resources and technical assistance to health care providers and patients related to state and national privacy, security, and consent laws governing clinical health information, including the requirements in sections 144.291 to 144.298. In carrying out these activities, the commissioner's technical assistance does not constitute legal advice;

~~(5)~~ (3) assessing Minnesota's legal, financial, and regulatory framework for health information exchange, including the requirements in sections 144.291 to 144.298, and making recommendations for modifications that would strengthen the ability of Minnesota health care providers to securely exchange data in compliance with patient preferences and in a way that is efficient and financially sustainable; and

~~(6)~~ (4) seeking public input on both patient impact and costs associated with requirements related to patient consent for release of health records for the purposes of treatment, payment, and health care operations, as required in section 144.293, subdivision 2. The commissioner shall provide a report to the legislature on the findings of this public input process no later than February 1, 2017.

(c) The commissioner, in consultation with the e-Health Advisory Committee, shall monitor national activity related to health information technology and shall coordinate statewide input on policy development. The commissioner shall coordinate statewide responses to proposed federal health information technology regulations in order to ensure

(b) The commissioner, in consultation with the e-Health Advisory Committee, shall work to ensure coordination between state, regional, and national efforts to support and accelerate efforts to effectively use health information technology to improve the quality and coordination of health care and the continuity of patient care among health care providers, to reduce medical errors, to improve population health, to reduce health disparities, and to reduce chronic disease. The commissioner's coordination efforts shall include but not be limited to:

~~(1) assisting in the development and support of health information technology regional extension centers established under section 3012(e) of the HITECH Act to provide technical assistance and disseminate best practices;~~

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~~(3)~~ (1) providing financial and technical support to Minnesota health care providers to encourage implementation of admission, discharge and transfer alerts, and care summary document exchange transactions and to evaluate the impact of health information technology on cost and quality of care. Communications about available financial and technical support shall include clear information about the interoperable health record requirements in subdivision 1, including a separate statement in bold-face type clarifying the exceptions to those requirements;

~~(4)~~ (2) providing educational resources and technical assistance to health care providers and patients related to state and national privacy, security, and consent laws governing clinical health information, including the requirements in sections 144.291 to 144.298. In carrying out these activities, the commissioner's technical assistance does not constitute legal advice;

~~(5)~~ (3) assessing Minnesota's legal, financial, and regulatory framework for health information exchange, including the requirements in sections 144.291 to 144.298, and making recommendations for modifications that would strengthen the ability of Minnesota health care providers to securely exchange data in compliance with patient preferences and in a way that is efficient and financially sustainable; and

~~(6)~~ (4) seeking public input on both patient impact and costs associated with requirements related to patient consent for release of health records for the purposes of treatment, payment, and health care operations, as required in section 144.293, subdivision 2. The commissioner shall provide a report to the legislature on the findings of this public input process no later than February 1, 2017.

(c) The commissioner, in consultation with the e-Health Advisory Committee, shall monitor national activity related to health information technology and shall coordinate statewide input on policy development. The commissioner shall coordinate statewide responses to proposed federal health information technology regulations in order to ensure

that the needs of the Minnesota health care community are adequately and efficiently addressed in the proposed regulations. The commissioner's responses may include, but are not limited to:

(1) reviewing and evaluating any standard, implementation specification, or certification criteria proposed by the national HIT standards ~~committee~~ committees;

(2) reviewing and evaluating policy proposed by ~~the~~ national HIT policy ~~committee~~ committees relating to the implementation of a nationwide health information technology infrastructure; and

(3) ~~monitoring and responding to activity related to the development of quality measures and other measures as required by section 4101 of the HITECH Act. Any response related to quality measures shall consider and address the quality efforts required under chapter 62U; and~~

~~(4)~~ monitoring and responding to national activity related to privacy, security, and data stewardship of electronic health information and individually identifiable health information.

(d) To the extent that the state is either required or allowed to apply, or designate an entity to apply for or carry out activities and programs ~~under section 3013 of the HITECH Act~~, the commissioner of health, in consultation with the e-Health Advisory Committee and the commissioner of human services, shall be the lead applicant or sole designating authority. The commissioner shall make such designations consistent with the goals and objectives of sections 62J.495 to 62J.497 and 62J.50 to 62J.61.

(e) The commissioner of human services shall apply for funding necessary to administer the incentive payments to providers authorized under title IV of the American Recovery and Reinvestment Act.

~~(f) The commissioner shall include in the report to the legislature information on the activities of this subdivision and provide recommendations on any relevant policy changes that should be considered in Minnesota.~~

Sec. 5. Minnesota Statutes 2020, section 62J.497, subdivision 1, is amended to read:

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

~~(b) "Backward compatible" means that the newer version of a data transmission standard would retain, at a minimum, the full functionality of the versions previously adopted, and would permit the successful completion of the applicable transactions with entities that continue to use the older versions.~~

~~(c)~~ (b) "Dispense" or "dispensing" has the meaning given in section 151.01, subdivision 30. Dispensing does not include the direct administering of a controlled substance to a patient by a licensed health care professional.

that the needs of the Minnesota health care community are adequately and efficiently addressed in the proposed regulations. The commissioner's responses may include, but are not limited to:

(1) reviewing and evaluating any standard, implementation specification, or certification criteria proposed by the national HIT standards ~~committee~~ committees;

(2) reviewing and evaluating policy proposed by ~~the~~ national HIT policy ~~committee~~ committees relating to the implementation of a nationwide health information technology infrastructure; and

(3) ~~monitoring and responding to activity related to the development of quality measures and other measures as required by section 4101 of the HITECH Act. Any response related to quality measures shall consider and address the quality efforts required under chapter 62U; and~~

~~(4)~~ monitoring and responding to national activity related to privacy, security, and data stewardship of electronic health information and individually identifiable health information.

(d) To the extent that the state is either required or allowed to apply, or designate an entity to apply for or carry out activities and programs ~~under section 3013 of the HITECH Act~~, the commissioner of health, in consultation with the e-Health Advisory Committee and the commissioner of human services, shall be the lead applicant or sole designating authority. The commissioner shall make such designations consistent with the goals and objectives of sections 62J.495 to 62J.497 and 62J.50 to 62J.61.

(e) The commissioner of human services shall apply for funding necessary to administer the incentive payments to providers authorized under title IV of the American Recovery and Reinvestment Act.

~~(f) The commissioner shall include in the report to the legislature information on the activities of this subdivision and provide recommendations on any relevant policy changes that should be considered in Minnesota.~~

~~(d)~~ (c) "Dispenser" means a person authorized by law to dispense a controlled substance, pursuant to a valid prescription.

~~(e)~~ (d) "Electronic media" has the meaning given under Code of Federal Regulations, title 45, part 160.103.

~~(f)~~ (e) "E-prescribing" means the transmission using electronic media of prescription or prescription-related information between a prescriber, dispenser, pharmacy benefit manager, or group purchaser, either directly or through an intermediary, including an e-prescribing network. E-prescribing includes, but is not limited to, two-way transmissions between the point of care and the dispenser and two-way transmissions related to eligibility, formulary, and medication history information.

~~(g)~~ (f) "Electronic prescription drug program" means a program that provides for e-prescribing.

~~(h)~~ (g) "Group purchaser" has the meaning given in section 62J.03, subdivision 6.

~~(i)~~ (h) "HL7 messages" means a standard approved by the standards development organization known as Health Level Seven.

~~(j)~~ (i) "National Provider Identifier" or "NPI" means the identifier described under Code of Federal Regulations, title 45, part 162.406.

~~(k)~~ (j) "NCPDP" means the National Council for Prescription Drug Programs, Inc.

~~(l)~~ (k) "NCPDP Formulary and Benefits Standard" means the most recent version of the National Council for Prescription Drug Programs Formulary and Benefits Standard~~, Implementation Guide, Version 1, Release 0, October 2005~~ or the most recent standard adopted by the Centers for Medicare and Medicaid Services for e-prescribing under Medicare Part D as required by section 1860D-4(e)(4)(D) of the Social Security Act and regulations adopted under it. The standards shall be implemented according to the Centers for Medicare and Medicaid Services schedule for compliance.

~~(m)~~ (l) "NCPDP SCRIPT Standard" means the most recent version of the National Council for Prescription Drug Programs ~~Prescriber/Pharmacist Interface~~ SCRIPT Standard, ~~Implementation Guide Version 8, Release 1 (Version 8.1), October 2005,~~ or the most recent standard adopted by the Centers for Medicare and Medicaid Services for e-prescribing under Medicare Part D as required by section 1860D-4(e)(4)(D) of the Social Security Act, and regulations adopted under it. The standards shall be implemented according to the Centers for Medicare and Medicaid Services schedule for compliance. ~~Subsequently released versions of the NCPDP SCRIPT Standard may be used, provided that the new version of the standard is backward compatible to the current version adopted by the Centers for Medicare and Medicaid Services.~~

~~(n)~~ (m) "Pharmacy" has the meaning given in section 151.01, subdivision 2.

~~(o)~~ (n) "Prescriber" means a licensed health care practitioner, other than a veterinarian, as defined in section 151.01, subdivision 23.

~~(p)~~ (o) "Prescription-related information" means information regarding eligibility for drug benefits, medication history, or related health or drug information.

~~(q)~~ (p) "Provider" or "health care provider" has the meaning given in section 62J.03, subdivision 8.

Sec. 6. Minnesota Statutes 2020, section 62J.497, subdivision 3, is amended to read:

Subd. 3. **Standards for electronic prescribing.** (a) Prescribers and dispensers must use the NCPDP SCRIPT Standard for the communication of a prescription or prescription-related information. ~~The NCPDP SCRIPT Standard shall be used to conduct the following transactions:~~

~~(1) get message transaction;~~

~~(2) status response transaction;~~

~~(3) error response transaction;~~

~~(4) new prescription transaction;~~

~~(5) prescription change request transaction;~~

~~(6) prescription change response transaction;~~

~~(7) refill prescription request transaction;~~

~~(8) refill prescription response transaction;~~

~~(9) verification transaction;~~

~~(10) password change transaction;~~

~~(11) cancel prescription request transaction; and~~

~~(12) cancel prescription response transaction.~~

(b) Providers, group purchasers, prescribers, and dispensers must use the NCPDP SCRIPT Standard for communicating and transmitting medication history information.

(c) Providers, group purchasers, prescribers, and dispensers must use the NCPDP Formulary and Benefits Standard for communicating and transmitting formulary and benefit information.

(d) Providers, group purchasers, prescribers, and dispensers must use the national provider identifier to identify a health care provider in e-prescribing or prescription-related transactions when a health care provider's identifier is required.

(e) Providers, group purchasers, prescribers, and dispensers must communicate eligibility information and conduct health care eligibility benefit inquiry and response transactions according to the requirements of section 62J.536.

Sec. 7. Minnesota Statutes 2020, section 62J.498, is amended to read:

62J.498 HEALTH INFORMATION EXCHANGE.

Subdivision 1. **Definitions.** (a) The following definitions apply to sections 62J.498 to 62J.4982:

(b) "Clinical data repository" means a real time database that consolidates data from a variety of clinical sources to present a unified view of a single patient and is used by a ~~state-certified~~ health information exchange service provider to enable health information exchange among health care providers that are not related health care entities as defined in section 144.291, subdivision 2, paragraph (k). This does not include clinical data that are submitted to the commissioner for public health purposes required or permitted by law, including any rules adopted by the commissioner.

(c) "Clinical transaction" means any meaningful use transaction or other health information exchange transaction that is not covered by section 62J.536.

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

(e) "Health care provider" or "provider" means a health care provider or provider as defined in section 62J.03, subdivision 8.

(f) "Health data intermediary" means an entity that provides the technical capabilities or related products and services to enable health information exchange among health care providers that are not related health care entities as defined in section 144.291, subdivision 2, paragraph (k). This includes but is not limited to health information service providers (HISP), electronic health record vendors, and pharmaceutical electronic data intermediaries as defined in section 62J.495.

(g) "Health information exchange" means the electronic transmission of health-related information between organizations according to nationally recognized standards.

(h) "Health information exchange service provider" means a health data intermediary or health information organization.

(i) "Health information organization" means an organization that oversees, governs, and facilitates health information exchange among health care providers that are not related health care entities as defined in section 144.291, subdivision 2, paragraph (k), to improve coordination of patient care and the efficiency of health care delivery.

~~(j) "HITECH Act" means the Health Information Technology for Economic and Clinical Health Act as defined in section 62J.495.~~

~~(k)~~ (j) "Major participating entity" means:

Sec. 5. Minnesota Statutes 2020, section 62J.498, is amended to read:

62J.498 HEALTH INFORMATION EXCHANGE.

Subdivision 1. **Definitions.** (a) The following definitions apply to sections 62J.498 to 62J.4982:

(b) "Clinical data repository" means a real time database that consolidates data from a variety of clinical sources to present a unified view of a single patient and is used by a ~~state-certified~~ health information exchange service provider to enable health information exchange among health care providers that are not related health care entities as defined in section 144.291, subdivision 2, paragraph (k). This does not include clinical data that are submitted to the commissioner for public health purposes required or permitted by law, including any rules adopted by the commissioner.

(c) "Clinical transaction" means any meaningful use transaction or other health information exchange transaction that is not covered by section 62J.536.

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

(e) "Health care provider" or "provider" means a health care provider or provider as defined in section 62J.03, subdivision 8.

(f) "Health data intermediary" means an entity that provides the technical capabilities or related products and services to enable health information exchange among health care providers that are not related health care entities as defined in section 144.291, subdivision 2, paragraph (k). This includes but is not limited to health information service providers (HISP), electronic health record vendors, and pharmaceutical electronic data intermediaries as defined in section 62J.495.

(g) "Health information exchange" means the electronic transmission of health-related information between organizations according to nationally recognized standards.

(h) "Health information exchange service provider" means a health data intermediary or health information organization.

(i) "Health information organization" means an organization that oversees, governs, and facilitates health information exchange among health care providers that are not related health care entities as defined in section 144.291, subdivision 2, paragraph (k), to improve coordination of patient care and the efficiency of health care delivery.

~~(j) "HITECH Act" means the Health Information Technology for Economic and Clinical Health Act as defined in section 62J.495.~~

~~(k)~~ (j) "Major participating entity" means:

(1) a participating entity that receives compensation for services that is greater than 30 percent of the health information organization's gross annual revenues from the health information exchange service provider;

(2) a participating entity providing administrative, financial, or management services to the health information organization, if the total payment for all services provided by the participating entity exceeds three percent of the gross revenue of the health information organization; and

(3) a participating entity that nominates or appoints 30 percent or more of the board of directors or equivalent governing body of the health information organization.

~~(l)~~ (k) "Master patient index" means an electronic database that holds unique identifiers of patients registered at a care facility and is used by a ~~state-certified~~ health information exchange service provider to enable health information exchange among health care providers that are not related health care entities as defined in section 144.291, subdivision 2, paragraph (k). This does not include data that are submitted to the commissioner for public health purposes required or permitted by law, including any rules adopted by the commissioner.

~~(m) "Meaningful use" means use of certified electronic health record technology to improve quality, safety, and efficiency and reduce health disparities; engage patients and families; improve care coordination and population and public health; and maintain privacy and security of patient health information as established by the Centers for Medicare and Medicaid Services and the Minnesota Department of Human Services pursuant to sections 4101, 4102, and 4201 of the HITECH Act.~~

~~(n) "Meaningful use transaction" means an electronic transaction that a health care provider must exchange to receive Medicare or Medicaid incentives or avoid Medicare penalties pursuant to sections 4101, 4102, and 4201 of the HITECH Act.~~

~~(o)~~ (l) "Participating entity" means any of the following persons, health care providers, companies, or other organizations with which a health information organization ~~or health data intermediary~~ has contracts or other agreements for the provision of health information exchange services:

(1) a health care facility licensed under sections 144.50 to 144.56, a nursing home licensed under sections 144A.02 to 144A.10, and any other health care facility otherwise licensed under the laws of this state or registered with the commissioner;

(2) a health care provider, and any other health care professional otherwise licensed under the laws of this state or registered with the commissioner;

(3) a group, professional corporation, or other organization that provides the services of individuals or entities identified in clause (2), including but not limited to a medical clinic, a medical group, a home health care agency, an urgent care center, and an emergent care center;

(4) a health plan as defined in section 62A.011, subdivision 3; and

(1) a participating entity that receives compensation for services that is greater than 30 percent of the health information organization's gross annual revenues from the health information exchange service provider;

(2) a participating entity providing administrative, financial, or management services to the health information organization, if the total payment for all services provided by the participating entity exceeds three percent of the gross revenue of the health information organization; and

(3) a participating entity that nominates or appoints 30 percent or more of the board of directors or equivalent governing body of the health information organization.

~~(l)~~ (k) "Master patient index" means an electronic database that holds unique identifiers of patients registered at a care facility and is used by a ~~state-certified~~ health information exchange service provider to enable health information exchange among health care providers that are not related health care entities as defined in section 144.291, subdivision 2, paragraph (k). This does not include data that are submitted to the commissioner for public health purposes required or permitted by law, including any rules adopted by the commissioner.

~~(m) "Meaningful use" means use of certified electronic health record technology to improve quality, safety, and efficiency and reduce health disparities; engage patients and families; improve care coordination and population and public health; and maintain privacy and security of patient health information as established by the Centers for Medicare and Medicaid Services and the Minnesota Department of Human Services pursuant to sections 4101, 4102, and 4201 of the HITECH Act.~~

~~(n) "Meaningful use transaction" means an electronic transaction that a health care provider must exchange to receive Medicare or Medicaid incentives or avoid Medicare penalties pursuant to sections 4101, 4102, and 4201 of the HITECH Act.~~

~~(o)~~ (l) "Participating entity" means any of the following persons, health care providers, companies, or other organizations with which a health information organization ~~or health data intermediary~~ has contracts or other agreements for the provision of health information exchange services:

(1) a health care facility licensed under sections 144.50 to 144.56, a nursing home licensed under sections 144A.02 to 144A.10, and any other health care facility otherwise licensed under the laws of this state or registered with the commissioner;

(2) a health care provider, and any other health care professional otherwise licensed under the laws of this state or registered with the commissioner;

(3) a group, professional corporation, or other organization that provides the services of individuals or entities identified in clause (2), including but not limited to a medical clinic, a medical group, a home health care agency, an urgent care center, and an emergent care center;

(4) a health plan as defined in section 62A.011, subdivision 3; and

(5) a state agency as defined in section 13.02, subdivision 17.

~~(p)~~ (m) "Reciprocal agreement" means an arrangement in which two or more health information exchange service providers agree to share in-kind services and resources to allow for the pass-through of clinical transactions.

~~(q) "State-certified health data intermediary" means a health data intermediary that has been issued a certificate of authority to operate in Minnesota.~~

~~(r)~~ (n) "State-certified health information organization" means a health information organization that has been issued a certificate of authority to operate in Minnesota.

Subd. 2. **Health information exchange oversight.** (a) The commissioner shall protect the public interest on matters pertaining to health information exchange. The commissioner shall:

(1) review and act on applications from ~~health data intermediaries and~~ health information organizations for certificates of authority to operate in Minnesota;

(2) require information to be provided as needed from health information exchange service providers in order to meet requirements established under sections 62J.498 to 62J.4982;

~~(2)~~ (3) provide ongoing monitoring to ensure compliance with criteria established under sections 62J.498 to 62J.4982;

~~(3)~~ (4) respond to public complaints related to health information exchange services;

~~(4)~~ (5) take enforcement actions as necessary, including the imposition of fines, suspension, or revocation of certificates of authority as outlined in section 62J.4982;

~~(5)~~ (6) provide a biennial report on the status of health information exchange services that includes but is not limited to:

(i) recommendations on actions necessary to ensure that health information exchange services are adequate to meet the needs of Minnesota citizens and providers statewide;

(ii) recommendations on enforcement actions to ensure that health information exchange service providers act in the public interest without causing disruption in health information exchange services;

(iii) recommendations on updates to criteria for obtaining certificates of authority under this section; and

(iv) recommendations on standard operating procedures for health information exchange, including but not limited to the management of consumer preferences; and

~~(6)~~ (7) other duties necessary to protect the public interest.

(5) a state agency as defined in section 13.02, subdivision 17.

~~(p)~~ (m) "Reciprocal agreement" means an arrangement in which two or more health information exchange service providers agree to share in-kind services and resources to allow for the pass-through of clinical transactions.

~~(q) "State-certified health data intermediary" means a health data intermediary that has been issued a certificate of authority to operate in Minnesota.~~

~~(r)~~ (n) "State-certified health information organization" means a health information organization that has been issued a certificate of authority to operate in Minnesota.

Subd. 2. **Health information exchange oversight.** (a) The commissioner shall protect the public interest on matters pertaining to health information exchange. The commissioner shall:

(1) review and act on applications from ~~health data intermediaries and~~ health information organizations for certificates of authority to operate in Minnesota;

(2) require information to be provided as needed from health information exchange service providers in order to meet requirements established under sections 62J.498 to 62J.4982;

~~(2)~~ (3) provide ongoing monitoring to ensure compliance with criteria established under sections 62J.498 to 62J.4982;

~~(3)~~ (4) respond to public complaints related to health information exchange services;

~~(4)~~ (5) take enforcement actions as necessary, including the imposition of fines, suspension, or revocation of certificates of authority as outlined in section 62J.4982;

~~(5)~~ (6) provide a biennial report on the status of health information exchange services that includes but is not limited to:

(i) recommendations on actions necessary to ensure that health information exchange services are adequate to meet the needs of Minnesota citizens and providers statewide;

(ii) recommendations on enforcement actions to ensure that health information exchange service providers act in the public interest without causing disruption in health information exchange services;

(iii) recommendations on updates to criteria for obtaining certificates of authority under this section; and

(iv) recommendations on standard operating procedures for health information exchange, including but not limited to the management of consumer preferences; and

~~(6)~~ (7) other duties necessary to protect the public interest.

(b) As part of the application review process for certification under paragraph (a), prior to issuing a certificate of authority, the commissioner shall:

(1) make all portions of the application classified as public data available to the public for at least ten days while an application is under consideration. At the request of the commissioner, the applicant shall participate in a public hearing by presenting an overview of their application and responding to questions from interested parties; and

(2) consult with hospitals, physicians, and other providers prior to issuing a certificate of authority.

(c) When the commissioner is actively considering a suspension or revocation of a certificate of authority as described in section 62J.4982, subdivision 3, all investigatory data that are collected, created, or maintained related to the suspension or revocation are classified as confidential data on individuals and as protected nonpublic data in the case of data not on individuals.

(d) The commissioner may disclose data classified as protected nonpublic or confidential under paragraph (c) if disclosing the data will protect the health or safety of patients.

(e) After the commissioner makes a final determination regarding a suspension or revocation of a certificate of authority, all minutes, orders for hearing, findings of fact, conclusions of law, and the specification of the final disciplinary action, are classified as public data.

Sec. 8. Minnesota Statutes 2020, section 62J.4981, is amended to read:

62J.4981 CERTIFICATE OF AUTHORITY TO PROVIDE HEALTH INFORMATION EXCHANGE SERVICES.

Subdivision 1. **Authority to require organizations to apply.** The commissioner shall require ~~a health data intermediary or~~ a health information organization to apply for a certificate of authority under this section. An applicant may continue to operate until the commissioner acts on the application. If the application is denied, the applicant is considered a health information exchange service provider whose certificate of authority has been revoked under section 62J.4982, subdivision 2, paragraph (d).

~~Subd. 2. **Certificate of authority for health data intermediaries.** (a) A health data intermediary must be certified by the state and comply with requirements established in this section.~~

~~(b) Notwithstanding any law to the contrary, any corporation organized to do so may apply to the commissioner for a certificate of authority to establish and operate as a health data intermediary in compliance with this section. No person shall establish or operate a health data intermediary in this state, nor sell or offer to sell, or solicit offers to purchase or receive advance or periodic consideration in conjunction with a health data intermediary~~

(b) As part of the application review process for certification under paragraph (a), prior to issuing a certificate of authority, the commissioner shall:

(1) make all portions of the application classified as public data available to the public for at least ten days while an application is under consideration. At the request of the commissioner, the applicant shall participate in a public hearing by presenting an overview of their application and responding to questions from interested parties; and

(2) consult with hospitals, physicians, and other providers prior to issuing a certificate of authority.

(c) When the commissioner is actively considering a suspension or revocation of a certificate of authority as described in section 62J.4982, subdivision 3, all investigatory data that are collected, created, or maintained related to the suspension or revocation are classified as confidential data on individuals and as protected nonpublic data in the case of data not on individuals.

(d) The commissioner may disclose data classified as protected nonpublic or confidential under paragraph (c) if disclosing the data will protect the health or safety of patients.

(e) After the commissioner makes a final determination regarding a suspension or revocation of a certificate of authority, all minutes, orders for hearing, findings of fact, conclusions of law, and the specification of the final disciplinary action, are classified as public data.

Sec. 6. Minnesota Statutes 2020, section 62J.4981, is amended to read:

62J.4981 CERTIFICATE OF AUTHORITY TO PROVIDE HEALTH INFORMATION EXCHANGE SERVICES.

Subdivision 1. **Authority to require organizations to apply.** The commissioner shall require ~~a health data intermediary or~~ a health information organization to apply for a certificate of authority under this section. An applicant may continue to operate until the commissioner acts on the application. If the application is denied, the applicant is considered a health information exchange service provider whose certificate of authority has been revoked under section 62J.4982, subdivision 2, paragraph (d).

~~Subd. 2. **Certificate of authority for health data intermediaries.** (a) A health data intermediary must be certified by the state and comply with requirements established in this section.~~

~~(b) Notwithstanding any law to the contrary, any corporation organized to do so may apply to the commissioner for a certificate of authority to establish and operate as a health data intermediary in compliance with this section. No person shall establish or operate a health data intermediary in this state, nor sell or offer to sell, or solicit offers to purchase or receive advance or periodic consideration in conjunction with a health data intermediary~~

~~contract unless the organization has a certificate of authority or has an application under active consideration under this section.~~

~~(c) In issuing the certificate of authority, the commissioner shall determine whether the applicant for the certificate of authority has demonstrated that the applicant meets the following minimum criteria:~~

~~(1) hold reciprocal agreements with at least one state-certified health information organization to access patient data, and for the transmission and receipt of clinical transactions. Reciprocal agreements must meet the requirements established in subdivision 5; and~~

~~(2) participate in statewide shared health information exchange services as defined by the commissioner to support interoperability between state-certified health information organizations and state-certified health data intermediaries.~~

Subd. 3. **Certificate of authority for health information organizations.** (a) A health information organization must obtain a certificate of authority from the commissioner and demonstrate compliance with the criteria in paragraph (c).

(b) Notwithstanding any law to the contrary, an organization may apply for a certificate of authority to establish and operate a health information organization under this section. No person shall establish or operate a health information organization in this state, nor sell or offer to sell, or solicit offers to purchase or receive advance or periodic consideration in conjunction with a health information organization or health information contract unless the organization has a certificate of authority under this section.

(c) In issuing the certificate of authority, the commissioner shall determine whether the applicant for the certificate of authority has demonstrated that the applicant meets the following minimum criteria:

(1) the entity is a legally established organization;

(2) appropriate insurance, including liability insurance, for the operation of the health information organization is in place and sufficient to protect the interest of the public and participating entities;

(3) strategic and operational plans address governance, technical infrastructure, legal and policy issues, finance, and business operations in regard to how the organization will expand to support providers in achieving health information exchange goals over time;

(4) the entity addresses the parameters to be used with participating entities and other health information exchange service providers for clinical transactions, compliance with Minnesota law, and interstate health information exchange trust agreements;

(5) the entity's board of directors or equivalent governing body is composed of members that broadly represent the health information organization's participating entities and consumers;

(6) the entity maintains a professional staff responsible to the board of directors or equivalent governing body with the capacity to ensure accountability to the organization's mission;

(7) the organization is compliant with national certification and accreditation programs designated by the commissioner;

(8) the entity maintains the capability to query for patient information based on national standards. The query capability may utilize a master patient index, clinical data repository, or record locator service as defined in section 144.291, subdivision 2, paragraph (j). The entity must be compliant with the requirements of section 144.293, subdivision 8, when conducting clinical transactions;

(9) the organization demonstrates interoperability with all other state-certified health information organizations using nationally recognized standards;

(10) the organization demonstrates compliance with all privacy and security requirements required by state and federal law; and

(11) the organization uses financial policies and procedures consistent with generally accepted accounting principles and has an independent audit of the organization's financials on an annual basis.

(d) Health information organizations that have obtained a certificate of authority must:

(1) meet the requirements established for connecting to the National eHealth Exchange;

(2) annually submit strategic and operational plans for review by the commissioner that address:

(i) progress in achieving objectives included in previously submitted strategic and operational plans across the following domains: business and technical operations, technical infrastructure, legal and policy issues, finance, and organizational governance;

(ii) plans for ensuring the necessary capacity to support clinical transactions;

(iii) approach for attaining financial sustainability, including public and private financing strategies, and rate structures;

(iv) rates of adoption, utilization, and transaction volume, and mechanisms to support health information exchange; and

(v) an explanation of methods employed to address the needs of community clinics, critical access hospitals, and free clinics in accessing health information exchange services;

(3) enter into reciprocal agreements with all other state-certified health information organizations ~~and state-certified health data intermediaries~~ to enable access to patient data, and for the transmission and receipt of clinical transactions. Reciprocal agreements must meet the requirements in subdivision 5;

(4) participate in statewide shared health information exchange services as defined by the commissioner to support interoperability ~~between state-certified health information organizations and state-certified health data intermediaries~~; and

(5) comply with additional requirements for the certification or recertification of health information organizations that may be established by the commissioner.

Subd. 4. **Application for certificate of authority for health information ~~exchange service providers~~ organizations.** (a) Each application for a certificate of authority shall be in a form prescribed by the commissioner and verified by an officer or authorized representative of the applicant. Each application shall include the following in addition to information described in the criteria in ~~subdivisions 2 and~~ subdivision 3:

(1) ~~for health information organizations only,~~ a copy of the basic organizational document, if any, of the applicant and of each major participating entity, such as the articles of incorporation, or other applicable documents, and all amendments to it;

(2) ~~for health information organizations only,~~ a list of the names, addresses, and official positions of the following:

(i) all members of the board of directors or equivalent governing body, and the principal officers and, if applicable, shareholders of the applicant organization; and

(ii) all members of the board of directors or equivalent governing body, and the principal officers of each major participating entity and, if applicable, each shareholder beneficially owning more than ten percent of any voting stock of the major participating entity;

(3) ~~for health information organizations only,~~ the name and address of each participating entity and the agreed-upon duration of each contract or agreement if applicable;

(4) a copy of each standard agreement or contract intended to bind the participating entities and the health information ~~exchange service provider~~ organization. Contractual provisions shall be consistent with the purposes of this section, in regard to the services to be performed under the standard agreement or contract, the manner in which payment for services is determined, the nature and extent of responsibilities to be retained by the health information organization, and contractual termination provisions;

(5) a statement generally describing the health information ~~exchange service provider~~ organization, its health information exchange contracts, facilities, and personnel, including a statement describing the manner in which the applicant proposes to provide participants with comprehensive health information exchange services;

(6) a statement reasonably describing the geographic area or areas to be served and the type or types of participants to be served;

(7) a description of the complaint procedures to be used as required under this section;

(8) a description of the mechanism by which participating entities will have an opportunity to participate in matters of policy and operation;

(9) a copy of any pertinent agreements between the health information organization and insurers, including liability insurers, demonstrating coverage is in place;

(10) a copy of the conflict of interest policy that applies to all members of the board of directors or equivalent governing body and the principal officers of the health information organization; and

(11) other information as the commissioner may reasonably require to be provided.

(b) Within 45 days after the receipt of the application for a certificate of authority, the commissioner shall determine whether or not the application submitted meets the requirements for completion in paragraph (a), and notify the applicant of any further information required for the application to be processed.

(c) Within 90 days after the receipt of a complete application for a certificate of authority, the commissioner shall issue a certificate of authority to the applicant if the commissioner determines that the applicant meets the minimum criteria requirements of ~~subdivision 2 for health data intermediaries or~~ subdivision 3 ~~for health information organizations~~. If the commissioner determines that the applicant is not qualified, the commissioner shall notify the applicant and specify the reasons for disqualification.

(d) Upon being granted a certificate of authority to operate as a state-certified health information organization ~~or state-certified health data intermediary~~, the organization must operate in compliance with the provisions of this section. Noncompliance may result in the imposition of a fine or the suspension or revocation of the certificate of authority according to section 62J.4982.

Subd. 5. **Reciprocal agreements between health information ~~exchange entities~~ organizations.** (a) Reciprocal agreements between two health information organizations ~~or between a health information organization and a health data intermediary~~ must include a fair and equitable model for charges between the entities that:

(1) does not impede the secure transmission of clinical transactions;

(2) does not charge a fee for the exchange of ~~meaningful use~~ transactions transmitted according to nationally recognized standards where no additional value-added service is rendered to the sending or receiving health information organization ~~or health data intermediary~~ either directly or on behalf of the client;

(3) is consistent with fair market value and proportionately reflects the value-added services accessed as a result of the agreement; and

(4) prevents health care stakeholders from being charged multiple times for the same service.

(b) Reciprocal agreements must include comparable quality of service standards that ensure equitable levels of services.

(c) Reciprocal agreements are subject to review and approval by the commissioner.

(d) Nothing in this section precludes a state-certified health information organization ~~or state-certified health data intermediary~~ from entering into contractual agreements for the provision of value-added services ~~beyond meaningful use transactions~~.

Sec. 9. Minnesota Statutes 2020, section 62J.4982, is amended to read:

62J.4982 ENFORCEMENT AUTHORITY; COMPLIANCE.

Subdivision 1. **Penalties and enforcement.** (a) The commissioner may, for any violation of statute or rule applicable to a health information ~~exchange service provider~~ organization, levy an administrative penalty in an amount up to $25,000 for each violation. In determining the level of an administrative penalty, the commissioner shall consider the following factors:

(1) the number of participating entities affected by the violation;

(2) the effect of the violation on participating entities' access to health information exchange services;

(3) if only one participating entity is affected, the effect of the violation on the patients of that entity;

(4) whether the violation is an isolated incident or part of a pattern of violations;

(5) the economic benefits derived by the health information organization ~~or a health data intermediary~~ by virtue of the violation;

(6) whether the violation hindered or facilitated an individual's ability to obtain health care;

(7) whether the violation was intentional;

(8) whether the violation was beyond the direct control of the health information ~~exchange service provider~~ organization;

(9) any history of prior compliance with the provisions of this section, including violations;

(10) whether and to what extent the health information ~~exchange service provider~~ organization attempted to correct previous violations;

(11) how the health information ~~exchange service provider~~ organization responded to technical assistance from the commissioner provided in the context of a compliance effort; and

(12) the financial condition of the health information ~~exchange service provider~~ organization including~~,~~ but not limited to~~,~~ whether the health information ~~exchange service~~

(b) Reciprocal agreements must include comparable quality of service standards that ensure equitable levels of services.

(c) Reciprocal agreements are subject to review and approval by the commissioner.

(d) Nothing in this section precludes a state-certified health information organization ~~or state-certified health data intermediary~~ from entering into contractual agreements for the provision of value-added services ~~beyond meaningful use transactions~~.

Sec. 7. Minnesota Statutes 2020, section 62J.4982, is amended to read:

62J.4982 ENFORCEMENT AUTHORITY; COMPLIANCE.

Subdivision 1. **Penalties and enforcement.** (a) The commissioner may, for any violation of statute or rule applicable to a health information ~~exchange service provider~~ organization, levy an administrative penalty in an amount up to $25,000 for each violation. In determining the level of an administrative penalty, the commissioner shall consider the following factors:

(1) the number of participating entities affected by the violation;

(2) the effect of the violation on participating entities' access to health information exchange services;

(3) if only one participating entity is affected, the effect of the violation on the patients of that entity;

(4) whether the violation is an isolated incident or part of a pattern of violations;

(5) the economic benefits derived by the health information organization ~~or a health data intermediary~~ by virtue of the violation;

(6) whether the violation hindered or facilitated an individual's ability to obtain health care;

(7) whether the violation was intentional;

(8) whether the violation was beyond the direct control of the health information ~~exchange service provider~~ organization;

(9) any history of prior compliance with the provisions of this section, including violations;

(10) whether and to what extent the health information ~~exchange service provider~~ organization attempted to correct previous violations;

(11) how the health information ~~exchange service provider~~ organization responded to technical assistance from the commissioner provided in the context of a compliance effort; and

(12) the financial condition of the health information ~~exchange service provider~~ organization including~~,~~ but not limited to~~,~~ whether the health information ~~exchange service~~

~~provider~~ organization had financial difficulties that affected its ability to comply or whether the imposition of an administrative monetary penalty would jeopardize the ability of the health information ~~exchange service provider~~ organization to continue to deliver health information exchange services.

