..... moves to amend H.F. No. 2930 as follows:

Delete everything after the enacting clause and insert:

"ARTICLE 1

DEPARTMENT OF HUMAN SERVICES HEALTH CARE

Section 1. Minnesota Statutes 2022, section 62A.045, is amended to read:

62A.045 PAYMENTS ON BEHALF OF ENROLLEES IN GOVERNMENT HEALTH PROGRAMS.

(a) As a condition of doing business in Minnesota or providing coverage to residents of Minnesota covered by this section, each health insurer shall comply with the requirements ~~of~~ for health insurers under the federal Deficit Reduction Act of 2005, Public Law 109-171 and the federal Consolidated Appropriations Act of 2022, Public Law 117-103, including any federal regulations adopted under ~~that act~~ those acts, to the extent that ~~it imposes~~ they impose a requirement that applies in this state and that is not also required by the laws of this state. This section does not require compliance with any provision of the federal ~~act~~ acts prior to the effective ~~date~~ dates provided for ~~that provision~~ those provisions in the federal ~~act~~ acts. The commissioner shall enforce this section.

For the purpose of this section, "health insurer" includes self-insured plans, group health plans (as defined in section 607(1) of the Employee Retirement Income Security Act of 1974), service benefit plans, managed care organizations, pharmacy benefit managers, or other parties that are by contract legally responsible to pay a claim for a health-care item or service for an individual receiving benefits under paragraph (b).

(b) No plan offered by a health insurer issued or renewed to provide coverage to a Minnesota resident shall contain any provision denying or reducing benefits because services are rendered to a person who is eligible for or receiving medical benefits pursuant to title

XIX of the Social Security Act (Medicaid) in this or any other state; chapter 256 or 256B; or services pursuant to section 252.27; 256L.01 to 256L.10; 260B.331, subdivision 2; 260C.331, subdivision 2; or 393.07, subdivision 1 or 2. No health insurer providing benefits under plans covered by this section shall use eligibility for medical programs named in this section as an underwriting guideline or reason for nonacceptance of the risk.

(c) If payment for covered expenses has been made under state medical programs for health care items or services provided to an individual, and a third party has a legal liability to make payments, the rights of payment and appeal of an adverse coverage decision for the individual, or in the case of a child their responsible relative or caretaker, will be subrogated to the state agency. The state agency may assert its rights under this section within three years of the date the service was rendered. For purposes of this section, "state agency" includes prepaid health plans under contract with the commissioner according to sections 256B.69 and 256L.12; children's mental health collaboratives under section 245.493; demonstration projects for persons with disabilities under section 256B.77; nursing homes under the alternative payment demonstration project under section 256B.434; and county-based purchasing entities under section 256B.692.

(d) Notwithstanding any law to the contrary, when a person covered by a plan offered by a health insurer receives medical benefits according to any statute listed in this section, payment for covered services or notice of denial for services billed by the provider must be issued directly to the provider. If a person was receiving medical benefits through the Department of Human Services at the time a service was provided, the provider must indicate this benefit coverage on any claim forms submitted by the provider to the health insurer for those services. If the commissioner of human services notifies the health insurer that the commissioner has made payments to the provider, payment for benefits or notices of denials issued by the health insurer must be issued directly to the commissioner. Submission by the department to the health insurer of the claim on a Department of Human Services claim form is proper notice and shall be considered proof of payment of the claim to the provider and supersedes any contract requirements of the health insurer relating to the form of submission. Liability to the insured for coverage is satisfied to the extent that payments for those benefits are made by the health insurer to the provider or the commissioner as required by this section.

(e) When a state agency has acquired the rights of an individual eligible for medical programs named in this section and has health benefits coverage through a health insurer, the health insurer shall not impose requirements that are different from requirements applicable to an agent or assignee of any other individual covered.

(f) A health insurer must process a clean claim made by a state agency for covered expenses paid under state medical programs within 90 business days of the claim's submission. A health insurer must process all other claims made by a state agency for covered expenses paid under a state medical program within the timeline set forth in Code of Federal Regulations, title 42, section 447.45(d)(4).

(g) A health insurer may request a refund of a claim paid in error to the Department of Human Services within two years of the date the payment was made to the department. A request for a refund shall not be honored by the department if the health insurer makes the request after the time period has lapsed.

Sec. 2. Minnesota Statutes 2022, section 62A.673, subdivision 2, is amended to read:

Subd. 2. **Definitions.** (a) For purposes of this section, the terms defined in this subdivision have the meanings given.

(b) "Distant site" means a site at which a health care provider is located while providing health care services or consultations by means of telehealth.

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

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

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

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

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

(h) "Telehealth" means the delivery of health care services or consultations through the use of real time two-way interactive audio and visual communications to provide or support health care delivery and facilitate the assessment, diagnosis, consultation, treatment, education, and care management of a patient's health care. Telehealth includes the application of secure video conferencing, store-and-forward technology, and synchronous interactions between a patient located at an originating site and a health care provider located at a distant site. Until July 1, ~~2023~~ 2025, telehealth also includes audio-only communication between a health care provider and a patient in accordance with subdivision 6, paragraph (b). Telehealth does not include communication between health care providers that consists solely of a telephone conversation, email, or facsimile transmission. Telehealth does not include communication between a health care provider and a patient that consists solely of an email or facsimile transmission. Telehealth does not include telemonitoring services as defined in paragraph (i).

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

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

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

Sec. 4. Minnesota Statutes 2022, section 256.0471, subdivision 1, is amended to read:

Subdivision 1. **Qualifying overpayment.** Any overpayment for assistance granted under chapter 119B, the MFIP program formerly codified under sections 256.031 to 256.0361,

and the AFDC program formerly codified under sections 256.72 to 256.871; section 256.045, subdivision 10; chapters 256B for state-funded medical assistance, 256D, 256I, 256J, 256K, and 256L for state-funded MinnesotaCare; and the Supplemental Nutrition Assistance Program (SNAP), except agency error claims, become a judgment by operation of law 90 days after the notice of overpayment is personally served upon the recipient in a manner that is sufficient under rule 4.03(a) of the Rules of Civil Procedure for district courts, or by certified mail, return receipt requested. This judgment shall be entitled to full faith and credit in this and any other state.

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

Sec. 5. Minnesota Statutes 2022, section 256.969, subdivision 2b, is amended to read:

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

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

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

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

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

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

(c) Effective for discharges occurring on and after November 1, 2014, payment rates for hospital inpatient services provided by hospitals located in Minnesota or the local trade area, except for the hospitals paid under the methodologies described in paragraph (a), clauses (2) and (3), shall be rebased, incorporating cost and payment methodologies in a manner similar to Medicare. The base year or years for the rates effective November 1,

2014, shall be calendar year 2012. The rebasing under this paragraph shall be budget neutral, ensuring that the total aggregate payments under the rebased system are equal to the total aggregate payments that were made for the same number and types of services in the base year. Separate budget neutrality calculations shall be determined for payments made to critical access hospitals and payments made to hospitals paid under the DRG system. Only the rate increases or decreases under subdivision 3a or 3c that applied to the hospitals being rebased during the entire base period shall be incorporated into the budget neutrality calculation.

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

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

(1) pediatric services;

(2) behavioral health services;

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

(4) transplant services;

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

(6) outlier admissions;

(7) low-volume providers; and

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

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

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

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

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

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

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

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

(i) Effective for discharges occurring on or after July 1, 2015, inpatient payment rates for critical access hospitals located in Minnesota or the local trade area shall be determined using a new cost-based methodology. The commissioner shall establish within the methodology tiers of payment designed to promote efficiency and cost-effectiveness. Payment rates for hospitals under this paragraph shall be set at a level that does not exceed the total cost for critical access hospitals as reflected in base year cost reports. Until the next rebasing that occurs, the new methodology shall result in no greater than a five percent decrease from the base year payments for any hospital, except a hospital that had payments that were greater than 100 percent of the hospital's costs in the base year shall have their rate set equal to 100 percent of costs in the base year. The rates paid for discharges on and after July 1, 2016, covered under this paragraph shall be increased by the inflation factor in subdivision 1, paragraph (a). The new cost-based rate shall be the final rate and shall not be settled to actual incurred costs. Hospitals shall be assigned a payment tier based on the following criteria:

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

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

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

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

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

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

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

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

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

(6) geographic location.

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

Sec. 6. Minnesota Statutes 2022, section 256.969, subdivision 25, is amended to read:

Subd. 25. **Long-term hospital rates.** (a) Long-term hospitals shall be paid on a per diem basis.

(b) For admissions occurring on or after April 1, 1995, a long-term hospital as designated by Medicare that does not have admissions in the base year shall have inpatient rates established at the average of other hospitals with the same designation. For subsequent rate-setting periods in which base years are updated, the hospital's base year shall be the first Medicare cost report filed with the long-term hospital designation and shall remain in effect until it falls within the same period as other hospitals.

(c) For admissions occurring on or after July 1, 2023, long-term hospitals must be paid the higher of a per diem amount computed using the methodology described in subdivision 2b, paragraph (i), or the per diem rate as of July 1, 2021.

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

Sec. 7. Minnesota Statutes 2022, section 256.969, is amended by adding a subdivision to read:

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

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

EFFECTIVE DATE. This section is effective January 1, 2024.

Sec. 8. Minnesota Statutes 2022, section 256B.04, subdivision 14, is amended to read:

Subd. 14. **Competitive bidding.** (a) When determined to be effective, economical, and feasible, the commissioner may utilize volume purchase through competitive bidding and

negotiation under the provisions of chapter 16C, to provide items under the medical assistance program including but not limited to the following:

(1) eyeglasses;

(2) oxygen. The commissioner shall provide for oxygen needed in an emergency situation on a short-term basis, until the vendor can obtain the necessary supply from the contract dealer;

(3) hearing aids and supplies;

(4) durable medical equipment, including but not limited to:

(i) hospital beds;

(ii) commodes;

(iii) glide-about chairs;

(iv) patient lift apparatus;

(v) wheelchairs and accessories;

(vi) oxygen administration equipment;

(vii) respiratory therapy equipment;

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

(ix) allergen-reducing products as described in section 256B.0625, subdivision 67, paragraph (c) or (d);

(5) nonemergency medical transportation level of need determinations, disbursement of public transportation passes and tokens, and volunteer and recipient mileage and parking reimbursements; ~~and~~

(6) drugs~~.~~; and

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

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

(c) The commissioner may not utilize volume purchase through competitive bidding and negotiation under the provisions of chapter 16C for special transportation services or incontinence products and related supplies.

Sec. 9. Minnesota Statutes 2022, section 256B.055, subdivision 17, is amended to read:

Subd. 17. **Adults who were in foster care at the age of 18.** (a) Medical assistance may be paid for a person under 26 years of age who was in foster care under the commissioner's responsibility on the date of attaining 18 years of age, and who was enrolled in medical assistance under the state plan or a waiver of the plan while in foster care, in accordance with section 2004 of the Affordable Care Act.

(b) Beginning July 1, 2023, medical assistance may be paid for a person under 26 years of age who was in foster care on the date of attaining 18 years of age and enrolled in another state's Medicaid program while in foster care in accordance with the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act of 2018. Public Law 115-271, section 1002.

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

Sec. 10. Minnesota Statutes 2022, section 256B.0625, subdivision 9, is amended to read:

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

~~(b) Medical assistance dental coverage for nonpregnant adults is limited to the following services:~~

~~(1) comprehensive exams, limited to once every five years;~~

~~(2) periodic exams, limited to one per year;~~

~~(3) limited exams;~~

~~(4) bitewing x-rays, limited to one per year;~~

~~(5) periapical x-rays;~~

~~(6) panoramic x-rays, limited to one every five years except (1) when medically necessary for the diagnosis and follow-up of oral and maxillofacial pathology and trauma or (2) once every two years for patients who cannot cooperate for intraoral film due to a developmental disability or medical condition that does not allow for intraoral film placement;~~

~~(7) prophylaxis, limited to one per year;~~

~~(8) application of fluoride varnish, limited to one per year;~~

~~(9) posterior fillings, all at the amalgam rate;~~

~~(10) anterior fillings;~~

~~(11) endodontics, limited to root canals on the anterior and premolars only;~~

~~(12) removable prostheses, each dental arch limited to one every six years;~~

~~(13) oral surgery, limited to extractions, biopsies, and incision and drainage of abscesses;~~

~~(14) palliative treatment and sedative fillings for relief of pain;~~

~~(15) full-mouth debridement, limited to one every five years; and~~

~~(16) nonsurgical treatment for periodontal disease, including scaling and root planing once every two years for each quadrant, and routine periodontal maintenance procedures.~~

~~(c) In addition to the services specified in paragraph (b), medical assistance covers the following services for adults, if provided in an outpatient hospital setting or freestanding ambulatory surgical center as part of outpatient dental surgery:~~

~~(1) periodontics, limited to periodontal scaling and root planing once every two years;~~

~~(2) general anesthesia; and~~

~~(3) full-mouth survey once every five years.~~

~~(d) Medical assistance covers medically necessary dental services for children and pregnant women.~~ The following guidelines apply:

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

(2) application of sealants are covered once every five years per permanent molar ~~for children only~~;

(3) application of fluoride varnish is covered once every six months; and

(4) orthodontia is eligible for coverage for children only.

~~(e)~~ (b) In addition to the services specified in ~~paragraphs (b) and (c)~~ paragraph (a), medical assistance covers the following services for adults:

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

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

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

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

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

EFFECTIVE DATE. This section is effective January 1, 2024, or upon federal approval, whichever is later.

Sec. 11. Minnesota Statutes 2022, section 256B.0625, subdivision 13c, is amended to read:

Subd. 13c. **Formulary Committee.** The commissioner, after receiving recommendations from professional medical associations and professional pharmacy associations, and consumer groups shall designate a Formulary Committee to carry out duties as described in subdivisions 13 to 13g. The Formulary Committee shall be comprised of ~~four~~ at least five licensed physicians actively engaged in the practice of medicine in Minnesota, one of whom ~~must be actively engaged in the treatment of persons with mental illness~~ is an actively practicing psychiatrist, one of whom specializes in the diagnosis and treatment of rare diseases, one of whom specializes in pediatrics, and one of whom actively treats persons with disabilities; at least three licensed pharmacists actively engaged in the practice of pharmacy in Minnesota, one of whom practices outside the metropolitan counties listed in section 473.121, subdivision 4, one of whom practices in the metropolitan counties listed in section 473.121, subdivision 4, and one of whom is a practicing hospital pharmacist; ~~and one~~ at least four consumer ~~representative~~ representatives, all of whom must have a personal or professional connection to medical assistance; and one representative designated by the Minnesota Rare Disease Advisory Council established under section 256.4835; the remainder to be made up of health care professionals who are licensed in their field and have recognized knowledge in the clinically appropriate prescribing, dispensing, and monitoring of covered outpatient drugs. Members of the Formulary Committee shall not be employed by the Department of Human Services, but the committee shall be staffed by an employee of the department who shall serve as an ex officio, nonvoting member of the committee. The department's medical director shall also serve as an ex officio, nonvoting member for the committee. Committee members shall serve three-year terms and may be reappointed by the commissioner. The Formulary Committee shall meet at least ~~twice~~ per year. The commissioner may require more frequent Formulary Committee meetings as needed. An honorarium of $100 per meeting and reimbursement for mileage shall be paid to each committee member in attendance. Notwithstanding section 15.059, subdivision 6, the Formulary Committee ~~expires June 30, 2023~~ does not expire.

Sec. 12. Minnesota Statutes 2022, section 256B.0625, subdivision 13e, is amended to read:

Subd. 13e. **Payment rates.** (a) The basis for determining the amount of payment shall be the lower of the ingredient costs of the drugs plus the professional dispensing fee; or the usual and customary price charged to the public. The usual and customary price means the lowest price charged by the provider to a patient who pays for the prescription by cash, check, or charge account and includes prices the pharmacy charges to a patient enrolled in a prescription savings club or prescription discount club administered by the pharmacy or pharmacy chain. The amount of payment basis must be reduced to reflect all discount amounts applied to the charge by any third-party provider/insurer agreement or contract for submitted charges to medical assistance programs. The net submitted charge may not be greater than the patient liability for the service. The professional dispensing fee shall be $10.77 for prescriptions filled with legend drugs meeting the definition of "covered outpatient drugs" according to United States Code, title 42, section 1396r-8(k)(2). The dispensing fee for intravenous solutions that must be compounded by the pharmacist shall be $10.77 per claim. The professional dispensing fee for prescriptions filled with over-the-counter drugs meeting the definition of covered outpatient drugs shall be $10.77 for dispensed quantities equal to or greater than the number of units contained in the manufacturer's original package. The professional dispensing fee shall be prorated based on the percentage of the package dispensed when the pharmacy dispenses a quantity less than the number of units contained in the manufacturer's original package. The pharmacy dispensing fee for prescribed over-the-counter drugs not meeting the definition of covered outpatient drugs shall be $3.65 for quantities equal to or greater than the number of units contained in the manufacturer's original package and shall be prorated based on the percentage of the package dispensed when the pharmacy dispenses a quantity less than the number of units contained in the manufacturer's original package. The National Average Drug Acquisition Cost (NADAC) shall be used to determine the ingredient cost of a drug. For drugs for which a NADAC is not reported, the commissioner shall estimate the ingredient cost at the wholesale acquisition cost minus two percent. The ingredient cost of a drug for a provider participating in the federal 340B Drug Pricing Program shall be either the 340B Drug Pricing Program ceiling price established by the Health Resources and Services Administration or NADAC, whichever is lower. Wholesale acquisition cost is defined as the manufacturer's list price for a drug or biological to wholesalers or direct purchasers in the United States, not including prompt pay or other discounts, rebates, or reductions in price, for the most recent month for which information is available, as reported in wholesale price guides or other publications of drug or biological pricing data. The maximum allowable cost of a multisource drug may

be set by the commissioner and it shall be comparable to the actual acquisition cost of the drug product and no higher than the NADAC of the generic product. Establishment of the amount of payment for drugs shall not be subject to the requirements of the Administrative Procedure Act.

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

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

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

(e) The basis for determining the amount of payment for drugs administered in an outpatient setting shall be the lower of the usual and customary cost submitted by the provider, 106 percent of the average sales price as determined by the United States Department of Health and Human Services pursuant to title XVIII, section 1847a of the federal Social Security Act, the specialty pharmacy rate, or the maximum allowable cost set by the commissioner. If average sales price is unavailable, the amount of payment must be lower of the usual and customary cost submitted by the provider, the wholesale acquisition cost, the specialty pharmacy rate, or the maximum allowable cost set by the commissioner. The commissioner shall discount the payment rate for drugs obtained through the federal 340B Drug Pricing Program by 28.6 percent. The payment for drugs administered in an outpatient setting shall be made to the administering facility or practitioner. A retail or

specialty pharmacy dispensing a drug for administration in an outpatient setting is not eligible for direct reimbursement.