The commissioner shall give reasonable notice in writing to the health information ~~exchange service provider~~ organization of the intent to levy the penalty and the reasons for it. A health information ~~exchange service provider~~ organization may have 15 days within which to contest whether the facts found constitute a violation of sections 62J.4981 and 62J.4982, according to the contested case and judicial review provisions of sections 14.57 to 14.69.

(b) If the commissioner has reason to believe that a violation of section 62J.4981 or 62J.4982 has occurred or is likely, the commissioner may confer with the persons involved before commencing action under subdivision 2. The commissioner may notify the health information ~~exchange service provider~~ organization and the representatives, or other persons who appear to be involved in the suspected violation, to arrange a voluntary conference with the alleged violators or their authorized representatives. The purpose of the conference is to attempt to learn the facts about the suspected violation and, if it appears that a violation has occurred or is threatened, to find a way to correct or prevent it. The conference is not governed by any formal procedural requirements, and may be conducted as the commissioner considers appropriate.

(c) The commissioner may issue an order directing a health information ~~exchange service provider~~ organization or a representative of a health information ~~exchange service provider~~ organization to cease and desist from engaging in any act or practice in violation of sections 62J.4981 and 62J.4982.

(d) Within 20 days after service of the order to cease and desist, a health information ~~exchange service provider~~ organization may contest whether the facts found constitute a violation of sections 62J.4981 and 62J.4982 according to the contested case and judicial review provisions of sections 14.57 to 14.69.

(e) In the event of noncompliance with a cease and desist order issued under this subdivision, the commissioner may institute a proceeding to obtain injunctive relief or other appropriate relief in Ramsey County District Court.

Subd. 2. **Suspension or revocation of certificates of authority.** (a) The commissioner may suspend or revoke a certificate of authority issued to a ~~health data intermediary or~~ health information organization under section 62J.4981 if the commissioner finds that:

(1) the health information ~~exchange service provider~~ organization is operating significantly in contravention of its basic organizational document, or in a manner contrary to that described in and reasonably inferred from any other information submitted under section 62J.4981, unless amendments to the submissions have been filed with and approved by the commissioner;

~~provider~~ organization had financial difficulties that affected its ability to comply or whether the imposition of an administrative monetary penalty would jeopardize the ability of the health information ~~exchange service provider~~ organization to continue to deliver health information exchange services.

The commissioner shall give reasonable notice in writing to the health information ~~exchange service provider~~ organization of the intent to levy the penalty and the reasons for it. A health information ~~exchange service provider~~ organization may have 15 days within which to contest whether the facts found constitute a violation of sections 62J.4981 and 62J.4982, according to the contested case and judicial review provisions of sections 14.57 to 14.69.

(b) If the commissioner has reason to believe that a violation of section 62J.4981 or 62J.4982 has occurred or is likely, the commissioner may confer with the persons involved before commencing action under subdivision 2. The commissioner may notify the health information ~~exchange service provider~~ organization and the representatives, or other persons who appear to be involved in the suspected violation, to arrange a voluntary conference with the alleged violators or their authorized representatives. The purpose of the conference is to attempt to learn the facts about the suspected violation and, if it appears that a violation has occurred or is threatened, to find a way to correct or prevent it. The conference is not governed by any formal procedural requirements, and may be conducted as the commissioner considers appropriate.

(c) The commissioner may issue an order directing a health information ~~exchange service provider~~ organization or a representative of a health information ~~exchange service provider~~ organization to cease and desist from engaging in any act or practice in violation of sections 62J.4981 and 62J.4982.

(d) Within 20 days after service of the order to cease and desist, a health information ~~exchange service provider~~ organization may contest whether the facts found constitute a violation of sections 62J.4981 and 62J.4982 according to the contested case and judicial review provisions of sections 14.57 to 14.69.

(e) In the event of noncompliance with a cease and desist order issued under this subdivision, the commissioner may institute a proceeding to obtain injunctive relief or other appropriate relief in Ramsey County District Court.

Subd. 2. **Suspension or revocation of certificates of authority.** (a) The commissioner may suspend or revoke a certificate of authority issued to a ~~health data intermediary or~~ health information organization under section 62J.4981 if the commissioner finds that:

(1) the health information ~~exchange service provider~~ organization is operating significantly in contravention of its basic organizational document, or in a manner contrary to that described in and reasonably inferred from any other information submitted under section 62J.4981, unless amendments to the submissions have been filed with and approved by the commissioner;

(2) the health information ~~exchange service provider~~ organization is unable to fulfill its obligations to furnish comprehensive health information exchange services as required under its health information exchange contract;

(3) the health information ~~exchange service provider~~ organization is no longer financially solvent or may not reasonably be expected to meet its obligations to participating entities;

(4) the health information ~~exchange service provider~~ organization has failed to implement the complaint system in a manner designed to reasonably resolve valid complaints;

(5) the health information ~~exchange service provider~~ organization, or any person acting with its sanction, has advertised or merchandised its services in an untrue, misleading, deceptive, or unfair manner;

(6) the continued operation of the health information ~~exchange service provider~~ organization would be hazardous to its participating entities or the patients served by the participating entities; or

(7) the health information ~~exchange service provider~~ organization has otherwise failed to substantially comply with section 62J.4981 or with any other statute or administrative rule applicable to health information exchange service providers, or has submitted false information in any report required under sections 62J.498 to 62J.4982.

(b) A certificate of authority shall be suspended or revoked only after meeting the requirements of subdivision 3.

(c) If the certificate of authority of a health information ~~exchange service provider~~ organization is suspended, the health information ~~exchange service provider~~ organization shall not, during the period of suspension, enroll any additional participating entities, and shall not engage in any advertising or solicitation.

(d) If the certificate of authority of a health information ~~exchange service provider~~ organization is revoked, the organization shall proceed, immediately following the effective date of the order of revocation, to wind up its affairs, and shall conduct no further business except as necessary to the orderly conclusion of the affairs of the organization. The organization shall engage in no further advertising or solicitation. The commissioner may, by written order, permit further operation of the organization as the commissioner finds to be in the best interest of participating entities, to the end that participating entities will be given the greatest practical opportunity to access continuing health information exchange services.

Subd. 3. **Denial, suspension, and revocation; administrative procedures.** (a) When the commissioner has cause to believe that grounds for the denial, suspension, or revocation of a certificate of authority exist, the commissioner shall notify the health information ~~exchange service provider~~ organization in writing stating the grounds for denial, suspension, or revocation and setting a time within 20 days for a hearing on the matter.

(2) the health information ~~exchange service provider~~ organization is unable to fulfill its obligations to furnish comprehensive health information exchange services as required under its health information exchange contract;

(3) the health information ~~exchange service provider~~ organization is no longer financially solvent or may not reasonably be expected to meet its obligations to participating entities;

(4) the health information ~~exchange service provider~~ organization has failed to implement the complaint system in a manner designed to reasonably resolve valid complaints;

(5) the health information ~~exchange service provider~~ organization, or any person acting with its sanction, has advertised or merchandised its services in an untrue, misleading, deceptive, or unfair manner;

(6) the continued operation of the health information ~~exchange service provider~~ organization would be hazardous to its participating entities or the patients served by the participating entities; or

(7) the health information ~~exchange service provider~~ organization has otherwise failed to substantially comply with section 62J.4981 or with any other statute or administrative rule applicable to health information exchange service providers, or has submitted false information in any report required under sections 62J.498 to 62J.4982.

(b) A certificate of authority shall be suspended or revoked only after meeting the requirements of subdivision 3.

(c) If the certificate of authority of a health information ~~exchange service provider~~ organization is suspended, the health information ~~exchange service provider~~ organization shall not, during the period of suspension, enroll any additional participating entities, and shall not engage in any advertising or solicitation.

(d) If the certificate of authority of a health information ~~exchange service provider~~ organization is revoked, the organization shall proceed, immediately following the effective date of the order of revocation, to wind up its affairs, and shall conduct no further business except as necessary to the orderly conclusion of the affairs of the organization. The organization shall engage in no further advertising or solicitation. The commissioner may, by written order, permit further operation of the organization as the commissioner finds to be in the best interest of participating entities, to the end that participating entities will be given the greatest practical opportunity to access continuing health information exchange services.

Subd. 3. **Denial, suspension, and revocation; administrative procedures.** (a) When the commissioner has cause to believe that grounds for the denial, suspension, or revocation of a certificate of authority exist, the commissioner shall notify the health information ~~exchange service provider~~ organization in writing stating the grounds for denial, suspension, or revocation and setting a time within 20 days for a hearing on the matter.

(b) After a hearing before the commissioner at which the health information ~~exchange service provider~~ organization may respond to the grounds for denial, suspension, or revocation, or upon the failure of the health information ~~exchange service provider~~ organization to appear at the hearing, the commissioner shall take action as deemed necessary and shall issue written findings and mail them to the health information ~~exchange service provider~~ organization.

(c) If suspension, revocation, or administrative penalty is proposed according to this section, the commissioner must deliver, or send by certified mail with return receipt requested, to the health information ~~exchange service provider~~ organization written notice of the commissioner's intent to impose a penalty. This notice of proposed determination must include:

(1) a reference to the statutory basis for the penalty;

(2) a description of the findings of fact regarding the violations with respect to which the penalty is proposed;

(3) the nature and amount of the proposed penalty;

(4) any circumstances described in subdivision 1, paragraph (a), that were considered in determining the amount of the proposed penalty;

(5) instructions for responding to the notice, including a statement of the health information ~~exchange service provider's~~ organization's right to a contested case proceeding and a statement that failure to request a contested case proceeding within 30 calendar days permits the imposition of the proposed penalty; and

(6) the address to which the contested case proceeding request must be sent.

Subd. 4. **Coordination.** The commissioner shall, to the extent possible, seek the advice of the Minnesota e-Health Advisory Committee, in the review and update of criteria for the certification and recertification of health information ~~exchange service providers~~ organizations when implementing sections 62J.498 to 62J.4982.

Subd. 5. **Fees and monetary penalties.** (a) The commissioner shall assess fees on every health information ~~exchange service provider~~ organization subject to sections 62J.4981 and 62J.4982 as follows:

(1) filing an application for certificate of authority to operate as a health information organization, $7,000; and

(2) ~~filing an application for certificate of authority to operate as a health data intermediary, $7,000;~~

~~(3)~~ annual health information organization certificate fee, $7,000~~; and~~.

~~(4) annual health data intermediary certificate fee, $7,000.~~

(b) After a hearing before the commissioner at which the health information ~~exchange service provider~~ organization may respond to the grounds for denial, suspension, or revocation, or upon the failure of the health information ~~exchange service provider~~ organization to appear at the hearing, the commissioner shall take action as deemed necessary and shall issue written findings and mail them to the health information ~~exchange service provider~~ organization.

(c) If suspension, revocation, or administrative penalty is proposed according to this section, the commissioner must deliver, or send by certified mail with return receipt requested, to the health information ~~exchange service provider~~ organization written notice of the commissioner's intent to impose a penalty. This notice of proposed determination must include:

(1) a reference to the statutory basis for the penalty;

(2) a description of the findings of fact regarding the violations with respect to which the penalty is proposed;

(3) the nature and amount of the proposed penalty;

(4) any circumstances described in subdivision 1, paragraph (a), that were considered in determining the amount of the proposed penalty;

(5) instructions for responding to the notice, including a statement of the health information ~~exchange service provider's~~ organization's right to a contested case proceeding and a statement that failure to request a contested case proceeding within 30 calendar days permits the imposition of the proposed penalty; and

(6) the address to which the contested case proceeding request must be sent.

Subd. 4. **Coordination.** The commissioner shall, to the extent possible, seek the advice of the Minnesota e-Health Advisory Committee, in the review and update of criteria for the certification and recertification of health information ~~exchange service providers~~ organizations when implementing sections 62J.498 to 62J.4982.

Subd. 5. **Fees and monetary penalties.** (a) The commissioner shall assess fees on every health information ~~exchange service provider~~ organization subject to sections 62J.4981 and 62J.4982 as follows:

(1) filing an application for certificate of authority to operate as a health information organization, $7,000; and

(2) ~~filing an application for certificate of authority to operate as a health data intermediary, $7,000;~~

~~(3)~~ annual health information organization certificate fee, $7,000~~; and~~.

~~(4) annual health data intermediary certificate fee, $7,000.~~

(b) Fees collected under this section shall be deposited in the state treasury and credited to the state government special revenue fund.

(c) Administrative monetary penalties imposed under this subdivision shall be credited to an account in the special revenue fund and are appropriated to the commissioner for the purposes of sections 62J.498 to 62J.4982.

Sec. 10. Minnesota Statutes 2020, section 62J.63, subdivision 1, is amended to read:

Subdivision 1. **~~Establishment; administration~~ Support for state health care purchasing and performance measurement.** The commissioner of health shall ~~establish and administer the Center for Health Care Purchasing Improvement as an administrative unit within the Department of Health. The Center for Health Care Purchasing Improvement shall~~ support the state in its efforts to be a more prudent and efficient purchaser of quality health care services~~. The center shall~~, aid the state in developing and using more common strategies and approaches for health care performance measurement and health care purchasing~~. The common strategies and approaches shall~~, promote greater transparency of health care costs and quality~~;~~ and greater accountability for health care results and improvement~~. The center shall also~~, and identify barriers to more efficient, effective, quality health care and options for overcoming the barriers.

Sec. 11. Minnesota Statutes 2020, section 62J.63, subdivision 2, is amended to read:

Subd. 2. **~~Staffing;~~ Duties; scope.** ~~(a)~~ The commissioner of health may ~~appoint a director, and up to three additional senior-level staff or codirectors, and other staff as needed who are under the direction of the commissioner. The staff of the center are in the unclassified service.~~:

~~(b) With the authorization of the commissioner of health, and in consultation or interagency agreement with the appropriate commissioners of state agencies, the director, or codirectors, may:~~

~~(1) initiate projects to develop plan designs for state health care purchasing;~~

~~(2)~~ (1) require reports or surveys to evaluate the performance of current health care purchasing or administrative simplification strategies;

~~(3)~~ (2) calculate fiscal impacts, including net savings and return on investment, of health care purchasing strategies and initiatives;

~~(4) conduct policy audits of state programs to measure conformity to state statute or other purchasing initiatives or objectives;~~

~~(5)~~ (3) support the Administrative Uniformity Committee under ~~section~~ sections 62J.50 and 62J.536 and other relevant groups or activities to advance agreement on health care administrative process streamlining;

(b) Fees collected under this section shall be deposited in the state treasury and credited to the state government special revenue fund.

(c) Administrative monetary penalties imposed under this subdivision shall be credited to an account in the special revenue fund and are appropriated to the commissioner for the purposes of sections 62J.498 to 62J.4982.

~~(6) consult with the Health Economics Unit of the Department of Health regarding reports and assessments of the health care marketplace;~~

~~(7) consult with the Department of Commerce regarding health care regulatory issues and legislative initiatives;~~

~~(8) work with appropriate Department of Human Services staff and the Centers for Medicare and Medicaid Services to address federal requirements and conformity issues for health care purchasing;~~

~~(9) assist the Minnesota Comprehensive Health Association in health care purchasing strategies;~~

~~(10) convene medical directors of agencies engaged in health care purchasing for advice, collaboration, and exploring possible synergies;~~

~~(11)~~ (4) contact and participate with other relevant health care task forces, study activities, and similar efforts with regard to health care performance measurement and performance-based purchasing; and

~~(12)~~ (5) assist in seeking external funding through appropriate grants or other funding opportunities and may administer grants and externally funded projects.

Sec. 12. **[62J.826] MEDICAL PRACTICES; CURRENT STANDARD CHARGES.**

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

(b) "Chargemaster" means the list of all individual items and services maintained by a medical practice for which the medical practice has established a charge.

(c) "Diagnostic laboratory testing" means a service charged using a CPT code within the CPT code range of 80047 to 89398.

(d) "Diagnostic radiology service" means a service charged using a CPT code within the CPT code range of 70010 to 7999 and includes the provision of x-rays, computed tomography scans, positron emission tomography scans, magnetic resonance imaging scans, and mammographies.

(e) "Hospital" means an acute care institution licensed under sections 144.50 to 144.58, but does not include a health care institution conducted for those who rely primarily upon treatment by prayer or spiritual means in accordance with the creed or tenets of any church or denomination.

(f) "Medical practice" means a business that:

(1) earns revenue by providing medical care to the public;

(2) issues payment claims to health plan companies and other payers; and

(3) may be identified by its federal tax identification number.

(g) "Outpatient surgical center" means a health care facility other than a hospital offering elective outpatient surgery under a license issued under sections 144.50 to 144.58.

Subd. 2. **Requirement; current standard charges.** The following medical practices must make available to the public a list of the medical practice's current standard charges, as reflected in the medical practice's chargemaster, for all items and services provided by the medical practice:

(1) hospitals;

(2) outpatient surgical centers; and

(3) any other medical practice that has revenue of greater than $50,000,000 per year and that derives the majority of the medical practice's revenue by providing one or more of the following services:

(i) diagnostic radiology services;

(ii) diagnostic laboratory testing;

(iii) orthopedic surgical procedures, including joint arthroplasty procedures within the CPT code range of 26990 to 27899;

(iv) ophthalmologic surgical procedures, including cataract surgery coded using CPT code 66982 or 66984, or refractive correction surgery to improve visual acuity;

(v) anesthesia services commonly provided as an ancillary to services provided at a hospital, outpatient surgical center, or medical practice that provides orthopedic surgical procedures or ophthalmologic surgical procedures; or

(vi) oncology services, including radiation oncology treatments within the CPT code range of 77261 to 77799 and drug infusions.

Subd. 3. **Required file format and data attributes.** (a) A medical practice required to post the medical practice's current standard charges must post the following data attributes in the listed order:

(1) federal tax identification number for the medical practice;

(2) name of the medical practice, defined as the provider name that the medical practice enters on the CMS claim form 1500 or a successor form when the medical practice submits health care claims to a payer organization;

(3) internal chargemaster record identification, defined as the internal record identifier for this chargemaster line item in the medical practice's billing system;

(4) service billing code system, defined as a code signifying the HIPAA-compliant billing code system from which the service billing code was drawn;

(5) service billing code, defined as a specific billing code drawn from the service billing code system denoted by the value in the service billing code type field;

(6) service description, defined as the shortest, nonabbreviated official description associated with the service billing code in the applicable service billing code system;

(7) revenue code, defined as the National Uniform Billing Committee revenue code denoting the patient's location within the medical practice where the patient will receive the item or service subject to this charge. This value is required only if the charge amount is dependent on the location within the medical practice where the item or service is provided;

(8) revenue code description, defined as the description provided by the National Uniform Billing Committee for the revenue code. This value is required only if the charge amount is dependent on the location within the medical practice where the item or service is provided;

(9) national drug code, defined as the national drug code for a drug that is administered as part of the service subject to this charge. This field is required only when the charge amount is dependent on which, if any, drug is being administered as part of this service;

(10) national drug code description, defined as the official description associated with the national drug code for a drug that is administered as part of the service subject to this charge. This field is required only when the charge amount is dependent on which, if any, drug is being administered as part of this service;

(11) inpatient gross charge, defined as the charge for an individual item or service that is reflected on a hospital's chargemaster, absent any discounts as defined in Code of Federal Regulations, title 45, section 180.20, for an item or service provided on an inpatient basis;

(12) outpatient gross charge, defined as the charge for an individual item or service that is reflected on a chargemaster, absent any discounts as defined in Code of Federal Regulations, title 45, section 180.20, for an item or service provided on an outpatient basis;

(13) inpatient discounted cash price, defined as the charge that applies to an individual who pays cash or a cash equivalent for an item or service being reported under this section and provided on an inpatient basis;

(14) outpatient discounted cash price, defined as the charge that applies to an individual who pays cash or a cash equivalent for an item or service being reported under this section and provided on an outpatient basis;

(15) charge unit, defined as the unit cost basis for the charge;

(16) effective date of the charge; and

(17) payer-specific negotiated charges, as defined in Code of Federal Regulations, title 45, section 180.20. There must be a separate field for each payer's rate and the payers must be listed in alphabetical order.

(b) The data attributes specified in paragraph (a) must be posted in the form of a comma-separated values file, with all text values quoted and all leading and trailing white spaces trimmed before and after data attribute values.

(c) The data attributes specified in paragraph (a) must be posted on a web page labeled "Cost of Care at [Name of Medical Practice]" which members of the public can access via a direct, clearly labeled link on the medical practice's main billing web page, and which is searchable by entering the words "cost of care at [name of medical practice]" into an Internet search engine. The consumer-friendly list of standard charges for a limited set of shoppable services required under Code of Federal Regulations, title 45, section 180.60, must be presented on the same web page.

(d) The file must be named according to the following convention: <ein>_<hospital-name>_standardcharges.csv as required by Code of Federal Regulations, title 45, section 180.50.

EFFECTIVE DATE. This section is effective January 1, 2022.

Sec. 8. Minnesota Statutes 2020, section 62J.84, subdivision 6, is amended to read:

Subd. 6. **Public posting of prescription drug price information.** (a) The commissioner shall post on the department's website, or may contract with a private entity or consortium that satisfies the standards of section 62U.04, subdivision 6, to meet this requirement, the following information:

(1) a list of the prescription drugs reported under subdivisions 3, 4, and 5, and the manufacturers of those prescription drugs; and

(2) information reported to the commissioner under subdivisions 3, 4, and 5.

(b) The information must be published in an easy-to-read format and in a manner that identifies the information that is disclosed on a per-drug basis and must not be aggregated in a manner that prevents the identification of the prescription drug.

(c) The commissioner shall not post to the department's website or a private entity contracting with the commissioner shall not post any information described in this section if the information is not public data under section 13.02, subdivision 8a; or is trade secret information under section 13.37, subdivision 1, paragraph (b); or is trade secret information pursuant to the Defend Trade Secrets Act of 2016, United States Code, title 18, section 1836, as amended. If a manufacturer believes information should be withheld from public disclosure pursuant to this paragraph, the manufacturer must clearly and specifically identify that information and describe the legal basis in writing when the manufacturer submits the

Sec. 13. Minnesota Statutes 2020, section 62U.04, subdivision 4, is amended to read:

Subd. 4. **Encounter data.** (a) ~~Beginning July 1, 2009, and every six months thereafter,~~ All health plan companies and third-party administrators shall submit encounter data on a monthly basis to a private entity designated by the commissioner of health. The data shall be submitted in a form and manner specified by the commissioner subject to the following requirements:

(1) the data must be de-identified data as described under the Code of Federal Regulations, title 45, section 164.514;

(2) the data for each encounter must include an identifier for the patient's health care home if the patient has selected a health care home and, for claims incurred on or after January 1, 2019, data deemed necessary by the commissioner to uniquely identify claims in the individual health insurance market; and

(3) except for the identifier described in clause (2), the data must not include information that is not included in a health care claim or equivalent encounter information transaction that is required under section 62J.536.

(b) The commissioner or the commissioner's designee shall only use the data submitted under paragraph (a) to carry out the commissioner's responsibilities in this section, including supplying the data to providers so they can verify their results of the peer grouping process consistent with the recommendations developed pursuant to subdivision 3c, paragraph (d), and adopted by the commissioner and, if necessary, submit comments to the commissioner or initiate an appeal.

(c) Data on providers collected under this subdivision are private data on individuals or nonpublic data, as defined in section 13.02. Notwithstanding the data classifications in this paragraph, data on providers collected under this subdivision may be released or published information under this section. If the commissioner disagrees with the manufacturer's request to withhold information from public disclosure, the commissioner shall provide the manufacturer written notice that the information will be publicly posted 30 days after the date of the notice.

(d) If the commissioner withholds any information from public disclosure pursuant to this subdivision, the commissioner shall post to the department's website a report describing the nature of the information and the commissioner's basis for withholding the information from disclosure.

(e) To the extent the information required to be posted under this subdivision is collected and made available to the public by another state, by the University of Minnesota, or through an online drug pricing reference and analytical tool, the commissioner may reference the availability of this drug price data from another source including, within existing appropriations, creating the ability of the public to access the data from the source for purposes of meeting the reporting requirements of this subdivision.

as authorized in subdivision 11. Notwithstanding the definition of summary data in section 13.02, subdivision 19, summary data prepared under this subdivision may be derived from nonpublic data. The commissioner or the commissioner's designee shall establish procedures and safeguards to protect the integrity and confidentiality of any data that it maintains.

(d) The commissioner or the commissioner's designee shall not publish analyses or reports that identify, or could potentially identify, individual patients.

(e) The commissioner shall compile summary information on the data submitted under this subdivision. The commissioner shall work with its vendors to assess the data submitted in terms of compliance with the data submission requirements and the completeness of the data submitted by comparing the data with summary information compiled by the commissioner and with established and emerging data quality standards to ensure data quality.

Sec. 14. Minnesota Statutes 2020, section 62U.04, subdivision 5, is amended to read:

Subd. 5. **Pricing data.** (a) Beginning July 1, 2009, and annually on January 1 thereafter, all health plan companies and third-party administrators shall submit data on their contracted prices with health care providers to a private entity designated by the commissioner of health for the purposes of performing the analyses required under this subdivision. The data shall be submitted in the form and manner specified by the commissioner of health.

(b) The commissioner or the commissioner's designee shall only use the data submitted under this subdivision to carry out the commissioner's responsibilities under this section, including supplying the data to providers so they can verify their results of the peer grouping process consistent with the recommendations developed pursuant to subdivision 3c, paragraph (d), and adopted by the commissioner and, if necessary, submit comments to the commissioner or initiate an appeal.

(c) Data collected under this subdivision are nonpublic data as defined in section 13.02. Notwithstanding the data classification in this paragraph, data collected under this subdivision may be released or published as authorized in subdivision 11. Notwithstanding the definition of summary data in section 13.02, subdivision 19, summary data prepared under this section may be derived from nonpublic data. The commissioner shall establish procedures and safeguards to protect the integrity and confidentiality of any data that it maintains.

Sec. 15. Minnesota Statutes 2020, section 62U.04, subdivision 11, is amended to read:

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

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

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

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

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

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

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

(ii) not identify individual patients~~,~~ or payers~~, or providers~~ but that may identify the rendering or billing hospital, clinic, or medical practice;

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

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

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

(b) The commissioner may publish the results of the authorized uses identified in paragraph (a) ~~so long as the data released publicly do not contain information or descriptions in which the identity of individual hospitals, clinics, or other providers may be discerned~~. The data published under this paragraph may identify hospitals, clinics, and medical practices so long as no individual health professionals are identified and the commissioner finds the data to be accurate, valid, and suitable for publication for such use.

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

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

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

Sec. 16. Minnesota Statutes 2020, section 103H.201, subdivision 1, is amended to read:

Subdivision 1. **Procedure.** (a) If groundwater quality monitoring results show that there is a degradation of groundwater, the commissioner of health may promulgate health risk limits under subdivision 2 for substances degrading the groundwater.

(b) Health risk limits shall be determined by two methods depending on their toxicological end point.

(c) For systemic toxicants that are not carcinogens, the adopted health risk limits shall be derived using United States Environmental Protection Agency risk assessment methods using a reference dose, a drinking water equivalent, and a relative source contribution factor.

(d) For toxicants that are known or probable carcinogens, the adopted health risk limits shall be derived from a quantitative estimate of the chemical's carcinogenic potency published by the United States Environmental Protection Agency ~~and~~ or determined by the commissioner to have undergone thorough scientific review.

Sec. 9. Minnesota Statutes 2020, section 144.05, is amended by adding a subdivision to read:

Subd. 7. **Expiration of report mandates.** (a) If the submission of a report by the commissioner of health to the legislature is mandated by statute and the enabling legislation does not include a date for the submission of a final report, the mandate to submit the report shall expire in accordance with this section.

(b) If the mandate requires the submission of an annual report and the mandate was enacted before January 1, 2021, the mandate shall expire on January 1,2023. If the mandate requires the submission of a biennial or less frequent report and the mandate was enacted before January 1, 2021, the mandate shall expire on January 1, 2024.

(c) Any reporting mandate enacted on or after January 1, 2021 shall expire three years after the date of enactment if the mandate requires the submission of an annual report and shall expire five years after the date of enactment if the mandate requires the submission of a biennial or less frequent report, unless the enacting legislation provides for a difference expiration date.

(d) The commissioner shall submit a list to the chairs and ranking minority members of the legislative committee with jurisdiction over health by February 15 of each year, beginning February 15, 2022, of all reports set to expire during the following calendar year in accordance with this section.

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

Sec. 10. **[144.064] THE VIVIAN ACT.**

Subdivision 1. **Short title.** This section shall be known and may be cited as the "Vivian Act."

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

(1) "commissioner" means the commissioner of health;

(2) "health care practitioner" means a medical professional that provides prenatal or postnatal care;

(3) "CMV" means the human herpesvirus cytomegalovirus, also called HCMV, human herpesvirus 5, and HHV-5; and

(4) "congenital CMV" means the transmission of a CMV infection from a pregnant mother to her fetus.

Subd. 3. **Commissioner duties.** (a) The commissioner shall make available to health care practitioners, women who may become pregnant, expectant parents, and parents of infants up-to-date and evidence-based information about congenital CMV that has been reviewed by experts with knowledge of the disease. The information shall include the following:

(1) the recommendation to consider testing for congenital CMV if the parent or legal guardian of the infant elected not to have newborn screening performed under section 144.125, and the infant failed a newborn hearing screening or pregnancy history suggests increased risk for congenital CMV infection;

(2) the incidence of CMV;

(3) the transmission of CMV to pregnant women and women who may become pregnant;

(4) birth defects caused by congenital CMV;

(5) available preventative measures to avoid the infection of women who are pregnant or may become pregnant; and

(6) resources available for families of children born with congenital CMV.

(b) The commissioner shall follow existing department practice, inclusive of community engagement, to ensure that the information in paragraph (a) is culturally and linguistically appropriate for all recipients.

(c) The department shall establish an outreach program to:

(1) educate women who may become pregnant, expectant parents, and parents of infants about CMV; and

Sec. 17. **[144.066] DISTRIBUTION OF COVID-19 VACCINES.**

Subdivision 1. **Definitions.** (a) The terms defined in this subdivision apply to this section and sections 144.0661 to 144.0663.

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

(c) "COVID-19 vaccine" means a vaccine against severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2).

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

(e) "Disproportionately impacted community" means a community or population that has been disproportionately and negatively impacted by the COVID-19 pandemic.

(f) "Local health department" has the meaning given in section 145A.02, subdivision 8b.

(g) "Mobile vaccination vehicle" means a vehicle-mounted unit that is either motorized or trailered, that is readily movable without disassembling, and at which vaccines are provided in more than one geographic location.

Subd. 2. **Distribution.** The commissioner shall establish and maintain partnerships or agreements with local health departments; local health care providers, including community health centers and primary care providers; and local pharmacies to administer COVID-19 vaccines throughout the state. COVID-19 vaccines may also be administered via mobile vaccination vehicles authorized under section 144.0662.

Subd. 3. **Second dose or booster.** For all COVID-19 vaccines for which a second dose or booster is required, during the first vaccine appointment the registered vaccine provider should be directed by the department during the vaccine provider registration process to assist vaccine recipients with scheduling an appointment for the second dose or booster. This assistance may be provided during the observation period following vaccine administration.

Subd. 4. **Nondiscrimination.** Nothing in sections 144.066 to 144.0663 shall be construed to allow or require the denial of any benefit or opportunity on the basis of race, color, creed, marital status, status with regard to public assistance, disability, genetic information, sexual orientation, age, religion, national origin, sex, or membership in a local human rights commission.

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

(2) raise awareness for CMV among health care providers who provide care to expectant mothers or infants.

Sec. 18. **[144.0661] EQUITABLE COVID-19 VACCINE DISTRIBUTION.**

Subdivision 1. **COVID-19 vaccination equity and outreach.** The commissioner shall establish positions to continue the department's COVID-19 vaccination equity and outreach activities and to plan and implement actions and programs to overcome disparities in COVID-19 vaccination rates that are rooted in historic and current racism; biases based on ethnicity, income, primary language, immigration status, or disability; geography; or transportation access, language access, or Internet access. This work shall be managed by a director who shall serve in a leadership role in the department's COVID-19 response.

Subd. 2. **Vaccine education and outreach campaign; direct delivery of information.** (a) The commissioner shall administer a COVID-19 vaccine education and outreach campaign that engages in direct delivery of information to members of disproportionately impacted communities. In this campaign, the commissioner shall contract with community-based organizations including community faith-based organizations, tribal governments, local health departments, and local health care providers, including community health centers and primary care providers, to deliver the following information in a culturally relevant and linguistically appropriate manner:

(1) medically and scientifically accurate information on the safety, efficacy, science, and benefits of vaccines generally and COVID-19 vaccines in particular;

(2) information on how members of disproportionately impacted communities may obtain a COVID-19 vaccine including, if applicable, obtaining a vaccine from a mobile vaccination vehicle; and

(3) measures to prevent transmission of COVID-19, including adequate indoor ventilation, wearing face coverings, and physical distancing from individuals outside the household.

(b) This information must be delivered directly by methods that include phone calls, text messages, physically distanced door-to-door and street canvassing, and digital event-based communication involving live and interactive messengers. For purposes of this subdivision, direct delivery shall not include delivery by television, radio, newspaper, or other forms of mass media.

Subd. 3. **Vaccine education and outreach campaign; mass media.** The commissioner shall administer a mass media campaign to provide COVID-19 vaccine education and outreach to members of disproportionately impacted communities. In this campaign, the commissioner shall contract with media vendors to provide the following information to members of disproportionately impacted communities in a manner that is culturally relevant and linguistically appropriate:

(1) medically and scientifically accurate information on the safety, efficacy, science, and benefits of COVID-19 vaccines; and

(2) information on how members of disproportionately impacted communities may obtain a COVID-19 vaccine.

Subd. 4. **Community assistance.** The commissioner shall administer a program to help members of disproportionately impacted communities arrange for and prepare to obtain a COVID-19 vaccine and to support transportation-limited members of these communities with transportation to vaccination appointments or otherwise arrange for vaccine providers to reach members of these communities.

Subd. 5. **Equitable distribution of COVID-19 vaccines.** The commissioner shall establish a set of metrics to measure the equitable distribution of COVID-19 vaccines in the state, and shall set and periodically update goals for COVID-19 vaccine distribution in the state that are focused on equity.

Subd. 6. **Expiration of programs.** The vaccine education and outreach programs in subdivisions 2 and 3 and the community assistance program in subdivision 4 shall operate until a sufficient percentage of individuals in each county or census tract have received the full series of COVID-19 vaccines to protect individuals in each county or census tract from COVID-19.

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

Sec. 19. **[144.0662] MOBILE VACCINATION PROGRAM.**

Subdivision 1. **Administration.** The commissioner, in partnership with local health departments and the regional health care coalitions, shall administer a mobile vaccination program in which mobile vaccination vehicles are deployed to communities around the state to provide COVID-19 vaccines to individuals. The commissioner shall deploy mobile vaccination vehicles to communities to improve access to vaccines based on factors that include but are not limited to vulnerability, likelihood of exposure, limits to transportation access, rate of vaccine uptake, and limited access to vaccines or barriers to obtaining vaccines.

Subd. 2. **Eligibility.** Notwithstanding the phases and priorities of the state's COVID-19 allocation and prioritization plan or guidance, all individuals in a community to which a mobile vaccination vehicle is deployed shall be eligible to receive COVID-19 vaccines from the vehicle.

Subd. 3. **Staffing.** Each mobile vaccination vehicle must be staffed in accordance with Centers for Disease Control and Prevention guidelines and may be staffed with additional support staff based on needs determined by local request. Additional support staff may include but are not limited to community partners and translators.