(f) The commissioner may establish maximum allowable cost rates for specialty pharmacy products that are lower than the ingredient cost formulas specified in paragraph (a). The commissioner may require individuals enrolled in the health care programs administered by the department to obtain specialty pharmacy products from providers with whom the commissioner has negotiated lower reimbursement rates. Specialty pharmacy products are defined as those used by a small number of recipients or recipients with complex and chronic diseases that require expensive and challenging drug regimens. Examples of these conditions include, but are not limited to: multiple sclerosis, HIV/AIDS, transplantation, hepatitis C, growth hormone deficiency, Crohn's Disease, rheumatoid arthritis, and certain forms of cancer. Specialty pharmaceutical products include injectable and infusion therapies, biotechnology drugs, antihemophilic factor products, high-cost therapies, and therapies that require complex care. The commissioner shall consult with the Formulary Committee to develop a list of specialty pharmacy products subject to maximum allowable cost reimbursement. In consulting with the Formulary Committee in developing this list, the commissioner shall take into consideration the population served by specialty pharmacy products, the current delivery system and standard of care in the state, and access to care issues. The commissioner shall have the discretion to adjust the maximum allowable cost to prevent access to care issues.

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

(h) The commissioner shall contract with a vendor to conduct a cost of dispensing survey for all pharmacies that are physically located in the state of Minnesota that dispense outpatient drugs under medical assistance. The commissioner shall ensure that the vendor has prior experience in conducting cost of dispensing surveys. Each pharmacy enrolled with the department to dispense outpatient prescription drugs to fee-for-service members must respond to the cost of dispensing survey. The commissioner may sanction a pharmacy under section 256B.064 for failure to respond. The commissioner shall require the vendor to measure a single statewide cost of dispensing for specialty prescription drugs and a single statewide cost of dispensing for nonspecialty prescription drugs for all responding pharmacies to measure the mean, mean weighted by total prescription volume, mean weighted by medical assistance prescription volume, median, median weighted by total prescription volume, and median weighted by total medical assistance prescription volume. The commissioner shall post a copy of the final cost of dispensing survey report on the

department's website. The initial survey must be completed no later than January 1, 2021, and repeated every three years. The commissioner shall provide a summary of the results of each cost of dispensing survey and provide recommendations for any changes to the dispensing fee to the chairs and ranking members of the legislative committees with jurisdiction over medical assistance pharmacy reimbursement. Notwithstanding section 256.01, subdivision 42, this paragraph does not expire.

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

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

Sec. 13. Minnesota Statutes 2022, section 256B.0625, is amended by adding a subdivision to read:

Subd. 13k. **Value-based purchasing arrangements.** (a) The commissioner may enter into a value-based purchasing arrangement for the medical assistance or MinnesotaCare program by written arrangement with a drug manufacturer based on agreed-upon metrics. The commissioner may enter into a contract with a vendor for the purpose of participating in a value-based purchasing arrangement. A value-based purchasing arrangement may include a rebate, a discount, a price reduction, risk sharing, a reimbursement, a guarantee, shared savings payments, withholds, a bonus, or any other thing of value. A value-based purchasing arrangement must provide the same amount or more of a value or discount in the aggregate as would claiming the mandatory federal drug rebate under the Federal Social Security Act, section 1927.

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

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

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

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

Sec. 14. Minnesota Statutes 2022, section 256B.0625, subdivision 16, is amended to read:

Subd. 16. **Abortion services.** Medical assistance covers abortion services~~, but only if one of the following conditions is met:~~ determined to be medically necessary by the treating provider and delivered in accordance with all applicable Minnesota laws.

~~(a) The abortion is a medical necessity. "Medical necessity" means (1) the signed written statement of two physicians indicating the abortion is medically necessary to prevent the death of the mother, and (2) the patient has given her consent to the abortion in writing unless the patient is physically or legally incapable of providing informed consent to the procedure, in which case consent will be given as otherwise provided by law;~~

~~(b) The pregnancy is the result of criminal sexual conduct as defined in section 609.342, subdivision 1, clauses (a), (b), (c)(i) and (ii), and (e), and subdivision 1a, clauses (a), (b), (c)(i) and (ii), and (d), and the incident is reported within 48 hours after the incident occurs to a valid law enforcement agency for investigation, unless the victim is physically unable to report the criminal sexual conduct, in which case the report shall be made within 48 hours after the victim becomes physically able to report the criminal sexual conduct; or~~

~~(c) The pregnancy is the result of incest, but only if the incident and relative are reported to a valid law enforcement agency for investigation prior to the abortion.~~

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

Sec. 15. Minnesota Statutes 2022, section 256B.0625, subdivision 22, is amended to read:

Subd. 22. **Hospice care.** Medical assistance covers hospice care services under Public Law 99-272, section 9505, to the extent authorized by rule, except that a recipient age 21 or under who elects to receive hospice services does not waive coverage for services that are related to the treatment of the condition for which a diagnosis of terminal illness has been made. Hospice respite and end-of-life care under subdivision 22a are not hospice care services under this subdivision.

Sec. 16. Minnesota Statutes 2022, section 256B.0625, is amended by adding a subdivision to read:

Subd. 22a. **Residential hospice facility; hospice respite and end-of-life care for children.** (a) Medical assistance covers hospice respite and end-of-life care if the care is for recipients age 21 or under who elect to receive hospice care delivered in a facility that is licensed under sections 144A.75 to 144A.755 and that is a residential hospice facility

under section 144A.75, subdivision 13, paragraph (a). Hospice care services under subdivision 22 are not hospice respite or end-of-life care under this subdivision.

(b) The payment rates for coverage under this subdivision must be 100 percent of the Medicare rate for continuous home care hospice services as published in the Centers for Medicare and Medicaid Services annual final rule updating payments and policies for hospice care. The commissioner must seek to obtain federal financial participation for payment for hospice respite and end-of-life care under this subdivision. Payment must be made using state-only funds, if federal financial participation is not obtained. Payment for hospice respite and end-of-life care must be paid to the residential hospice facility and are not included in any limit or cap amount applicable to hospice services payments to the elected hospice services provider.

(c) Certification of the residential hospice facility by the federal Medicare program must not be a requirement of medical assistance payment for hospice respite and end-of-life care under this subdivision.

Sec. 17. Minnesota Statutes 2022, section 256B.0625, subdivision 28b, is amended to read:

Subd. 28b. **Doula services.** Medical assistance covers doula services provided by a certified doula as defined in section 148.995, subdivision 2, of the mother's choice. For purposes of this section, "doula services" means childbirth education and support services, including emotional and physical support provided during pregnancy, labor, birth, and postpartum. The commissioner shall enroll doula agencies and individual treating doulas to provide direct reimbursement.

EFFECTIVE DATE. This section is effective January 1, 2024, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 18. Minnesota Statutes 2022, section 256B.0625, subdivision 30, is amended to read:

Subd. 30. **Other clinic services.** (a) Medical assistance covers rural health clinic services, federally qualified health center services, nonprofit community health clinic services, and public health clinic services. Rural health clinic services and federally qualified health center services mean services defined in United States Code, title 42, section 1396d(a)(2)(B) and (C). Payment for rural health clinic and federally qualified health center services shall be made according to applicable federal law and regulation.

(b) A federally qualified health center (FQHC) that is beginning initial operation shall submit an estimate of budgeted costs and visits for the initial reporting period in the form and detail required by the commissioner. An FQHC that is already in operation shall submit an initial report using actual costs and visits for the initial reporting period. Within 90 days of the end of its reporting period, an FQHC shall submit, in the form and detail required by the commissioner, a report of its operations, including allowable costs actually incurred for the period and the actual number of visits for services furnished during the period, and other information required by the commissioner. FQHCs that file Medicare cost reports shall provide the commissioner with a copy of the most recent Medicare cost report filed with the Medicare program intermediary for the reporting year which support the costs claimed on their cost report to the state.

(c) In order to continue cost-based payment under the medical assistance program according to paragraphs (a) and (b), an FQHC or rural health clinic must apply for designation as an essential community provider within six months of final adoption of rules by the Department of Health according to section 62Q.19, subdivision 7. For those FQHCs and rural health clinics that have applied for essential community provider status within the six-month time prescribed, medical assistance payments will continue to be made according to paragraphs (a) and (b) for the first three years after application. For FQHCs and rural health clinics that either do not apply within the time specified above or who have had essential community provider status for three years, medical assistance payments for health services provided by these entities shall be according to the same rates and conditions applicable to the same service provided by health care providers that are not FQHCs or rural health clinics.

(d) Effective July 1, 1999, the provisions of paragraph (c) requiring an FQHC or a rural health clinic to make application for an essential community provider designation in order to have cost-based payments made according to paragraphs (a) and (b) no longer apply.

(e) Effective January 1, 2000, payments made according to paragraphs (a) and (b) shall be limited to the cost phase-out schedule of the Balanced Budget Act of 1997.

(f) Effective January 1, 2001, through December 31, 2020, each FQHC and rural health clinic may elect to be paid either under the prospective payment system established in United States Code, title 42, section 1396a(aa), or under an alternative payment methodology consistent with the requirements of United States Code, title 42, section 1396a(aa), and approved by the Centers for Medicare and Medicaid Services. The alternative payment methodology shall be 100 percent of cost as determined according to Medicare cost principles.

(g) Effective for services provided on or after January 1, 2021, all claims for payment of clinic services provided by FQHCs and rural health clinics shall be paid by the commissioner, according to an annual election by the FQHC or rural health clinic, under the current prospective payment system described in paragraph (f) or the alternative payment methodology described in paragraph (l).

(h) For purposes of this section, "nonprofit community clinic" is a clinic that:

(1) has nonprofit status as specified in chapter 317A;

(2) has tax exempt status as provided in Internal Revenue Code, section 501(c)(3);

(3) is established to provide health services to low-income population groups, uninsured, high-risk and special needs populations, underserved and other special needs populations;

(4) employs professional staff at least one-half of which are familiar with the cultural background of their clients;

(5) charges for services on a sliding fee scale designed to provide assistance to low-income clients based on current poverty income guidelines and family size; and

(6) does not restrict access or services because of a client's financial limitations or public assistance status and provides no-cost care as needed.

(i) Effective for services provided on or after January 1, 2015, all claims for payment of clinic services provided by FQHCs and rural health clinics shall be paid by the commissioner. the commissioner shall determine the most feasible method for paying claims from the following options:

(1) FQHCs and rural health clinics submit claims directly to the commissioner for payment, and the commissioner provides claims information for recipients enrolled in a managed care or county-based purchasing plan to the plan, on a regular basis; or

(2) FQHCs and rural health clinics submit claims for recipients enrolled in a managed care or county-based purchasing plan to the plan, and those claims are submitted by the plan to the commissioner for payment to the clinic.

(j) For clinic services provided prior to January 1, 2015, the commissioner shall calculate and pay monthly the proposed managed care supplemental payments to clinics, and clinics shall conduct a timely review of the payment calculation data in order to finalize all supplemental payments in accordance with federal law. Any issues arising from a clinic's review must be reported to the commissioner by January 1, 2017. Upon final agreement between the commissioner and a clinic on issues identified under this subdivision, and in

accordance with United States Code, title 42, section 1396a(bb), no supplemental payments for managed care plan or county-based purchasing plan claims for services provided prior to January 1, 2015, shall be made after June 30, 2017. If the commissioner and clinics are unable to resolve issues under this subdivision, the parties shall submit the dispute to the arbitration process under section 14.57.

(k) The commissioner shall seek a federal waiver, authorized under section 1115 of the Social Security Act, to obtain federal financial participation at the 100 percent federal matching percentage available to facilities of the Indian Health Service or tribal organization in accordance with section 1905(b) of the Social Security Act for expenditures made to organizations dually certified under Title V of the Indian Health Care Improvement Act, Public Law 94-437, and as a federally qualified health center under paragraph (a) that provides services to American Indian and Alaskan Native individuals eligible for services under this subdivision.

(l) All claims for payment of clinic services provided by FQHCs and rural health clinics, that have elected to be paid under this paragraph, shall be paid by the commissioner according to the following requirements:

(1) the commissioner shall establish a single medical and single dental organization encounter rate for each FQHC and rural health clinic when applicable;

(2) each FQHC and rural health clinic is eligible for same day reimbursement of one medical and one dental organization encounter rate if eligible medical and dental visits are provided on the same day;

(3) the commissioner shall reimburse FQHCs and rural health clinics, in accordance with current applicable Medicare cost principles, their allowable costs, including direct patient care costs and patient-related support services. Nonallowable costs include, but are not limited to:

(i) general social services and administrative costs;

(ii) retail pharmacy;

(iii) patient incentives, food, housing assistance, and utility assistance;

(iv) external lab and x-ray;

(v) navigation services;

(vi) health care taxes;

(vii) advertising, public relations, and marketing;

(viii) office entertainment costs, food, alcohol, and gifts;

(ix) contributions and donations;

(x) bad debts or losses on awards or contracts;

(xi) fines, penalties, damages, or other settlements;

(xii) fundraising, investment management, and associated administrative costs;

(xiii) research and associated administrative costs;

(xiv) nonpaid workers;

(xv) lobbying;

(xvi) scholarships and student aid; and

(xvii) nonmedical assistance covered services;

(4) the commissioner shall review the list of nonallowable costs in the years between the rebasing process established in clause (5), in consultation with the Minnesota Association of Community Health Centers, FQHCs, and rural health clinics. The commissioner shall publish the list and any updates in the Minnesota health care programs provider manual;

(5) the initial applicable base year organization encounter rates for FQHCs and rural health clinics shall be computed for services delivered on or after January 1, 2021, and:

(i) must be determined using each FQHC's and rural health clinic's Medicare cost reports from 2017 and 2018;

(ii) must be according to current applicable Medicare cost principles as applicable to FQHCs and rural health clinics without the application of productivity screens and upper payment limits or the Medicare prospective payment system FQHC aggregate mean upper payment limit;

(iii) must be subsequently rebased every two years thereafter using the Medicare cost reports that are three and four years prior to the rebasing year. Years in which organizational cost or claims volume is reduced or altered due to a pandemic, disease, or other public health emergency shall not be used as part of a base year when the base year includes more than one year. The commissioner may use the Medicare cost reports of a year unaffected by a pandemic, disease, or other public health emergency, or previous two consecutive years, inflated to the base year as established under item (iv);

(iv) must be inflated to the base year using the inflation factor described in clause (6); and

(v) the commissioner must provide for a 60-day appeals process under section 14.57;

(6) the commissioner shall annually inflate the applicable organization encounter rates for FQHCs and rural health clinics from the base year payment rate to the effective date by using the CMS FQHC Market Basket inflator established under United States Code, title 42, section 1395m(o), less productivity;

(7) FQHCs and rural health clinics that have elected the alternative payment methodology under this paragraph shall submit all necessary documentation required by the commissioner to compute the rebased organization encounter rates no later than six months following the date the applicable Medicare cost reports are due to the Centers for Medicare and Medicaid Services;

(8) the commissioner shall reimburse FQHCs and rural health clinics an additional amount relative to their medical and dental organization encounter rates that is attributable to the tax required to be paid according to section 295.52, if applicable;

(9) FQHCs and rural health clinics may submit change of scope requests to the commissioner if the change of scope would result in an increase or decrease of 2.5 percent or higher in the medical or dental organization encounter rate currently received by the FQHC or rural health clinic;

(10) for FQHCs and rural health clinics seeking a change in scope with the commissioner under clause (9) that requires the approval of the scope change by the federal Health Resources Services Administration:

(i) FQHCs and rural health clinics shall submit the change of scope request, including the start date of services, to the commissioner within seven business days of submission of the scope change to the federal Health Resources Services Administration;

(ii) the commissioner shall establish the effective date of the payment change as the federal Health Resources Services Administration date of approval of the FQHC's or rural health clinic's scope change request, or the effective start date of services, whichever is later; and

(iii) within 45 days of one year after the effective date established in item (ii), the commissioner shall conduct a retroactive review to determine if the actual costs established under clause (3) or encounters result in an increase or decrease of 2.5 percent or higher in the medical or dental organization encounter rate, and if this is the case, the commissioner shall revise the rate accordingly and shall adjust payments retrospectively to the effective date established in item (ii);

(11) for change of scope requests that do not require federal Health Resources Services Administration approval, the FQHC and rural health clinic shall submit the request to the commissioner before implementing the change, and the effective date of the change is the date the commissioner received the FQHC's or rural health clinic's request, or the effective start date of the service, whichever is later. The commissioner shall provide a response to the FQHC's or rural health clinic's request within 45 days of submission and provide a final approval within 120 days of submission. This timeline may be waived at the mutual agreement of the commissioner and the FQHC or rural health clinic if more information is needed to evaluate the request;

(12) the commissioner, when establishing organization encounter rates for new FQHCs and rural health clinics, shall consider the patient caseload of existing FQHCs and rural health clinics in a 60-mile radius for organizations established outside of the seven-county metropolitan area, and in a 30-mile radius for organizations in the seven-county metropolitan area. If this information is not available, the commissioner may use Medicare cost reports or audited financial statements to establish base rates;

(13) the commissioner shall establish a quality measures workgroup that includes representatives from the Minnesota Association of Community Health Centers, FQHCs, and rural health clinics, to evaluate clinical and nonclinical measures; and

(14) the commissioner shall not disallow or reduce costs that are related to an FQHC's or rural health clinic's participation in health care educational programs to the extent that the costs are not accounted for in the alternative payment methodology encounter rate established in this paragraph.

(m) Effective July 1, 2023, an enrolled Indian health service facility or a Tribal health center operating under a 638 contract or compact may elect to also enroll as a Tribal FQHC. Requirements that otherwise apply to an FQHC covered in this subdivision do not apply to a Tribal FQHC enrolled under this paragraph, except that any requirements necessary to comply with federal regulations do apply to a Tribal FQHC. The commissioner shall establish an alternative payment method for a Tribal FQHC enrolled under this paragraph that uses the same method and rates applicable to a Tribal facility or health center that does not enroll as a Tribal FQHC.

Sec. 19. Minnesota Statutes 2022, section 256B.0625, subdivision 31, is amended to read:

Subd. 31. **Medical supplies and equipment.** (a) Medical assistance covers medical supplies and equipment. Separate payment outside of the facility's payment rate shall be made for wheelchairs and wheelchair accessories for recipients who are residents of

intermediate care facilities for the developmentally disabled. Reimbursement for wheelchairs and wheelchair accessories for ICF/DD recipients shall be subject to the same conditions and limitations as coverage for recipients who do not reside in institutions. A wheelchair purchased outside of the facility's payment rate is the property of the recipient.

(b) Vendors of durable medical equipment, prosthetics, orthotics, or medical supplies must enroll as a Medicare provider.

(c) When necessary to ensure access to durable medical equipment, prosthetics, orthotics, or medical supplies, the commissioner may exempt a vendor from the Medicare enrollment requirement if:

(1) the vendor supplies only one type of durable medical equipment, prosthetic, orthotic, or medical supply;

(2) the vendor serves ten or fewer medical assistance recipients per year;

(3) the commissioner finds that other vendors are not available to provide same or similar durable medical equipment, prosthetics, orthotics, or medical supplies; and

(4) the vendor complies with all screening requirements in this chapter and Code of Federal Regulations, title 42, part 455. The commissioner may also exempt a vendor from the Medicare enrollment requirement if the vendor is accredited by a Centers for Medicare and Medicaid Services approved national accreditation organization as complying with the Medicare program's supplier and quality standards and the vendor serves primarily pediatric patients.