Subd. 4. **Second doses.** For vaccine recipients who receive a first dose of a COVID-19 vaccine from a mobile vaccination vehicle, vehicle staff shall provide assistance in scheduling an appointment with a mobile vaccination vehicle or with another vaccine provider for any needed second dose or booster. The commissioner shall, to the extent possible, deploy

mobile vaccination vehicles in a manner that allows vaccine recipients to receive second doses or boosters from a mobile vaccination vehicle.

Subd. 5. **Expiration.** The commissioner shall administer the mobile vaccination vehicle program until a sufficient percentage of individuals in each county or census tract have received the full series of COVID-19 vaccines to protect individuals in each county or census tract from the spread of COVID-19.

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

Sec. 20. **[144.0663] COVID-19 VACCINATION PLAN AND DATA; REPORTS.**

Subdivision 1. **COVID-19 vaccination plan; implementation protocols.** The commissioner shall:

(1) publish the set of metrics and goals for equitable COVID-19 vaccine distribution established by the commissioner under section 144.0661, subdivision 5; and

(2) publish implementation protocols to address the disparities in COVID-19 vaccination rates in certain communities and ensure that members of disproportionately impacted communities are given adequate access to COVID-19 vaccines.

Subd. 2. **Data on COVID-19 vaccines.** On at least a weekly basis, the commissioner shall publish on the department website:

(1) data measuring compliance with the set of metrics and goals for equitable COVID-19 vaccine distribution established by the commissioner under section 144.0661, subdivision 5; and

(2) summary data on individuals who have received one or two doses of a COVID-19 vaccine, broken out by race, gender, ethnicity, age within an age range, and zip code.

Subd. 3. **Quarterly reports.** On a quarterly basis while funds are available, the commissioner shall report to the chairs and ranking minority members of the legislative committees with jurisdiction over finance, ways and means, and health care:

(1) funds distributed to local health departments for COVID-19 activities and the sources of the funds; and

(2) funds expended to implement sections 144.066 to 144.0663.

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

Sec. 21. Minnesota Statutes 2020, section 144.0724, subdivision 1, is amended to read:

Subdivision 1. **Resident reimbursement case mix classifications.** The commissioner of health shall establish resident reimbursement case mix classifications based upon the assessments of residents of nursing homes and boarding care homes conducted under this section and according to section 256R.17.

Sec. 22. Minnesota Statutes 2020, section 144.0724, subdivision 2, is amended to read:

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

(a) "Assessment reference date" or "ARD" means the specific end point for look-back periods in the MDS assessment process. This look-back period is also called the observation or assessment period.

(b) "Case mix index" means the weighting factors assigned to the RUG-IV classifications.

(c) "Index maximization" means classifying a resident who could be assigned to more than one category, to the category with the highest case mix index.

(d) "Minimum Data Set" or "MDS" means a core set of screening, clinical assessment, and functional status elements, that include common definitions and coding categories specified by the Centers for Medicare and Medicaid Services and designated by the ~~Minnesota~~ Department of Health.

(e) "Representative" means a person who is the resident's guardian or conservator, the person authorized to pay the nursing home expenses of the resident, a representative of the Office of Ombudsman for Long-Term Care whose assistance has been requested, or any other individual designated by the resident.

(f) "Resource utilization groups" or "RUG" means the system for grouping a nursing facility's residents according to their clinical and functional status identified in data supplied by the facility's Minimum Data Set.

(g) "Activities of daily living" ~~means grooming,~~ includes personal hygiene, dressing, bathing, transferring, bed mobility, ~~positioning,~~ locomotion, eating, and toileting.

(h) "Nursing facility level of care determination" means the assessment process that results in a determination of a resident's or prospective resident's need for nursing facility level of care as established in subdivision 11 for purposes of medical assistance payment of long-term care services for:

(1) nursing facility services under section 256B.434 or chapter 256R;

(2) elderly waiver services under chapter 256S;

(3) CADI and BI waiver services under section 256B.49; and

(4) state payment of alternative care services under section 256B.0913.

Sec. 23. Minnesota Statutes 2020, section 144.0724, subdivision 3a, is amended to read:

Subd. 3a. **Resident reimbursement case mix classifications beginning January 1, 2012.** (a) Beginning January 1, 2012, resident reimbursement case mix classifications shall be based on the Minimum Data Set, version 3.0 assessment instrument, or its successor version mandated by the Centers for Medicare and Medicaid Services that nursing facilities

are required to complete for all residents. The commissioner of health shall establish resident classifications according to the RUG-IV, 48 group, resource utilization groups. Resident classification must be established based on the individual items on the Minimum Data Set, which must be completed according to the Long Term Care Facility Resident Assessment Instrument User's Manual Version 3.0 or its successor issued by the Centers for Medicare and Medicaid Services.

(b) Each resident must be classified based on the information from the Minimum Data Set according to general categories ~~as defined in the Case Mix Classification Manual for Nursing Facilities~~ issued by the Minnesota Department of Health.

Sec. 24. Minnesota Statutes 2020, section 144.0724, subdivision 5, is amended to read:

Subd. 5. **Short stays.** (a) A facility must submit to the commissioner of health an admission assessment for all residents who stay in the facility 14 days or less~~.~~, unless the resident is admitted and discharged from the facility on the same day, in which case the admission assessment is not required. When an admission assessment is not submitted, the case mix classification shall be the rate with a case mix index of 1.0.

(b) Notwithstanding the admission assessment requirements of paragraph (a), a facility may elect to accept a short stay rate with a case mix index of 1.0 for all facility residents who stay 14 days or less in lieu of submitting an admission assessment. Facilities shall make this election annually.

(c) Nursing facilities must elect one of the options described in paragraphs (a) and (b) by reporting to the commissioner of health, as prescribed by the commissioner. The election is effective on July 1 each year.

Sec. 25. Minnesota Statutes 2020, section 144.0724, subdivision 7, is amended to read:

Subd. 7. **Notice of resident reimbursement case mix classification.** (a) The commissioner of health shall provide to a nursing facility a notice for each resident of the ~~reimbursement~~ classification established under subdivision 1. The notice must inform the resident of the case mix classification ~~that was~~ assigned, the opportunity to review the documentation supporting the classification, the opportunity to obtain clarification from the commissioner, and the opportunity to request a reconsideration of the classification and the address and telephone number of the Office of Ombudsman for Long-Term Care. The commissioner must transmit the notice of resident classification by electronic means to the nursing facility. ~~A~~ The nursing facility is responsible for the distribution of the notice to each resident~~, to the person responsible for the payment of the resident's nursing home expenses, or to another person designated by the resident~~ or the resident's representative. This notice must be distributed within three ~~working~~ business days after the facility's receipt ~~of the electronic file of notice of case mix classifications from the commissioner of health~~.

(b) If a facility submits a ~~modification to the most recent assessment used to establish a case mix classification conducted under subdivision 3 that results~~ modifying assessment resulting in a change in the case mix classification, the facility ~~shall give~~ must provide a

written notice to the resident or the resident's representative ~~about~~ regarding the item or items that ~~was~~ were modified and the reason for the ~~modification~~ modifications. The notice ~~of modified assessment may~~ must be provided ~~at the same time that the resident or resident's representative is provided the resident's modified notice of classification~~ within three business days after distribution of the resident case mix classification notice.

Sec. 26. Minnesota Statutes 2020, section 144.0724, subdivision 8, is amended to read:

Subd. 8. **Request for reconsideration of resident classifications.** (a) The resident, or resident's representative, or the nursing facility or boarding care home may request that the commissioner of health reconsider the assigned reimbursement case mix classification and any item or items changed during the audit process. The request for reconsideration must be submitted in writing to the commissioner ~~within 30 days of the day the resident or the resident's representative receives the resident classification notice~~ of health.

(b) For reconsideration requests initiated by the resident or the resident's representative:

(1) The resident or the resident's representative must submit in writing a reconsideration request to the facility administrator within 30 days of receipt of the resident classification notice. The written request ~~for reconsideration~~ must include the ~~name of the resident, the name and address of the facility in which the resident resides, the~~ reasons for the reconsideration~~, and documentation supporting the~~ request. ~~The documentation accompanying the reconsideration request is limited to a copy of the MDS that determined the classification and other documents that would support or change the MDS findings.~~

(2) Within three business days of receiving the reconsideration request, the nursing facility must submit to the commissioner of health a completed reconsideration request form, a copy of the resident's or resident's representative's written request, and all supporting documentation used to complete the assessment being considered. If the facility fails to provide the required information, the reconsideration will be completed with the information submitted and the facility cannot make further reconsideration requests on this classification.

~~(b)~~ (3) Upon written request and within three business days, the nursing facility must give the resident or the resident's representative a copy of the assessment ~~form~~ being reconsidered and ~~the other~~ all supporting documentation ~~that was given to the commissioner of health~~ used to ~~support~~ complete the assessment ~~findings~~. ~~The nursing facility shall also provide access to and a copy of other information from the resident's record that has been requested by or on behalf of the resident to support a resident's reconsideration request. A copy of any requested material must be provided within three working days of receipt of a written request for the information.~~ Notwithstanding any law to the contrary, the facility may not charge a fee for providing copies of the requested documentation. If a facility fails to provide the ~~material~~ required documents within this time, it is subject to the issuance of a correction order and penalty assessment under sections 144.653 and 144A.10. Notwithstanding those sections, any correction order issued under this subdivision must require that the nursing facility immediately comply with the request for information, and ~~that~~ as of the date of the issuance of the correction order, the facility shall forfeit to the state

a $100 fine for the first day of noncompliance, and an increase in the $100 fine by $50 increments for each day the noncompliance continues.

(c) ~~in addition to the information required under paragraphs (a) and (b), a reconsideration request from a nursing facility must contain the following information: (i) the date the reimbursement classification notices were received by the facility; (ii) the date the classification notices were distributed to the resident or the resident's representative; and~~ ~~(iii)~~ For reconsideration requests initiated by the facility:

(1) The facility is required to inform the resident or the resident's representative in writing that a reconsideration of the resident's case mix classification is being requested. The notice must inform the resident or the resident's representative:

(i) of the date and reason for the reconsideration request;

(ii) of the potential for a classification and subsequent rate change;

(iii) of the extent of the potential rate change;

(iv) that copies of the request and supporting documentation are available for review; and

(v) that the resident or the resident's representative has the right to request a reconsideration.

(2) Within 30 days of receipt of the audit exit report or resident classification notice, the facility must submit to the commissioner of health a completed reconsideration request form, all supporting documentation used to complete the assessment being reconsidered, and a copy of ~~a~~ the notice ~~sent to~~ informing the resident or ~~to~~ the resident's representative~~. This notice must inform the resident or the resident's representative~~ that a reconsideration of the resident's classification is being requested~~, the reason for the request, that the resident's rate will change if the request is approved by the commissioner, the extent of the change, that copies of the facility's request and supporting documentation are available for review, and that the resident also has the right to request a reconsideration~~.

(3) If the facility fails to provide the required information ~~listed in item (iii) with the reconsideration request, the commissioner may request that the facility provide the information within 14 calendar days.~~, the reconsideration request ~~must~~ may be denied ~~if the information is then not provided,~~ and the facility may not make further reconsideration requests on ~~that specific reimbursement~~ this classification.

(d) Reconsideration by the commissioner must be made by individuals not involved in reviewing the assessment, audit, or reconsideration that established the disputed classification. The reconsideration must be based upon the assessment that determined the classification and upon the information provided to the commissioner of health under paragraphs (a) ~~and~~ ~~(b)~~ to (c). If necessary for evaluating the reconsideration request, the commissioner may conduct on-site reviews. Within 15 ~~working~~ business days of receiving the request for reconsideration, the commissioner shall affirm or modify the original resident classification.

The original classification must be modified if the commissioner determines that the assessment resulting in the classification did not accurately reflect characteristics of the resident at the time of the assessment. ~~The resident and the nursing facility or boarding care home shall be notified within five working days after the decision is made.~~ The commissioner must transmit the reconsideration classification notice by electronic means to the nursing facility. The nursing facility is responsible for the distribution of the notice to the resident or the resident's representative. The notice must be distributed by the nursing facility within three business days after receipt. A decision by the commissioner under this subdivision is the final administrative decision of the agency for the party requesting reconsideration.

(e) The ~~resident~~ case mix classification established by the commissioner shall be the classification ~~that~~ which applies to the resident while the request for reconsideration is pending. If a request for reconsideration applies to an assessment used to determine nursing facility level of care under subdivision 4, paragraph (c), the resident shall continue to be eligible for nursing facility level of care while the request for reconsideration is pending.

(f) The commissioner may request additional documentation regarding a reconsideration necessary to make an accurate reconsideration determination.

Sec. 27. Minnesota Statutes 2020, section 144.0724, subdivision 9, is amended to read:

Subd. 9. **Audit authority.** (a) The commissioner shall audit the accuracy of resident assessments performed under section 256R.17 through any of the following: desk audits; on-site review of residents and their records; and interviews with staff, residents, or residents' families. The commissioner shall reclassify a resident if the commissioner determines that the resident was incorrectly classified.

(b) The commissioner is authorized to conduct on-site audits on an unannounced basis.

(c) A facility must grant the commissioner access to examine the medical records relating to the resident assessments selected for audit under this subdivision. The commissioner may also observe and speak to facility staff and residents.

(d) The commissioner shall consider documentation under the time frames for coding items on the minimum data set as set out in the Long-Term Care Facility Resident Assessment Instrument User's Manual published by the Centers for Medicare and Medicaid Services.

(e) The commissioner shall develop an audit selection procedure that includes the following factors:

(1) Each facility shall be audited annually. If a facility has two successive audits in which the percentage of change is five percent or less and the facility has not been the subject of a special audit in the past 36 months, the facility may be audited biannually. A stratified sample of 15 percent, with a minimum of ten assessments, of the most current assessments shall be selected for audit. If more than 20 percent of the RUG-IV classifications are changed as a result of the audit, the audit shall be expanded to a second 15 percent sample, with a minimum of ten assessments. If the total change between the first and second samples is

35 percent or greater, the commissioner may expand the audit to all of the remaining assessments.

(2) If a facility qualifies for an expanded audit, the commissioner may audit the facility again within six months. If a facility has two expanded audits within a 24-month period, that facility will be audited at least every six months for the next 18 months.

(3) The commissioner may conduct special audits if the commissioner determines that circumstances exist that could alter or affect the validity of case mix classifications of residents. These circumstances include, but are not limited to, the following:

(i) frequent changes in the administration or management of the facility;

(ii) an unusually high percentage of residents in a specific case mix classification;

(iii) a high frequency in the number of reconsideration requests received from a facility;

(iv) frequent adjustments of case mix classifications as the result of reconsiderations or audits;

(v) a criminal indictment alleging provider fraud;

(vi) other similar factors that relate to a facility's ability to conduct accurate assessments;

(vii) an atypical pattern of scoring minimum data set items;

(viii) nonsubmission of assessments;

(ix) late submission of assessments; or

(x) a previous history of audit changes of 35 percent or greater.

(f) ~~Within 15 working days of completing the audit process, the commissioner shall make available electronically the results of the audit to the facility. If the results of the audit reflect a change in the resident's case mix classification, a case mix classification notice will be made available electronically to the facility, using the procedure in subdivision 7, paragraph (a). The notice must contain the resident's classification and a statement informing the resident, the resident's authorized representative, and the facility of their right to review the commissioner's documents supporting the classification and to request a reconsideration of the classification. This notice must also include the address and telephone number of the Office of Ombudsman for Long-Term Care.~~ If the audit results in a case mix classification change, the commissioner must transmit the audit classification notice by electronic means to the nursing facility within 15 business days of completing an audit. The nursing facility is responsible for distribution of the notice to each resident or the resident's representative. This notice must be distributed by the nursing facility within three business days after receipt. The notice must inform the resident of the case mix classification assigned, the opportunity to review the documentation supporting the classification, the opportunity to obtain clarification from the commissioner, the opportunity to request a reconsideration of

the classification, and the address and telephone number of the Office of Ombudsman for Long-Term Care.

Sec. 28. Minnesota Statutes 2020, section 144.0724, subdivision 12, is amended to read:

Subd. 12. **Appeal of nursing facility level of care determination.** (a) A resident or prospective resident whose level of care determination results in a denial of long-term care services can appeal the determination as outlined in section 256B.0911, subdivision 3a, paragraph (h), clause (9).

(b) The commissioner of human services shall ensure that notice of changes in eligibility due to a nursing facility level of care determination is provided to each affected recipient or the recipient's guardian at least 30 days before the effective date of the change. The notice shall include the following information:

(1) how to obtain further information on the changes;

(2) how to receive assistance in obtaining other services;

(3) a list of community resources; and

(4) appeal rights.

~~A recipient who meets the criteria in section 256B.0922, subdivision 2, paragraph (a), clauses (1) and (2), may request continued services pending appeal within the time period allowed to request an appeal under section 256.045, subdivision 3, paragraph (i). This paragraph is in effect for appeals filed between January 1, 2015, and December 31, 2016.~~

Sec. 29. Minnesota Statutes 2020, section 144.1205, subdivision 2, is amended to read:

Subd. 2. **Initial and annual fee.** (a) A licensee must pay an initial fee that is equivalent to the annual fee upon issuance of the initial license.

(b) A licensee must pay an annual fee at least 60 days before the anniversary date of the issuance of the license. The annual fee is as follows:

TYPE	~~ANNUAL~~ LICENSE FEE
	~~$19,920~~
Academic broad scope - type A, B, or C	$25,896
~~Academic broad scope - type B~~	~~19,920~~
~~Academic broad scope - type C~~	~~19,920~~
Academic broad scope - type A, B, or C (4-8 locations)	$31,075

Sec. 11. Minnesota Statutes 2020, section 144.1205, subdivision 2, is amended to read:

Subd. 2. **Initial and annual fee.** (a) A licensee must pay an initial fee that is equivalent to the annual fee upon issuance of the initial license.

(b) A licensee must pay an annual fee at least 60 days before the anniversary date of the issuance of the license. The annual fee is as follows:

TYPE	~~ANNUAL~~ LICENSE FEE
	~~$19,920~~
Academic broad scope - type A, B, or C	$25,896
~~Academic broad scope - type B~~	~~19,920~~
~~Academic broad scope - type C~~	~~19,920~~
Academic broad scope - type A, B, or C (4-8 locations)	$31,075

Academic broad scope - type A, B, or C (9 or more locations)	$36,254	
	~~19,920~~	
Medical broad scope - type A	$25,896	
Medical broad scope- type A (4-8 locations)	$31,075	
Medical broad scope- type A (9 or more locations)	$36,254	
~~Medical institution - diagnostic and therapeutic~~	~~3,680~~	
Medical - diagnostic, diagnostic and therapeutic, mobile nuclear medicine, eye applicators, high dose rate afterloaders, and medical therapy emerging technologies	$4,784	
Medical - diagnostic, diagnostic and therapeutic, mobile nuclear medicine, eye applicators, high dose rate afterloaders, and medical therapy emerging technologies (4-8 locations)	$5,740	
Medical - diagnostic, diagnostic and therapeutic, mobile nuclear medicine, eye applicators, high dose rate afterloaders, and medical therapy emerging technologies (9 or more locations)	$6,697	
~~Medical institution - diagnostic (no written directives)~~	~~3,680~~	
~~Medical private practice - diagnostic and therapeutic~~	~~3,680~~	
~~Medical private practice - diagnostic (no written directives)~~	~~3,680~~	
~~Eye applicators~~	~~3,680~~	
~~Nuclear medical vans~~	~~3,680~~	
~~High dose rate afterloader~~	~~3,680~~	
~~Mobile high dose rate afterloader~~	~~3,680~~	
~~Medical therapy - other emerging technology~~	~~3,680~~	
	~~8,960~~	
Teletherapy	$11,648	
	~~8,960~~	
Gamma knife	$11,648	
Veterinary medicine	~~2,000~~ $2,600	

Academic broad scope - type A, B, or C (9 or more locations)	$36,254	
	~~19,920~~	
Medical broad scope - type A	$25,896	
Medical broad scope- type A (4-8 locations)	$31,075	
Medical broad scope- type A (9 or more locations)	$36,254	
~~Medical institution - diagnostic and therapeutic~~	~~3,680~~	
Medical - diagnostic, diagnostic and therapeutic, mobile nuclear medicine, eye applicators, high dose rate afterloaders, and medical therapy emerging technologies	$4,784	
Medical - diagnostic, diagnostic and therapeutic, mobile nuclear medicine, eye applicators, high dose rate afterloaders, and medical therapy emerging technologies (4-8 locations)	$5,740	
Medical - diagnostic, diagnostic and therapeutic, mobile nuclear medicine, eye applicators, high dose rate afterloaders, and medical therapy emerging technologies (9 or more locations)	$6,697	
~~Medical institution - diagnostic (no written directives)~~	~~3,680~~	
~~Medical private practice - diagnostic and therapeutic~~	~~3,680~~	
~~Medical private practice - diagnostic (no written directives)~~	~~3,680~~	
~~Eye applicators~~	~~3,680~~	
~~Nuclear medical vans~~	~~3,680~~	
~~High dose rate afterloader~~	~~3,680~~	
~~Mobile high dose rate afterloader~~	~~3,680~~	
~~Medical therapy - other emerging technology~~	~~3,680~~	
	~~8,960~~	
Teletherapy	$11,648	
	~~8,960~~	
Gamma knife	$11,648	
Veterinary medicine	~~2,000~~ $2,600	

In vitro testing lab	~~2,000~~ $2,600
	~~8,800~~
Nuclear pharmacy	$11,440
Nuclear pharmacy (5 or more locations)	$13,728
Radiopharmaceutical distribution (10 CFR 32.72)	~~3,840~~ $4,992
Radiopharmaceutical processing and distribution (10 CFR 32.72)	~~8,800~~ $11,440
Radiopharmaceutical processing and distribution (10 CFR 32.72) (5 or more locations)	$13,728
Medical sealed sources - distribution (10 CFR 32.74)	~~3,840~~ $4,992
Medical sealed sources - processing and distribution (10 CFR 32.74)	~~8,800~~ $11,440
Medical sealed sources - processing and distribution (10 CFR 32.74) (5 or more locations)	$13,728
Well logging - sealed sources	~~3,760~~ $4,888
Measuring systems - (fixed gauge, portable gauge, gas chromatograph, other)	~~2,000~~ $2,600
~~Measuring systems - portable gauge~~	~~2,000~~
Measuring systems - (fixed gauge, portable gauge, gas chromatograph, other) (4-8 locations)	$3,120
Measuring systems - (fixed gauge, portable gauge, gas chromatograph, other) (9 or more locations)	$3,640
X-ray fluorescent analyzer	~~1,520~~ $1,976
~~Measuring systems - gas chromatograph~~	~~2,000~~
~~Measuring systems - other~~	~~2,000~~
~~Broad scope~~ Manufacturing and distribution - type A broad scope	~~19,920~~ $25,896

In vitro testing lab	~~2,000~~ $2,600
	~~8,800~~
Nuclear pharmacy	$11,440
Nuclear pharmacy (5 or more locations)	$13,728
Radiopharmaceutical distribution (10 CFR 32.72)	~~3,840~~ $4,992
Radiopharmaceutical processing and distribution (10 CFR 32.72)	~~8,800~~ $11,440
Radiopharmaceutical processing and distribution (10 CFR 32.72) (5 or more locations)	$13,728
Medical sealed sources - distribution (10 CFR 32.74)	~~3,840~~ $4,992
Medical sealed sources - processing and distribution (10 CFR 32.74)	~~8,800~~ $11,440
Medical sealed sources - processing and distribution (10 CFR 32.74) (5 or more locations)	$13,728
Well logging - sealed sources	~~3,760~~ $4,888
Measuring systems - (fixed gauge, portable gauge, gas chromatograph, other)	~~2,000~~ $2,600
~~Measuring systems - portable gauge~~	~~2,000~~
Measuring systems - (fixed gauge, portable gauge, gas chromatograph, other) (4-8 locations)	$3,120
Measuring systems - (fixed gauge, portable gauge, gas chromatograph, other) (9 or more locations)	$3,640
X-ray fluorescent analyzer	~~1,520~~ $1,976
~~Measuring systems - gas chromatograph~~	~~2,000~~
~~Measuring systems - other~~	~~2,000~~
~~Broad scope~~ Manufacturing and distribution - type A broad scope	~~19,920~~ $25,896

Manufacturing and distribution - type A broad scope (4-8 locations)	$31,075	
Manufacturing and distribution - type A broad scope (9 or more locations)	$36,254	
~~Broad scope~~ Manufacturing and distribution - type B or C broad scope	~~17,600~~ $22,880	
~~Broad scope Manufacturing and distribution - type C~~	~~17,600~~	
Manufacturing and distribution - type B or C broad scope (4-8 locations)	$27,456	
Manufacturing and distribution - type B or C broad scope (9 or more locations)	$32,032	
Manufacturing and distribution - other	~~5,280~~ $6,864	
Manufacturing and distribution - other (4-8 locations)	$8,236	
Manufacturing and distribution - other (9 or more locations)	$9,609	
Nuclear laundry	~~18,640~~ $24,232	
Decontamination services	~~4,960~~ $6,448	
Leak test services only	~~2,000~~ $2,600	
Instrument calibration service only~~, less than 100 curies~~	~~2,000~~ $2,600	
~~Instrument calibration service only, 100 curies or more~~	~~2,000~~	
Service, maintenance, installation, source changes, etc.	~~4,960~~ $6,448	
Waste disposal service, prepackaged only	~~6,000~~ $7,800	
Waste disposal	~~8,320~~ $10,816	
Distribution - general licensed devices (sealed sources)	~~1,760~~ $2,288	
Distribution - general licensed material (unsealed sources)	~~1,120~~ $1,456	

		~~9,840~~
Industrial radiography - fixed or temporary location		$12,792
~~Industrial radiography - temporary job sites~~		~~9,840~~
Industrial radiography - fixed or temporary location (5 or more locations)		$16,629
Irradiators, self-shielding~~, less than 10,000 curies~~		~~2,880~~ $3,744
Irradiators, other, less than 10,000 curies		~~5,360~~ $6,968
~~Irradiators, self-shielding, 10,000 curies or more~~		~~2,880~~
		~~9,520~~
Research and development - type A, B, or C broad scope		$12,376
~~Research and development - type B broad scope~~		~~9,520~~
~~Research and development - type C broad scope~~		~~9,520~~
Research and development - type A, B, or C broad scope (4-8 locations)		$14,851
Research and development - type A, B, or C broad scope (9 or more locations)		$17,326
Research and development - other		~~4,480~~ $5,824
Storage - no operations		~~2,000~~ $2,600
Source material - shielding		~~584~~ $759
Special nuclear material plutonium - neutron source in device		~~3,680~~ $4,784
Pacemaker by-product and/or special nuclear material - medical (institution)		~~3,680~~ $4,784
Pacemaker by-product and/or special nuclear material - manufacturing and distribution		~~5,280~~ $6,864
Accelerator-produced radioactive material		~~3,840~~ $4,992
Nonprofit educational institutions		~~300~~ $500
~~General license registration~~		~~150~~

Sec. 30. Minnesota Statutes 2020, section 144.1205, subdivision 4, is amended to read:

Subd. 4. **Initial and renewal application fee.** A licensee must pay an initial and a renewal application fee ~~as follows:~~ according to this subdivision.

TYPE	APPLICATION FEE
	~~$ 5,920~~
Academic broad scope - type A, B, or C	$6,808
~~Academic broad scope - type B~~	~~5,920~~
~~Academic broad scope - type C~~	~~5,920~~
Medical broad scope - type A	~~3,920~~ $4,508
Medical - diagnostic, diagnostic and therapeutic, mobile nuclear medicine, eye applicators, high dose rate afterloaders, and medical therapy emerging technologies	$1,748
~~Medical institution - diagnostic and therapeutic~~	~~1,520~~
~~Medical institution - diagnostic (no written directives)~~	~~1,520~~
~~Medical private practice - diagnostic and therapeutic~~	~~1,520~~
~~Medical private practice - diagnostic (no written directives)~~	~~1,520~~
~~Eye applicators~~	~~1,520~~
~~Nuclear medical vans~~	~~1,520~~
~~High dose rate afterloader~~	~~1,520~~
~~Mobile high dose rate afterloader~~	~~1,520~~
~~Medical therapy - other emerging technology~~	~~1,520~~
Teletherapy	~~5,520~~ $6,348
Gamma knife	~~5,520~~ $6,348
Veterinary medicine	~~960~~ $1,104
In vitro testing lab	~~960~~ $1,104
Nuclear pharmacy	~~4,880~~ $5,612

Sec. 12. Minnesota Statutes 2020, section 144.1205, subdivision 4, is amended to read:

Subd. 4. **Initial and renewal application fee.** A licensee must pay an initial and a renewal application fee ~~as follows:~~ according to this subdivision.

TYPE	APPLICATION FEE
	~~$ 5,920~~
Academic broad scope - type A, B, or C	$6,808
~~Academic broad scope - type B~~	~~5,920~~
~~Academic broad scope - type C~~	~~5,920~~
Medical broad scope - type A	~~3,920~~ $4,508
Medical - diagnostic, diagnostic and therapeutic, mobile nuclear medicine, eye applicators, high dose rate afterloaders, and medical therapy emerging technologies	$1,748
~~Medical institution - diagnostic and therapeutic~~	~~1,520~~
~~Medical institution - diagnostic (no written directives)~~	~~1,520~~
~~Medical private practice - diagnostic and therapeutic~~	~~1,520~~
~~Medical private practice - diagnostic (no written directives)~~	~~1,520~~
~~Eye applicators~~	~~1,520~~
~~Nuclear medical vans~~	~~1,520~~
~~High dose rate afterloader~~	~~1,520~~
~~Mobile high dose rate afterloader~~	~~1,520~~
~~Medical therapy - other emerging technology~~	~~1,520~~
Teletherapy	~~5,520~~ $6,348
Gamma knife	~~5,520~~ $6,348
Veterinary medicine	~~960~~ $1,104
In vitro testing lab	~~960~~ $1,104
Nuclear pharmacy	~~4,880~~ $5,612

Radiopharmaceutical distribution (10 CFR 32.72)	~~2,160~~ $2,484	
Radiopharmaceutical processing and distribution (10 CFR 32.72)	~~4,880~~ $5,612	
Medical sealed sources - distribution (10 CFR 32.74)	~~2,160~~ $2,484	
Medical sealed sources - processing and distribution (10 CFR 32.74)	~~4,880~~ $5,612	
Well logging - sealed sources	~~1,600~~ $1,840	
Measuring systems - (fixed gauge, portable gauge, gas chromatograph, other)	~~960~~ $1,104	
~~Measuring systems - portable gauge~~	~~960~~	
X-ray fluorescent analyzer	~~584~~ $671	
~~Measuring systems - gas chromatograph~~	~~960~~	
~~Measuring systems - other~~	~~960~~	
~~Broad scope~~ Manufacturing and distribution - type A, B, and C broad scope	~~5,920~~ $6,854	
~~Broad scope manufacturing and distribution - type B~~	~~5,920~~	
~~Broad scope manufacturing and distribution - type C~~	~~5,920~~	
Manufacturing and distribution - other	~~2,320~~ $2,668	
	~~10,080~~	
Nuclear laundry	$11,592	
Decontamination services	~~2,640~~ $3,036	
Leak test services only	~~960~~ $1,104	
Instrument calibration service only~~, less than 100 curies~~	~~960~~ $1,104	
~~Instrument calibration service only, 100 curies or more~~	~~960~~	
Service, maintenance, installation, source changes, etc.	~~2,640~~ $3,036	
Waste disposal service, prepackaged only	~~2,240~~ $2,576	

Waste disposal	~~1,520~~ $1,748
Distribution - general licensed devices (sealed sources)	~~880~~ $1,012
Distribution - general licensed material (unsealed sources)	~~520~~ $598
Industrial radiography - fixed or temporary location	~~2,640~~ $3,036
~~Industrial radiography - temporary job sites~~	~~2,640~~
Irradiators, self-shielding~~, less than 10,000 curies~~	~~1,440~~ $1,656
Irradiators, other, less than 10,000 curies	~~2,960~~ $3,404
~~Irradiators, self-shielding, 10,000 curies or more~~	~~1,440~~
Research and development - type A, B, or C broad scope	~~4,960~~ $5,704
~~Research and development - type B broad scope~~	~~4,960~~
~~Research and development - type C broad scope~~	~~4,960~~
Research and development - other	~~2,400~~ $2,760
Storage - no operations	~~960~~ $1,104
Source material - shielding	~~136~~ $156
Special nuclear material plutonium - neutron source in device	~~1,200~~ $1,380
Pacemaker by-product and/or special nuclear material - medical (institution)	~~1,200~~ $1,380
Pacemaker by-product and/or special nuclear material - manufacturing and distribution	~~2,320~~ $2,668
Accelerator-produced radioactive material	~~4,100~~ $4,715
Nonprofit educational institutions	~~300~~ $345
~~General license registration~~	~~0~~
~~Industrial radiographer certification~~	~~150~~

Sec. 31. Minnesota Statutes 2020, section 144.1205, subdivision 8, is amended to read:

Subd. 8. **Reciprocity fee.** A licensee submitting an application for reciprocal recognition of a materials license issued by another agreement state or the United States Nuclear

Waste disposal	~~1,520~~ $1,748
Distribution - general licensed devices (sealed sources)	~~880~~ $1,012
Distribution - general licensed material (unsealed sources)	~~520~~ $598
Industrial radiography - fixed or temporary location	~~2,640~~ $3,036
~~Industrial radiography - temporary job sites~~	~~2,640~~
Irradiators, self-shielding~~, less than 10,000 curies~~	~~1,440~~ $1,656
Irradiators, other, less than 10,000 curies	~~2,960~~ $3,404
~~Irradiators, self-shielding, 10,000 curies or more~~	~~1,440~~
Research and development - type A, B, or C broad scope	~~4,960~~ $5,704
~~Research and development - type B broad scope~~	~~4,960~~
~~Research and development - type C broad scope~~	~~4,960~~
Research and development - other	~~2,400~~ $2,760
Storage - no operations	~~960~~ $1,104
Source material - shielding	~~136~~ $156
Special nuclear material plutonium - neutron source in device	~~1,200~~ $1,380
Pacemaker by-product and/or special nuclear material - medical (institution)	~~1,200~~ $1,380
Pacemaker by-product and/or special nuclear material - manufacturing and distribution	~~2,320~~ $2,668
Accelerator-produced radioactive material	~~4,100~~ $4,715
Nonprofit educational institutions	~~300~~ $345
~~General license registration~~	~~0~~
~~Industrial radiographer certification~~	~~150~~

Sec. 13. Minnesota Statutes 2020, section 144.1205, subdivision 8, is amended to read:

Subd. 8. **Reciprocity fee.** A licensee submitting an application for reciprocal recognition of a materials license issued by another agreement state or the United States Nuclear

Regulatory Commission for a period of 180 days or less during a calendar year must pay ~~$1,200~~ $2,400. For a period of 181 days or more, the licensee must obtain a license under subdivision 4.

Sec. 32. Minnesota Statutes 2020, section 144.1205, subdivision 9, is amended to read:

Subd. 9. **Fees for license amendments.** A licensee must pay a fee of ~~$300~~ $600 to amend a license as follows:

(1) to amend a license requiring review including, but not limited to, addition of isotopes, procedure changes, new authorized users, or a new radiation safety officer; ~~and~~ or

(2) to amend a license requiring review and a site visit including, but not limited to, facility move or addition of processes.

Sec. 33. Minnesota Statutes 2020, section 144.1205, is amended by adding a subdivision to read:

Subd. 10. **Fees for general license registrations.** A person required to register generally licensed devices according to Minnesota Rules, part 4731.3215, must pay an annual registration fee of $450.

Sec. 34. Minnesota Statutes 2020, section 144.125, subdivision 1, is amended to read:

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

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

(c) The fee to support the newborn screening program, including tests administered under this section and section 144.966, shall be ~~$135~~ $177 per specimen. This fee amount shall be deposited in the state treasury and credited to the state government special revenue fund.

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

Regulatory Commission for a period of 180 days or less during a calendar year must pay ~~$1,200~~ $2,400. For a period of 181 days or more, the licensee must obtain a license under subdivision 4.