(d) Durable medical equipment means a device or equipment that:

(1) can withstand repeated use;

(2) is generally not useful in the absence of an illness, injury, or disability; and

(3) is provided to correct or accommodate a physiological disorder or physical condition or is generally used primarily for a medical purpose.

(e) Electronic tablets may be considered durable medical equipment if the electronic tablet will be used as an augmentative and alternative communication system as defined under subdivision 31a, paragraph (a). To be covered by medical assistance, the device must be locked in order to prevent use not related to communication.

(f) Notwithstanding the requirement in paragraph (e) that an electronic tablet must be locked to prevent use not as an augmentative communication device, a recipient of waiver services may use an electronic tablet for a use not related to communication when the

recipient has been authorized under the waiver to receive one or more additional applications that can be loaded onto the electronic tablet, such that allowing the additional use prevents the purchase of a separate electronic tablet with waiver funds.

(g) An order or prescription for medical supplies, equipment, or appliances must meet the requirements in Code of Federal Regulations, title 42, part 440.70.

(h) Allergen-reducing products provided according to subdivision 67, paragraph (c) or (d), shall be considered durable medical equipment.

(i) Seizure detection devices are covered as durable medical equipment under this subdivision if:

(1) the seizure detection device is medically appropriate based on the recipient's medical condition or status; and

(2) the recipient's health care provider has identified that a seizure detection device would:

(i) likely assist in reducing bodily harm to or death of the recipient as a result of the recipient experiencing a seizure; or

(ii) provide data to the health care provider necessary to appropriately diagnose or treat a health condition of the recipient that causes the seizure activity.

(j) For purposes of paragraph (i), "seizure detection device" means a United States Food and Drug Administration-approved monitoring device and related service or subscription supporting the prescribed use of the device, including technology that provides ongoing patient monitoring and alert services that detect seizure activity and transmit notification of the seizure activity to a caregiver for appropriate medical response or collects data of the seizure activity of the recipient that can be used by a health care provider to diagnose or appropriately treat a health care condition that causes the seizure activity.

EFFECTIVE DATE. This section is effective January 1, 2024, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 20. Minnesota Statutes 2022, section 256B.0625, is amended by adding a subdivision to read:

Subd. 68. **Tobacco and nicotine cessation.** (a) Medical assistance covers tobacco and nicotine cessation services, drugs to treat tobacco and nicotine addiction or dependence, and drugs to help individuals discontinue use of tobacco and nicotine products. Medical

assistance must cover services and drugs as provided in this subdivision consistent with evidence-based or evidence-informed best practices.

(b) Medical assistance must cover in-person individual and group tobacco and nicotine cessation education and counseling services if provided by a health care practitioner whose scope of practice encompasses tobacco and nicotine cessation education and counseling. Service providers include but are not limited to the following:

(1) mental health practitioners under section 245.462, subdivision 17;

(2) mental health professionals under section 245.462, subdivision 18;

(3) mental health certified peer specialists under section 256B.0615;

(4) alcohol and drug counselors licensed under chapter 148F;

(5) recovery peers as defined in section 245F.02, subdivision 21;

(6) certified tobacco treatment specialists;

(7) community health workers;

(8) physicians;

(9) physician assistants;

(10) advanced practice registered nurses; or

(11) other licensed or nonlicensed professionals or paraprofessionals with training in providing tobacco and nicotine cessation education and counseling services.

(c) Medical assistance covers telephone cessation counseling services provided through a quitline. Notwithstanding section 256B.0625, subdivision 3b, quitline services may be provided through audio-only communications. The commissioner of human services may utilize volume purchasing for quitline services consistent with section 256B.04, subdivision 14.

(d) Medical assistance must cover all prescription and over-the-counter pharmacotherapy drugs approved by the United States Food and Drug Administration for cessation of tobacco and nicotine use or treatment of tobacco and nicotine dependence, and that are subject to a Medicaid drug rebate agreement.

(e) Services covered under this subdivision may be provided by telemedicine.

(f) The commissioner must not:

(1) restrict or limit the type, duration, or frequency of tobacco and nicotine cessation services;

(2) prohibit the simultaneous use of multiple cessation services, including but not limited to simultaneous use of counseling and drugs;

(3) require counseling before receiving drugs or as a condition of receiving drugs;

(4) limit pharmacotherapy drug dosage amounts for a dosing regimen for treatment of a medically accepted indication as defined in United States Code, title 14, section 1396r-8(K)(6); limit dosing frequency; or impose duration limits;

(5) prohibit simultaneous use of multiple drugs, including prescription and over-the-counter drugs;

(6) require or authorize step therapy; or

(7) require or utilize prior authorization or require a co-payment or deductible for any tobacco and nicotine cessation services and drugs covered under this subdivision.

Sec. 21. Minnesota Statutes 2022, section 256B.0625, is amended by adding a subdivision to read:

Subd. 68. **Recuperative care services.** (a) Medical assistance covers recuperative care services provided in a setting that meets the requirements in paragraph (b) for recipients who meet the eligibility requirements in paragraph (c). For purposes of this subdivision, "recuperative care" means a model of care that prevents hospitalization or that provides postacute medical care and support services for recipients experiencing homelessness who are too ill or frail to recover from a physical illness or injury while living in a shelter or are otherwise unhoused but who are not sick enough to be hospitalized, or remain hospitalized, or to need other levels of care.

(b) Recuperative care may be provided in any setting, including but not limited to homeless shelters, congregate care settings, single room occupancy settings, or supportive housing, so long as the provider of recuperative care or provider of housing is able to provide to the recipient within the designated setting, at a minimum:

(1) 24-hour access to a bed and bathroom;

(2) access to three meals a day;

(3) availability to environmental services;

(4) access to a telephone;

(5) a secure place to store belongings; and

(6) staff available within the setting to provide a wellness check as needed, but at a minimum, at least once every 24 hours.

(c) To be eligible for this covered service, a recipient must:

(1) be 21 years of age or older;

(2) be experiencing homelessness;

(3) be in need of short term acute medical care for a period of no more than 60 days;

(4) meet clinical criteria, as established by the commissioner, that indicates that the recipient is in need of recuperative care; and

(5) not have behavioral health needs that are greater than what can be managed by the provider within the setting.

(d) Payment for recuperative care shall consist of two components. The first component must be for the services provided to the member and is a bundled daily per diem payment of at least $300 per day. The second component must be for the facility costs and must be paid using state funds equivalent to the amount paid as the medical assistance room and board rate and annual adjustments. The eligibility standards in chapter 256I shall not apply. The second component is only paid when the first component is paid to a provider. Providers may opt to only be reimbursed for the first component. A provider under this subdivision means a recuperative care provider and is defined by the standards established by the National Institute for Medical Respite Care. Services provided within the bundled payment may include but are not limited to:

(1) basic nursing care, including:

(i) monitoring a patient's physical health and pain level;

(ii) providing wound care;

(iii) medication support;

(iv) patient education;

(v) immunization review and update; and

(vi) establishing clinical goals for the recuperative care period and discharge plan;

(2) care coordination, including:

(i) initial assessment of medical, behavioral, and social needs;

(ii) development of a care plan;

(iii) support and referral assistance for legal services, housing, community social services, case management, health care benefits, health and other eligible benefits, and transportation needs and services; and

(iv) monitoring and follow-up to ensure that the care plan is effectively implemented to address the medical, behavioral, and social needs;

(3) basic behavioral needs, including counseling and peer support, that can be provided in this recuperative care setting; and

(4) services provided by a community health worker as defined under subdivision 49.

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

(f) If a recipient is temporarily absent due to an admission at a residential behavioral health facility, inpatient hospital, or nursing facility for a period of time exceeding the limits described in paragraph (d), the agency may request in a format prescribed by the commissioner an absence day limit exception to continue payments until the recipient is discharged.

(g) The commissioner shall submit an initial report to the chairs and ranking minority members of the legislative committees having jurisdiction over health and human services by February 1, 2025, and a final report by February 1, 2027, on coverage of recuperative care services. The reports must include, but are not limited to:

(1) a list of the recuperative care services in Minnesota and the number of recipients;

(2) the estimated return on investment, including health care savings due to reduced hospitalizations;

(3) follow-up information, if available, on whether recipients' hospital visits decreased since recuperative care services were provided compared to before the services were provided; and

(4) any other information that can be used to determine the effectiveness of the program and its funding, including recommendations for improvements to the program.

EFFECTIVE DATE. This section is effective January 1, 2024.

Sec. 22. Minnesota Statutes 2022, section 256B.196, subdivision 2, is amended to read:

Subd. 2. **Commissioner's duties.** (a) For the purposes of this subdivision and subdivision 3, the commissioner shall determine the fee-for-service outpatient hospital services upper payment limit for nonstate government hospitals. The commissioner shall then determine the amount of a supplemental payment to Hennepin County Medical Center and Regions Hospital for these services that would increase medical assistance spending in this category to the aggregate upper payment limit for all nonstate government hospitals in Minnesota. In making this determination, the commissioner shall allot the available increases between Hennepin County Medical Center and Regions Hospital based on the ratio of medical assistance fee-for-service outpatient hospital payments to the two facilities. The commissioner shall adjust this allotment as necessary based on federal approvals, the amount of intergovernmental transfers received from Hennepin and Ramsey Counties, and other factors, in order to maximize the additional total payments. The commissioner shall inform Hennepin County and Ramsey County of the periodic intergovernmental transfers necessary to match federal Medicaid payments available under this subdivision in order to make supplementary medical assistance payments to Hennepin County Medical Center and Regions Hospital equal to an amount that when combined with existing medical assistance payments to nonstate governmental hospitals would increase total payments to hospitals in this category for outpatient services to the aggregate upper payment limit for all hospitals in this category in Minnesota. Upon receipt of these periodic transfers, the commissioner shall make supplementary payments to Hennepin County Medical Center and Regions Hospital.