Sec. 14. Minnesota Statutes 2020, section 144.1205, subdivision 9, is amended to read:

Subd. 9. **Fees for license amendments.** A licensee must pay a fee of ~~$300~~ $600 to amend a license as follows:

(1) to amend a license requiring review including, but not limited to, addition of isotopes, procedure changes, new authorized users, or a new radiation safety officer; and

(2) to amend a license requiring review and a site visit including, but not limited to, facility move or addition of processes.

Sec. 15. Minnesota Statutes 2020, section 144.1205, is amended by adding a subdivision to read:

Subd. 10. **Fees for general license registrations.** A person required to register generally licensed devices according to Minnesota Rules, part 4731.3215, must pay an annual registration fee of $450.

Sec. 16. Minnesota Statutes 2020, section 144.125, subdivision 1, is amended to read:

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

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

(c) The fee to support the newborn screening program, including tests administered under this section and section 144.966, shall be ~~$135~~ $177 per specimen. This fee amount shall be deposited in the state treasury and credited to the state government special revenue fund.

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

Sec. 17. Minnesota Statutes 2020, section 144.125, subdivision 2, is amended to read:

Subd. 2. **Determination of tests to be administered.** (a) The commissioner shall periodically revise the list of tests to be administered for determining the presence of a

Sec. 35. **[144.1461] DIGNITY IN PREGNANCY AND CHILDBIRTH.**

Subdivision 1. **Citation.** This section may be cited as the "Dignity in Pregnancy and Childbirth Act."

Subd. 2. **Continuing education requirement.** (a) Hospitals with obstetric care and birth centers must provide continuing education on anti-racism training and implicit bias. The continuing education must be evidence-based and must include at a minimum the following criteria:

(1) education aimed at identifying personal, interpersonal, institutional, structural, and cultural barriers to inclusion;

(2) identifying and implementing corrective measures to promote anti-racism practices and decrease implicit bias at the interpersonal and institutional levels, including the institution's ongoing policies and practices;

(3) providing information on the ongoing effects of historical and contemporary exclusion and oppression of Black and Indigenous communities with the greatest health disparities related to maternal and infant mortality and morbidity;

(4) providing information and discussion of health disparities in the perinatal health care field including how systemic racism and implicit bias have different impacts on health outcomes for different racial and ethnic communities; and

(5) soliciting perspectives of diverse, local constituency groups and experts on racial, identity, cultural, and provider-community relationship issues.

(b) In addition to the initial continuing educational requirement in paragraph (a), hospitals with obstetric care and birth centers must provide an annual refresher course that reflects current trends on race, culture, identity, and anti-racism principles and institutional implicit bias.

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

(b) Notwithstanding paragraph (a), a test to detect congenital human herpesvirus cytomegalovirus shall be added to the list of tests to be administered under this section.

Sec. 18. **[144.1461] PREGNANCY AND CHILDBIRTH; MIDWIFE AND DOULA CARE.**

(c) Hospitals with obstetric care and birth centers must develop continuing education materials on anti-racism and implicit bias that must be provided and updated annually for direct care employees and contractors who routinely care for patients who are pregnant or postpartum.

(d) Hospitals with obstetric care and birth centers shall coordinate with health-related licensing boards to obtain continuing education credits for the trainings and materials required in this section. The commissioner of health shall monitor compliance with this section. Initial training for the continuing education requirements in this subdivision must be completed by December 31, 2022. The commissioner may inspect the training records or require reports on the continuing education materials in this section from hospitals with obstetric care and birth centers.

(e) A facility described in paragraph (d) must provide a certificate of training completion to another facility or a training attendee upon request. A facility may accept the training certificate from another facility for a health care provider that works in more than one facility.

Subd. 3. **Midwife and doula care.** In order to improve maternal and infant health and to improve birth outcomes in groups with the most significant disparities, including Black communities, Indigenous communities, and other communities of color; rural communities; and people with low incomes, the commissioner of health, in partnership with patient groups and culturally based community organizations, shall:

(1) develop procedures and services to increase the availability of midwife and doula services to groups with the most significant disparities in maternal and infant morbidity and mortality;

(2) propose changes to midwife licensure to allow midwives with nationally recognized credentials to practice to the full scope of their competencies and education;

(3) promote racial, ethnic, and language diversity in the midwife and doula workforce that better aligns with the childbearing populations in groups with the most significant disparities in maternal and infant morbidity and mortality; and

(4) ensure that midwife and doula training and licensure are culturally responsive to the specific needs of groups with the most significant disparities in maternal and infant morbidity and mortality, including training on providing trauma-informed care and training on maternal mood disorders, intimate partner violence, and implicit bias and anti-racism.

Sec. 36. Minnesota Statutes 2020, section 144.1481, subdivision 1, is amended to read:

Subdivision 1. **Establishment; membership.** The commissioner of health shall establish a ~~15-member~~ 16-member Rural Health Advisory Committee. The committee shall consist of the following members, all of whom must reside outside the seven-county metropolitan area, as defined in section 473.121, subdivision 2:

In order to improve maternal and infant health as well as improving birth outcomes in groups with the most significant disparities that include Black, Indigenous, and other communities of color; rural communities; and people with low incomes, the commissioner of health in partnership with patient groups and culturally based community organizations shall, within existing appropriations:

(1) develop procedures and services designed for making midwife and doula services available to groups with the most maternal and infant mortality and morbidity disparities;

(2) promote racial, ethnic, and language diversity in the midwife and doula workforce that better aligns with the childbearing population in groups with the most significant maternal and infant mortality and morbidity disparities; and

(3) ensure that midwife and doula training and education is tailored to the specific needs of groups with the most significant maternal and infant mortality and morbidity disparities, including trauma-informed care, maternal mood disorders, intimate partner violence, and systemic racism.

Sec. 19. Minnesota Statutes 2020, section 144.1481, subdivision 1, is amended to read:

Subdivision 1. **Establishment; membership.** The commissioner of health shall establish a ~~15-member~~ 16-member Rural Health Advisory Committee. The committee shall consist of the following members, all of whom must reside outside the seven-county metropolitan area, as defined in section 473.121, subdivision 2:

(1) two members from the house of representatives of the state of Minnesota, one from the majority party and one from the minority party;

(2) two members from the senate of the state of Minnesota, one from the majority party and one from the minority party;

(3) a volunteer member of an ambulance service based outside the seven-county metropolitan area;

(4) a representative of a hospital located outside the seven-county metropolitan area;

(5) a representative of a nursing home located outside the seven-county metropolitan area;

(6) a medical doctor or doctor of osteopathic medicine licensed under chapter 147;

(7) a dentist licensed under chapter 150A;

(8) a midlevel practitioner;

~~(8)~~ (9) a registered nurse or licensed practical nurse;

~~(9)~~ (10) a licensed health care professional from an occupation not otherwise represented on the committee;

~~(10)~~ (11) a representative of an institution of higher education located outside the seven-county metropolitan area that provides training for rural health care providers; and

~~(11)~~ (12) three consumers, at least one of whom must be an advocate for persons who are mentally ill or developmentally disabled.

The commissioner will make recommendations for committee membership. Committee members will be appointed by the governor. In making appointments, the governor shall ensure that appointments provide geographic balance among those areas of the state outside the seven-county metropolitan area. The chair of the committee shall be elected by the members. The advisory committee is governed by section 15.059, except that the members do not receive per diem compensation.

Sec. 37. Minnesota Statutes 2020, section 144.1501, subdivision 1, is amended to read:

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

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

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

(1) two members from the house of representatives of the state of Minnesota, one from the majority party and one from the minority party;

(2) two members from the senate of the state of Minnesota, one from the majority party and one from the minority party;

(3) a volunteer member of an ambulance service based outside the seven-county metropolitan area;

(4) a representative of a hospital located outside the seven-county metropolitan area;

(5) a representative of a nursing home located outside the seven-county metropolitan area;

(6) a medical doctor or doctor of osteopathic medicine licensed under chapter 147;

(7) a dentist licensed under chapter 150A;

(8) a midlevel practitioner;

~~(8)~~ (9) a registered nurse or licensed practical nurse;

~~(9)~~ (10) a licensed health care professional from an occupation not otherwise represented on the committee;

~~(10)~~ (11) a representative of an institution of higher education located outside the seven-county metropolitan area that provides training for rural health care providers; and

~~(11)~~ (12) three consumers, at least one of whom must be an advocate for persons who are mentally ill or developmentally disabled.

The commissioner will make recommendations for committee membership. Committee members will be appointed by the governor. In making appointments, the governor shall ensure that appointments provide geographic balance among those areas of the state outside the seven-county metropolitan area. The chair of the committee shall be elected by the members. The advisory committee is governed by section 15.059, except that the members do not receive per diem compensation.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

~~(r)~~ (s) "Underserved urban community" means a Minnesota urban area or population included in the list of designated primary medical care health professional shortage areas (HPSAs), medically underserved areas (MUAs), or medically underserved populations

(MUPs) maintained and updated by the United States Department of Health and Human Services.

Sec. 38. Minnesota Statutes 2020, section 144.1501, subdivision 2, is amended to read:

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

(1) for medical residents ~~and~~, mental health professionals, and alcohol and drug counselors agreeing to practice in designated rural areas or underserved urban communities or specializing in the area of pediatric psychiatry;

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

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

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

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

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

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

Sec. 39. Minnesota Statutes 2020, section 144.1501, subdivision 3, is amended to read:

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

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

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

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

Sec. 40. Minnesota Statutes 2020, section 144.1911, subdivision 6, is amended to read:

Subd. 6. **International medical graduate primary care residency grant program and revolving account.** (a) The commissioner shall award grants to support primary care residency positions designated for Minnesota immigrant physicians who are willing to serve in rural or underserved areas of the state. No grant shall exceed $150,000 per residency position per year. Eligible primary care residency grant recipients include accredited family medicine, general surgery, internal medicine, obstetrics and gynecology, psychiatry, and pediatric residency programs. Eligible primary care residency programs shall apply to the commissioner. Applications must include the number of anticipated residents to be funded using grant funds and a budget. Notwithstanding any law to the contrary, funds awarded to grantees in a grant agreement do not lapse until the grant agreement expires. Before any funds are distributed, a grant recipient shall provide the commissioner with the following:

(1) a copy of the signed contract between the primary care residency program and the participating international medical graduate;

(2) certification that the participating international medical graduate has lived in Minnesota for at least two years and is certified by the Educational Commission on Foreign Medical Graduates. Residency programs may also require that participating international medical graduates hold a Minnesota certificate of clinical readiness for residency, once the certificates become available; and

(3) verification that the participating international medical graduate has executed a participant agreement pursuant to paragraph (b).

(b) Upon acceptance by a participating residency program, international medical graduates shall enter into an agreement with the commissioner to provide primary care for at least five years in a rural or underserved area of Minnesota after graduating from the residency program and make payments to the revolving international medical graduate residency account for five years beginning in their second year of postresidency employment. Participants shall pay $15,000 or ten percent of their annual compensation each year, whichever is less.

(c) A revolving international medical graduate residency account is established as an account in the special revenue fund in the state treasury. The commissioner of management and budget shall credit to the account appropriations, payments, and transfers to the account. Earnings, such as interest, dividends, and any other earnings arising from fund assets, must be credited to the account. Funds in the account are appropriated annually to the commissioner to award grants and administer the grant program established in paragraph (a). Notwithstanding any law to the contrary, any funds deposited in the account do not expire. The commissioner may accept contributions to the account from private sector entities subject to the following provisions:

(1) the contributing entity may not specify the recipient or recipients of any grant issued under this subdivision;

(2) the commissioner shall make public the identity of any private contributor to the account, as well as the amount of the contribution provided; and

(3) a contributing entity may not specify that the recipient or recipients of any funds use specific products or services, nor may the contributing entity imply that a contribution is an endorsement of any specific product or service.

Sec. 41. Minnesota Statutes 2020, section 144.212, is amended by adding a subdivision to read:

Subd. 12. **Homeless youth.** "Homeless youth" has the meaning given in section 256K.45, subdivision 1a.

Sec. 20. Minnesota Statutes 2020, section 144.216, is amended by adding a subdivision to read:

Subd. 3. **Reporting safe place newborn births.** A hospital that receives a safe place newborn under section 145.902 shall report the birth of the newborn to the Office of Vital Records within five days after receiving the newborn. The state registrar must register information about the safe place newborn according to Minnesota Rules, part 4601.0600, subpart 4, item C.

EFFECTIVE DATE. This section is effective August 1, 2021.

Sec. 21. Minnesota Statutes 2020, section 144.216, is amended by adding a subdivision to read:

Subd. 4. **Status of safe place birth registrations.** (a) Information about the safe place newborn registered under subdivision 3 shall constitute the record of birth for the child. The birth record for the child is confidential data on individuals as defined in section 13.02, subdivision 3. Information about the child's birth record or a child's birth certificate issued from the child's birth record shall be disclosed only to the responsible social services agency as defined in section 260C.007, subdivision 27a, or pursuant to court order.

(b) Pursuant to section 144.218, subdivision 6, if the safe place newborn was born in a hospital and it is known that the child's record of birth was registered, the Office of Vital Records shall replace the original birth record registered under section 144.215.

EFFECTIVE DATE. This section is effective August 1, 2021.

Sec. 22. Minnesota Statutes 2020, section 144.218, is amended by adding a subdivision to read:

Subd. 6. **Safe place newborns.** If a hospital receives a safe place newborn under section 145.902 and it is known that the child's record of birth was registered, the hospital shall report the newborn to the Office of Vital Records and identify the child's birth record. The state registrar shall issue a replacement birth record for the child that is free of information that identifies a parent. The prior vital record is confidential data on individuals as defined in section 13.02, subdivision 3, and shall not be disclosed except pursuant to court order.

EFFECTIVE DATE. This section is effective August 1, 2021.

Sec. 23. Minnesota Statutes 2020, section 144.223, is amended to read:

144.223 REPORT OF MARRIAGE.

Data relating to certificates of marriage registered shall be reported to the state registrar by the local registrar or designee of the county board in each of the 87 registration districts pursuant to the rules of the commissioner. The information in clause (1) necessary to compile the report shall be furnished by the applicant prior to the issuance of the marriage license. The report shall contain the following:

(1) personal information on bride and groom:

(i) name;

(ii) residence;

(iii) date and place of birth;

~~(iv) race;~~

~~(v)~~ (iv) if previously married, how terminated; and

Sec. 42. Minnesota Statutes 2020, section 144.225, subdivision 2, is amended to read:

Subd. 2. **Data about births.** (a) Except as otherwise provided in this subdivision, data pertaining to the birth of a child to a woman who was not married to the child's father when the child was conceived nor when the child was born, including the original record of birth and the certified vital record, are confidential data. At the time of the birth of a child to a woman who was not married to the child's father when the child was conceived nor when the child was born, the mother may designate demographic data pertaining to the birth as public. Notwithstanding the designation of the data as confidential, it may be disclosed:

(1) to a parent or guardian of the child;

(2) to the child when the child is 16 years of age or older, except as provided in clause (3);

(3) to the child if the child is a homeless youth;

~~(3)~~ (4) under paragraph (b), (e), ~~or~~ (f), or (g); or

~~(4)~~ (5) pursuant to a court order. For purposes of this section, a subpoena does not constitute a court order.

(b) Unless the child is adopted, data pertaining to the birth of a child that are not accessible to the public become public data if 100 years have elapsed since the birth of the child who is the subject of the data, or as provided under section 13.10, whichever occurs first.

(c) If a child is adopted, data pertaining to the child's birth are governed by the provisions relating to adoption records, including sections 13.10, subdivision 5; 144.218, subdivision 1; 144.2252; and 259.89.

(d) The name and address of a mother under paragraph (a) and the child's date of birth may be disclosed to the county social services, tribal health department, or public health member of a family services collaborative for purposes of providing services under section 124D.23.

(e) The commissioner of human services shall have access to birth records for:

(1) the purposes of administering medical assistance and the MinnesotaCare program;

(2) child support enforcement purposes; and

~~(vi)~~ (v) signature of applicant, date signed, and Social Security number; and

(2) information concerning the marriage:

(i) date of marriage;

(ii) place of marriage; and

(iii) civil or religious ceremony.

(3) other public health purposes as determined by the commissioner of health.

(f) Tribal child support programs shall have access to birth records for child support enforcement purposes.

(g) An entity administering a children's savings program that starts at birth shall have access to birth records for the purpose of opening an account in the program for the child as a beneficiary. For purposes of this paragraph, "children's savings program" means a long-term savings or investment program that helps children and their families build savings for the future.

Sec. 43. Minnesota Statutes 2020, section 144.225, subdivision 7, is amended to read:

Subd. 7. **Certified birth or death record.** (a) The state registrar or local issuance office shall issue a certified birth or death record or a statement of no vital record found to an individual upon the individual's proper completion of an attestation provided by the commissioner and, except as provided in section 144.2255, payment of the required fee:

(1) to a person who ~~has a tangible interest in the requested vital record. A person who has a tangible interest~~ is:

(i) the subject of the vital record;

(ii) a child of the subject;

(iii) the spouse of the subject;

(iv) a parent of the subject;

(v) the grandparent or grandchild of the subject;

(vi) if the requested record is a death record, a sibling of the subject;

~~(vii) the party responsible for filing the vital record;~~

~~(viii)~~ (vii) the legal custodian, guardian or conservator, or health care agent of the subject;

~~(ix)~~ (viii) a personal representative, by sworn affidavit of the fact that the certified copy is required for administration of the estate;

~~(x)~~ (ix) a successor of the subject, as defined in section 524.1-201, if the subject is deceased, by sworn affidavit of the fact that the certified copy is required for administration of the estate;

~~(xi)~~ (x) if the requested record is a death record, a trustee of a trust by sworn affidavit of the fact that the certified copy is needed for the proper administration of the trust;

~~(xii)~~ (xi) a person or entity who demonstrates that a certified vital record is necessary for the determination or protection of a personal or property right, pursuant to rules adopted by the commissioner; or

Sec. 24. Minnesota Statutes 2020, section 144.225, subdivision 7, is amended to read:

Subd. 7. **Certified birth or death record.** (a) The state registrar or local issuance office shall issue a certified birth or death record or a statement of no vital record found to an individual upon the individual's proper completion of an attestation provided by the commissioner and payment of the required fee:

(1) to a person who ~~has a tangible interest in the requested vital record. A person who has a tangible interest~~ is:

(i) the subject of the vital record;

(ii) a child of the subject;

(iii) the spouse of the subject;

(iv) a parent of the subject;

(v) the grandparent or grandchild of the subject;

(vi) if the requested record is a death record, a sibling of the subject;

~~(vii) the party responsible for filing the vital record;~~

~~(viii)~~ (vii) the legal custodian, guardian or conservator, or health care agent of the subject;

~~(ix)~~ (viii) a personal representative, by sworn affidavit of the fact that the certified copy is required for administration of the estate;

~~(x)~~ (ix) a successor of the subject, as defined in section 524.1-201, if the subject is deceased, by sworn affidavit of the fact that the certified copy is required for administration of the estate;

~~(xi)~~ (x) if the requested record is a death record, a trustee of a trust by sworn affidavit of the fact that the certified copy is needed for the proper administration of the trust;

~~(xii)~~ (xi) a person or entity who demonstrates that a certified vital record is necessary for the determination or protection of a personal or property right, pursuant to rules adopted by the commissioner; or

~~(xiii)~~ (xii) an adoption agency in order to complete confidential postadoption searches as required by section 259.83;

(2) to any local, state, tribal, or federal governmental agency upon request if the certified vital record is necessary for the governmental agency to perform its authorized duties;

(3) to an attorney representing the subject of the vital record or another person listed in clause (1), upon evidence of the attorney's license;

(4) pursuant to a court order issued by a court of competent jurisdiction. For purposes of this section, a subpoena does not constitute a court order; or

(5) to a representative authorized by a person under clauses (1) to (4).

(b) The state registrar or local issuance office shall also issue a certified death record to an individual described in paragraph (a), clause (1), items (ii) to ~~(viii)~~ (xi), if, on behalf of the individual, a licensed mortician furnishes the registrar with a properly completed attestation in the form provided by the commissioner within 180 days of the time of death of the subject of the death record. This paragraph is not subject to the requirements specified in Minnesota Rules, part 4601.2600, subpart 5, item B.

Sec. 44. **[144.2255] CERTIFIED BIRTH RECORD FOR HOMELESS YOUTH.**

Subdivision 1. **Application; certified birth record.** A subject of a birth record who is a homeless youth in Minnesota or another state may apply to the state registrar or a local issuance office for a certified birth record according to this section. The state registrar or local issuance office shall issue a certified birth record or statement of no vital record found to a subject of a birth record who submits:

(1) a completed application signed by the subject of the birth record;

(2) a statement that the subject of the birth record is a homeless youth, signed by the subject of the birth record; and

(3) one of the following:

(i) a document of identity listed in Minnesota Rules, part 4601.2600, subpart 8, or, at the discretion of the state registrar or local issuance office, Minnesota Rules, part 4601.2600, subpart 9;

(ii) a statement that complies with Minnesota Rules, part 4601.2600, subparts 6 and 7; or

(iii) a statement verifying that the subject of the birth record is a homeless youth that complies with the requirements in subdivision 2 and is from an employee of a human services agency that receives public funding to provide services to homeless youth, runaway youth, youth with mental illness, or youth with substance use disorders; a school staff person who provides services to homeless youth; or a school social worker.

~~(xiii)~~ (xii) an adoption agency in order to complete confidential postadoption searches as required by section 259.83;

(2) to any local, state, tribal, or federal governmental agency upon request if the certified vital record is necessary for the governmental agency to perform its authorized duties;

(3) to an attorney representing the subject of the vital record or another person listed in clause (1), upon evidence of the attorney's license;

(4) pursuant to a court order issued by a court of competent jurisdiction. For purposes of this section, a subpoena does not constitute a court order; or

(5) to a representative authorized by a person under clauses (1) to (4).

(b) The state registrar or local issuance office shall also issue a certified death record to an individual described in paragraph (a), clause (1), items (ii) to ~~(viii)~~ (xi), if, on behalf of the individual, a licensed mortician furnishes the registrar with a properly completed attestation in the form provided by the commissioner within 180 days of the time of death of the subject of the death record. This paragraph is not subject to the requirements specified in Minnesota Rules, part 4601.2600, subpart 5, item B.

Subd. 2. **Statement verifying subject is a homeless youth.** A statement verifying that a subject of a birth record is a homeless youth must include:

(1) the following information regarding the individual providing the statement: first name, middle name, if any, and last name; home or business address; telephone number, if any; and e-mail address, if any;

(2) the first name, middle name, if any, and last name of the subject of the birth record; and

(3) a statement specifying the relationship of the individual providing the statement to the subject of the birth record and verifying that the subject of the birth record is a homeless youth.

The individual providing the statement must also provide a copy of the individual's employment identification.

Subd. 3. **Expiration; reissuance.** If a subject of a birth record obtains a certified birth record under this section using the statement specified in subdivision 1, clause (3), item (iii), the certified birth record issued shall expire six months after the date of issuance. Upon expiration of the certified birth record, the subject of the birth record may surrender the expired birth record to the state registrar or a local issuance office and obtain another birth record. Each certified birth record obtained under this subdivision shall expire six months after the date of issuance. If the subject of the birth record does not surrender the expired birth record, the subject may apply for a certified birth record using the process in subdivision 1.

Subd. 4. **Fees waived.** The state registrar or local issuance office shall not charge any fee for issuance of a certified birth record or statement of no vital record found under this section.

Subd. 5. **Data practices.** Data listed under subdivision 1, clauses (2) and (3), item (iii), are private data on individuals.

EFFECTIVE DATE. This section is effective the day following final enactment for applications for and the issuance of certified birth records on or after January 1, 2022.

Sec. 25. Minnesota Statutes 2020, section 144.226, subdivision 1, is amended to read:

Subdivision 1. **Which services are for fee.** (a) The fees for the following services shall be the following or an amount prescribed by rule of the commissioner:

(b) The fee for the administrative review and processing of a request for a certified vital record or a certification that the vital record cannot be found is $9. The fee is payable at the time of application and is nonrefundable.

Sec. 45. Minnesota Statutes 2020, section 144.226, is amended by adding a subdivision to read:

Subd. 7. **Transaction fees.** The state registrar may charge and permit agents to charge a convenience fee and a transaction fee for electronic transactions and transactions by telephone or Internet, as well as the fees established under subdivisions 1 to 4. The convenience fee may not exceed three percent of the cost of the charges for payment. The state registrar may permit agents to charge and retain a transaction fee as payment agreed upon under contract. When an electronic convenience fee or transaction fee is charged, the agent charging the fee is required to post information on their web page informing individuals of the fee. The information must be near the point of payment, clearly visible, include the amount of the fee, and state: "This contracted agent is allowed by state law to charge a convenience fee and transaction fee for this electronic transaction."

Sec. 46. Minnesota Statutes 2020, section 144.226, is amended by adding a subdivision to read:

Subd. 8. **Birth record fees waived for homeless youth.** A subject of a birth record who is a homeless youth shall not be charged any of the fees specified in this section for a certified birth record or statement of no vital record found under section 144.2255.

(c) The fee for processing a request for the replacement of a birth record for all events, except for safe place newborns pursuant to section 144.218, subdivision 6, and when filing a recognition of parentage pursuant to section 257.73, subdivision 1, is $40. The fee is payable at the time of application and is nonrefundable.

(d) The fee for administrative review and processing of a request for the filing of a delayed registration of birth, stillbirth, or death is $40. The fee is payable at the time of application and is nonrefundable.

(e) The fee for administrative review and processing of a request for the amendment of any vital record is $40. The fee is payable at the time of application and is nonrefundable.

(f) The fee for administrative review and processing of a request for the verification of information from vital records is $9 when the applicant furnishes the specific information to locate the vital record. When the applicant does not furnish specific information, the fee is $20 per hour for staff time expended. Specific information includes the correct date of the event and the correct name of the subject of the record. Fees charged shall approximate the costs incurred in searching and copying the vital records. The fee is payable at the time of application and is nonrefundable.

(g) The fee for administrative review and processing of a request for the issuance of a copy of any document on file pertaining to a vital record or statement that a related document cannot be found is $9. The fee is payable at the time of application and is nonrefundable.

EFFECTIVE DATE. This section is effective August 1, 2021.

EFFECTIVE DATE. This section is effective the day following final enactment for applications for and the issuance of certified birth records on or after January 1, 2022.

Sec. 47. Minnesota Statutes 2020, section 144.55, subdivision 4, is amended to read:

Subd. 4. **Routine inspections; presumption.** Any hospital surveyed and accredited under the standards of the hospital accreditation program of an approved accrediting organization that submits to the commissioner within a reasonable time copies of (a) its currently valid accreditation certificate and accreditation letter, together with accompanying recommendations and comments and (b) any further recommendations, progress reports and correspondence directly related to the accreditation is presumed to comply with application requirements of subdivision 1 and the standards requirements of subdivision 3 and no further routine inspections or accreditation information shall be required by the commissioner to determine compliance. Notwithstanding the provisions of sections 144.54 and 144.653, subdivisions 2 and 4, hospitals shall be inspected only as provided in this section. The provisions of section 144.653 relating to the assessment and collection of fines shall not apply to any hospital. The commissioner of health shall annually conduct, with notice, validation inspections of a selected sample of the number of hospitals accredited by an approved accrediting organization, not to exceed ten percent of accredited hospitals, for the purpose of determining compliance with the provisions of subdivision 3. If a validation survey discloses a failure to comply with subdivision 3, the provisions of section 144.653 relating to correction orders, reinspections, and notices of noncompliance shall apply. The commissioner shall also conduct any inspection necessary to determine whether hospital construction, addition, or remodeling projects comply with standards for construction promulgated in rules pursuant to subdivision 3. The commissioner shall also conduct any inspections necessary to determine whether a hospital or hospital corporate system continues to satisfy the conditions on which a hospital construction moratorium exception was granted under section 144.551. Pursuant to section 144.653, the commissioner shall inspect any hospital that does not have a currently valid hospital accreditation certificate from an approved accrediting organization. Nothing in this subdivision shall be construed to limit the investigative powers of the Office of Health Facility Complaints as established in sections 144A.51 to 144A.54.

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

Sec. 48. Minnesota Statutes 2020, section 144.55, subdivision 6, is amended to read:

Subd. 6. **Suspension, revocation, and refusal to renew.** (a) The commissioner may refuse to grant or renew, or may suspend or revoke, a license on any of the following grounds:

(1) violation of any of the provisions of sections 144.50 to 144.56 or the rules or standards issued pursuant thereto, or Minnesota Rules, chapters 4650 and 4675;

(2) permitting, aiding, or abetting the commission of any illegal act in the institution;

(3) conduct or practices detrimental to the welfare of the patient; or

(4) obtaining or attempting to obtain a license by fraud or misrepresentation; or

(5) with respect to hospitals and outpatient surgical centers, if the commissioner determines that there is a pattern of conduct that one or more physicians or advanced practice registered nurses who have a "financial or economic interest," as defined in section 144.6521, subdivision 3, in the hospital or outpatient surgical center, have not provided the notice and disclosure of the financial or economic interest required by section 144.6521.

(b) The commissioner shall not renew a license for a boarding care bed in a resident room with more than four beds.

(c) The commissioner shall not renew licenses for hospital beds issued to a hospital or hospital corporate system pursuant to a hospital construction moratorium exception under section 144.551 if the commissioner determines the hospital or hospital corporate system is not satisfying the conditions on which the exception was granted.

EFFECTIVE DATE. This section is effective the day following final enactment for license renewals occurring on or after that date.

Sec. 49. Minnesota Statutes 2020, section 144.551, subdivision 1, is amended to read:

Subdivision 1. **Restricted construction or modification.** (a) The following construction or modification may not be commenced:

(1) any erection, building, alteration, reconstruction, modernization, improvement, extension, lease, or other acquisition by or on behalf of a hospital that increases the bed capacity of a hospital, relocates hospital beds from one physical facility, complex, or site to another, or otherwise results in an increase or redistribution of hospital beds within the state; and

(2) the establishment of a new hospital.

(b) This section does not apply to:

(1) construction or relocation within a county by a hospital, clinic, or other health care facility that is a national referral center engaged in substantial programs of patient care, medical research, and medical education meeting state and national needs that receives more than 40 percent of its patients from outside the state of Minnesota;

(2) a project for construction or modification for which a health care facility held an approved certificate of need on May 1, 1984, regardless of the date of expiration of the certificate;

(3) a project for which a certificate of need was denied before July 1, 1990, if a timely appeal results in an order reversing the denial;

(4) a project exempted from certificate of need requirements by Laws 1981, chapter 200, section 2;

Sec. 26. Minnesota Statutes 2020, section 144.551, subdivision 1, is amended to read:

Subdivision 1. **Restricted construction or modification.** (a) The following construction or modification may not be commenced:

(1) any erection, building, alteration, reconstruction, modernization, improvement, extension, lease, or other acquisition by or on behalf of a hospital that increases the bed capacity of a hospital, relocates hospital beds from one physical facility, complex, or site to another, or otherwise results in an increase or redistribution of hospital beds within the state; and

(2) the establishment of a new hospital.