(b) For the purposes of this subdivision and subdivision 3, the commissioner shall determine an upper payment limit for physicians and other billing professionals affiliated with Hennepin County Medical Center and with Regions Hospital. The upper payment limit shall be based on the average commercial rate or be determined using another method acceptable to the Centers for Medicare and Medicaid Services. The commissioner shall inform Hennepin County and Ramsey County of the periodic intergovernmental transfers necessary to match the federal Medicaid payments available under this subdivision in order to make supplementary payments to physicians and other billing professionals affiliated with Hennepin County Medical Center and to make supplementary payments to physicians and other billing professionals affiliated with Regions Hospital through HealthPartners Medical Group equal to the difference between the established medical assistance payment for physician and other billing professional services and the upper payment limit. Upon receipt of these periodic transfers, the commissioner shall make supplementary payments to physicians and other billing professionals affiliated with Hennepin County Medical Center

and shall make supplementary payments to physicians and other billing professionals affiliated with Regions Hospital through HealthPartners Medical Group.

(c) Beginning January 1, 2010, Ramsey County may make monthly voluntary intergovernmental transfers to the commissioner in amounts not to exceed $6,000,000 per year. The commissioner shall increase the medical assistance capitation payments to any licensed health plan under contract with the medical assistance program that agrees to make enhanced payments to Regions Hospital. The increase shall be in an amount equal to the annual value of the monthly transfers plus federal financial participation, with each health plan receiving its pro rata share of the increase based on the pro rata share of medical assistance admissions to Regions Hospital by those plans. For the purposes of this paragraph, "the base amount" means the total annual value of increased medical assistance capitation payments, including the voluntary intergovernmental transfers, under this paragraph in calendar year 2017. For managed care contracts beginning on or after January 1, 2018, the commissioner shall reduce the total annual value of increased medical assistance capitation payments under this paragraph by an amount equal to ten percent of the base amount, and by an additional ten percent of the base amount for each subsequent contract year until December 31, 2025. Upon the request of the commissioner, health plans shall submit individual-level cost data for verification purposes. The commissioner may ratably reduce these payments on a pro rata basis in order to satisfy federal requirements for actuarial soundness. If payments are reduced, transfers shall be reduced accordingly. Any licensed health plan that receives increased medical assistance capitation payments under the intergovernmental transfer described in this paragraph shall increase its medical assistance payments to Regions Hospital by the same amount as the increased payments received in the capitation payment described in this paragraph. This paragraph expires January 1, 2026.

(d) For the purposes of this subdivision and subdivision 3, the commissioner shall determine an upper payment limit for ambulance services affiliated with Hennepin County Medical Center and the city of St. Paul, and ambulance services owned and operated by another governmental entity that chooses to participate by requesting the commissioner to determine an upper payment limit. The upper payment limit shall be based on the average commercial rate or be determined using another method acceptable to the Centers for Medicare and Medicaid Services. The commissioner shall inform Hennepin County, the city of St. Paul, and other participating governmental entities of the periodic intergovernmental transfers necessary to match the federal Medicaid payments available under this subdivision in order to make supplementary payments to Hennepin County Medical Center, the city of St. Paul, and other participating governmental entities equal to

the difference between the established medical assistance payment for ambulance services and the upper payment limit. Upon receipt of these periodic transfers, the commissioner shall make supplementary payments to Hennepin County Medical Center, the city of St. Paul, and other participating governmental entities. A tribal government that owns and operates an ambulance service is not eligible to participate under this subdivision.

(e) For the purposes of this subdivision and subdivision 3, the commissioner shall determine an upper payment limit for physicians, dentists, and other billing professionals affiliated with the University of Minnesota and University of Minnesota Physicians. The upper payment limit shall be based on the average commercial rate or be determined using another method acceptable to the Centers for Medicare and Medicaid Services. The commissioner shall inform the University of Minnesota Medical School and University of Minnesota School of Dentistry of the periodic intergovernmental transfers necessary to match the federal Medicaid payments available under this subdivision in order to make supplementary payments to physicians, dentists, and other billing professionals affiliated with the University of Minnesota and the University of Minnesota Physicians equal to the difference between the established medical assistance payment for physician, dentist, and other billing professional services and the upper payment limit. Upon receipt of these periodic transfers, the commissioner shall make supplementary payments to physicians, dentists, and other billing professionals affiliated with the University of Minnesota and the University of Minnesota Physicians.

(f) The commissioner shall inform the transferring governmental entities on an ongoing basis of the need for any changes needed in the intergovernmental transfers in order to continue the payments under paragraphs (a) to (e), at their maximum level, including increases in upper payment limits, changes in the federal Medicaid match, and other factors.

(g) The payments in paragraphs (a) to (e) shall be implemented independently of each other, subject to federal approval and to the receipt of transfers under subdivision 3.

(h) All of the data and funding transactions related to the payments in paragraphs (a) to (e) shall be between the commissioner and the governmental entities. The commissioner shall not make payments to governmental entities eligible to receive payments described in paragraphs (a) to (e) that fail to submit the data needed to compute the payments within 24 months of the initial request from the commissioner.

(i) For purposes of this subdivision, billing professionals are limited to physicians, nurse practitioners, nurse midwives, clinical nurse specialists, physician assistants,

anesthesiologists, certified registered nurse anesthetists, dentists, dental hygienists, and dental therapists.

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

Sec. 23. Minnesota Statutes 2022, section 256B.69, subdivision 5a, is amended to read:

Subd. 5a. **Managed care contracts.** (a) Managed care contracts under this section and section 256L.12 shall be entered into or renewed on a calendar year basis. The commissioner may issue separate contracts with requirements specific to services to medical assistance recipients age 65 and older.

(b) A prepaid health plan providing covered health services for eligible persons pursuant to chapters 256B and 256L is responsible for complying with the terms of its contract with the commissioner. Requirements applicable to managed care programs under chapters 256B and 256L established after the effective date of a contract with the commissioner take effect when the contract is next issued or renewed.

(c) The commissioner shall withhold five percent of managed care plan payments under this section and county-based purchasing plan payments under section 256B.692 for the prepaid medical assistance program pending completion of performance targets. Each performance target must be quantifiable, objective, measurable, and reasonably attainable, except in the case of a performance target based on a federal or state law or rule. Criteria for assessment of each performance target must be outlined in writing prior to the contract effective date. Clinical or utilization performance targets and their related criteria must consider evidence-based research and reasonable interventions when available or applicable to the populations served, and must be developed with input from external clinical experts and stakeholders, including managed care plans, county-based purchasing plans, and providers. The managed care or county-based purchasing plan must demonstrate, to the commissioner's satisfaction, that the data submitted regarding attainment of the performance target is accurate. The commissioner shall periodically change the administrative measures used as performance targets in order to improve plan performance across a broader range of administrative services. The performance targets must include measurement of plan efforts to contain spending on health care services and administrative activities. The commissioner may adopt plan-specific performance targets that take into account factors affecting only one plan, including characteristics of the plan's enrollee population. The withheld funds must be returned no sooner than July of the following year if performance targets in the contract are achieved. The commissioner may exclude special demonstration projects under subdivision 23.

(d) The commissioner shall require that managed care plans:

(1) use the assessment and authorization processes, forms, timelines, standards, documentation, and data reporting requirements, protocols, billing processes, and policies consistent with medical assistance fee-for-service or the Department of Human Services contract requirements for all personal care assistance services under section 256B.0659 and community first services and supports under section 256B.85; and

(2) by January 30 of each year that follows a rate increase for any aspect of services under section 256B.0659 or 256B.85, inform the commissioner and the chairs and ranking minority members of the legislative committees with jurisdiction over rates determined under section 256B.851 of the amount of the rate increase that is paid to each personal care assistance provider agency with which the plan has a contract.

~~(e) Effective for services rendered on or after January 1, 2012, the commissioner shall include as part of the performance targets described in paragraph (c) a reduction in the health plan's emergency department utilization rate for medical assistance and MinnesotaCare enrollees, as determined by the commissioner. For 2012, the reduction shall be based on the health plan's utilization in 2009. To earn the return of the withhold each subsequent year, the managed care plan or county-based purchasing plan must achieve a qualifying reduction of no less than ten percent of the plan's emergency department utilization rate for medical assistance and MinnesotaCare enrollees, excluding enrollees in programs described in subdivisions 23 and 28, compared to the previous measurement year until the final performance target is reached. When measuring performance, the commissioner must consider the difference in health risk in a managed care or county-based purchasing plan's membership in the baseline year compared to the measurement year, and work with the managed care or county-based purchasing plan to account for differences that they agree are significant.~~

~~The withheld funds must be returned no sooner than July 1 and no later than July 31 of the following calendar year if the managed care plan or county-based purchasing plan demonstrates to the satisfaction of the commissioner that a reduction in the utilization rate was achieved. The commissioner shall structure the withhold so that the commissioner returns a portion of the withheld funds in amounts commensurate with achieved reductions in utilization less than the targeted amount.~~

~~The withhold described in this paragraph shall continue for each consecutive contract period until the plan's emergency room utilization rate for state health care program enrollees is reduced by 25 percent of the plan's emergency room utilization rate for medical assistance~~

~~and MinnesotaCare enrollees for calendar year 2009. Hospitals shall cooperate with the health plans in meeting this performance target and shall accept payment withholds that may be returned to the hospitals if the performance target is achieved.~~

~~(f) Effective for services rendered on or after January 1, 2012, the commissioner shall include as part of the performance targets described in paragraph (c) a reduction in the plan's hospitalization admission rate for medical assistance and MinnesotaCare enrollees, as determined by the commissioner. To earn the return of the withhold each year, the managed care plan or county-based purchasing plan must achieve a qualifying reduction of no less than five percent of the plan's hospital admission rate for medical assistance and MinnesotaCare enrollees, excluding enrollees in programs described in subdivisions 23 and 28, compared to the previous calendar year until the final performance target is reached. When measuring performance, the commissioner must consider the difference in health risk in a managed care or county-based purchasing plan's membership in the baseline year compared to the measurement year, and work with the managed care or county-based purchasing plan to account for differences that they agree are significant.~~

~~The withheld funds must be returned no sooner than July 1 and no later than July 31 of the following calendar year if the managed care plan or county-based purchasing plan demonstrates to the satisfaction of the commissioner that this reduction in the hospitalization rate was achieved. The commissioner shall structure the withhold so that the commissioner returns a portion of the withheld funds in amounts commensurate with achieved reductions in utilization less than the targeted amount.~~

~~The withhold described in this paragraph shall continue until there is a 25 percent reduction in the hospital admission rate compared to the hospital admission rates in calendar year 2011, as determined by the commissioner. The hospital admissions in this performance target do not include the admissions applicable to the subsequent hospital admission performance target under paragraph (g). Hospitals shall cooperate with the plans in meeting this performance target and shall accept payment withholds that may be returned to the hospitals if the performance target is achieved.~~

~~(g) Effective for services rendered on or after January 1, 2012, the commissioner shall include as part of the performance targets described in paragraph (c) a reduction in the plan's hospitalization admission rates for subsequent hospitalizations within 30 days of a previous hospitalization of a patient regardless of the reason, for medical assistance and MinnesotaCare enrollees, as determined by the commissioner. To earn the return of the withhold each year, the managed care plan or county-based purchasing plan must achieve a qualifying reduction of the subsequent hospitalization rate for medical assistance and MinnesotaCare enrollees,~~

~~excluding enrollees in programs described in subdivisions 23 and 28, of no less than five percent compared to the previous calendar year until the final performance target is reached.~~

~~The withheld funds must be returned no sooner than July 1 and no later than July 31 of the following calendar year if the managed care plan or county-based purchasing plan demonstrates to the satisfaction of the commissioner that a qualifying reduction in the subsequent hospitalization rate was achieved. The commissioner shall structure the withhold so that the commissioner returns a portion of the withheld funds in amounts commensurate with achieved reductions in utilization less than the targeted amount.~~

~~The withhold described in this paragraph must continue for each consecutive contract period until the plan's subsequent hospitalization rate for medical assistance and MinnesotaCare enrollees, excluding enrollees in programs described in subdivisions 23 and 28, is reduced by 25 percent of the plan's subsequent hospitalization rate for calendar year 2011. Hospitals shall cooperate with the plans in meeting this performance target and shall accept payment withholds that must be returned to the hospitals if the performance target is achieved.~~

~~(h)~~ (e) Effective for services rendered on or after January 1, 2013, through December 31, 2013, the commissioner shall withhold 4.5 percent of managed care plan payments under this section and county-based purchasing plan payments under section 256B.692 for the prepaid medical assistance program. The withheld funds must be returned no sooner than July 1 and no later than July 31 of the following year. The commissioner may exclude special demonstration projects under subdivision 23.

~~(i)~~ (f) Effective for services rendered on or after January 1, 2014, the commissioner shall withhold three percent of managed care plan payments under this section and county-based purchasing plan payments under section 256B.692 for the prepaid medical assistance program. The withheld funds must be returned no sooner than July 1 and no later than July 31 of the following year. The commissioner may exclude special demonstration projects under subdivision 23.

~~(j)~~ (g) A managed care plan or a county-based purchasing plan under section 256B.692 may include as admitted assets under section 62D.044 any amount withheld under this section that is reasonably expected to be returned.

~~(k)~~ (h) Contracts between the commissioner and a prepaid health plan are exempt from the set-aside and preference provisions of section 16C.16, subdivisions 6, paragraph (a), and 7.

~~(l)~~ (i) The return of the withhold under paragraphs (h) and (i) is not subject to the requirements of paragraph (c).

~~(m)~~ (j) Managed care plans and county-based purchasing plans shall maintain current and fully executed agreements for all subcontractors, including bargaining groups, for administrative services that are expensed to the state's public health care programs. Subcontractor agreements determined to be material, as defined by the commissioner after taking into account state contracting and relevant statutory requirements, must be in the form of a written instrument or electronic document containing the elements of offer, acceptance, consideration, payment terms, scope, duration of the contract, and how the subcontractor services relate to state public health care programs. Upon request, the commissioner shall have access to all subcontractor documentation under this paragraph. Nothing in this paragraph shall allow release of information that is nonpublic data pursuant to section 13.02.

EFFECTIVE DATE. This section is effective January 1, 2024.

Sec. 24. Minnesota Statutes 2022, section 256B.76, subdivision 1, is amended to read:

Subdivision 1. **Physician reimbursement.** (a) Effective for services rendered on or after October 1, 1992, the commissioner shall make payments for physician services as follows:

(1) payment for level one Centers for Medicare and Medicaid Services' common procedural coding system codes titled "office and other outpatient services," "preventive medicine new and established patient," "delivery, antepartum, and postpartum care," "critical care," cesarean delivery and pharmacologic management provided to psychiatric patients, and level three codes for enhanced services for prenatal high risk, shall be paid at the lower of (i) submitted charges, or (ii) 25 percent above the rate in effect on June 30, 1992;

(2) payments for all other services shall be paid at the lower of (i) submitted charges, or (ii) 15.4 percent above the rate in effect on June 30, 1992; and

(3) all physician rates shall be converted from the 50th percentile of 1982 to the 50th percentile of 1989, less the percent in aggregate necessary to equal the above increases except that payment rates for home health agency services shall be the rates in effect on September 30, 1992.

(b) Effective for services rendered on or after January 1, 2000, payment rates for physician and professional services shall be increased by three percent over the rates in effect on December 31, 1999, except for home health agency and family planning agency services. The increases in this paragraph shall be implemented January 1, 2000, for managed care.

(c) Effective for services rendered on or after July 1, 2009, payment rates for physician and professional services shall be reduced by five percent, except that for the period July 1, 2009, through June 30, 2010, payment rates shall be reduced by 6.5 percent for the medical assistance and general assistance medical care programs, over the rates in effect on June 30, 2009. This reduction and the reductions in paragraph (d) do not apply to office or other outpatient visits, preventive medicine visits and family planning visits billed by physicians, advanced practice nurses, or physician assistants in a family planning agency or in one of the following primary care practices: general practice, general internal medicine, general pediatrics, general geriatrics, and family medicine. This reduction and the reductions in paragraph (d) do not apply to federally qualified health centers, rural health centers, and Indian health services. Effective October 1, 2009, payments made to managed care plans and county-based purchasing plans under sections 256B.69, 256B.692, and 256L.12 shall reflect the payment reduction described in this paragraph.

(d) Effective for services rendered on or after July 1, 2010, payment rates for physician and professional services shall be reduced an additional seven percent over the five percent reduction in rates described in paragraph (c). This additional reduction does not apply to physical therapy services, occupational therapy services, and speech pathology and related services provided on or after July 1, 2010. This additional reduction does not apply to physician services billed by a psychiatrist or an advanced practice nurse with a specialty in mental health. Effective October 1, 2010, payments made to managed care plans and county-based purchasing plans under sections 256B.69, 256B.692, and 256L.12 shall reflect the payment reduction described in this paragraph.

(e) Effective for services rendered on or after September 1, 2011, through June 30, 2013, payment rates for physician and professional services shall be reduced three percent from the rates in effect on August 31, 2011. This reduction does not apply to physical therapy services, occupational therapy services, and speech pathology and related services.

(f) Effective for services rendered on or after September 1, 2014, payment rates for physician and professional services, including physical therapy, occupational therapy, speech pathology, and mental health services shall be increased by five percent from the rates in effect on August 31, 2014. In calculating this rate increase, the commissioner shall not include in the base rate for August 31, 2014, the rate increase provided under section 256B.76, subdivision 7. This increase does not apply to federally qualified health centers, rural health centers, and Indian health services. Payments made to managed care plans and county-based purchasing plans shall not be adjusted to reflect payments under this paragraph.

(g) Effective for services rendered on or after July 1, 2015, payment rates for physical therapy, occupational therapy, and speech pathology and related services provided by a hospital meeting the criteria specified in section 62Q.19, subdivision 1, paragraph (a), clause (4), shall be increased by 90 percent from the rates in effect on June 30, 2015. Payments made to managed care plans and county-based purchasing plans shall not be adjusted to reflect payments under this paragraph.

(h) Any ratables effective before July 1, 2015, do not apply to early intensive developmental and behavioral intervention (EIDBI) benefits described in section 256B.0949.

(i) The commissioner may reimburse the cost incurred to pay the Department of Health for metabolic disorder testing of newborns who are medical assistance recipients when the sample is collected outside of an inpatient hospital setting or freestanding birth center setting because the newborn was born outside of a hospital setting or freestanding birth center setting or because it is not medically appropriate to collect the sample during the inpatient stay for the birth.

Sec. 25. Minnesota Statutes 2022, section 256B.764, is amended to read:

256B.764 REIMBURSEMENT FOR FAMILY PLANNING SERVICES.

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

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

(c) Effective for services provided on or after January 1, 2024, payment rates for family planning and abortion services shall be increased by ten percent. This increase does not apply to federally qualified health centers, rural health centers, or Indian health services.