(b) This section does not apply to:

(1) construction or relocation within a county by a hospital, clinic, or other health care facility that is a national referral center engaged in substantial programs of patient care, medical research, and medical education meeting state and national needs that receives more than 40 percent of its patients from outside the state of Minnesota;

(2) a project for construction or modification for which a health care facility held an approved certificate of need on May 1, 1984, regardless of the date of expiration of the certificate;

(3) a project for which a certificate of need was denied before July 1, 1990, if a timely appeal results in an order reversing the denial;

(4) a project exempted from certificate of need requirements by Laws 1981, chapter 200, section 2;

(5) a project involving consolidation of pediatric specialty hospital services within the Minneapolis-St. Paul metropolitan area that would not result in a net increase in the number of pediatric specialty hospital beds among the hospitals being consolidated;

(6) a project involving the temporary relocation of pediatric-orthopedic hospital beds to an existing licensed hospital that will allow for the reconstruction of a new philanthropic, pediatric-orthopedic hospital on an existing site and that will not result in a net increase in the number of hospital beds. Upon completion of the reconstruction, the licenses of both hospitals must be reinstated at the capacity that existed on each site before the relocation;

(7) the relocation or redistribution of hospital beds within a hospital building or identifiable complex of buildings provided the relocation or redistribution does not result in: (i) an increase in the overall bed capacity at that site; (ii) relocation of hospital beds from one physical site or complex to another; or (iii) redistribution of hospital beds within the state or a region of the state;

(8) relocation or redistribution of hospital beds within a hospital corporate system that involves the transfer of beds from a closed facility site or complex to an existing site or complex provided that: (i) no more than 50 percent of the capacity of the closed facility is transferred; (ii) the capacity of the site or complex to which the beds are transferred does not increase by more than 50 percent; (iii) the beds are not transferred outside of a federal health systems agency boundary in place on July 1, 1983; ~~and~~ (iv) the relocation or redistribution does not involve the construction of a new hospital building; and (v) the transferred beds are used first to replace within the hospital corporate system the total number of beds previously used in the closed facility site or complex for mental health services and substance use disorder services. Only after the hospital corporate system has fulfilled the requirements of this item may the remainder of the available capacity of the closed facility site or complex be transferred for any other purpose;

(9) a construction project involving up to 35 new beds in a psychiatric hospital in Rice County that primarily serves adolescents and that receives more than 70 percent of its patients from outside the state of Minnesota;

(10) a project to replace a hospital or hospitals with a combined licensed capacity of 130 beds or less if: (i) the new hospital site is located within five miles of the current site; and (ii) the total licensed capacity of the replacement hospital, either at the time of construction of the initial building or as the result of future expansion, will not exceed 70 licensed hospital beds, or the combined licensed capacity of the hospitals, whichever is less;

(11) the relocation of licensed hospital beds from an existing state facility operated by the commissioner of human services to a new or existing facility, building, or complex operated by the commissioner of human services; from one regional treatment center site to another; or from one building or site to a new or existing building or site on the same campus;

(5) a project involving consolidation of pediatric specialty hospital services within the Minneapolis-St. Paul metropolitan area that would not result in a net increase in the number of pediatric specialty hospital beds among the hospitals being consolidated;

(6) a project involving the temporary relocation of pediatric-orthopedic hospital beds to an existing licensed hospital that will allow for the reconstruction of a new philanthropic, pediatric-orthopedic hospital on an existing site and that will not result in a net increase in the number of hospital beds. Upon completion of the reconstruction, the licenses of both hospitals must be reinstated at the capacity that existed on each site before the relocation;

(7) the relocation or redistribution of hospital beds within a hospital building or identifiable complex of buildings provided the relocation or redistribution does not result in: (i) an increase in the overall bed capacity at that site; (ii) relocation of hospital beds from one physical site or complex to another; or (iii) redistribution of hospital beds within the state or a region of the state;

(8) relocation or redistribution of hospital beds within a hospital corporate system that involves the transfer of beds from a closed facility site or complex to an existing site or complex provided that: (i) no more than 50 percent of the capacity of the closed facility is transferred; (ii) the capacity of the site or complex to which the beds are transferred does not increase by more than 50 percent; (iii) the beds are not transferred outside of a federal health systems agency boundary in place on July 1, 1983; and (iv) the relocation or redistribution does not involve the construction of a new hospital building;

(9) a construction project involving up to 35 new beds in a psychiatric hospital in Rice County that primarily serves adolescents and that receives more than 70 percent of its patients from outside the state of Minnesota;

(10) a project to replace a hospital or hospitals with a combined licensed capacity of 130 beds or less if: (i) the new hospital site is located within five miles of the current site; and (ii) the total licensed capacity of the replacement hospital, either at the time of construction of the initial building or as the result of future expansion, will not exceed 70 licensed hospital beds, or the combined licensed capacity of the hospitals, whichever is less;

(11) the relocation of licensed hospital beds from an existing state facility operated by the commissioner of human services to a new or existing facility, building, or complex operated by the commissioner of human services; from one regional treatment center site to another; or from one building or site to a new or existing building or site on the same campus;

(12) the construction or relocation of hospital beds operated by a hospital having a statutory obligation to provide hospital and medical services for the indigent that does not result in a net increase in the number of hospital beds, notwithstanding section 144.552, 27 beds, of which 12 serve mental health needs, may be transferred from Hennepin County Medical Center to Regions Hospital under this clause;

(13) a construction project involving the addition of up to 31 new beds in an existing nonfederal hospital in Beltrami County;

(14) a construction project involving the addition of up to eight new beds in an existing nonfederal hospital in Otter Tail County with 100 licensed acute care beds;

(15) a construction project involving the addition of 20 new hospital beds in an existing hospital in Carver County serving the southwest suburban metropolitan area;

(16) a project for the construction or relocation of up to 20 hospital beds for the operation of up to two psychiatric facilities or units for children provided that the operation of the facilities or units have received the approval of the commissioner of human services;

(17) a project involving the addition of 14 new hospital beds to be used for rehabilitation services in an existing hospital in Itasca County;

(18) a project to add 20 licensed beds in existing space at a hospital in Hennepin County that closed 20 rehabilitation beds in 2002, provided that the beds are used only for rehabilitation in the hospital's current rehabilitation building. If the beds are used for another purpose or moved to another location, the hospital's licensed capacity is reduced by 20 beds;

(19) a critical access hospital established under section 144.1483, clause (9), and section 1820 of the federal Social Security Act, United States Code, title 42, section 1395i-4, that delicensed beds since enactment of the Balanced Budget Act of 1997, Public Law 105-33, to the extent that the critical access hospital does not seek to exceed the maximum number of beds permitted such hospital under federal law;

(20) notwithstanding section 144.552, a project for the construction of a new hospital in the city of Maple Grove with a licensed capacity of up to 300 beds provided that:

(i) the project, including each hospital or health system that will own or control the entity that will hold the new hospital license, is approved by a resolution of the Maple Grove City Council as of March 1, 2006;

(ii) the entity that will hold the new hospital license will be owned or controlled by one or more not-for-profit hospitals or health systems that have previously submitted a plan or plans for a project in Maple Grove as required under section 144.552, and the plan or plans have been found to be in the public interest by the commissioner of health as of April 1, 2005;

(iii) the new hospital's initial inpatient services must include, but are not limited to, medical and surgical services, obstetrical and gynecological services, intensive care services,

(12) the construction or relocation of hospital beds operated by a hospital having a statutory obligation to provide hospital and medical services for the indigent that does not result in a net increase in the number of hospital beds, notwithstanding section 144.552, 27 beds, of which 12 serve mental health needs, may be transferred from Hennepin County Medical Center to Regions Hospital under this clause;

(13) a construction project involving the addition of up to 31 new beds in an existing nonfederal hospital in Beltrami County;

(14) a construction project involving the addition of up to eight new beds in an existing nonfederal hospital in Otter Tail County with 100 licensed acute care beds;

(15) a construction project involving the addition of 20 new hospital beds in an existing hospital in Carver County serving the southwest suburban metropolitan area;

(16) a project for the construction or relocation of up to 20 hospital beds for the operation of up to two psychiatric facilities or units for children provided that the operation of the facilities or units have received the approval of the commissioner of human services;

(17) a project involving the addition of 14 new hospital beds to be used for rehabilitation services in an existing hospital in Itasca County;

(18) a project to add 20 licensed beds in existing space at a hospital in Hennepin County that closed 20 rehabilitation beds in 2002, provided that the beds are used only for rehabilitation in the hospital's current rehabilitation building. If the beds are used for another purpose or moved to another location, the hospital's licensed capacity is reduced by 20 beds;

(19) a critical access hospital established under section 144.1483, clause (9), and section 1820 of the federal Social Security Act, United States Code, title 42, section 1395i-4, that delicensed beds since enactment of the Balanced Budget Act of 1997, Public Law 105-33, to the extent that the critical access hospital does not seek to exceed the maximum number of beds permitted such hospital under federal law;

(20) notwithstanding section 144.552, a project for the construction of a new hospital in the city of Maple Grove with a licensed capacity of up to 300 beds provided that:

(i) the project, including each hospital or health system that will own or control the entity that will hold the new hospital license, is approved by a resolution of the Maple Grove City Council as of March 1, 2006;

(ii) the entity that will hold the new hospital license will be owned or controlled by one or more not-for-profit hospitals or health systems that have previously submitted a plan or plans for a project in Maple Grove as required under section 144.552, and the plan or plans have been found to be in the public interest by the commissioner of health as of April 1, 2005;

(iii) the new hospital's initial inpatient services must include, but are not limited to, medical and surgical services, obstetrical and gynecological services, intensive care services,

orthopedic services, pediatric services, noninvasive cardiac diagnostics, behavioral health services, and emergency room services;

(iv) the new hospital:

(A) will have the ability to provide and staff sufficient new beds to meet the growing needs of the Maple Grove service area and the surrounding communities currently being served by the hospital or health system that will own or control the entity that will hold the new hospital license;

(B) will provide uncompensated care;

(C) will provide mental health services, including inpatient beds;

(D) will be a site for workforce development for a broad spectrum of health-care-related occupations and have a commitment to providing clinical training programs for physicians and other health care providers;

(E) will demonstrate a commitment to quality care and patient safety;

(F) will have an electronic medical records system, including physician order entry;

(G) will provide a broad range of senior services;

(H) will provide emergency medical services that will coordinate care with regional providers of trauma services and licensed emergency ambulance services in order to enhance the continuity of care for emergency medical patients; and

(I) will be completed by December 31, 2009, unless delayed by circumstances beyond the control of the entity holding the new hospital license; and

(v) as of 30 days following submission of a written plan, the commissioner of health has not determined that the hospitals or health systems that will own or control the entity that will hold the new hospital license are unable to meet the criteria of this clause;

(21) a project approved under section 144.553;

(22) a project for the construction of a hospital with up to 25 beds in Cass County within a 20-mile radius of the state Ah-Gwah-Ching facility, provided the hospital's license holder is approved by the Cass County Board;

(23) a project for an acute care hospital in Fergus Falls that will increase the bed capacity from 108 to 110 beds by increasing the rehabilitation bed capacity from 14 to 16 and closing a separately licensed 13-bed skilled nursing facility;

(24) notwithstanding section 144.552, a project for the construction and expansion of a specialty psychiatric hospital in Hennepin County for up to 50 beds, exclusively for patients who are under 21 years of age on the date of admission. The commissioner conducted a public interest review of the mental health needs of Minnesota and the Twin Cities

orthopedic services, pediatric services, noninvasive cardiac diagnostics, behavioral health services, and emergency room services;

(iv) the new hospital:

(A) will have the ability to provide and staff sufficient new beds to meet the growing needs of the Maple Grove service area and the surrounding communities currently being served by the hospital or health system that will own or control the entity that will hold the new hospital license;

(B) will provide uncompensated care;

(C) will provide mental health services, including inpatient beds;

(D) will be a site for workforce development for a broad spectrum of health-care-related occupations and have a commitment to providing clinical training programs for physicians and other health care providers;

(E) will demonstrate a commitment to quality care and patient safety;

(F) will have an electronic medical records system, including physician order entry;

(G) will provide a broad range of senior services;

(H) will provide emergency medical services that will coordinate care with regional providers of trauma services and licensed emergency ambulance services in order to enhance the continuity of care for emergency medical patients; and

(I) will be completed by December 31, 2009, unless delayed by circumstances beyond the control of the entity holding the new hospital license; and

(v) as of 30 days following submission of a written plan, the commissioner of health has not determined that the hospitals or health systems that will own or control the entity that will hold the new hospital license are unable to meet the criteria of this clause;

(21) a project approved under section 144.553;

(22) a project for the construction of a hospital with up to 25 beds in Cass County within a 20-mile radius of the state Ah-Gwah-Ching facility, provided the hospital's license holder is approved by the Cass County Board;

(23) a project for an acute care hospital in Fergus Falls that will increase the bed capacity from 108 to 110 beds by increasing the rehabilitation bed capacity from 14 to 16 and closing a separately licensed 13-bed skilled nursing facility;

(24) notwithstanding section 144.552, a project for the construction and expansion of a specialty psychiatric hospital in Hennepin County for up to 50 beds, exclusively for patients who are under 21 years of age on the date of admission. The commissioner conducted a public interest review of the mental health needs of Minnesota and the Twin Cities

metropolitan area in 2008. No further public interest review shall be conducted for the construction or expansion project under this clause;

(25) a project for a 16-bed psychiatric hospital in the city of Thief River Falls, if the commissioner finds the project is in the public interest after the public interest review conducted under section 144.552 is complete;

(26)(i) a project for a 20-bed psychiatric hospital, within an existing facility in the city of Maple Grove, exclusively for patients who are under 21 years of age on the date of admission, if the commissioner finds the project is in the public interest after the public interest review conducted under section 144.552 is complete;

(ii) this project shall serve patients in the continuing care benefit program under section 256.9693. The project may also serve patients not in the continuing care benefit program; and

(iii) if the project ceases to participate in the continuing care benefit program, the commissioner must complete a subsequent public interest review under section 144.552. If the project is found not to be in the public interest, the license must be terminated six months from the date of that finding. If the commissioner of human services terminates the contract without cause or reduces per diem payment rates for patients under the continuing care benefit program below the rates in effect for services provided on December 31, 2015, the project may cease to participate in the continuing care benefit program and continue to operate without a subsequent public interest review;

(27) a project involving the addition of 21 new beds in an existing psychiatric hospital in Hennepin County that is exclusively for patients who are under 21 years of age on the date of admission; ~~or~~

(28) a project to add 55 licensed beds in an existing safety net, level I trauma center hospital in Ramsey County as designated under section 383A.91, subdivision 5, of which 15 beds are to be used for inpatient mental health and 40 are to be used for other services. In addition, five unlicensed observation mental health beds shall be added~~.~~;

(29) notwithstanding section 144.552, a project to add 45 licensed beds in an existing safety net, level I trauma center hospital in Ramsey County as designated under section 383A.91, subdivision 5. The commissioner conducted a public interest review of the construction and expansion of this hospital in 2018. No further public interest review shall be conducted for the project under this clause; or

(30) the addition of licensed beds in a hospital or hospital corporate system to primarily provide mental health services or substance use disorder services. In order to add beds under this clause, a hospital must have an emergency department and must not be a hospital that solely provides treatment to adults for mental illnesses or substance use disorders. Beds added under this clause must be available to serve medical assistance and MinnesotaCare

metropolitan area in 2008. No further public interest review shall be conducted for the construction or expansion project under this clause;

(25) a project for a 16-bed psychiatric hospital in the city of Thief River Falls, if the commissioner finds the project is in the public interest after the public interest review conducted under section 144.552 is complete;

(26)(i) a project for a 20-bed psychiatric hospital, within an existing facility in the city of Maple Grove, exclusively for patients who are under 21 years of age on the date of admission, if the commissioner finds the project is in the public interest after the public interest review conducted under section 144.552 is complete;

(ii) this project shall serve patients in the continuing care benefit program under section 256.9693. The project may also serve patients not in the continuing care benefit program; and

(iii) if the project ceases to participate in the continuing care benefit program, the commissioner must complete a subsequent public interest review under section 144.552. If the project is found not to be in the public interest, the license must be terminated six months from the date of that finding. If the commissioner of human services terminates the contract without cause or reduces per diem payment rates for patients under the continuing care benefit program below the rates in effect for services provided on December 31, 2015, the project may cease to participate in the continuing care benefit program and continue to operate without a subsequent public interest review;

(27) a project involving the addition of 21 new beds in an existing psychiatric hospital in Hennepin County that is exclusively for patients who are under 21 years of age on the date of admission; ~~or~~

(28) a project to add 55 licensed beds in an existing safety net, level I trauma center hospital in Ramsey County as designated under section 383A.91, subdivision 5, of which 15 beds are to be used for inpatient mental health and 40 are to be used for other services. In addition, five unlicensed observation mental health beds shall be added~~.~~;

(29) notwithstanding section 144.552, a project to add 45 licensed beds in an existing safety net, level I trauma center hospital in Ramsey County as designated under section 383A.91, subdivision 5. The commissioner conducted a public interest review of the construction and expansion of this hospital in 2018. No further public interest review shall be conducted for the project under this clause; or

(30) the addition of licensed beds in a hospital or hospital corporate system to provide primarily mental health services or substance use disorder services. Beds added under this clause must be available to serve medical assistance and MinnesotaCare enrollees. Notwithstanding section 144.552, a public interest review shall not be required for the addition of beds under this clause.

enrollees. Notwithstanding section 144.552, public interest review shall not be required for an addition of beds under this clause.

EFFECTIVE DATE. (a) Paragraph (b), clause (29), is effective the day following final enactment, contingent upon:

(1) the addition of the 15 inpatient mental health beds specified in paragraph (b), clause (28), to the Ramsey County level I trauma center's bed capacity;

(2) five of the 45 additional beds authorized in paragraph (b), clause (29), being designated for use for inpatient mental health and added to the hospital's bed capacity before the remaining 40 beds authorized under that clause are added; and

(3) the Ramsey County level I trauma center's agreement to not participate in the Revenue Recapture Act under Minnesota Statutes, chapter 270, and Minnesota Statutes, section 270C.41.

(b) The amendment to paragraph (b), clause (8), and paragraph (b), clause (30), are effective the day following final enactment.

Sec. 50. Minnesota Statutes 2020, section 144.551, is amended by adding a subdivision to read:

Subd. 5. **Monitoring.** The commissioner shall monitor the implementation of exceptions under this section. Each hospital or hospital corporate system granted an exception under this section shall submit to the commissioner each year a report on how the hospital or hospital corporate system continues to satisfy the conditions on which the exception was granted.

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

Sec. 51. Minnesota Statutes 2020, section 144.555, is amended to read:

144.555 ~~HOSPITAL~~ FACILITY OR CAMPUS CLOSINGS, RELOCATING SERVICES, OR CEASING TO OFFER CERTAIN SERVICES; PATIENT RELOCATIONS.

Subdivision 1. **Notice of closing or curtailing ~~service~~ operations; facilities other than hospitals.** If a facility licensed under sections 144.50 to 144.56, other than a hospital, voluntarily plans to cease operations or to curtail operations to the extent that patients or residents must be relocated, the controlling persons of the facility must notify the commissioner of health at least 90 days before the scheduled cessation or curtailment. The commissioner shall cooperate with the controlling persons and advise them about relocating the patients or residents.

Subd. 1a. **Notice of closing, curtailing operations, relocating services, or ceasing to offer certain services; hospitals.** (a) The controlling persons of a hospital licensed under sections 144.50 to 144.56 or a hospital campus must notify the commissioner of health at

least nine months before a scheduled action if the hospital or hospital campus voluntarily plans to:

(1) cease operations;

(2) curtail operations to the extent that patients must be relocated;

(3) relocate the provision of health services to another hospital or another hospital campus; or

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

(b) The commissioner shall cooperate with the controlling persons and advise them about relocating the patients. The controlling persons of the hospital or hospital campus must comply with section 144.556.

Subd. 1b. **Public hearing.** Upon receiving notice under subdivision 1a, the commissioner shall conduct a public hearing on the scheduled cessation of operations, curtailment of operations, relocation of health services, or cessation in offering health services. The commissioner must provide adequate public notice of the hearing in a time and manner determined by the commissioner. The public hearing must be held in the community where the hospital or hospital campus is located at least six months before the scheduled cessation or curtailment of operations, relocation of health services, or cessation in offering health services. The controlling persons of the hospital or hospital campus must participate in the public hearing. The public hearing must include:

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

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

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

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

Subd. 2. **Penalty.** Failure to notify the commissioner under subdivision 1 or 1a or failure to participate in a public hearing under subdivision 1b may result in issuance of a correction order under section 144.653, subdivision 5.

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

Sec. 52. **[144.556] RIGHT OF FIRST REFUSAL FOR HOSPITAL OR HOSPITAL CAMPUS.**

Subdivision 1. **Prerequisite before sale, conveyance, or ceasing operations of hospital or hospital campus.** The controlling persons of a hospital licensed under sections 144.50 to 144.56 shall not sell or convey the hospital or a campus of the hospital, offer to sell or convey the hospital or hospital campus, or voluntarily cease operations of the hospital or hospital campus unless the controlling persons have first made a good faith offer to sell or convey the hospital or hospital campus to the home rule charter or statutory city, county, town, or hospital district in which the hospital or hospital campus is located.

Subd. 2. **Offer.** The offer to sell or convey the hospital or hospital campus must be at a price that does not exceed the current fair market value of the hospital or hospital campus. A party to whom an offer is made under subdivision 1 must accept or decline the offer within 60 days after receipt. If the party fails to respond within 60 days after receipt, the offer is deemed declined.

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

Sec. 53. Minnesota Statutes 2020, section 144.9501, subdivision 17, is amended to read:

Subd. 17. **Lead hazard reduction.** "Lead hazard reduction" means abatement or interim controls undertaken to make a residence, child care facility, school, ~~or~~ playground, or other location where lead hazards are identified lead-safe by complying with the lead standards and methods adopted under section 144.9508.

Sec. 54. Minnesota Statutes 2020, section 144.9502, subdivision 3, is amended to read:

Subd. 3. **Reports of blood lead analysis required.** (a) Every hospital, medical clinic, medical laboratory, other facility, or individual performing blood lead analysis shall report the results after the analysis of each specimen analyzed, for both capillary and venous specimens, and epidemiologic information required in this section to the commissioner of health, within the time frames set forth in clauses (1) and (2):

(1) within two working days by telephone, fax, or electronic transmission as prescribed by the commissioner, with written or electronic confirmation within one month as prescribed by the commissioner, for a venous blood lead level equal to or greater than 15 micrograms of lead per deciliter of whole blood; or

(2) within one month in writing or by electronic transmission as prescribed by the commissioner, for any capillary result or for a venous blood lead level less than 15 micrograms of lead per deciliter of whole blood.

(b) If a blood lead analysis is performed outside of Minnesota and the facility performing the analysis does not report the blood lead analysis results and epidemiological information required in this section to the commissioner, the provider who collected the blood specimen must satisfy the reporting requirements of this section. For purposes of this section, "provider" has the meaning given in section 62D.02, subdivision 9.

(c) The commissioner shall coordinate with hospitals, medical clinics, medical laboratories, and other facilities performing blood lead analysis to develop a universal reporting form and mechanism.

Sec. 55. Minnesota Statutes 2020, section 144.9504, subdivision 2, is amended to read:

Subd. 2. **Lead risk assessment.** (a) Notwithstanding section 144.9501, subdivision 6a, for purposes of this subdivision, "child" means an individual under 18 years of age.

(b) An assessing agency shall conduct a lead risk assessment of a residence, residential or commercial child care facility, playground, school, or other location where lead hazards are suspected according to the venous blood lead level and time frame set forth in clauses (1) to (4) for purposes of secondary prevention:

(1) within 48 hours of a child or pregnant female in the residence, residential or commercial child care facility, playground, school, or other location where lead hazards are suspected being identified to the agency as having a venous blood lead level equal to or greater than 60 micrograms of lead per deciliter of whole blood;

(2) within five working days of a child or pregnant female in the residence, residential or commercial child care facility, playground, school, or other location where lead hazards are suspected being identified to the agency as having a venous blood lead level equal to or greater than 45 micrograms of lead per deciliter of whole blood;

~~(3) within ten working days of a child in the residence being identified to the agency as having a venous blood lead level equal to or greater than 15 micrograms of lead per deciliter of whole blood; or~~

~~(4)~~ (3) within ten working days of a child or pregnant female in the residence, residential or commercial child care facility, playground, school, or other location where lead hazards are suspected being identified to the agency as having a venous blood lead level equal to or greater than ten micrograms of lead per deciliter of whole blood~~.~~; or

(4) within 20 working days of a child or pregnant female in the residence, residential or commercial child care facility, playground, school, or other location where lead hazards are suspected being identified to the agency as having a venous blood lead level equal to or greater than five micrograms per deciliter of whole blood.

An assessing agency may refer investigations at sites other than the child's or pregnant female's residence to the commissioner.

~~(b)~~ (c) Within the limits of available local, state, and federal appropriations, an assessing agency may also conduct a lead risk assessment for children with any elevated blood lead level.

~~(c)~~ (d) In a building with two or more dwelling units, an assessing agency shall assess the individual unit in which the conditions of this section are met and shall inspect all common areas accessible to a child. If a child visits one or more other sites such as another

residence, or a residential or commercial child care facility, playground, or school, the assessing agency shall also inspect the other sites. The assessing agency shall have one additional day added to the time frame set forth in this subdivision to complete the lead risk assessment for each additional site.

~~(d)~~ (e) Within the limits of appropriations, the assessing agency shall identify the known addresses for the previous 12 months of the child or pregnant female with venous blood lead levels of at least 15 micrograms per deciliter for the child or at least ten micrograms per deciliter for the pregnant female; notify the property owners, landlords, and tenants at those addresses that an elevated blood lead level was found in a person who resided at the property; and give them primary prevention information. Within the limits of appropriations, the assessing agency may perform a risk assessment and issue corrective orders in the properties, if it is likely that the previous address contributed to the child's or pregnant female's blood lead level. The assessing agency shall provide the notice required by this subdivision without identifying the child or pregnant female with the elevated blood lead level. The assessing agency is not required to obtain the consent of the child's parent or guardian or the consent of the pregnant female for purposes of this subdivision. This information shall be classified as private data on individuals as defined under section 13.02, subdivision 12.

~~(e)~~ (f) The assessing agency shall conduct the lead risk assessment according to rules adopted by the commissioner under section 144.9508. An assessing agency shall have lead risk assessments performed by lead risk assessors licensed by the commissioner according to rules adopted under section 144.9508. If a property owner refuses to allow a lead risk assessment, the assessing agency shall begin legal proceedings to gain entry to the property and the time frame for conducting a lead risk assessment set forth in this subdivision no longer applies. A lead risk assessor or assessing agency may observe the performance of lead hazard reduction in progress and shall enforce the provisions of this section under section 144.9509. Deteriorated painted surfaces, bare soil, and dust must be tested with appropriate analytical equipment to determine the lead content, except that deteriorated painted surfaces or bare soil need not be tested if the property owner agrees to engage in lead hazard reduction on those surfaces. The lead content of drinking water must be measured if another probable source of lead exposure is not identified. Within a standard metropolitan statistical area, an assessing agency may order lead hazard reduction of bare soil without measuring the lead content of the bare soil if the property is in a census tract in which soil sampling has been performed according to rules established by the commissioner and at least 25 percent of the soil samples contain lead concentrations above the standard in section 144.9508.

~~(f)~~ (g) Each assessing agency shall establish an administrative appeal procedure which allows a property owner to contest the nature and conditions of any lead order issued by the assessing agency. Assessing agencies must consider appeals that propose lower cost methods that make the residence lead safe. The commissioner shall use the authority and appeal procedure granted under sections 144.989 to 144.993.

~~(g)~~ (h) Sections 144.9501 to 144.9512 neither authorize nor prohibit an assessing agency from charging a property owner for the cost of a lead risk assessment.

Sec. 56. Minnesota Statutes 2020, section 144.9504, subdivision 5, is amended to read:

Subd. 5. **Lead orders.** (a) An assessing agency, after conducting a lead risk assessment, shall order a property owner to perform lead hazard reduction on all lead sources that exceed a standard adopted according to section 144.9508. If lead risk assessments and lead orders are conducted at times when weather or soil conditions do not permit the lead risk assessment or lead hazard reduction, external surfaces and soil lead shall be assessed, and lead orders complied with, if necessary, at the first opportunity that weather and soil conditions allow.

(b) If, after conducting a lead risk assessment, an assessing agency determines that the property owner's lead hazard originated from another source location, the assessing agency may order the responsible person of the source location to:

(1) perform lead hazard reduction at the site where the assessing agency conducted the lead risk assessment; and

(2) remediate the conditions at the source location that allowed the lead hazard, pollutant, or contaminant to migrate from the source location.

(c) For purposes of this subdivision, "pollutant or contaminant" has the meaning given in section 115B.02, subdivision 13, and "responsible person" has the meaning given in section 115B.03.

~~(b)~~ (d) If the paint standard under section 144.9508 is violated, but the paint is intact, the assessing agency shall not order the paint to be removed unless the intact paint is a known source of actual lead exposure to a specific person. Before the assessing agency may order the intact paint to be removed, a reasonable effort must be made to protect the child and preserve the intact paint by the use of guards or other protective devices and methods.

~~(c)~~ (e) Whenever windows and doors or other components covered with deteriorated lead-based paint have sound substrate or are not rotting, those components should be repaired, sent out for stripping or planed down to remove deteriorated lead-based paint, or covered with protective guards instead of being replaced, provided that such an activity is the least cost method. However, a property owner who has been ordered to perform lead hazard reduction may choose any method to address deteriorated lead-based paint on windows, doors, or other components, provided that the method is approved in rules adopted under section 144.9508 and that it is appropriate to the specific property.

~~(d)~~ (f) Lead orders must require that any source of damage, such as leaking roofs, plumbing, and windows, be repaired or replaced, as needed, to prevent damage to lead-containing interior surfaces.

~~(e)~~ (g) The assessing agency is not required to pay for lead hazard reduction. The assessing agency shall enforce the lead orders issued to a property owner under this section.

Sec. 57. Minnesota Statutes 2020, section 144G.08, subdivision 7, as amended by Laws 2020, Seventh Special Session chapter 1, article 6, section 5, is amended to read:

Subd. 7. **Assisted living facility.** "Assisted living facility" means ~~a facility that~~ an establishment where an operating person or legal entity, either directly or through contract, business relationship, or common ownership with another person or entity, provides sleeping accommodations and assisted living services to one or more adults in the facility. Assisted living facility includes assisted living facility with dementia care, and does not include:

(1) emergency shelter, transitional housing, or any other residential units serving exclusively or primarily homeless individuals, as defined under section 116L.361;

(2) a nursing home licensed under chapter 144A;

(3) a hospital, certified boarding care, or supervised living facility licensed under sections 144.50 to 144.56;

(4) a lodging establishment licensed under chapter 157 and Minnesota Rules, parts 9520.0500 to 9520.0670, or under chapter 245D or 245G;

(5) services and residential settings licensed under chapter 245A, including adult foster care and services and settings governed under the standards in chapter 245D;

(6) a private home in which the residents are related by kinship, law, or affinity with the provider of services;

(7) a duly organized condominium, cooperative, and common interest community, or owners' association of the condominium, cooperative, and common interest community where at least 80 percent of the units that comprise the condominium, cooperative, or common interest community are occupied by individuals who are the owners, members, or shareholders of the units;

(8) a temporary family health care dwelling as defined in sections 394.307 and 462.3593;

(9) a setting offering services conducted by and for the adherents of any recognized church or religious denomination for its members exclusively through spiritual means or by prayer for healing;

(10) housing financed pursuant to sections 462A.37 and 462A.375, units financed with low-income housing tax credits pursuant to United States Code, title 26, section 42, and units financed by the Minnesota Housing Finance Agency that are intended to serve individuals with disabilities or individuals who are homeless, except for those developments that market or hold themselves out as assisted living facilities and provide assisted living services;

(11) rental housing developed under United States Code, title 42, section 1437, or United States Code, title 12, section 1701q;

(12) rental housing designated for occupancy by only elderly or elderly and disabled residents under United States Code, title 42, section 1437e, or rental housing for qualifying families under Code of Federal Regulations, title 24, section 983.56;

(13) rental housing funded under United States Code, title 42, chapter 89, or United States Code, title 42, section 8011;

~~(14) a covered setting as defined in section 325F.721, subdivision 1, paragraph (b);~~ or

~~(15)~~ (14) any establishment that exclusively or primarily serves as a shelter or temporary shelter for victims of domestic or any other form of violence.

EFFECTIVE DATE. This section is effective August 1, 2021.

Sec. 58. Minnesota Statutes 2020, section 144G.54, subdivision 3, is amended to read:

Subd. 3. **Appeals process.** (a) The Office of Administrative Hearings must conduct an expedited hearing using the procedures in Minnesota Rules, parts 1400.8505 to 1400.8612, as soon as practicable under this section, but in no event later than 14 calendar days after the office receives the request, unless the parties agree otherwise or the chief administrative law judge deems the timing to be unreasonable, given the complexity of the issues presented.

(b) The hearing must be held at the facility where the resident lives, unless holding the hearing at that location is impractical, the parties agree to hold the hearing at a different location, or the chief administrative law judge grants a party's request to appear at another location or by telephone or interactive video.

(c) The hearing is not a formal contested case proceeding conducted according to the procedures in Minnesota Rules, parts 1400.5010 to 1400.8400, except when determined necessary by the chief administrative law judge.

(d) Parties may but are not required to be represented by counsel. The appearance of a party without counsel does not constitute the unauthorized practice of law.

(e) The hearing shall be limited to the amount of time necessary for the participants to expeditiously present the facts about the proposed termination. The administrative law judge shall issue a recommendation to the commissioner as soon as practicable, but in no event later than ten business days after the hearing.

EFFECTIVE DATE. This section is effective August 1, 2021.

Sec. 59. Minnesota Statutes 2020, section 144G.84, is amended to read:

144G.84 SERVICES FOR RESIDENTS WITH DEMENTIA.

(a) In addition to the minimum services required in section 144G.41, an assisted living facility with dementia care must also provide the following services:

(1) assistance with activities of daily living that address the needs of each resident with dementia due to cognitive or physical limitations. These services must meet or be in addition

to the requirements in the licensing rules for the facility. Services must be provided in a person-centered manner that promotes resident choice, dignity, and sustains the resident's abilities;

(2) nonpharmacological practices that are person-centered and evidence-informed;

(3) services to prepare and educate persons living with dementia and their legal and designated representatives about transitions in care and ensuring complete, timely communication between, across, and within settings; and

(4) services that provide residents with choices for meaningful engagement with other facility residents and the broader community.

(b) Each resident must be evaluated for activities according to the licensing rules of the facility. In addition, the evaluation must address the following:

(1) past and current interests;

(2) current abilities and skills;

(3) emotional and social needs and patterns;

(4) physical abilities and limitations;

(5) adaptations necessary for the resident to participate; and

(6) identification of activities for behavioral interventions.

(c) An individualized activity plan must be developed for each resident based on their activity evaluation. The plan must reflect the resident's activity preferences and needs.

(d) A selection of daily structured and non-structured activities must be provided and included on the resident's activity service or care plan as appropriate. Daily activity options based on resident evaluation may include but are not limited to:

(1) occupation or chore related tasks;

(2) scheduled and planned events such as entertainment or outings;

(3) spontaneous activities for enjoyment or those that may help defuse a behavior;

(4) one-to-one activities that encourage positive relationships between residents and staff such as telling a life story, reminiscing, or playing music;

(5) spiritual, creative, and intellectual activities;

(6) sensory stimulation activities;

(7) physical activities that enhance or maintain a resident's ability to ambulate or move; and

(8) a resident's individualized activity plan for regular outdoor ~~activities~~ activity.

(e) Behavioral symptoms that negatively impact the resident and others in the assisted living facility with dementia care must be evaluated and included on the service or care plan. The staff must initiate and coordinate outside consultation or acute care when indicated.

(f) Support must be offered to family and other significant relationships on a regularly scheduled basis but not less than quarterly.

(g) ~~Access to secured outdoor space and walkways that allow residents to enter and return without staff assistance must be provided.~~ Existing housing with services establishments registered under chapter 144D prior to August 1, 2021, that obtain an assisted living facility license must provide residents with regular access to outdoor space. A licensee with new construction on or after August 1, 2021, or a new licensee that was not previously registered under chapter 144D prior to August 1, 2021, must provide regular access to secured outdoor space on the premises of the facility. A resident's access to outdoor space must be in accordance with the resident's documented care plan.

EFFECTIVE DATE. This section is effective August 1, 2021.

Sec. 27. Minnesota Statutes 2020, section 145.32, subdivision 1, is amended to read:

Subdivision 1. **Hospital records.** The superintendent or other chief administrative officer of any public or private hospital, by and with the consent and approval of the board of directors or other governing body of the hospital, may divest the files and records of that hospital of any individual case records and, with that consent and approval, may destroy the records. The records shall first have been transferred and recorded as authorized in section 145.30.

Portions of individual hospital medical records that comprise an individual permanent medical record, as defined by the commissioner of health, shall be retained as authorized in section 145.30. Other portions of the individual medical record, including any miscellaneous documents, papers, and correspondence in connection with them, may be divested and destroyed after seven years without transfer to photographic film, electronic image, or other state-of-the-art electronic preservation technology.

All portions of individual hospital medical records of minors shall be maintained for seven years ~~following the age of majority~~ or until the patient reaches the age of majority, whichever occurs last, at which time the patient may request that the patient's hospital records be deleted.

Nothing in this section shall be construed to prohibit the retention of hospital medical records beyond the periods described in this section. Nor shall anything in this section be construed to prohibit patient access to hospital medical records as provided in sections 144.291 to 144.298.

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

Sec. 28. **[145.4161] LICENSURE OF ABORTION FACILITIES.**

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

(b) "Abortion facility" means a clinic, health center, or other facility in which the pregnancies of ten or more women known to be pregnant are willfully terminated or aborted each month. A facility licensed as a hospital or as an outpatient surgical center pursuant to sections 144.50 to 144.56 shall not be considered an abortion facility.

(c) "Accrediting or membership organization" means a national organization that establishes evidence-based clinical standards for abortion care and accredits abortion facilities or accepts as members abortion facilities following an application and inspection process.

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

Subd. 2. **License required.** (a) Beginning July 1, 2022, no abortion facility shall be established, operated, or maintained in the state without first obtaining a license from the commissioner according to this section.

(b) A license issued under this section is not transferable or assignable and is subject to suspension or revocation at any time for failure to comply with this section.

(c) If a single entity maintains abortion facilities on different premises, each facility must obtain a separate license.

(d) To be eligible for licensure under this section, an abortion facility must be accredited or a member of an accrediting or membership organization or must obtain accreditation or membership within six months of the date of the application for licensure. If the abortion facility loses its accreditation or membership, the abortion facility must immediately notify the commissioner.

(e) The commissioner, the attorney general, an appropriate county attorney, or a woman upon whom an abortion has been performed or attempted to be performed at an unlicensed facility may seek an injunction in district court against the continued operation of the facility. Proceedings for securing an injunction may be brought by the attorney general or by the appropriate county attorney.

(f) Sanctions provided in this subdivision do not restrict other available sanctions.

Subd. 3. **Temporary license.** For new abortion facilities planning to begin operations on or after July 1, 2022, the commissioner may issue a temporary license to the abortion facility that is valid for a period of six months from the date of issuance. The abortion facility must submit to the commissioner an application and applicable fee for licensure as required by subdivisions 4 and 7. The application must include the information required under subdivision 4, clauses (1), (2), and (4), and provide documentation that the abortion facility has submitted the application for accreditation or membership from an accrediting or membership organization. Upon receipt of accreditation or membership verification, the

abortion facility must submit to the commissioner the information required in subdivision 4, clause (3), and the applicable fee under subdivision 7. The commissioner shall then issue a new license.

Subd. 4. **Application.** An application for a license to operate an abortion facility and the applicable fee under subdivision 7 must be submitted to the commissioner on a form provided by the commissioner and must contain:

(1) the name of the applicant;

(2) the site location of the abortion facility;

(3) documentation that the abortion facility is accredited or an approved member of an accrediting or membership organization, including the effective date and the expiration date of the accreditation or membership, and the date of the last site visit by the accrediting or membership organization; and

(4) any other information that the commissioner deems necessary.

Subd. 5. **Inspections.** Prior to initial licensure and at least once every two years thereafter, the commissioner shall perform a routine and comprehensive inspection of each abortion facility. Facilities shall be open at all reasonable times to an inspection authorized in writing by the commissioner. No notice need be given to any person prior to an inspection authorized by the commissioner.

Subd. 6. **Suspension, revocation, and refusal to renew.** The commissioner may refuse to grant or renew, or may suspend or revoke, a license on any of the grounds described in section 144.55, subdivision 6, paragraph (a), clause (2), (3), or (4), or upon the loss of accreditation or membership described in subdivision 4, clause (3). The applicant or licensee is entitled to notice and a hearing as described under section 144.55, subdivision 7, and a new license may be issued after the proper inspection of an abortion facility has been conducted.

Subd. 7. **Fees.** (a) The biennial license fee for abortion facilities is $365.

(b) The temporary license fee is $365.

(c) Fees shall be collected and deposited according to section 144.122.

Subd. 8. **Renewal.** (a) A license issued under this section expires two years from the date of issuance.

(b) A temporary license issued under this section expires six months from the date of issuance and may be renewed for one additional six-month period.

Subd. 9. **Records.** All health records maintained on each client by an abortion facility are subject to sections 144.292 to 144.298.

Sec. 60. **[145.87] HOME VISITING FOR PREGNANT WOMEN AND FAMILIES WITH YOUNG CHILDREN.**

Subdivision 1. **Definitions.** (a) The terms defined in this subdivision apply to this section and have the meanings given them.

(b) "Evidence-based home visiting program" means a program that:

(1) is based on a clear, consistent program or model that is research-based and grounded in relevant, empirically based knowledge;

(2) is linked to program-determined outcomes and is associated with a national organization, institution of higher education, or national or state public health institute;

(3) has comprehensive home visitation standards that ensure high-quality service delivery and continuous quality improvement;

(4) has demonstrated significant, sustained positive outcomes; and

(5) either:

(i) has been evaluated using rigorous randomized controlled research designs and the evaluation results have been published in a peer-reviewed journal; or

(ii) is based on quasi-experimental research using two or more separate, comparable client samples.

(c) "Evidence-informed home visiting program" means a program that:

(1) has data or evidence demonstrating effectiveness at achieving positive outcomes for pregnant women and young children; and

(2) either:

(i) has an active evaluation of the program; or

(ii) has a plan and timeline for an active evaluation of the program to be conducted.

(d) "Health equity" means every individual has a fair opportunity to attain the individual's full health potential and no individual is disadvantaged from achieving this potential.

Subd. 10. **Severability.** If any one or more provision, section, subdivision, sentence, clause, phrase, or word of this section or the application of it to any person or circumstance is found to be unconstitutional, it is declared to be severable and the balance of this section shall remain effective notwithstanding such unconstitutionality. The legislature intends that it would have passed this section, and each provision, section, subdivision, sentence, clause, phrase, or word, regardless of the fact that any one provision, section, subdivision, sentence, clause, phrase, or word is declared unconstitutional.

Sec. 29. **[145.87] HOME VISITING FOR PREGNANT WOMEN AND FAMILIES WITH YOUNG CHILDREN.**

Subdivision 1. **Definitions.** (a) The terms defined in this subdivision apply to this section and have the meanings given them.

(b) "Evidence-based home visiting program" means a program that:

(1) is based on a clear, consistent program or model that is research-based and grounded in relevant, empirically based knowledge;

(2) is linked to program-determined outcomes and is associated with a national organization, institution of higher education, or national or state public health institute;

(3) has comprehensive home visitation standards that ensure high-quality service delivery and continuous quality improvement;

(4) has demonstrated significant, sustained positive outcomes; and

(5) either:

(i) has been evaluated using rigorous randomized controlled research designs and the evaluation results have been published in a peer-reviewed journal; or

(ii) is based on quasi-experimental research using two or more separate, comparable client samples.

(c) "Evidence-informed home visiting program" means a program that:

(1) has data or evidence demonstrating effectiveness at achieving positive outcomes for pregnant women and young children; and

(2) either:

(i) has an active evaluation of the program; or

(ii) has a plan and timeline for an active evaluation of the program to be conducted.

(d) "Health equity" means every individual has a fair opportunity to attain the individual's full health potential and no individual is disadvantaged from achieving this potential.

(e) "Promising practice home visiting program" means a program that has shown improvement toward achieving positive outcomes for pregnant women or young children.

Subd. 2. **Grants for home visiting programs.** (a) The commissioner of health shall award grants to community health boards, nonprofit organizations, and tribal nations to start up or expand voluntary home visiting programs serving pregnant women and families with young children. Home visiting programs supported under this section shall provide voluntary home visits by early childhood professionals or health professionals, including but not limited to nurses, social workers, early childhood educators, and trained paraprofessionals. Grant money shall be used to:

(1) establish or expand evidence-based, evidence-informed, or promising practice home visiting programs that address health equity and utilize community-driven health strategies;

(2) serve families with young children or pregnant women who have high needs or are high-risk, including but not limited to a family with low income, a parent or pregnant woman with a mental illness or a substance use disorder, or a parent or pregnant woman experiencing housing instability or domestic abuse; and

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

(i) maternal and newborn health;

(ii) school readiness and achievement;

(iii) family economic self-sufficiency;

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

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

(vi) reduction in crime or domestic violence.

(b) Grants awarded to evidence-informed and promising practice home visiting programs must include money to evaluate program outcomes for up to four of the areas listed in paragraph (a), clause (3).

Subd. 3. **Grant prioritization.** (a) In awarding grants, the commissioner shall give priority to community health boards, nonprofit organizations, and tribal nations seeking to expand home visiting services with community or regional partnerships.

(b) The commissioner shall allocate at least 75 percent of the grant money awarded each grant cycle to evidence-based home visiting programs that address health equity and up to 25 percent of the grant money awarded each grant cycle to evidence-informed or promising practice home visiting programs that address health equity and utilize community-driven health strategies.

Subd. 4. **Administrative costs.** The commissioner may use up to seven percent of the annual appropriation under this section to provide training and technical assistance and to

(e) "Promising practice home visiting program" means a program that has shown improvement toward achieving positive outcomes for pregnant women or young children.

Subd. 2. **Grants for home visiting programs.** (a) The commissioner of health shall award grants to community health boards, nonprofit organizations, and Tribal nations to start up or expand voluntary home visiting programs serving pregnant women and families with young children. Home visiting programs supported under this section shall provide voluntary home visits by early childhood professionals or health professionals, including but not limited to nurses, social workers, early childhood educators, and trained paraprofessionals. Grant money shall be used to:

(1) establish or expand evidence-based, evidence-informed, or promising practice home visiting programs that address health equity and utilize community-driven health strategies;

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

(i) maternal and newborn health;

(ii) school readiness and achievement;

(iii) family economic self-sufficiency;

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(b) The commissioner shall allocate at least 75 percent of the grant money awarded each grant cycle to evidence-based home visiting programs that address health equity and up to 25 percent of the grant money awarded each grant cycle to evidence-informed or promising practice home visiting programs that address health equity and utilize community-driven health strategies.

Subd. 4. **Administrative costs.** The commissioner may use up to seven percent of the annual appropriation under this section to provide training and technical assistance and to

administer and evaluate the program. The commissioner may contract for training, capacity-building support for grantees or potential grantees, technical assistance, and evaluation support.

Subd. 5. **Use of state general fund appropriations.** Appropriations dedicated to establishing or expanding evidence-based home visiting programs shall, for grants awarded on or after July 1, 2021, be awarded according to this section. This section shall not govern grant awards of federal funds for home visiting programs and shall not govern grant awards using state general fund appropriations dedicated to establishing or expanding nurse-family partnership home visiting programs.

Sec. 61. Minnesota Statutes 2020, section 145.893, subdivision 1, is amended to read:

Subdivision 1. ~~**Vouchers**~~ **Food benefits.** An eligible individual shall receive ~~vouchers~~ food benefits for the purchase of specified nutritional supplements in type and quantity approved by the commissioner. Alternate forms of delivery may be developed by the commissioner in appropriate cases.

Sec. 62. Minnesota Statutes 2020, section 145.894, is amended to read:

145.894 STATE COMMISSIONER OF HEALTH; DUTIES, RESPONSIBILITIES.

The commissioner of health shall:

(1) develop a comprehensive state plan for the delivery of nutritional supplements to pregnant and lactating women, infants, and children;

(2) contract with existing local public or private nonprofit organizations for the administration of the nutritional supplement program;

(3) develop and implement a public education program promoting the provisions of sections 145.891 to 145.897, and provide for the delivery of individual and family nutrition education and counseling at project sites. The education programs must include a campaign to promote breast feeding;

(4) develop in cooperation with other agencies and vendors a uniform state ~~voucher~~ food benefit system for the delivery of nutritional supplements;

(5) authorize local health agencies to issue ~~vouchers bimonthly~~ food benefits trimonthly to some or all eligible individuals served by the agency, provided the agency demonstrates that the federal minimum requirements for providing nutrition education will continue to be met and that the quality of nutrition education and health services provided by the agency will not be adversely impacted;

(6) investigate and implement a system to reduce the cost of nutritional supplements and maintain ongoing negotiations with nonparticipating manufacturers and suppliers to maximize cost savings;

administer and evaluate the program. The commissioner may contract for training, capacity-building support for grantees or potential grantees, technical assistance, and evaluation support.

Subd. 5. **Use of state general fund appropriations.** Appropriations dedicated to establishing or expanding evidence-based home visiting programs shall, for grants awarded on or after July 1, 2021, be awarded according to this section. This section shall not govern grant awards of federal funds for home visiting programs and shall not govern grant awards using state general fund appropriations dedicated to establishing or expanding nurse-family partnership home visiting programs.

(7) develop, analyze, and evaluate the health aspects of the nutritional supplement program and establish nutritional guidelines for the program;

(8) apply for, administer, and annually expend at least 99 percent of available federal or private funds;

(9) aggressively market services to eligible individuals by conducting ongoing outreach activities and by coordinating with and providing marketing materials and technical assistance to local human services and community service agencies and nonprofit service providers;

(10) determine, on July 1 of each year, the number of pregnant women participating in each special supplemental food program for women, infants, and children (WIC) ~~and, in 1986, 1987, and 1988, at the commissioner's discretion, designate a different food program deliverer if the current deliverer fails to increase the participation of pregnant women in the program by at least ten percent over the previous year's participation rate~~;

(11) promulgate all rules necessary to carry out the provisions of sections 145.891 to 145.897; and

(12) ensure that any state appropriation to supplement the federal program is spent consistent with federal requirements.

Sec. 63. Minnesota Statutes 2020, section 145.897, is amended to read:

145.897 ~~VOUCHERS~~ FOOD BENEFITS.

~~Vouchers~~ Food benefits issued pursuant to sections 145.891 to 145.897 shall be only for the purchase of those foods determined by the ~~commissioner~~ United States Department of Agriculture to be desirable nutritional supplements for pregnant and lactating women, infants and children. ~~These foods shall include, but not be limited to, iron fortified infant formula, vegetable or fruit juices, cereal, milk, cheese, and eggs.~~

Sec. 64. Minnesota Statutes 2020, section 145.899, is amended to read:

145.899 WIC ~~VOUCHERS~~ FOOD BENEFITS FOR ORGANICS.

~~Vouchers~~ Food benefits for the special supplemental nutrition program for women, infants, and children (WIC) may be used to purchase cost-neutral organic WIC allowable food. The commissioner of health shall regularly evaluate the list of WIC allowable food in accordance with federal requirements and shall add to the list any organic WIC allowable foods determined to be cost-neutral.

Sec. 65. Minnesota Statutes 2020, section 145.901, subdivision 2, is amended to read:

Subd. 2. **Access to data.** (a) The commissioner of health has access to medical data as defined in section 13.384, subdivision 1, paragraph (b), medical examiner data as defined in section 13.83, subdivision 1, and health records created, maintained, or stored by providers ~~as defined in section 144.291, subdivision 2, paragraph (i),~~ without the consent of the subject of the data, and without the consent of the parent, spouse, other guardian, or legal

representative of the subject of the data, when the subject of the data is a woman who died during a pregnancy or within 12 months of a fetal death, a live birth, or other termination of a pregnancy.

The commissioner has access only to medical data and health records related to deaths that occur on or after July 1, 2000, including the names of the providers, clinics, or other health services such as family home visiting programs; the women, infants, and children (WIC) program; prescription monitoring programs; and behavioral health services, where care was received before, during, or related to the pregnancy or death. The commissioner has access to records maintained by a medical examiner, a coroner, or hospitals or to hospital discharge data, for the purpose of providing the name and location of any pre-pregnancy, prenatal, or other care received by the subject of the data up to one year after the end of the pregnancy.

(b) The provider or responsible authority that creates, maintains, or stores the data shall furnish the data upon the request of the commissioner. The provider or responsible authority may charge a fee for providing the data, not to exceed the actual cost of retrieving and duplicating the data.

(c) The commissioner shall make a good faith reasonable effort to notify the parent, spouse, other guardian, or legal representative of the subject of the data before collecting data on the subject. For purposes of this paragraph, "reasonable effort" means one notice is sent by certified mail to the last known address of the parent, spouse, guardian, or legal representative informing the recipient of the data collection and offering a public health nurse support visit if desired.

(d) The commissioner does not have access to coroner or medical examiner data that are part of an active investigation as described in section 13.83.

(e) The commissioner may request and receive from a coroner or medical examiner the name of the health care provider that provided prenatal, postpartum, or other health services to the subject of the data.

(f) The commissioner may access Department of Human Services data to identify sources of care and services to assist with the evaluation of welfare systems, including housing, to reduce preventable maternal deaths.

(g) The commissioner may request and receive law enforcement reports or incident reports related to the subject of the data.

Sec. 66. Minnesota Statutes 2020, section 145.901, subdivision 4, is amended to read:

Subd. 4. **Classification of data.** (a) Data provided to the commissioner from source records under subdivision 2, including identifying information on individual providers, data subjects, or their children, and data derived by the commissioner under subdivision 3 for the purpose of carrying out maternal death studies, are classified as confidential data on

individuals or confidential data on decedents, as defined in sections 13.02, subdivision 3, and 13.10, subdivision 1, paragraph (a).

(b) Information classified under paragraph (a) shall not be subject to discovery or introduction into evidence in any administrative, civil, or criminal proceeding. Such information otherwise available from an original source shall not be immune from discovery or barred from introduction into evidence merely because it was utilized by the commissioner in carrying out maternal death studies.

(c) Summary data on maternal death studies created by the commissioner, which does not identify individual data subjects or individual providers, shall be public in accordance with section 13.05, subdivision 7.

(d) Data provided by the commissioner of human services to the commissioner of health under this section retain the same classification the data held when retained by the commissioner of human services, as required under section 13.03, subdivision 4, paragraph (c).

Sec. 30. Minnesota Statutes 2020, section 145.902, is amended to read:

145.902 GIVE LIFE A CHANCE; SAFE PLACE FOR NEWBORNS DUTIES; IMMUNITY.

Subdivision 1. **General.** (a) For purposes of this section, a "safe place" means a hospital licensed under sections 144.50 to 144.56, including the hospital where the newborn was born, a health care provider who provides urgent care medical services, or an ambulance service licensed under chapter 144E dispatched in response to a 911 call from a mother or a person with the mother's permission to relinquish a newborn infant.

(b) A safe place shall receive a newborn left with an employee on the premises of the safe place during its hours of operation, provided that:

(1) the newborn was born within seven days of being left at the safe place, as determined within a reasonable degree of medical certainty; and

(2) the newborn is left in an unharmed condition.

(c) The safe place must not inquire as to the identity of the mother or the person leaving the newborn or call the police, provided the newborn is unharmed when presented to the hospital. The safe place may ask the mother or the person leaving the newborn about the medical history of the mother or newborn and if the newborn may have lineage to an Indian Tribe and, if known, the name of the Tribe but the mother or the person leaving the newborn is not required to provide any information. The safe place may provide the mother or the person leaving the newborn with information about how to contact relevant social service agencies.

(d) A safe place that is a health care provider who provides urgent care medical services shall dial 911, advise the dispatcher that the call is being made from a safe place for newborns, and ask the dispatcher to send an ambulance or take other appropriate action to transport the newborn to a hospital. An ambulance with whom a newborn is left shall transport the newborn to a hospital for care. Hospitals must receive a newborn left with a safe place and make the report as required in subdivision 2.

Subd. 2. **Reporting.** (a) Within 24 hours of receiving a newborn under this section, the hospital must inform the responsible social service agency that a newborn has been left at the hospital, but must not do so in the presence of the mother or the person leaving the newborn. The hospital must provide necessary care to the newborn pending assumption of legal responsibility by the responsible social service agency pursuant to section 260C.139, subdivision 5.

(b) Within five days of receiving a newborn under this section, a hospital shall report the newborn to the Office of Vital Records pursuant to section 144.216, subdivision 3. If a hospital receives a safe place newborn under section 145.902 and it is known that the child's record of birth was registered because the newborn was born at that hospital, the hospital shall report the newborn to the Office of Vital Records and identify the child's birth record. The state registrar shall issue a replacement birth record for the child pursuant to section 144.218, subdivision 6.

Subd. 3. **Immunity.** (a) A safe place with responsibility for performing duties under this section, and any employee, doctor, ambulance personnel, or other medical professional working at the safe place, are immune from any criminal liability that otherwise might result from their actions, if they are acting in good faith in receiving a newborn, and are immune from any civil liability that otherwise might result from merely receiving a newborn.

(b) A safe place performing duties under this section, or an employee, doctor, ambulance personnel, or other medical professional working at the safe place who is a mandated reporter under chapter 260E, is immune from any criminal or civil liability that otherwise might result from the failure to make a report under that section if the person is acting in good faith in complying with this section.

EFFECTIVE DATE. This section is effective August 1, 2021.

Sec. 31. **[145A.145] NURSE-FAMILY PARTNERSHIP PROGRAMS.**

(a) The commissioner of health shall award expansion grants to community health boards and tribal nations to expand existing nurse-family partnership programs. Grant funds must be used to start up, expand, or sustain nurse-family partnership programs in the county, reservation, or region to serve families in accordance with the Nurse-Family Partnership Service Office nurse-family partnership model. The commissioner shall award grants to community health boards, nonprofit organizations, or tribal nations in metropolitan and rural areas of the state.

Sec. 67. Minnesota Statutes 2020, section 152.01, subdivision 23, is amended to read:

Subd. 23. **Analog.** (a) Except as provided in paragraph (b), "analog" means a substance, the chemical structure of which is substantially similar to the chemical structure of a controlled substance in Schedule I or II:

(1) that has a stimulant, depressant, or hallucinogenic effect on the central nervous system that is substantially similar to or greater than the stimulant, depressant, or hallucinogenic effect on the central nervous system of a controlled substance in Schedule I or II; or

(2) with respect to a particular person, if the person represents or intends that the substance have a stimulant, depressant, or hallucinogenic effect on the central nervous system that is substantially similar to or greater than the stimulant, depressant, or hallucinogenic effect on the central nervous system of a controlled substance in Schedule I or II.

(b) "Analog" does not include:

(1) a controlled substance;

(2) any substance for which there is an approved new drug application under the Federal Food, Drug, and Cosmetic Act; ~~or~~

(3) with respect to a particular person, any substance, if an exemption is in effect for investigational use, for that person, as provided by United States Code, title 21, section 355, and the person is registered as a controlled substance researcher as required under section 152.12, subdivision 3, to the extent conduct with respect to the substance is pursuant to the exemption and registration; or

(4) marijuana or tetrahydrocannabinols naturally contained in a plant of the genus cannabis or in the resinous extractives of the plant.

EFFECTIVE DATE. This section is effective August 1, 2021, and applies to crimes committed on or after that date.

Sec. 68. Minnesota Statutes 2020, section 152.02, subdivision 2, is amended to read:

Subd. 2. **Schedule I.** (a) Schedule I consists of the substances listed in this subdivision.

(b) Opiates. Unless specifically excepted or unless listed in another schedule, any of the following substances, including their analogs, isomers, esters, ethers, salts, and salts of

(b) Priority for all grants shall be given to nurse-family partnership programs that provide services through a Minnesota health care program-enrolled provider that accepts medical assistance. Priority for grants to rural areas shall be given to community health boards, nonprofit organizations, and tribal nations that start up, expand, or sustain services within regional partnerships that provide the nurse-family partnership program.

(c) Funding available under this section may only be used to supplement, not to replace, funds being used for nurse-family partnership home visiting services as of June 30, 2015.

isomers, esters, and ethers, whenever the existence of the analogs, isomers, esters, ethers, and salts is possible:

(1) acetylmethadol;

(2) allylprodine;

(3) alphacetylmethadol (except levo-alphacetylmethadol, also known as levomethadyl acetate);

(4) alphameprodine;

(5) alphamethadol;

(6) alpha-methylfentanyl benzethidine;

(7) betacetylmethadol;

(8) betameprodine;

(9) betamethadol;

(10) betaprodine;

(11) clonitazene;

(12) dextromoramide;

(13) diampromide;

(14) diethyliambutene;

(15) difenoxin;

(16) dimenoxadol;

(17) dimepheptanol;

(18) dimethyliambutene;

(19) dioxaphetyl butyrate;

(20) dipipanone;

(21) ethylmethylthiambutene;

(22) etonitazene;

(23) etoxeridine;

(24) furethidine;

(25) hydroxypethidine;

(26) ketobemidone;

(27) levomoramide;

(28) levophenacylmorphan;

(29) 3-methylfentanyl;

(30) acetyl-alpha-methylfentanyl;

(31) alpha-methylthiofentanyl;

(32) benzylfentanyl beta-hydroxyfentanyl;

(33) beta-hydroxy-3-methylfentanyl;

(34) 3-methylthiofentanyl;

(35) thenylfentanyl;

(36) thiofentanyl;

(37) para-fluorofentanyl;

(38) morpheridine;

(39) 1-methyl-4-phenyl-4-propionoxypiperidine;

(40) noracymethadol;

(41) norlevorphanol;

(42) normethadone;

(43) norpipanone;

(44) 1-(2-phenylethyl)-4-phenyl-4-acetoxypiperidine (PEPAP);

(45) phenadoxone;

(46) phenampromide;

(47) phenomorphan;

(48) phenoperidine;

(49) piritramide;

(50) proheptazine;

(51) properidine;

(52) propiram;

(53) racemoramide;

(54) tilidine;

(55) trimeperidine;

(56) N-(1-Phenethylpiperidin-4-yl)-N-phenylacetamide (acetyl fentanyl);

(57) 3,4-dichloro-N-[(1R,2R)-2-(dimethylamino)cyclohexyl]-N-methylbenzamide(U47700);

(58) N-phenyl-N-[1-(2-phenylethyl)piperidin-4-yl]furan-2-carboxamide(furanylfentanyl);

(59) 4-(4-bromophenyl)-4-dimethylamino-1-phenethylcyclohexanol (bromadol);

(60) N-(1-phenethylpiperidin-4-yl)-N-phenylcyclopropanecarboxamide (Cyclopropryl fentanyl);

(61) N-(1-phenethylpiperidin-4-yl)-N-phenylbutanamide) (butyryl fentanyl);

(62) 1-cyclohexyl-4-(1,2-diphenylethyl)piperazine) (MT-45);

(63) N-(1-phenethylpiperidin-4-yl)-N-phenylcyclopentanecarboxamide (cyclopentyl fentanyl);

(64) N-(1-phenethylpiperidin-4-yl)-N-phenylisobutyramide (isobutyryl fentanyl);

(65) N-(1-phenethylpiperidin-4-yl)-N-phenylpentanamide (valeryl fentanyl);

(66) N-(4-chlorophenyl)-N-(1-phenethylpiperidin-4-yl)isobutyramide (para-chloroisobutyryl fentanyl);

(67) N-(4-fluorophenyl)-N-(1-phenethylpiperidin-4-yl)butyramide (para-fluorobutyryl fentanyl);

(68) N-(4-methoxyphenyl)-N-(1-phenethylpiperidin-4-yl)butyramide (para-methoxybutyryl fentanyl);

(69) N-(2-fluorophenyl)-2-methoxy-N-(1-phenethylpiperidin-4-yl)acetamide (ocfentanil);

(70) N-(4-fluorophenyl)-N-(1-phenethylpiperidin-4-yl)isobutyramide (4-fluoroisobutyryl fentanyl or para-fluoroisobutyryl fentanyl);

(71) N-(1-phenethylpiperidin-4-yl)-N-phenylacrylamide (acryl fentanyl or acryloylfentanyl);

(72) 2-methoxy-N-(1-phenethylpiperidin-4-yl)-N-phenylacetamide (methoxyacetyl fentanyl);

(73) N-(2-fluorophenyl)-N-(1-phenethylpiperidin-4-yl)propionamide (ortho-fluorofentanyl or 2-fluorofentanyl);

(74) N-(1-phenethylpiperidin-4-yl)-N-phenyltetrahydrofuran-2-carboxamide (tetrahydrofuranyl fentanyl); and

(75) Fentanyl-related substances, their isomers, esters, ethers, salts and salts of isomers, esters and ethers, meaning any substance not otherwise listed under another federal Administration Controlled Substance Code Number or not otherwise listed in this section, and for which no exemption or approval is in effect under section 505 of the Federal Food, Drug, and Cosmetic Act, United States Code , title 21, section 355, that is structurally related to fentanyl by one or more of the following modifications:

(i) replacement of the phenyl portion of the phenethyl group by any monocycle, whether or not further substituted in or on the monocycle;

(ii) substitution in or on the phenethyl group with alkyl, alkenyl, alkoxyl, hydroxyl, halo, haloalkyl, amino, or nitro groups;

(iii) substitution in or on the piperidine ring with alkyl, alkenyl, alkoxyl, ester, ether, hydroxyl, halo, haloalkyl, amino, or nitro groups;

(iv) replacement of the aniline ring with any aromatic monocycle whether or not further substituted in or on the aromatic monocycle; or

(v) replacement of the N-propionyl group by another acyl group.

(c) Opium derivatives. Any of the following substances, their analogs, salts, isomers, and salts of isomers, unless specifically excepted or unless listed in another schedule, whenever the existence of the analogs, salts, isomers, and salts of isomers is possible:

(1) acetorphine;

(2) acetyldihydrocodeine;

(3) benzylmorphine;

(4) codeine methylbromide;

(5) codeine-n-oxide;

(6) cyprenorphine;

(7) desomorphine;

(8) dihydromorphine;

(9) drotebanol;

(10) etorphine;

(11) heroin;

(12) hydromorphinol;

(13) methyldesorphine;

(14) methyldihydromorphine;

(15) morphine methylbromide;

(16) morphine methylsulfonate;

(17) morphine-n-oxide;

(18) myrophine;

(19) nicocodeine;

(20) nicomorphine;

(21) normorphine;

(22) pholcodine; and

(23) thebacon.

(d) Hallucinogens. Any material, compound, mixture or preparation which contains any quantity of the following substances, their analogs, salts, isomers (whether optical, positional, or geometric), and salts of isomers, unless specifically excepted or unless listed in another schedule, whenever the existence of the analogs, salts, isomers, and salts of isomers is possible:

(1) methylenedioxy amphetamine;

(2) methylenedioxymethamphetamine;

(3) methylenedioxy-N-ethylamphetamine (MDEA);

(4) n-hydroxy-methylenedioxyamphetamine;

(5) 4-bromo-2,5-dimethoxyamphetamine (DOB);

(6) 2,5-dimethoxyamphetamine (2,5-DMA);

(7) 4-methoxyamphetamine;

(8) 5-methoxy-3, 4-methylenedioxyamphetamine;

(9) alpha-ethyltryptamine;

(10) bufotenine;

(11) diethyltryptamine;

(12) dimethyltryptamine;

(13) 3,4,5-trimethoxyamphetamine;

(14) 4-methyl-2, 5-dimethoxyamphetamine (DOM);

(15) ibogaine;

(16) lysergic acid diethylamide (LSD);

(17) mescaline;

(18) parahexyl;

(19) N-ethyl-3-piperidyl benzilate;

(20) N-methyl-3-piperidyl benzilate;

(21) psilocybin;

(22) psilocyn;

(23) tenocyclidine (TPCP or TCP);

(24) N-ethyl-1-phenyl-cyclohexylamine (PCE);

(25) 1-(1-phenylcyclohexyl) pyrrolidine (PCPy);

(26) 1-[1-(2-thienyl)cyclohexyl]-pyrrolidine (TCPy);

(27) 4-chloro-2,5-dimethoxyamphetamine (DOC);

(28) 4-ethyl-2,5-dimethoxyamphetamine (DOET);

(29) 4-iodo-2,5-dimethoxyamphetamine (DOI);

(30) 4-bromo-2,5-dimethoxyphenethylamine (2C-B);

(31) 4-chloro-2,5-dimethoxyphenethylamine (2C-C);

(32) 4-methyl-2,5-dimethoxyphenethylamine (2C-D);

(33) 4-ethyl-2,5-dimethoxyphenethylamine (2C-E);

(34) 4-iodo-2,5-dimethoxyphenethylamine (2C-I);

(35) 4-propyl-2,5-dimethoxyphenethylamine (2C-P);

(36) 4-isopropylthio-2,5-dimethoxyphenethylamine (2C-T-4);

(37) 4-propylthio-2,5-dimethoxyphenethylamine (2C-T-7);

(38) 2-(8-bromo-2,3,6,7-tetrahydrofuro [2,3-f][1]benzofuran-4-yl)ethanamine (2-CB-FLY);

(39) bromo-benzodifuranyl-isopropylamine (Bromo-DragonFLY);

(40) alpha-methyltryptamine (AMT);

(41) N,N-diisopropyltryptamine (DiPT);

(42) 4-acetoxy-N,N-dimethyltryptamine (4-AcO-DMT);

(43) 4-acetoxy-N,N-diethyltryptamine (4-AcO-DET);

(44) 4-hydroxy-N-methyl-N-propyltryptamine (4-HO-MPT);

(45) 4-hydroxy-N,N-dipropyltryptamine (4-HO-DPT);

(46) 4-hydroxy-N,N-diallyltryptamine (4-HO-DALT);

(47) 4-hydroxy-N,N-diisopropyltryptamine (4-HO-DiPT);

(48) 5-methoxy-N,N-diisopropyltryptamine (5-MeO-DiPT);

(49) 5-methoxy-α-methyltryptamine (5-MeO-AMT);

(50) 5-methoxy-N,N-dimethyltryptamine (5-MeO-DMT);

(51) 5-methylthio-N,N-dimethyltryptamine (5-MeS-DMT);

(52) 5-methoxy-N-methyl-N-isopropyltryptamine (5-MeO-MiPT);

(53) 5-methoxy-α-ethyltryptamine (5-MeO-AET);

(54) 5-methoxy-N,N-dipropyltryptamine (5-MeO-DPT);

(55) 5-methoxy-N,N-diethyltryptamine (5-MeO-DET);

(56) 5-methoxy-N,N-diallyltryptamine (5-MeO-DALT);

(57) methoxetamine (MXE);

(58) 5-iodo-2-aminoindane (5-IAI);

(59) 5,6-methylenedioxy-2-aminoindane (MDAI);

(60) 2-(4-bromo-2,5-dimethoxyphenyl)-N-(2-methoxybenzyl)ethanamine (25B-NBOMe);

(61) 2-(4-chloro-2,5-dimethoxyphenyl)-N-(2-methoxybenzyl)ethanamine (25C-NBOMe);

(62) 2-(4-iodo-2,5-dimethoxyphenyl)-N-(2-methoxybenzyl)ethanamine (25I-NBOMe);

(63) 2-(2,5-Dimethoxyphenyl)ethanamine (2C-H);

(64) 2-(4-Ethylthio-2,5-dimethoxyphenyl)ethanamine (2C-T-2);

(65) N,N-Dipropyltryptamine (DPT);

(66) 3-[1-(Piperidin-1-yl)cyclohexyl]phenol (3-HO-PCP);

(67) N-ethyl-1-(3-methoxyphenyl)cyclohexanamine (3-MeO-PCE);

(68) 4-[1-(3-methoxyphenyl)cyclohexyl]morpholine (3-MeO-PCMo);

(69) 1-[1-(4-methoxyphenyl)cyclohexyl]-piperidine (methoxydine, 4-MeO-PCP);

(70) 2-(2-Chlorophenyl)-2-(ethylamino)cyclohexan-1-one (N-Ethylnorketamine, ethketamine, NENK);

(71) methylenedioxy-N,N-dimethylamphetamine (MDDMA);

(72) 3-(2-Ethyl(methyl)aminoethyl)-1H-indol-4-yl (4-AcO-MET); and

(73) 2-Phenyl-2-(methylamino)cyclohexanone (deschloroketamine).

(e) Peyote. All parts of the plant presently classified botanically as Lophophora williamsii Lemaire, whether growing or not, the seeds thereof, any extract from any part of the plant, and every compound, manufacture, salts, derivative, mixture, or preparation of the plant, its seeds or extracts. The listing of peyote as a controlled substance in Schedule I does not apply to the nondrug use of peyote in bona fide religious ceremonies of the American Indian Church, and members of the American Indian Church are exempt from registration. Any person who manufactures peyote for or distributes peyote to the American Indian Church, however, is required to obtain federal registration annually and to comply with all other requirements of law.

(f) Central nervous system depressants. Unless specifically excepted or unless listed in another schedule, any material compound, mixture, or preparation which contains any quantity of the following substances, their analogs, salts, isomers, and salts of isomers whenever the existence of the analogs, salts, isomers, and salts of isomers is possible:

(1) mecloqualone;

(2) methaqualone;

(3) gamma-hydroxybutyric acid (GHB), including its esters and ethers;

(4) flunitrazepam;

(5) 2-(2-Methoxyphenyl)-2-(methylamino)cyclohexanone (2-MeO-2-deschloroketamine, methoxyketamine);

(6) tianeptine;

(7) clonazolam;

(8) etizolam;

(9) flubromazolam; and

(10) flubromazepam.

(g) Stimulants. Unless specifically excepted or unless listed in another schedule, any material compound, mixture, or preparation which contains any quantity of the following substances, their analogs, salts, isomers, and salts of isomers whenever the existence of the analogs, salts, isomers, and salts of isomers is possible:

(1) aminorex;

(2) cathinone;

(3) fenethylline;

(4) methcathinone;

(5) methylaminorex;

(6) N,N-dimethylamphetamine;

(7) N-benzylpiperazine (BZP);

(8) methylmethcathinone (mephedrone);

(9) 3,4-methylenedioxy-N-methylcathinone (methylone);

(10) methoxymethcathinone (methedrone);

(11) methylenedioxypyrovalerone (MDPV);

(12) 3-fluoro-N-methylcathinone (3-FMC);

(13) methylethcathinone (MEC);

(14) 1-benzofuran-6-ylpropan-2-amine (6-APB);

(15) dimethylmethcathinone (DMMC);

(16) fluoroamphetamine;

(17) fluoromethamphetamine;

(18) α-methylaminobutyrophenone (MABP or buphedrone);

(19) 1-(1,3-benzodioxol-5-yl)-2-(methylamino)butan-1-one (butylone);

(20) 2-(methylamino)-1-(4-methylphenyl)butan-1-one (4-MEMABP or BZ-6378);

(21) 1-(naphthalen-2-yl)-2-(pyrrolidin-1-yl) pentan-1-one (naphthylpyrovalerone or naphyrone);

(22) (alpha-pyrrolidinopentiophenone (alpha-PVP);

(23) (RS)-1-(4-methylphenyl)-2-(1-pyrrolidinyl)-1-hexanone (4-Me-PHP or MPHP);

(24) 2-(1-pyrrolidinyl)-hexanophenone (Alpha-PHP);

(25) 4-methyl-N-ethylcathinone (4-MEC);

(26) 4-methyl-alpha-pyrrolidinopropiophenone (4-MePPP);

(27) 2-(methylamino)-1-phenylpentan-1-one (pentedrone);

(28) 1-(1,3-benzodioxol-5-yl)-2-(methylamino)pentan-1-one (pentylone);

(29) 4-fluoro-N-methylcathinone (4-FMC);

(30) 3,4-methylenedioxy-N-ethylcathinone (ethylone);

(31) alpha-pyrrolidinobutiophenone (α-PBP);

(32) 5-(2-Aminopropyl)-2,3-dihydrobenzofuran (5-APDB);

(33) 1-phenyl-2-(1-pyrrolidinyl)-1-heptanone (PV8);

(34) 6-(2-Aminopropyl)-2,3-dihydrobenzofuran (6-APDB);

(35) 4-methyl-alpha-ethylaminopentiophenone (4-MEAPP);

(36) 4'-chloro-alpha-pyrrolidinopropiophenone (4'-chloro-PPP);

(37) 1-(1,3-Benzodioxol-5-yl)-2-(dimethylamino)butan-1-one (dibutylone, bk-DMBDB);

(38) 1-(3-chlorophenyl) piperazine (meta-chlorophenylpiperazine or mCPP);

(39) 1-(1,3-benzodioxol-5-yl)-2-(ethylamino)-pentan-1-one (N-ethylpentylone, ephylone); and

(40) any other substance, except bupropion or compounds listed under a different schedule, that is structurally derived from 2-aminopropan-1-one by substitution at the 1-position with either phenyl, naphthyl, or thiophene ring systems, whether or not the compound is further modified in any of the following ways:

(i) by substitution in the ring system to any extent with alkyl, alkylenedioxy, alkoxy, haloalkyl, hydroxyl, or halide substituents, whether or not further substituted in the ring system by one or more other univalent substituents;

(ii) by substitution at the 3-position with an acyclic alkyl substituent;

(iii) by substitution at the 2-amino nitrogen atom with alkyl, dialkyl, benzyl, or methoxybenzyl groups; or

(iv) by inclusion of the 2-amino nitrogen atom in a cyclic structure.

(h) ~~Marijuana,~~ Synthetic tetrahydrocannabinols~~,~~ and synthetic cannabinoids. Unless specifically excepted or unless listed in another schedule, any ~~natural or~~ synthetic material, compound, mixture, or preparation that contains any quantity of the following substances, their analogs, isomers, esters, ethers, salts, and salts of isomers, esters, and ethers, whenever the existence of the isomers, esters, ethers, or salts is possible:

~~(1) marijuana;~~

~~(2)~~ (1) synthetic tetrahydrocannabinols ~~naturally contained in a plant of the genus Cannabis,~~ that are the synthetic equivalents of the substances contained in the cannabis plant or in the resinous extractives of the plant, or synthetic substances with similar chemical structure and pharmacological activity to those substances contained in the plant or resinous

extract, including, but not limited to, 1 cis or trans tetrahydrocannabinol, 6 cis or trans tetrahydrocannabinol, and 3,4 cis or trans tetrahydrocannabinol;

~~(3)~~ (2) synthetic cannabinoids, including the following substances:

(i) Naphthoylindoles, which are any compounds containing a 3-(1-napthoyl)indole structure with substitution at the nitrogen atom of the indole ring by an alkyl, haloalkyl, alkenyl, cycloalkylmethyl, cycloalkylethyl, 1-(N-methyl-2-piperidinyl)methyl or 2-(4-morpholinyl)ethyl group, whether or not further substituted in the indole ring to any extent and whether or not substituted in the naphthyl ring to any extent. Examples of naphthoylindoles include, but are not limited to:

(A) 1-Pentyl-3-(1-naphthoyl)indole (JWH-018 and AM-678);

(B) 1-Butyl-3-(1-naphthoyl)indole (JWH-073);

(C) 1-Pentyl-3-(4-methoxy-1-naphthoyl)indole (JWH-081);

(D) 1-[2-(4-morpholinyl)ethyl]-3-(1-naphthoyl)indole (JWH-200);

(E) 1-Propyl-2-methyl-3-(1-naphthoyl)indole (JWH-015);

(F) 1-Hexyl-3-(1-naphthoyl)indole (JWH-019);

(G) 1-Pentyl-3-(4-methyl-1-naphthoyl)indole (JWH-122);

(H) 1-Pentyl-3-(4-ethyl-1-naphthoyl)indole (JWH-210);

(I) 1-Pentyl-3-(4-chloro-1-naphthoyl)indole (JWH-398);

(J) 1-(5-fluoropentyl)-3-(1-naphthoyl)indole (AM-2201).

(ii) Napthylmethylindoles, which are any compounds containing a 1H-indol-3-yl-(1-naphthyl)methane structure with substitution at the nitrogen atom of the indole ring by an alkyl, haloalkyl, alkenyl, cycloalkylmethyl, cycloalkylethyl, 1-(N-methyl-2-piperidinyl)methyl or 2-(4-morpholinyl)ethyl group, whether or not further substituted in the indole ring to any extent and whether or not substituted in the naphthyl ring to any extent. Examples of naphthylmethylindoles include, but are not limited to:

(A) 1-Pentyl-1H-indol-3-yl-(1-naphthyl)methane (JWH-175);

(B) 1-Pentyl-1H-indol-3-yl-(4-methyl-1-naphthyl)methane (JWH-184).

(iii) Naphthoylpyrroles, which are any compounds containing a 3-(1-naphthoyl)pyrrole structure with substitution at the nitrogen atom of the pyrrole ring by an alkyl, haloalkyl, alkenyl, cycloalkylmethyl, cycloalkylethyl, 1-(N-methyl-2-piperidinyl)methyl or 2-(4-morpholinyl)ethyl group whether or not further substituted in the pyrrole ring to any extent, whether or not substituted in the naphthyl ring to any extent. Examples of naphthoylpyrroles include, but are not limited to, (5-(2-fluorophenyl)-1-pentylpyrrol-3-yl)-naphthalen-1-ylmethanone (JWH-307).

(iv) Naphthylmethylindenes, which are any compounds containing a naphthylideneindene structure with substitution at the 3-position of the indene ring by an alkyl, haloalkyl, alkenyl, cycloalkylmethyl, cycloalkylethyl, 1-(N-methyl-2-piperidinyl)methyl or 2-(4-morpholinyl)ethyl group whether or not further substituted in the indene ring to any extent, whether or not substituted in the naphthyl ring to any extent. Examples of naphthylemethylindenes include, but are not limited to, E-1-[1-(1-naphthalenylmethylene)-1H-inden-3-yl]pentane (JWH-176).

(v) Phenylacetylindoles, which are any compounds containing a 3-phenylacetylindole structure with substitution at the nitrogen atom of the indole ring by an alkyl, haloalkyl, alkenyl, cycloalkylmethyl, cycloalkylethyl, 1-(N-methyl-2-piperidinyl)methyl or 2-(4-morpholinyl)ethyl group whether or not further substituted in the indole ring to any extent, whether or not substituted in the phenyl ring to any extent. Examples of phenylacetylindoles include, but are not limited to:

(A) 1-(2-cyclohexylethyl)-3-(2-methoxyphenylacetyl)indole (RCS-8);

(B) 1-pentyl-3-(2-methoxyphenylacetyl)indole (JWH-250);

(C) 1-pentyl-3-(2-methylphenylacetyl)indole (JWH-251);

(D) 1-pentyl-3-(2-chlorophenylacetyl)indole (JWH-203).

(vi) Cyclohexylphenols, which are compounds containing a 2-(3-hydroxycyclohexyl)phenol structure with substitution at the 5-position of the phenolic ring by an alkyl, haloalkyl, alkenyl, cycloalkylmethyl, cycloalkylethyl, 1-(N-methyl-2-piperidinyl)methyl or 2-(4-morpholinyl)ethyl group whether or not substituted in the cyclohexyl ring to any extent. Examples of cyclohexylphenols include, but are not limited to:

(A) 5-(1,1-dimethylheptyl)-2-[(1R,3S)-3-hydroxycyclohexyl]-phenol (CP 47,497);

(B) 5-(1,1-dimethyloctyl)-2-[(1R,3S)-3-hydroxycyclohexyl]-phenol (Cannabicyclohexanol or CP 47,497 C8 homologue);

(C) 5-(1,1-dimethylheptyl)-2-[(1R,2R)-5-hydroxy-2-(3-hydroxypropyl)cyclohexyl] -phenol (CP 55,940).

(vii) Benzoylindoles, which are any compounds containing a 3-(benzoyl)indole structure with substitution at the nitrogen atom of the indole ring by an alkyl, haloalkyl, alkenyl, cycloalkylmethyl, cycloalkylethyl, 1-(N-methyl-2-piperidinyl)methyl or 2-(4-morpholinyl)ethyl group whether or not further substituted in the indole ring to any extent and whether or not substituted in the phenyl ring to any extent. Examples of benzoylindoles include, but are not limited to:

(A) 1-Pentyl-3-(4-methoxybenzoyl)indole (RCS-4);

(B) 1-(5-fluoropentyl)-3-(2-iodobenzoyl)indole (AM-694);

(C) (4-methoxyphenyl-[2-methyl-1-(2-(4-morpholinyl)ethyl)indol-3-yl]methanone (WIN 48,098 or Pravadoline).

(viii) Others specifically named:

(A) (6aR,10aR)-9-(hydroxymethyl)-6,6-dimethyl-3-(2-methyloctan-2-yl) -6a,7,10,10a-tetrahydrobenzo[c]chromen-1-ol (HU-210);

(B) (6aS,10aS)-9-(hydroxymethyl)-6,6-dimethyl-3-(2-methyloctan-2-yl) -6a,7,10,10a-tetrahydrobenzo[c]chromen-1-ol (Dexanabinol or HU-211);

(C) 2,3-dihydro-5-methyl-3-(4-morpholinylmethyl)pyrrolo[1,2,3-de] -1,4-benzoxazin-6-yl-1-naphthalenylmethanone (WIN 55,212-2);

(D) (1-pentylindol-3-yl)-(2,2,3,3-tetramethylcyclopropyl)methanone (UR-144);

(E) (1-(5-fluoropentyl)-1H-indol-3-yl)(2,2,3,3-tetramethylcyclopropyl)methanone (XLR-11);

(F) 1-pentyl-N-tricyclo[3.3.1.13,7]dec-1-yl-1H-indazole-3-carboxamide (AKB-48(APINACA));

(G) N-((3s,5s,7s)-adamantan-1-yl)-1-(5-fluoropentyl)-1H-indazole-3-carboxamide (5-Fluoro-AKB-48);

(H) 1-pentyl-8-quinolinyl ester-1H-indole-3-carboxylic acid (PB-22);

(I) 8-quinolinyl ester-1-(5-fluoropentyl)-1H-indole-3-carboxylic acid (5-Fluoro PB-22);

(J) N-[(1S)-1-(aminocarbonyl)-2-methylpropyl]-1-pentyl-1H-indazole- 3-carboxamide (AB-PINACA);

(K) N-[(1S)-1-(aminocarbonyl)-2-methylpropyl]-1-[(4-fluorophenyl)methyl]- 1H-indazole-3-carboxamide (AB-FUBINACA);

(L) N-[(1S)-1-(aminocarbonyl)-2-methylpropyl]-1-(cyclohexylmethyl)-1H- indazole-3-carboxamide(AB-CHMINACA);

(M) (S)-methyl 2-(1-(5-fluoropentyl)-1H-indazole-3-carboxamido)-3- methylbutanoate (5-fluoro-AMB);

(N) [1-(5-fluoropentyl)-1H-indazol-3-yl](naphthalen-1-yl) methanone (THJ-2201);

(O) (1-(5-fluoropentyl)-1H-benzo[d]imidazol-2-yl)(naphthalen-1-yl)methanone) (FUBIMINA);

(P) (7-methoxy-1-(2-morpholinoethyl)-N-((1S,2S,4R)-1,3,3-trimethylbicyclo [2.2.1]heptan-2-yl)-1H-indole-3-carboxamide (MN-25 or UR-12);

(Q) (S)-N-(1-amino-3-methyl-1-oxobutan-2-yl)-1-(5-fluoropentyl) -1H-indole-3-carboxamide (5-fluoro-ABICA);

(R) N-(1-amino-3-phenyl-1-oxopropan-2-yl)-1-(5-fluoropentyl) -1H-indole-3-carboxamide;

(S) N-(1-amino-3-phenyl-1-oxopropan-2-yl)-1-(5-fluoropentyl) -1H-indazole-3-carboxamide;

(T) methyl 2-(1-(cyclohexylmethyl)-1H-indole-3-carboxamido) -3,3-dimethylbutanoate;

(U) N-(1-amino-3,3-dimethyl-1-oxobutan-2-yl)-1(cyclohexylmethyl)-1 H-indazole-3-carboxamide (MAB-CHMINACA);

(V) N-(1-Amino-3,3-dimethyl-1-oxo-2-butanyl)-1-pentyl-1H-indazole-3-carboxamide (ADB-PINACA);

(W) methyl (1-(4-fluorobenzyl)-1H-indazole-3-carbonyl)-L-valinate (FUB-AMB);

(X) N-[(1S)-2-amino-2-oxo-1-(phenylmethyl)ethyl]-1-(cyclohexylmethyl)-1H-Indazole-3-carboxamide. (APP-CHMINACA);

(Y) quinolin-8-yl 1-(4-fluorobenzyl)-1H-indole-3-carboxylate (FUB-PB-22); and

(Z) methyl N-[1-(cyclohexylmethyl)-1H-indole-3-carbonyl]valinate (MMB-CHMICA).

(ix) Additional substances specifically named:

(A) 1-(5-fluoropentyl)-N-(2-phenylpropan-2-yl)-1 H-pyrrolo[2,3-B]pyridine-3-carboxamide (5F-CUMYL-P7AICA);

(B) 1-(4-cyanobutyl)-N-(2- phenylpropan-2-yl)-1 H-indazole-3-carboxamide (4-CN-Cumyl-Butinaca);

(C) naphthalen-1-yl-1-(5-fluoropentyl)-1-H-indole-3-carboxylate (NM2201; CBL2201);

(D) N-(1-amino-3-methyl-1-oxobutan-2-yl)-1-(5-fluoropentyl)-1 H-indazole-3-carboxamide (5F-ABPINACA);

(E) methyl-2-(1-(cyclohexylmethyl)-1H-indole-3-carboxamido)-3,3-dimethylbutanoate (MDMB CHMICA);

(F) methyl 2-(1-(5-fluoropentyl)-1H-indazole-3-carboxamido)-3,3-dimethylbutanoate (5F-ADB; 5F-MDMB-PINACA); and

(G) N-(1-amino-3,3-dimethyl-1-oxobutan-2-yl)-1-(4-fluorobenzyl) 1H-indazole-3-carboxamide (ADB-FUBINACA).

(i) A controlled substance analog, to the extent that it is implicitly or explicitly intended for human consumption.

EFFECTIVE DATE. This section is effective August 1, 2021, and applies to crimes committed on or after that date.

Sec. 69. Minnesota Statutes 2020, section 152.02, subdivision 3, is amended to read:

Subd. 3. **Schedule II.** (a) Schedule II consists of the substances listed in this subdivision.

(b) Unless specifically excepted or unless listed in another schedule, any of the following substances whether produced directly or indirectly by extraction from substances of vegetable origin or independently by means of chemical synthesis, or by a combination of extraction and chemical synthesis:

(1) Opium and opiate, and any salt, compound, derivative, or preparation of opium or opiate.

(i) Excluding:

(A) apomorphine;

(B) thebaine-derived butorphanol;

(C) dextrophan;

(D) nalbuphine;

(E) nalmefene;

(F) naloxegol;

(G) naloxone;

(H) naltrexone; and

(I) their respective salts;

(ii) but including the following:

(A) opium, in all forms and extracts;

(B) codeine;

(C) dihydroetorphine;

(D) ethylmorphine;

(E) etorphine hydrochloride;

(F) hydrocodone;

(G) hydromorphone;

(H) metopon;

(I) morphine;

(J) oxycodone;

(K) oxymorphone;

(L) thebaine;

(M) oripavine;

(2) any salt, compound, derivative, or preparation thereof which is chemically equivalent or identical with any of the substances referred to in clause (1), except that these substances shall not include the isoquinoline alkaloids of opium;

(3) opium poppy and poppy straw;

(4) coca leaves and any salt, cocaine compound, derivative, or preparation of coca leaves (including cocaine and ecgonine and their salts, isomers, derivatives, and salts of isomers and derivatives), and any salt, compound, derivative, or preparation thereof which is chemically equivalent or identical with any of these substances, except that the substances shall not include decocainized coca leaves or extraction of coca leaves, which extractions do not contain cocaine or ecgonine;

(5) concentrate of poppy straw (the crude extract of poppy straw in either liquid, solid, or powder form which contains the phenanthrene alkaloids of the opium poppy).

(c) Any of the following opiates, including their isomers, esters, ethers, salts, and salts of isomers, esters and ethers, unless specifically excepted, or unless listed in another schedule, whenever the existence of such isomers, esters, ethers and salts is possible within the specific chemical designation:

(1) alfentanil;

(2) alphaprodine;

(3) anileridine;

(4) bezitramide;

(5) bulk dextropropoxyphene (nondosage forms);

(6) carfentanil;

(7) dihydrocodeine;

(8) dihydromorphinone;

(9) diphenoxylate;

(10) fentanyl;

(11) isomethadone;

(12) levo-alpha-acetylmethadol (LAAM);

(13) levomethorphan;

(14) levorphanol;

(15) metazocine;

(16) methadone;

(17) methadone - intermediate, 4-cyano-2-dimethylamino-4, 4-diphenylbutane;

(18) moramide - intermediate, 2-methyl-3-morpholino-1, 1-diphenyl-propane-carboxylic acid;

(19) pethidine;

(20) pethidine - intermediate - a, 4-cyano-1-methyl-4-phenylpiperidine;

(21) pethidine - intermediate - b, ethyl-4-phenylpiperidine-4-carboxylate;

(22) pethidine - intermediate - c, 1-methyl-4-phenylpiperidine-4-carboxylic acid;

(23) phenazocine;

(24) piminodine;

(25) racemethorphan;

(26) racemorphan;

(27) remifentanil;

(28) sufentanil;

(29) tapentadol;

(30) 4-Anilino-N-phenethylpiperidine.

(d) Unless specifically excepted or unless listed in another schedule, any material, compound, mixture, or preparation which contains any quantity of the following substances having a stimulant effect on the central nervous system:

(1) amphetamine, its salts, optical isomers, and salts of its optical isomers;

(2) methamphetamine, its salts, isomers, and salts of its isomers;

(3) phenmetrazine and its salts;

(4) methylphenidate;

(5) lisdexamfetamine.

(e) Unless specifically excepted or unless listed in another schedule, any material, compound, mixture, or preparation which contains any quantity of the following substances having a depressant effect on the central nervous system, including its salts, isomers, and

salts of isomers whenever the existence of such salts, isomers, and salts of isomers is possible within the specific chemical designation:

(1) amobarbital;

(2) glutethimide;

(3) secobarbital;

(4) pentobarbital;

(5) phencyclidine;

(6) phencyclidine immediate precursors:

(i) 1-phenylcyclohexylamine;

(ii) 1-piperidinocyclohexanecarbonitrile;

(7) phenylacetone.

(f) Cannabis and cannabinoids:

(1) nabilone;

(2) unless specifically excepted or unless listed in another schedule, any natural material, compound, mixture, or preparation that contains any quantity of the following substances, their analogs, isomers, esters, ethers, salts, and salts of isomers, esters, and ethers, whenever the existence of the isomers, esters, ethers, or salts is possible:

(i) marijuana; and

(ii) tetrahydrocannabinols naturally contained in a plant of the genus cannabis or in the resinous extractives of the plant; and

~~(2)~~ (3) dronabinol [(-)-delta-9-trans-tetrahydrocannabinol (delta-9-THC)] in an oral solution in a drug product approved for marketing by the United States Food and Drug Administration.

EFFECTIVE DATE. This section is effective August 1, 2021, and applies to crimes committed on or after that date.

Sec. 70. Minnesota Statutes 2020, section 152.11, subdivision 1a, is amended to read:

Subd. 1a. **Prescription requirements for Schedule II controlled substances.** Except as allowed under section 152.29, no person may dispense a controlled substance included in Schedule II of section 152.02 without a prescription issued by a doctor of medicine, a doctor of osteopathic medicine licensed to practice medicine, a doctor of dental surgery, a doctor of dental medicine, a doctor of podiatry, or a doctor of veterinary medicine, lawfully licensed to prescribe in this state or by a practitioner licensed to prescribe controlled substances by the state in which the prescription is issued, and having a current federal Drug

Enforcement Administration registration number. The prescription must either be printed or written in ink and contain the handwritten signature of the prescriber or be transmitted electronically or by facsimile as permitted under subdivision 1. Provided that in emergency situations, as authorized by federal law, such drug may be dispensed upon oral prescription reduced promptly to writing and filed by the pharmacist. Such prescriptions shall be retained in conformity with section 152.101. No prescription for a Schedule II substance may be refilled.

Sec. 71. Minnesota Statutes 2020, section 152.11, is amended by adding a subdivision to read:

Subd. 5. **Exception.** References in this section to Schedule II controlled substances do not extend to marijuana or tetrahydrocannabinols.

Sec. 72. Minnesota Statutes 2020, section 152.12, is amended by adding a subdivision to read:

Subd. 6. **Exception.** References in this section to Schedule II controlled substances do not extend to marijuana or tetrahydrocannabinols.

Sec. 73. Minnesota Statutes 2020, section 152.125, subdivision 3, is amended to read:

Subd. 3. **Limits on applicability.** This section does not apply to:

(1) a physician's treatment of an individual for chemical dependency resulting from the use of controlled substances in Schedules II to V of section 152.02;

(2) the prescription or administration of controlled substances in Schedules II to V of section 152.02 to an individual whom the physician knows to be using the controlled substances for nontherapeutic purposes;

(3) the prescription or administration of controlled substances in Schedules II to V of section 152.02 for the purpose of terminating the life of an individual having intractable pain; ~~or~~

(4) the prescription or administration of a controlled substance in Schedules II to V of section 152.02 that is not a controlled substance approved by the United States Food and Drug Administration for pain relief; or

(5) the administration of medical cannabis under sections 152.22 to 152.37.

Sec. 74. Minnesota Statutes 2020, section 152.22, is amended by adding a subdivision to read:

Subd. 5c. **Hemp processor.** "Hemp processor" means a person or business licensed by the commissioner of agriculture under chapter 18K to convert raw hemp into a product.

Sec. 75. Minnesota Statutes 2020, section 152.22, subdivision 6, is amended to read:

Subd. 6. **Medical cannabis.** (a) "Medical cannabis" means any species of the genus cannabis plant, or any mixture or preparation of them, including whole plant extracts and resins, and is delivered in the form of:

(1) liquid, including, but not limited to, oil;

(2) pill;

(3) vaporized delivery method with use of liquid or oil ~~but which does not require the use of dried leaves or plant form; or~~;

(4) combustion with use of dried raw cannabis; or

~~(4)~~ (5) any other method~~, excluding smoking,~~ approved by the commissioner.

(b) This definition includes any part of the genus cannabis plant prior to being processed into a form allowed under paragraph (a), that is possessed by a person while that person is engaged in employment duties necessary to carry out a requirement under sections 152.22 to 152.37 for a registered manufacturer or a laboratory under contract with a registered manufacturer. This definition also includes any hemp acquired by a manufacturer by a hemp grower as permitted under section 152.29, subdivision 1, paragraph (b).

EFFECTIVE DATE. This section is effective the earlier of (1) March 1, 2022, or (2) a date, as determined by the commissioner of health, by which (i) the rules adopted or amended under Minnesota Statutes, section 152.26, paragraph (b), are in effect and (ii) the independent laboratories under contract with the manufacturers have the necessary procedures and equipment in place to perform the required testing of dried raw cannabis. If this section is effective before March 1, 2022, the commissioner shall provide notice of that effective date to the public.

Sec. 76. Minnesota Statutes 2020, section 152.22, subdivision 11, is amended to read:

Subd. 11. **Registered designated caregiver.** "Registered designated caregiver" means a person who:

(1) is at least 18 years old;

(2) does not have a conviction for a disqualifying felony offense;

(3) has been approved by the commissioner to assist a patient who ~~has been identified by a health care practitioner as developmentally or physically disabled and therefore~~ requires assistance in administering medical cannabis or obtaining medical cannabis from a distribution facility ~~due to the disability~~; and

(4) is authorized by the commissioner to assist the patient with the use of medical cannabis.

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

Subd. 13a. **Tribal medical cannabis program.** "Tribal medical cannabis program" means a medical cannabis program operated by a federally recognized Indian Tribe located within the state that has been recognized by the commissioner of health in accordance with section 152.25, subdivision 5.

Sec. 78. Minnesota Statutes 2020, section 152.23, is amended to read:

152.23 LIMITATIONS.

(a) Nothing in sections 152.22 to 152.37 permits any person to engage in and does not prevent the imposition of any civil, criminal, or other penalties for:

(1) undertaking any task under the influence of medical cannabis that would constitute negligence or professional malpractice;

(2) possessing or engaging in the use of medical cannabis:

(i) on a school bus or van;

(ii) on the grounds of any preschool or primary or secondary school;

(iii) in any correctional facility; or

(iv) on the grounds of any child care facility or home day care;

(3) vaporizing or combusting medical cannabis pursuant to section 152.22, subdivision 6:

(i) on any form of public transportation;

(ii) where the vapor would be inhaled by a nonpatient minor child or where the smoke would be inhaled by a minor child; or

(iii) in any public place, including any indoor or outdoor area used by or open to the general public or a place of employment as defined under section 144.413, subdivision 1b; and

(4) operating, navigating, or being in actual physical control of any motor vehicle, aircraft, train, or motorboat, or working on transportation property, equipment, or facilities while under the influence of medical cannabis.

(b) Nothing in sections 152.22 to 152.37 require the medical assistance and MinnesotaCare programs to reimburse an enrollee or a provider for costs associated with the medical use of cannabis. Medical assistance and MinnesotaCare shall continue to provide coverage for all services related to treatment of an enrollee's qualifying medical condition if the service is covered under chapter 256B or 256L.

Sec. 79. Minnesota Statutes 2020, section 152.25, is amended by adding a subdivision to read:

Subd. 5. **Tribal medical cannabis programs.** Upon the request of an Indian Tribe operating a Tribal medical cannabis program, the commissioner shall determine if the standards for the Tribal medical cannabis program meet or exceed the standards required under sections 152.22 to 152.37 in terms of qualifying for the medical cannabis program, allowable forms of medical cannabis, production and distribution requirements, product safety and testing, and security measures. If the commissioner determines that the Tribal medical cannabis program meets or exceeds the standards in sections 152.22 to 152.37, the commissioner shall recognize the Tribal medical cannabis program and shall post the Tribal medical cannabis programs that have been recognized by the commissioner on the Department of Health's website.

Sec. 80. Minnesota Statutes 2020, section 152.26, is amended to read:

152.26 RULEMAKING.

(a) The commissioner may adopt rules to implement sections 152.22 to 152.37. Rules for which notice is published in the State Register before January 1, 2015, may be adopted using the process in section 14.389.

(b) The commissioner may adopt or amend rules, using the procedure in section 14.386, paragraph (a), to implement the addition of dried raw cannabis as an allowable form of medical cannabis under section 152.22, subdivision 6, paragraph (a), clause (4). Section 14.386, paragraph (b), does not apply to these rules.

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

Sec. 81. Minnesota Statutes 2020, section 152.27, subdivision 3, is amended to read:

Subd. 3. **Patient application.** (a) The commissioner shall develop a patient application for enrollment into the registry program. The application shall be available to the patient and given to health care practitioners in the state who are eligible to serve as health care practitioners. The application must include:

(1) the name, mailing address, and date of birth of the patient;

(2) the name, mailing address, and telephone number of the patient's health care practitioner;

(3) the name, mailing address, and date of birth of the patient's designated caregiver, if any, or the patient's parent, legal guardian, or spouse if the parent, legal guardian, or spouse will be acting as a caregiver;

(4) a copy of the certification from the patient's health care practitioner that is dated within 90 days prior to submitting the application ~~which~~ that certifies that the patient has been diagnosed with a qualifying medical condition ~~and, if applicable, that, in the health~~

~~care practitioner's medical opinion, the patient is developmentally or physically disabled and, as a result of that disability, the patient requires assistance in administering medical cannabis or obtaining medical cannabis from a distribution facility~~; and

(5) all other signed affidavits and enrollment forms required by the commissioner under sections 152.22 to 152.37, including, but not limited to, the disclosure form required under paragraph (c).

(b) The commissioner shall require a patient to resubmit a copy of the certification from the patient's health care practitioner on a yearly basis and shall require that the recertification be dated within 90 days of submission.

(c) The commissioner shall develop a disclosure form and require, as a condition of enrollment, all patients to sign a copy of the disclosure. The disclosure must include:

(1) a statement that, notwithstanding any law to the contrary, the commissioner, or an employee of any state agency, may not be held civilly or criminally liable for any injury, loss of property, personal injury, or death caused by any act or omission while acting within the scope of office or employment under sections 152.22 to 152.37; and

(2) the patient's acknowledgment that enrollment in the patient registry program is conditional on the patient's agreement to meet all of the requirements of sections 152.22 to 152.37.

Sec. 82. Minnesota Statutes 2020, section 152.27, subdivision 4, is amended to read:

Subd. 4. **Registered designated caregiver.** (a) The commissioner shall register a designated caregiver for a patient if ~~the patient's health care practitioner has certified that the patient, in the health care practitioner's medical opinion, is developmentally or physically disabled and, as a result of that disability,~~ the patient requires assistance in administering medical cannabis or obtaining medical cannabis from a distribution facility and the caregiver has agreed, in writing, to be the patient's designated caregiver. As a condition of registration as a designated caregiver, the commissioner shall require the person to:

(1) be at least 18 years of age;

(2) agree to only possess the patient's medical cannabis for purposes of assisting the patient; and

(3) agree that if the application is approved, the person will not be a registered designated caregiver for more than ~~one patient, unless the~~ six registered patients at one time. Patients who reside in the same residence shall count as one patient.

(b) The commissioner shall conduct a criminal background check on the designated caregiver prior to registration to ensure that the person does not have a conviction for a disqualifying felony offense. Any cost of the background check shall be paid by the person seeking registration as a designated caregiver. A designated caregiver must have the criminal background check renewed every two years.

(c) Nothing in sections 152.22 to 152.37 shall be construed to prevent a person registered as a designated caregiver from also being enrolled in the registry program as a patient and possessing and using medical cannabis as a patient.

Sec. 83. Minnesota Statutes 2020, section 152.27, subdivision 6, is amended to read:

Subd. 6. **Patient enrollment.** (a) After receipt of a patient's application, application fees, and signed disclosure, the commissioner shall enroll the patient in the registry program and issue the patient and patient's registered designated caregiver or parent, legal guardian, or spouse, if applicable, a registry verification. The commissioner shall approve or deny a patient's application for participation in the registry program within 30 days after the commissioner receives the patient's application and application fee. ~~The commissioner may approve applications up to 60 days after the receipt of a patient's application and application fees until January 1, 2016.~~ A patient's enrollment in the registry program shall only be denied if the patient:

(1) does not have certification from a health care practitioner that the patient has been diagnosed with a qualifying medical condition;

(2) has not signed and returned the disclosure form required under subdivision 3, paragraph (c), to the commissioner;

(3) does not provide the information required; or

~~(4) has previously been removed from the registry program for violations of section 152.30 or 152.33; or~~

~~(5)~~ (4) provides false information.

(b) The commissioner shall give written notice to a patient of the reason for denying enrollment in the registry program.

(c) Denial of enrollment into the registry program is considered a final decision of the commissioner and is subject to judicial review under the Administrative Procedure Act pursuant to chapter 14.

(d) A patient's enrollment in the registry program may only be revoked upon the death of the patient or if a patient violates a requirement under section 152.30 or 152.33. If a patient's enrollment in the registry program has been revoked due to a violation of section 152.30 or 152.33, the patient may reapply for enrollment 12 months from the date the patient's enrollment was revoked. The commissioner shall process the application in accordance with this section.

(e) The commissioner shall develop a registry verification to provide to the patient, the health care practitioner identified in the patient's application, and to the manufacturer. The registry verification shall include:

(1) the patient's name and date of birth;

(2) the patient registry number assigned to the patient; and

(3) the name and date of birth of the patient's registered designated caregiver, if any, or the name of the patient's parent, legal guardian, or spouse if the parent, legal guardian, or spouse will be acting as a caregiver.

(f) The commissioner shall not deny a patient's application for participation in the registry program or revoke a patient's enrollment in the registry program solely because the patient is also enrolled in a Tribal medical cannabis program.

Sec. 84. Minnesota Statutes 2020, section 152.28, subdivision 1, is amended to read:

Subdivision 1. **Health care practitioner duties.** (a) Prior to a patient's enrollment in the registry program, a health care practitioner shall:

(1) determine, in the health care practitioner's medical judgment, whether a patient suffers from a qualifying medical condition, and, if so determined, provide the patient with a certification of that diagnosis;

(2) ~~determine whether a patient is developmentally or physically disabled and, as a result of that disability, the patient requires assistance in administering medical cannabis or obtaining medical cannabis from a distribution facility, and, if so determined, include that determination on the patient's certification of diagnosis;~~

~~(3)~~ advise patients, registered designated caregivers, and parents, legal guardians, or spouses who are acting as caregivers of the existence of any nonprofit patient support groups or organizations;

~~(4)~~ (3) provide explanatory information from the commissioner to patients with qualifying medical conditions, including disclosure to all patients about the experimental nature of therapeutic use of medical cannabis; the possible risks, benefits, and side effects of the proposed treatment; the application and other materials from the commissioner; and provide patients with the Tennessen warning as required by section 13.04, subdivision 2; and

~~(5)~~ (4) agree to continue treatment of the patient's qualifying medical condition and report medical findings to the commissioner.

(b) Upon notification from the commissioner of the patient's enrollment in the registry program, the health care practitioner shall:

(1) participate in the patient registry reporting system under the guidance and supervision of the commissioner;

(2) report health records of the patient throughout the ongoing treatment of the patient to the commissioner in a manner determined by the commissioner and in accordance with subdivision 2;

(3) determine, on a yearly basis, if the patient continues to suffer from a qualifying medical condition and, if so, issue the patient a new certification of that diagnosis; and

(4) otherwise comply with all requirements developed by the commissioner.

(c) A health care practitioner may conduct a patient assessment to issue a recertification as required under paragraph (b), clause (3), via telemedicine as defined under section 62A.671, subdivision 9.

(d) Nothing in this section requires a health care practitioner to participate in the registry program.

Sec. 85. Minnesota Statutes 2020, section 152.29, subdivision 1, is amended to read:

Subdivision 1. **Manufacturer; requirements.** (a) A manufacturer may operate eight distribution facilities, which may include the manufacturer's single location for cultivation, harvesting, manufacturing, packaging, and processing but is not required to include that location. The commissioner shall designate the geographical service areas to be served by each manufacturer based on geographical need throughout the state to improve patient access. A manufacturer shall not have more than two distribution facilities in each geographical service area assigned to the manufacturer by the commissioner. A manufacturer shall operate only one location where all cultivation, harvesting, manufacturing, packaging, and processing of medical cannabis shall be conducted. This location may be one of the manufacturer's distribution facility sites. The additional distribution facilities may dispense medical cannabis and medical cannabis products but may not contain any medical cannabis in a form other than those forms allowed under section 152.22, subdivision 6, and the manufacturer shall not conduct any cultivation, harvesting, manufacturing, packaging, or processing at the other distribution facility sites. Any distribution facility operated by the manufacturer is subject to all of the requirements applying to the manufacturer under sections 152.22 to 152.37, including, but not limited to, security and distribution requirements.

(b) A manufacturer may acquire hemp grown in this state from a hemp grower, and may acquire hemp products produced by a hemp processor. A manufacturer may manufacture or process hemp and hemp products into an allowable form of medical cannabis under section 152.22, subdivision 6. Hemp and hemp products acquired by a manufacturer under this paragraph ~~is~~ are subject to the same quality control program, security and testing requirements, and other requirements that apply to medical cannabis under sections 152.22 to 152.37 and Minnesota Rules, chapter 4770.

(c) A medical cannabis manufacturer shall contract with a laboratory approved by the commissioner, subject to any additional requirements set by the commissioner, for purposes of testing medical cannabis manufactured or hemp or hemp products acquired by the medical cannabis manufacturer as to content, contamination, and consistency to verify the medical cannabis meets the requirements of section 152.22, subdivision 6. The cost of laboratory testing shall be paid by the manufacturer.

(d) The operating documents of a manufacturer must include:

(1) procedures for the oversight of the manufacturer and procedures to ensure accurate record keeping;

(2) procedures for the implementation of appropriate security measures to deter and prevent the theft of medical cannabis and unauthorized entrance into areas containing medical cannabis; and

(3) procedures for the delivery and transportation of hemp between hemp growers and manufacturers and for the delivery and transportation of hemp products between hemp processors and manufacturers.

(e) A manufacturer shall implement security requirements, including requirements for the delivery and transportation of hemp and hemp products, protection of each location by a fully operational security alarm system, facility access controls, perimeter intrusion detection systems, and a personnel identification system.

(f) A manufacturer shall not share office space with, refer patients to a health care practitioner, or have any financial relationship with a health care practitioner.

(g) A manufacturer shall not permit any person to consume medical cannabis on the property of the manufacturer.

(h) A manufacturer is subject to reasonable inspection by the commissioner.

(i) For purposes of sections 152.22 to 152.37, a medical cannabis manufacturer is not subject to the Board of Pharmacy licensure or regulatory requirements under chapter 151.

(j) A medical cannabis manufacturer may not employ any person who is under 21 years of age or who has been convicted of a disqualifying felony offense. An employee of a medical cannabis manufacturer must submit a completed criminal history records check consent form, a full set of classifiable fingerprints, and the required fees for submission to the Bureau of Criminal Apprehension before an employee may begin working with the manufacturer. The bureau must conduct a Minnesota criminal history records check and the superintendent is authorized to exchange the fingerprints with the Federal Bureau of Investigation to obtain the applicant's national criminal history record information. The bureau shall return the results of the Minnesota and federal criminal history records checks to the commissioner.

(k) A manufacturer may not operate in any location, whether for distribution or cultivation, harvesting, manufacturing, packaging, or processing, within 1,000 feet of a public or private school existing before the date of the manufacturer's registration with the commissioner.

(l) A manufacturer shall comply with reasonable restrictions set by the commissioner relating to signage, marketing, display, and advertising of medical cannabis.

(m) Before a manufacturer acquires hemp from a hemp grower or hemp products from a hemp processor, the manufacturer must verify that the hemp grower or hemp processor has a valid license issued by the commissioner of agriculture under chapter 18K.

(n) Until a state-centralized, seed-to-sale system is implemented that can track a specific medical cannabis plant from cultivation through testing and point of sale, the commissioner shall conduct at least one unannounced inspection per year of each manufacturer that includes inspection of:

(1) business operations;

(2) physical locations of the manufacturer's manufacturing facility and distribution facilities;

(3) financial information and inventory documentation, including laboratory testing results; and

(4) physical and electronic security alarm systems.

Sec. 86. Minnesota Statutes 2020, section 152.29, subdivision 3, is amended to read:

Subd. 3. **Manufacturer; distribution.** (a) A manufacturer shall require that employees licensed as pharmacists pursuant to chapter 151 be the only employees to give final approval for the distribution of medical cannabis to a patient. A manufacturer may transport medical cannabis or medical cannabis products that have been cultivated, harvested, manufactured, packaged, and processed by that manufacturer to another registered manufacturer for the other manufacturer to distribute.

(b) A manufacturer may distribute medical cannabis products, whether or not the products have been manufactured by that manufacturer.

(c) Prior to distribution of any medical cannabis, the manufacturer shall:

(1) verify that the manufacturer has received the registry verification from the commissioner for that individual patient;

(2) verify that the person requesting the distribution of medical cannabis is the patient, the patient's registered designated caregiver, or the patient's parent, legal guardian, or spouse listed in the registry verification using the procedures described in section 152.11, subdivision 2d;

(3) assign a tracking number to any medical cannabis distributed from the manufacturer;

(4) ensure that any employee of the manufacturer licensed as a pharmacist pursuant to chapter 151 has consulted with the patient to determine the proper dosage for the individual patient after reviewing the ranges of chemical compositions of the medical cannabis and the ranges of proper dosages reported by the commissioner. For purposes of this clause, a consultation may be conducted remotely ~~using a~~ by secure videoconference, telephone, or other remote means, so long as the employee providing the consultation is able to confirm the identity of the patient~~, the consultation occurs while the patient is at a distribution facility,~~ and the consultation adheres to patient privacy requirements that apply to health care services delivered through telemedicine. A pharmacist consultation under this clause is not required

when a manufacturer is distributing medical cannabis to a patient according to a patient-specific dosage plan established with that manufacturer and is not modifying the dosage or product being distributed under that plan and the medical cannabis is distributed by a pharmacy technician;

(5) properly package medical cannabis in compliance with the United States Poison Prevention Packing Act regarding child-resistant packaging and exemptions for packaging for elderly patients, and label distributed medical cannabis with a list of all active ingredients and individually identifying information, including:

(i) the patient's name and date of birth;

(ii) the name and date of birth of the patient's registered designated caregiver or, if listed on the registry verification, the name of the patient's parent or legal guardian, if applicable;

(iii) the patient's registry identification number;

(iv) the chemical composition of the medical cannabis; and

(v) the dosage; and

(6) ensure that the medical cannabis distributed contains a maximum of a 90-day supply of the dosage determined for that patient.

(d) A manufacturer shall require any employee of the manufacturer who is transporting medical cannabis or medical cannabis products to a distribution facility or to another registered manufacturer to carry identification showing that the person is an employee of the manufacturer.

(e) A manufacturer shall distribute medical cannabis in dried raw cannabis form only to a patient age 21 or older, or to the registered designated caregiver, parent, legal guardian, or spouse of a patient age 21 or older.

EFFECTIVE DATE. Paragraph (e) is effective the earlier of (1) March 1, 2022, or (2) a date, as determined by the commissioner of health, by which (i) the rules adopted or amended under Minnesota Statutes, section 152.26, paragraph (b), are in effect and (ii) the independent laboratories under contract with the manufacturers have the necessary procedures and equipment in place to perform the required testing of dried raw cannabis. If this section is effective before March 1, 2022, the commissioner shall provide notice of that effective date to the public.

Sec. 87. Minnesota Statutes 2020, section 152.29, is amended by adding a subdivision to read:

Subd. 3b. **Distribution to recipient in a motor vehicle.** A manufacturer may distribute medical cannabis to a patient, registered designated caregiver, or parent, legal guardian, or spouse of a patient who is at the distribution facility but remains in a motor vehicle, provided:

(1) distribution facility staff receive payment and distribute medical cannabis in a designated zone that is as close as feasible to the front door of the distribution facility;

(2) the manufacturer ensures that the receipt of payment and distribution of medical cannabis are visually recorded by a closed-circuit television surveillance camera at the distribution facility and provides any other necessary security safeguards;

(3) the manufacturer does not store medical cannabis outside a restricted access area at the distribution facility, and distribution facility staff transport medical cannabis from a restricted access area at the distribution facility to the designated zone for distribution only after confirming that the patient, designated caregiver, or parent, guardian, or spouse has arrived in the designated zone;

(4) the payment and distribution of medical cannabis take place only after a pharmacist consultation takes place, if required under subdivision 3, paragraph (c), clause (4);

(5) immediately following distribution of medical cannabis, distribution facility staff enter the transaction in the state medical cannabis registry information technology database; and

(6) immediately following distribution of medical cannabis, distribution facility staff take the payment received into the distribution facility.

Sec. 88. Minnesota Statutes 2020, section 152.29, is amended by adding a subdivision to read:

Subd. 3c. **Disposal of medical cannabis plant root balls.** Notwithstanding Minnesota Rules, part 4770.1200, subpart 2, item C, a manufacturer is not required to grind root balls of medical cannabis plants or incorporate them with a greater quantity of nonconsumable solid waste before transporting root balls to another location for disposal. For purposes of this subdivision, "root ball" means a compact mass of roots formed by a plant and any attached growing medium.

Sec. 89. Minnesota Statutes 2020, section 152.31, is amended to read:

152.31 DATA PRACTICES.

(a) Government data in patient files maintained by the commissioner and the health care practitioner, and data submitted to or by a medical cannabis manufacturer, are private data on individuals, as defined in section 13.02, subdivision 12, or nonpublic data, as defined in section 13.02, subdivision 9, but may be used for purposes of complying with chapter 13 and complying with a request from the legislative auditor or the state auditor in the performance of official duties. The provisions of section 13.05, subdivision 11, apply to a registration agreement entered between the commissioner and a medical cannabis manufacturer under section 152.25.

(b) Not public data maintained by the commissioner may not be used for any purpose not provided for in sections 152.22 to 152.37, and may not be combined or linked in any manner with any other list, dataset, or database.

(c) The commissioner may execute data sharing arrangements with the commissioner of agriculture to verify licensing, inspection, and compliance information related to hemp growers and hemp processors under chapter 18K.

Sec. 90. Minnesota Statutes 2020, section 152.32, subdivision 3, is amended to read:

Subd. 3. **Discrimination prohibited.** (a) No school or landlord may refuse to enroll or lease to and may not otherwise penalize a person solely for the person's status as a patient enrolled in the registry program under sections 152.22 to 152.37, unless failing to do so would violate federal law or regulations or cause the school or landlord to lose a monetary or licensing-related benefit under federal law or regulations.

(b) For the purposes of medical care, including organ transplants, a registry program enrollee's use of medical cannabis under sections 152.22 to 152.37 is considered the equivalent of the authorized use of any other medication used at the discretion of a physician or advanced practice registered nurse and does not constitute the use of an illicit substance or otherwise disqualify a patient from needed medical care.

(c) Unless a failure to do so would violate federal law or regulations or cause an employer to lose a monetary or licensing-related benefit under federal law or regulations, an employer may not discriminate against a person in hiring, termination, or any term or condition of employment, or otherwise penalize a person, if the discrimination is based upon either of the following:

(1) the person's status as a patient enrolled in the registry program under sections 152.22 to 152.37; or

(2) a patient's positive drug test for cannabis components or metabolites, unless the patient used, possessed, or was impaired by medical cannabis on the premises of the place of employment or during the hours of employment.

(d) An employee who is required to undergo employer drug testing pursuant to section 181.953 may present verification of enrollment in the patient registry as part of the employee's explanation under section 181.953, subdivision 6.

(e) A person shall not be denied custody of a minor child or visitation rights or parenting time with a minor child solely based on the person's status as a patient enrolled in the registry program under sections 152.22 to 152.37. There shall be no presumption of neglect or child endangerment for conduct allowed under sections 152.22 to 152.37, unless the person's behavior is such that it creates an unreasonable danger to the safety of the minor as established by clear and convincing evidence.

(f) This subdivision applies to any person enrolled in a Tribal medical cannabis program to the same extent as if the person was enrolled in the registry program under sections 152.22 to 152.37.

Sec. 32. Minnesota Statutes 2020, section 157.22, is amended to read:

157.22 EXEMPTIONS.

This chapter does not apply to:

(1) interstate carriers under the supervision of the United States Department of Health and Human Services;

(2) weddings, fellowship meals, or funerals conducted by a faith-based organization using any building constructed and primarily used for religious worship or education;

(3) any building owned, operated, and used by a college or university in accordance with health regulations promulgated by the college or university under chapter 14;

(4) any person, firm, or corporation whose principal mode of business is licensed under sections 28A.04 and 28A.05, is exempt at that premises from licensure as a food or beverage establishment; provided that the holding of any license pursuant to sections 28A.04 and 28A.05 shall not exempt any person, firm, or corporation from the applicable provisions of this chapter or the rules of the state commissioner of health relating to food and beverage service establishments;

(5) family day care homes and group family day care homes governed by sections 245A.01 to 245A.16;

(6) nonprofit senior citizen centers for the sale of home-baked goods;

(7) fraternal, sportsman, or patriotic organizations that are tax exempt under section 501(c)(3), 501(c)(4), 501(c)(6), 501(c)(7), 501(c)(10), or 501(c)(19) of the Internal Revenue Code of 1986, or organizations related to, affiliated with, or supported by such fraternal, sportsman, or patriotic organizations for events held in the building or on the grounds of the organization and at which home-prepared food is donated by organization members for sale at the events, provided:

(i) the event is not a circus, carnival, or fair;

(ii) the organization controls the admission of persons to the event, the event agenda, or both; and

(iii) the organization's licensed kitchen is not used in any manner for the event;

(8) food not prepared at an establishment and brought in by individuals attending a potluck event for consumption at the potluck event. An organization sponsoring a potluck event under this clause may advertise the potluck event to the public through any means.

Individuals who are not members of an organization sponsoring a potluck event under this clause may attend the potluck event and consume the food at the event. Licensed food establishments other than schools cannot be sponsors of potluck events. A school may sponsor and hold potluck events in areas of the school other than the school's kitchen, provided that the school's kitchen is not used in any manner for the potluck event. For purposes of this clause, "school" means a public school as defined in section 120A.05, subdivisions 9, 11, 13, and 17, or a nonpublic school, church, or religious organization at which a child is provided with instruction in compliance with sections 120A.22 and 120A.24. Potluck event food shall not be brought into a licensed food establishment kitchen;

(9) a home school in which a child is provided instruction at home;

(10) school concession stands serving commercially prepared, nonpotentially hazardous foods, as defined in Minnesota Rules, chapter 4626;

(11) group residential facilities of ten or fewer beds licensed by the commissioner of human services under Minnesota Rules, chapter 2960, provided the facility employs or contracts with a certified food manager under Minnesota Rules, part 4626.2015;

(12) food served at fund-raisers or community events, including fellowship meals, conducted in the building or on the grounds of a faith-based organization, or made available for curbside pickup or for delivery to members of the faith-based organization or the community in which the faith-based organization serves, provided that a certified food manager, or a volunteer trained in a food safety course, trains the food preparation workers in safe food handling practices. This exemption does not apply to faith-based organizations at the state agricultural society or county fairs or to faith-based organizations that choose to apply for a license;

(13) food service events conducted following a disaster for purposes of feeding disaster relief staff and volunteers serving commercially prepared, nonpotentially hazardous foods, as defined in Minnesota Rules, chapter 4626;

(14) chili or soup served at a chili or soup cook-off fund-raiser conducted by a community-based nonprofit organization, provided:

(i) the municipality where the event is located approves the event;

(ii) the sponsoring organization must develop food safety rules and ensure that participants follow these rules; and

(iii) if the food is not prepared in a kitchen that is licensed or inspected, a visible sign or placard must be posted that states: "These products are homemade and not subject to state inspection."

Foods exempt under this clause must be labeled to accurately reflect the name and address of the person preparing the foods; and

(15) a special event food stand or a seasonal temporary food stand provided:

Sec. 91. Minnesota Statutes 2020, section 171.07, is amended by adding a subdivision to read:

Subd. 3b. **Identification card for homeless youth.** (a) A homeless youth, as defined in section 256K.45, subdivision 1a, who meets the requirements of this subdivision may obtain a noncompliant identification card, notwithstanding section 171.06, subdivision 3.

(b) An applicant under this subdivision must:

(1) provide the applicant's full name, date of birth, and sex;

(2) provide the applicant's height in feet and inches, weight in pounds, and eye color;

(3) submit a certified copy of a birth certificate issued by a government bureau of vital statistics or equivalent agency in the applicant's state of birth, which must bear the raised or authorized seal of the issuing government entity; and

(4) submit a statement verifying that the applicant is a homeless youth who resides in Minnesota that is signed by:

(i) an employee of a human services agency receiving public funding to provide services to homeless youth, runaway youth, youth with mental illness, or youth with substance use disorders; or

(ii) staff at a school who provide services to homeless youth or a school social worker.

(c) For a noncompliant identification card under this subdivision:

(1) the commissioner must not impose a fee, surcharge, or filing fee under section 171.06, subdivision 2; and

(2) a driver's license agent must not impose a filing fee under section 171.061, subdivision 4.

(d) Minnesota Rules, parts 7410.0400 and 7410.0410, or successor rules, do not apply for an identification card under this subdivision.

EFFECTIVE DATE. This section is effective the day following final enactment for application and issuance of Minnesota identification cards on and after January 1, 2022.

(i) the stand is located on private property with the permission of the property owner;

(ii) the stand has gross receipts or contributions of $1,000 or less in a calendar year; and

(iii) the operator of the stand posts a sign or placard at the site that states "The products sold at this stand are not subject to state inspection or regulation." if the stand offers for sale potentially hazardous food as defined in Minnesota Rules, part 4626.0020, subpart 62.

Sec. 92. Minnesota Statutes 2020, section 256.98, subdivision 1, is amended to read:

Subdivision 1. **Wrongfully obtaining assistance.** (a) A person who commits any of the following acts or omissions with intent to defeat the purposes of sections 145.891 to 145.897, the MFIP program formerly codified in sections 256.031 to 256.0361, the AFDC program formerly codified in sections 256.72 to 256.871, chapter 256B, 256D, 256I, 256J, 256K, or 256L, child care assistance programs, and emergency assistance programs under section 256D.06, is guilty of theft and shall be sentenced under section 609.52, subdivision 3, clauses (1) to (5):

(1) obtains or attempts to obtain, or aids or abets any person to obtain by means of a willfully false statement or representation, by intentional concealment of any material fact, or by impersonation or other fraudulent device, assistance or the continued receipt of assistance, to include child care assistance or ~~vouchers~~ food benefits produced according to sections 145.891 to 145.897 and MinnesotaCare services according to sections 256.9365, 256.94, and 256L.01 to 256L.15, to which the person is not entitled or assistance greater than that to which the person is entitled;

(2) knowingly aids or abets in buying or in any way disposing of the property of a recipient or applicant of assistance without the consent of the county agency; or

(3) obtains or attempts to obtain, alone or in collusion with others, the receipt of payments to which the individual is not entitled as a provider of subsidized child care, or by furnishing or concurring in a willfully false claim for child care assistance.

(b) The continued receipt of assistance to which the person is not entitled or greater than that to which the person is entitled as a result of any of the acts, failure to act, or concealment described in this subdivision shall be deemed to be continuing offenses from the date that the first act or failure to act occurred.

Sec. 93. Minnesota Statutes 2020, section 256B.0625, subdivision 52, is amended to read:

Subd. 52. **Lead risk assessments.** (a) Effective October 1, 2007, or six months after federal approval, whichever is later, medical assistance covers lead risk assessments provided by a lead risk assessor who is licensed by the commissioner of health under section 144.9505 and employed by an assessing agency as defined in section 144.9501. Medical assistance covers a onetime on-site investigation of a recipient's home or primary residence to determine the existence of lead so long as the recipient is under the age of 21 and has a venous blood lead level specified in section 144.9504, subdivision 2, paragraph ~~(a)~~ (b).

(b) Medical assistance reimbursement covers the lead risk assessor's time to complete the following activities:

(1) gathering samples;

(2) interviewing family members;

(3) gathering data, including meter readings; and

(4) providing a report with the results of the investigation and options for reducing lead-based paint hazards.

Medical assistance coverage of lead risk assessment does not include testing of environmental substances such as water, paint, or soil or any other laboratory services. Medical assistance coverage of lead risk assessments is not included in the capitated services for children enrolled in health plans through the prepaid medical assistance program and the MinnesotaCare program.

(c) Payment for lead risk assessment must be cost-based and must meet the criteria for federal financial participation under the Medicaid program. The rate must be based on allowable expenditures from cost information gathered. Under section 144.9507, subdivision 5, federal medical assistance funds may not replace existing funding for lead-related activities. The nonfederal share of costs for services provided under this subdivision must be from state or local funds and is the responsibility of the agency providing the risk assessment. When the risk assessment is conducted by the commissioner of health, the state share must be from appropriations to the commissioner of health for this purpose. Eligible expenditures for the nonfederal share of costs may not be made from federal funds or funds used to match other federal funds. Any federal disallowances are the responsibility of the agency providing risk assessment services.

Sec. 94. Minnesota Statutes 2020, section 326.71, subdivision 4, is amended to read:

Subd. 4. **Asbestos-related work.** "Asbestos-related work" means the enclosure, removal, or encapsulation of asbestos-containing material in a quantity that meets or exceeds 260 linear feet of friable asbestos-containing material on pipes, 160 square feet of friable asbestos-containing material on other facility components, or, if linear feet or square feet cannot be measured, a total of 35 cubic feet of friable asbestos-containing material on or off all facility components in one facility. In the case of single or multifamily residences, "asbestos-related work" also means the enclosure, removal, or encapsulation of greater than ten but less than 260 linear feet of friable asbestos-containing material on pipes, greater than six but less than 160 square feet of friable asbestos-containing material on other facility components, or, if linear feet or square feet cannot be measured, greater than one cubic foot but less than 35 cubic feet of friable asbestos-containing material on or off all facility components in one facility. ~~This provision excludes asbestos-containing floor tiles and sheeting, roofing materials, siding, and all ceilings with asbestos-containing material in single family residences and buildings with no more than four dwelling units.~~ Asbestos-related work includes asbestos abatement area preparation; enclosure, removal, or encapsulation operations; and an air quality monitoring specified in rule to assure that the abatement and adjacent areas are not contaminated with asbestos fibers during the project and after completion.

For purposes of this subdivision, the quantity of ~~asbestos containing~~ asbestos-containing material applies separately for every project.

Sec. 33. Minnesota Statutes 2020, section 326.71, subdivision 4, is amended to read:

Subd. 4. **Asbestos-related work.** "Asbestos-related work" means the enclosure, removal, or encapsulation of asbestos-containing material in a quantity that meets or exceeds 260 linear feet of friable asbestos-containing material on pipes, 160 square feet of friable asbestos-containing material on other facility components, or, if linear feet or square feet cannot be measured, a total of 35 cubic feet of friable asbestos-containing material on or off all facility components in one facility. In the case of single or multifamily residences, "asbestos-related work" also means the enclosure, removal, or encapsulation of greater than ten but less than 260 linear feet of friable asbestos-containing material on pipes, greater than six but less than 160 square feet of friable asbestos-containing material on other facility components, or, if linear feet or square feet cannot be measured, greater than one cubic foot but less than 35 cubic feet of friable asbestos-containing material on or off all facility components in one facility. ~~This provision excludes asbestos-containing floor tiles and sheeting, roofing materials, siding, and all ceilings with asbestos-containing material in single family residences and buildings with no more than four dwelling units.~~ Asbestos-related work includes asbestos abatement area preparation; enclosure, removal, or encapsulation operations; and an air quality monitoring specified in rule to assure that the abatement and adjacent areas are not contaminated with asbestos fibers during the project and after completion.

For purposes of this subdivision, the quantity of ~~asbestos-containing~~ material applies separately for every project.

Sec. 95. Minnesota Statutes 2020, section 326.75, subdivision 1, is amended to read:

Subdivision 1. **Licensing fee.** A person required to be licensed under section 326.72 shall, before receipt of the license and before causing asbestos-related work to be performed, pay the commissioner an annual license fee of ~~$100~~ $105.

Sec. 96. Minnesota Statutes 2020, section 326.75, subdivision 2, is amended to read:

Subd. 2. **Certification fee.** An individual required to be certified as an asbestos worker or asbestos site supervisor under section 326.73, subdivision 1, shall pay the commissioner a certification fee of ~~$50~~ $52.50 before the issuance of the certificate. ~~The commissioner may establish by rule fees required before the issuance of~~ An individual required to be certified as an asbestos inspector, asbestos management planner, and asbestos project designer ~~certificates required~~ under section 326.73, subdivisions 2, 3, and 4, shall pay the commissioner a certification fee of $105 before the issuance of the certificate.

Sec. 97. Minnesota Statutes 2020, section 326.75, subdivision 3, is amended to read:

Subd. 3. **Permit fee.** Five calendar days before beginning asbestos-related work, a person shall pay a project permit fee to the commissioner equal to ~~one~~ two percent of the total costs of the asbestos-related work. For asbestos-related work performed in single or multifamily residences, of greater than ten but less than 260 linear feet of asbestos-containing material on pipes, or greater than six but less than 160 square feet of asbestos-containing material on other facility components, a person shall pay a project permit fee of $35 to the commissioner.

Sec. 98. Laws 2020, Seventh Special Session chapter 1, article 6, section 12, subdivision 4, is amended to read:

Subd. 4. **Housing with services establishment registration; conversion to an assisted living facility license.** (a) Housing with services establishments registered under chapter 144D, providing home care services according to chapter 144A to at least one resident, and intending to provide assisted living services on or after August 1, 2021, must submit an application for an assisted living facility license in accordance with section 144G.12 no later than June 1, 2021. The commissioner shall consider the application in accordance with section ~~144G.16~~ 144G.15.

(b) Notwithstanding the housing with services contract requirements identified in section 144D.04, any existing housing with services establishment registered under chapter 144D that does not intend to convert its registration to an assisted living facility license under this chapter must provide written notice to its residents at least 60 days before the expiration of its registration, or no later than May 31, 2021, whichever is earlier. The notice must:

(1) state that the housing with services establishment does not intend to convert to an assisted living facility;

(2) include the date when the housing with services establishment will no longer provide housing with services;

Sec. 34. Minnesota Statutes 2020, section 326.75, subdivision 1, is amended to read:

Subdivision 1. **Licensing fee.** A person required to be licensed under section 326.72 shall, before receipt of the license and before causing asbestos-related work to be performed, pay the commissioner an annual license fee of ~~$100~~ $105.

Sec. 35. Minnesota Statutes 2020, section 326.75, subdivision 2, is amended to read:

Subd. 2. **Certification fee.** An individual required to be certified as an asbestos worker or asbestos site supervisor under section 326.73, subdivision 1, shall pay the commissioner a certification fee of ~~$50~~ $52.50 before the issuance of the certificate. ~~The commissioner may establish by rule fees required before the issuance of~~ An individual required to be certified as an asbestos inspector, asbestos management planner, ~~and~~ or asbestos project designer ~~certificates required~~ under section 326.73, subdivisions 2, 3, and 4, shall pay the commissioner a certification fee of $105 before the issuance of the certificate.

Sec. 36. Minnesota Statutes 2020, section 326.75, subdivision 3, is amended to read:

Subd. 3. **Permit fee.** Five calendar days before beginning asbestos-related work, a person shall pay a project permit fee to the commissioner equal to ~~one~~ two percent of the total costs of the asbestos-related work. For asbestos-related work performed in single or multifamily residences, of greater than ten but less than 260 linear feet of asbestos-containing material on pipes, or greater than six but less than 160 square feet of asbestos-containing material on other facility components, a person shall pay a project permit fee of $35 to the commissioner.

(3) include the name, e-mail address, and phone number of the individual associated with the housing with services establishment that the recipient of home care services may contact to discuss the notice;

(4) include the contact information consisting of the phone number, e-mail address, mailing address, and website for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; and

(5) for residents who receive home and community-based waiver services under section 256B.49 and chapter 256S, also be provided to the resident's case manager at the same time that it is provided to the resident.

(c) A housing with services registrant that obtains an assisted living facility license, but does so under a different business name as a result of reincorporation, and continues to provide services to the recipient, is not subject to the 60-day notice required under paragraph (b). However, the provider must otherwise provide notice to the recipient as required under sections 144D.04 and 144D.045, as applicable, and section 144D.09.

(d) All registered housing with services establishments providing assisted living under sections 144G.01 to 144G.07 prior to August 1, 2021, must have an assisted living facility license under this chapter.

(e) Effective August 1, 2021, any housing with services establishment registered under chapter 144D that has not converted its registration to an assisted living facility license under this chapter is prohibited from providing assisted living services.

EFFECTIVE DATE. This section is effective retroactively from December 17, 2020.

Sec. 99. **ADDITIONAL MEMBER TO COVID-19 VACCINE ALLOCATION ADVISORY GROUP.**

The commissioner of health shall appoint an individual who is an expert on vaccine disinformation to the state COVID-19 Vaccine Allocation Advisory Group no later than .....

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

Sec. 100. **REVIEW OF COVID-19 MEASURES.**

Subdivision 1. **Review.** The commissioner may contract with an independent third-party entity that includes epidemiologists to conduct a review of measures to prevent and control the spread of COVID-19.

Subd. 2. **Costs.** If this review is performed, the commissioner may contract for the performance of this review using existing resources, including federal funds that are available for or that may be used for this purpose.

Subd. 3. **Report.** No later than 30 days after completion of the review, the commissioner may provide a report to the chairs and ranking minority members of the legislative

committees with jurisdiction over health policy and data practices and the Legislative Commission on Data Practices and Personal Data. Results of the review shall be public data. The report shall de-identify any information used in the report. The report may be submitted as required under Minnesota Statutes, section 3.195. Findings from the review may be used to help develop strategies for improving COVID-19 prevention and control measures.

Sec. 101. **FEDERAL SCHEDULE I EXEMPTION APPLICATION FOR MEDICAL USE OF CANNABIS.**

By September 1, 2021, the commissioner of health shall apply to the Drug Enforcement Administration's Office of Diversion Control for an exception under Code of Federal Regulations, title 21, section 1307.03, and request formal written acknowledgment that the listing of marijuana, marijuana extract, and tetrahydrocannabinols as controlled substances in federal Schedule I does not apply to the protected activities in Minnesota Statutes, section 152.32, subdivision 2, pursuant to the medical cannabis program established under Minnesota Statutes, sections 152.22 to 152.37. The application shall include the presumption in Minnesota Statutes, section 152.32, subdivision 1.

Sec. 102. **LEGISLATIVE AUDITOR EXAMINATION OF PATIENT DISCHARGES FROM HOSPITALS TO NURSING HOMES.**

Subdivision 1. **Topic to consider for evaluation.** (a) The Legislative Audit Commission shall consider as a topic for evaluation by the legislative auditor during the next evaluation cycle, an examination of patient discharges from hospitals to nursing homes during the COVID-19 pandemic. If the Legislative Audit Commission chooses this topic for evaluation according to Minnesota Statutes, section 3.97, subdivision 3a, the legislative auditor shall review and analyze at least the following:

(1) the number of patients discharged from hospitals to nursing homes during the COVID-19 pandemic;

(2) the effects of these patient discharges on the discharged patients and nursing home residents, including the effect on the numbers of positive COVID-19 cases of nursing home residents and employees whose cases may be traced to discharged patients and on the number of hospitalizations and deaths of nursing home residents due to COVID-19 whose cases may be traced to discharged patients;

(3) whether these patient discharges occurred in compliance with federal and state agency rules or guidance in effect when the discharges took place, including rules or guidance on testing patients for COVID-19 prior to and following discharge, quarantine following discharge of patients with an unknown COVID-19 infection status at discharge, isolation following discharge of patients infected with COVID-19, and other COVID-19 infection control measures;

(4) for patient discharges that did not comply with federal and state agency rules or guidance, the effect of failing to comply with such rules or guidance, including the effect

on the health of patients discharged to nursing homes and on the health of residents of nursing homes to which patients were discharged; and

(5) the impact of these patient discharges on reimbursement received by hospitals and nursing homes for care provided to these patients.

(b) If chosen for evaluation, the legislative auditor shall conduct this examination using existing resources, including federal funds that are available for or that may be used for this purpose.

Subd. 2. **Cooperation.** If this evaluation is conducted, the commissioner of health, the commissioner of human services, hospitals, and nursing homes must cooperate with this examination and must provide the legislative auditor with access to data and records necessary to perform this examination.

Subd. 3. **Report.** By January 15, 2022, the legislative auditor shall submit a written report on this evaluation according to Minnesota Statutes, section 3.974, if this evaluation is conducted.

Sec. 103. **MENTAL HEALTH CULTURAL COMMUNITY CONTINUING EDUCATION GRANT PROGRAM.**

The commissioner of health shall develop a grant program, in consultation with the relevant mental health licensing boards, to provide for the continuing education necessary for social workers, marriage and family therapists, psychologists, and professional clinical counselors who are members of communities of color or underrepresented communities, as defined in Minnesota Statutes, section 148E.010, subdivision 20, and who work for community mental health providers, to become supervisors for individuals pursuing licensure in mental health professions.

Sec. 104. **RECOMMENDATIONS; EXPANDED ACCESS TO DATA FROM ALL-PAYER CLAIMS DATABASE.**

The commissioner of health shall develop recommendations to expand access to data in the all-payer claims database under Minnesota Statutes, section 62U.04, to additional outside entities for public health or research purposes. In the recommendations, the commissioner must address an application process for outside entities to access the data, how the department will exercise ongoing oversight over data use by outside entities, purposes for which the data may be used by outside entities, establishment of a data access committee to advise the department on selecting outside entities that may access the data, and steps outside entities must take to protect data held by those entities from unauthorized use. Following development of these recommendations, an outside entity that accesses data in compliance with these recommendations may publish results that identify hospitals, clinics, and medical practices so long as no individual health professionals are identified and the commissioner finds the data to be accurate, valid, and suitable for publication for such use. The commissioner shall submit these recommendations by December 15, 2021,

to the chairs and ranking minority members of the legislative committees with jurisdiction over health policy and civil law.

Sec. 105. **SKIN LIGHTENING PRODUCTS PUBLIC AWARENESS AND EDUCATION GRANT PROGRAM.**

Subdivision 1. **Establishment; purpose.** The commissioner of health shall develop a grant program for the purpose of increasing public awareness and education on the health dangers associated with using skin lightening creams and products that contain mercury that are manufactured in other countries and brought into this country and sold illegally online or in stores.

Subd. 2. **Grants authorized.** The commissioner shall award grants through a request for proposal process to community-based, nonprofit organizations that serve ethnic communities and that focus on public health outreach to Black, Indigenous, and people of color communities on the issue of skin lightening products and chemical exposure from these products. Priority in awarding grants shall be given to organizations that have historically provided services to ethnic communities on the skin lightening and chemical exposure issue for the past three years.

Subd. 3. **Grant allocation.** (a) Grantees must use the funds to conduct public awareness and education activities that are culturally specific and community-based and focus on:

(1) the dangers of exposure to mercury through dermal absorption, inhalation, hand-to-mouth contact, and through contact with individuals who have used these skin lightening products;

(2) the signs and symptoms of mercury poisoning;

(3) the health effects of mercury poisoning, including the permanent effects on the central nervous system and kidneys;

(4) the dangers of using these products or being exposed to these products during pregnancy and breastfeeding to the mother and to the infant;

(5) knowing how to identify products that contain mercury; and

(6) proper disposal of the product if the product contains mercury.

(b) The grant application must include:

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

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

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

Sec. 106. **TRAUMA-INFORMED GUN VIOLENCE REDUCTION; PILOT PROGRAM.**

Subdivision 1. **Pilot program.** (a) The commissioner of health shall establish a pilot program to aid in the reduction of trauma resulting from gun violence and address the root causes of gun violence by making the following resources available to professionals and organizations in health care, public health, mental health, social service, law enforcement, and victim advocacy and other professionals who are most likely to encounter individuals who have been victims, witnesses, or perpetrators of gun violence occurring in a community, or in a domestic or other setting:

(1) training on recognizing trauma as both a result and a cause of gun violence;

(2) developing skills to address the effects of trauma on individuals and family members;

(3) investments in community-based organizations to enable high-quality, targeted services to individuals in need. This may include resources for additional training, hiring of specialized staff needed to address trauma-related issues, management information systems to facilitate data collection, and expansion of existing programming;

(4) replication and expansion of effective community-based gun violence prevention initiatives, such as Project Life, the Minneapolis Group Violence Intervention initiative, to connect at-risk individuals to mental health services, job readiness programs, and employment opportunities; and

(5) education campaigns and outreach materials to educate communities, organizations, and the public about the relationship between trauma and gun violence.

(b) The pilot program shall address the traumatic effects of gun violence exposure using a holistic treatment modality.

Subd. 2. **Program guidelines and protocols.** (a) The commissioner, with advice from an advisory panel knowledgeable about gun violence and its traumatic impact, shall develop protocols and program guidelines that address resources and training to be used by professionals who encounter individuals who have perpetrated or been impacted by gun violence. Educational, training, and outreach material must be culturally appropriate for the community and provided in multiple languages for those with limited English language proficiency. The materials developed must address necessary responses by local, state, and other governmental entities tasked with addressing gun violence. The protocols must include a method of informing affected communities and local governments representing those communities on effective strategies to target community, domestic, and other forms of gun violence.

(b) The commissioner may enter into contractual agreements with community-based organizations or experts in the field to perform any of the activities under this section.

Subd. 3. **Report.** By November 15, 2021, the commissioner shall submit a report on the progress of the pilot program to the chairs and ranking minority members of the committees with jurisdiction over health and public safety.

Sec. 107. **REVISOR INSTRUCTION.**

The revisor of statutes shall amend the section headnote for Minnesota Statutes, section 62J.63, to read "HEALTH CARE PURCHASING AND PERFORMANCE MEASUREMENT."

Sec. 108. **REPEALER.**

Minnesota Statutes 2020, sections 62J.63, subdivision 3; 144.0721, subdivision 1; 144.0722; 144.0724, subdivision 10; and 144.693, are repealed.

Sec. 37. **DIRECTION TO MODIFY MARRIAGE LICENSE APPLICATIONS.**

A local registrar or a designee of the county board shall delete from the county's marriage license application any space or other manner in which the applicant is required to specify the applicant's race.