Sec. 26. Minnesota Statutes 2022, section 256L.03, subdivision 1, is amended to read:

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

~~(b) No public funds shall be used for coverage of abortion under MinnesotaCare except where the life of the female would be endangered or substantial and irreversible impairment of a major bodily function would result if the fetus were carried to term; or where the pregnancy is the result of rape or incest.~~

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

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

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

Sec. 27. Minnesota Statutes 2022, section 256L.03, subdivision 5, is amended to read:

Subd. 5. **Cost-sharing.** (a) Co-payments, coinsurance, and deductibles do not apply to children under the age of 21 and to American Indians as defined in Code of Federal Regulations, title 42, section 600.5.

(b) The commissioner ~~shall~~ must adjust co-payments, coinsurance, and deductibles for covered services in a manner sufficient to maintain the actuarial value of the benefit to 94 percent. The cost-sharing changes described in this paragraph do not apply to eligible recipients or services exempt from cost-sharing under state law. The cost-sharing changes described in this paragraph shall not be implemented prior to January 1, 2016.

(c) The cost-sharing changes authorized under paragraph (b) must satisfy the requirements for cost-sharing under the Basic Health Program as set forth in Code of Federal Regulations, title 42, sections 600.510 and 600.520.

(d) Cost-sharing must not apply to drugs used for tobacco and nicotine cessation or to tobacco and nicotine cessation services covered under section 256B.0625, subdivision 68.

Sec. 28. Laws 2021, First Special Session chapter 7, article 6, section 26, is amended to read:

Sec. 26. **COMMISSIONER OF HUMAN SERVICES; EXTENSION OF COVID-19 HUMAN SERVICES PROGRAM MODIFICATIONS.**

Notwithstanding Laws 2020, First Special Session chapter 7, section 1, subdivision 2, as amended by Laws 2020, Third Special Session chapter 1, section 3, when the peacetime emergency declared by the governor in response to the COVID-19 outbreak expires, is terminated, or is rescinded by the proper authority, the following modifications issued by the commissioner of human services pursuant to Executive Orders 20-11 and 20-12, and including any amendments to the modification issued before the peacetime emergency expires, shall remain in effect until July 1, ~~2023~~ 2025:

(1) CV16: expanding access to telemedicine services for Children's Health Insurance Program, Medical Assistance, and MinnesotaCare enrollees; and

(2) CV21: allowing telemedicine alternative for school-linked mental health services and intermediate school district mental health services.

Sec. 29. **DENTAL HOME PILOT PROJECT.**

Subdivision 1. **Establishment; requirements.** (a) The commissioner of human services shall establish a dental home pilot project to increase access of medical assistance and MinnesotaCare enrollees to dental care, improve patient experience, and improve oral health clinical outcomes, in a manner that sustains the financial viability of the dental workforce and broader dental care delivery and financing system. Dental homes must provide high-quality, patient-centered, comprehensive, and coordinated oral health services across clinical and community-based settings, including virtual oral health care.

(b) The design and operation of the dental home pilot project must be consistent with the recommendations made by the Dental Services Advisory Committee to the legislature under Laws 2021, First Special Session chapter 7, article 1, section 33.

(c) The commissioner shall establish baseline requirements and performance measures for dental homes participating in the pilot project. These baseline requirements and performance measures must address access and patient experience and oral health clinical outcomes.

Subd. 2. **Project design and timeline.** (a) The commissioner shall issue a preliminary project description and a request for information to obtain stakeholder feedback and input on project design issues, including but not limited to:

(1) the timeline for project implementation;

(2) the length of each project phase and the date for full project implementation;

(3) the number of providers to be selected for participation;

(4) grant amounts;

(5) criteria and procedures for any value-based payments;

(6) the extent to which pilot project requirements may vary with provider characteristics;

(7) procedures for data collection;

(8) the role of dental partners, such as dental professional organizations and educational institutions;

(9) provider support and education; and

(10) other topics identified by the commissioner.

(b) The commissioner shall consider the feedback and input obtained in paragraph (a) and shall develop and issue a request for proposals for participation in the pilot project.

(c) The pilot project must be implemented by July 1, 2024, and must include initial pilot testing and the collection and analysis of data on baseline requirements and performance measures to evaluate whether these requirements and measures are appropriate. Under this phase, the commissioner shall provide grants to individual providers and provider networks in addition to medical assistance and MinnesotaCare payments received for services provided.

(d) The pilot project may test and analyze value-based payments to providers to determine whether varying payments based on dental home performance measures is appropriate and effective.

(e) The commissioner shall ensure provider diversity in selecting project participants. In selecting providers, the commissioner shall consider: geographic distribution; provider size, type, and location; providers serving different priority populations; health equity issues; and provider accessibility for patients with varying levels and types of disability.

(f) In designing and implementing the pilot project, the commissioner shall regularly consult with project participants and other stakeholders, and as relevant shall continue to seek the input of participants and other stakeholders on the topics listed in paragraph (a).

Subd. 3. **Reporting.** (a) The commissioner, beginning February 15, 2024, and each February 15 thereafter for the duration of the demonstration project, shall report on the design, implementation, operation, and results of the demonstration project to the chairs and ranking minority members of the legislative committees with jurisdiction over health care finance and policy.

(b) The commissioner, within six months from the date the pilot project ceases operation, shall report to the chairs and ranking minority members of the legislative committees with jurisdiction over health care finance and policy on the results of the demonstration project, and shall include in the report recommendations on whether the demonstration project, or specific features of the demonstration project, should be extended to all dental providers serving medical assistance and MinnesotaCare enrollees.

Sec. 30. **REPEALER.**

Minnesota Rules, part 9505.0235, is repealed the day following final enactment.

ARTICLE 2
HEALTH CARE AFFORDABILITY AND DELIVERY

Section 1. **[62J.0411] HEALTH CARE AFFORDABILITY COMMISSION.**

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

(b) "Commission" means the Health Care Affordability Commission.

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

(d) "Health care entity" includes, but is not limited to, clinics, hospitals, ambulatory surgical centers, physician organizations, accountable care organizations, integrated provider and plan systems, county-based purchasing plans, and health plan companies.

(e) "Health care provider" or "provider" means a health care professional who is licensed or registered by the state to perform health care services within the provider's scope of practice and in accordance with state law.

(f) "Health plan" means a health plan as defined in section 62A.011, subdivision 3.

(g) "Health plan company" means a health carrier as defined under section 62A.011, subdivision 2.

(h) "Hospital" means an entity licensed under sections 144.50 to 144.58.

Subd. 2. **Commission membership.** (a) The commissioner of health shall establish a health care affordability commission that shall consist of the following 15 members:

(1) two members with expertise and experience in advocating on behalf of patients;

(2) two Minnesota residents who are health care consumers, one residing in greater Minnesota and one residing in a metropolitan area, one of whom represents an underserved community;

(3) one member representing Indian Tribes;

(4) two members of the business community who purchase health insurance for their employees, one of whom purchases coverage in the small group market;

(5) two members representing public purchasers of health insurance for their employees;

(6) one licensed and certified health care provider employed at a federally qualified health center;

(7) one member representing a health care system or urban hospitals;

(8) one member representing rural hospitals;

(9) one member representing health plans;

(10) one member who is an expert in health care financing and administration; and

(11) one member who is an expert in health economics.

(b) All members appointed must have the knowledge and demonstrated expertise in one of the following areas of expertise, and each area of expertise must be met by at least one member of the commission:

(1) health care finance, health economics, and health care management or administration at a senior level;

(2) health care consumer advocacy;

(3) representing the health care workforce as a leader in a labor organization;

(4) purchasing health insurance representing business management or health benefits administration;

(5) delivering primary care, health plan administration, or public or population health; or

(6) addressing health disparities and structural inequities.

(c) No member may participate in commission proceedings involving an individual provider, purchaser, or patient, or specific activity or transaction, if the member has direct financial interest in the outcome of the commission's proceedings other than as an individual consumer of health care services.

Subd. 3. **Terms.** (a) The commissioners of health, human services, and commerce shall make recommendations for commission membership. Commission members shall be appointed by the governor. The initial appointments to the commission shall be made by September 1, 2023. The initial appointed commission members shall serve staggered terms of three or four years determined by lot by the secretary of state. Following the initial appointments, the commission members shall serve four-year terms. Members may not serve more than two consecutive terms.

(b) The commission is governed by section 15.0575, except as otherwise provided in this section.

(c) A commission member may resign at any time by giving written notice to the commission.

Subd. 4. **Chair; other officers.** (a) The governor shall annually designate a member to serve as chair of the commission. The chair shall serve for one year. If there is a vacancy for any cause, the governor shall make an appointment for that category of membership and expertise, to become immediately effective.

(b) The commission shall elect a vice-chair and other officers from its membership as it deems necessary.

Subd. 5. **Compensation.** Commission members may be compensated according to section 15.0575.

Subd. 6. **Meetings.** (a) Meetings of the commission, including any public hearings, are subject to chapter 13D.

(b) The commission must meet publicly on at least a monthly basis until the initial growth targets are established.

(c) After the initial growth targets are established, the commission shall meet at least quarterly at which it considers summary data presented by the commissioner and drafts main findings for their reporting, considers updates to the program and growth target levels, discusses findings with health care providers and payers, and identifies additional needed analysis and strategies to limit health care spending growth.

Subd. 7. **Hearings.** At least annually, the commission shall hold public hearings to present findings from spending growth target monitoring. The commission shall also regularly hold public hearings to take testimony from stakeholders on health care spending growth, setting and revising health care spending growth targets, the impact of spending growth and growth targets on health care access and quality, and as needed to perform assigned duties.

Subd. 8. **Staff; technical assistance; contracting.** (a) The commission shall hire a full-time executive director and administrative staff, who shall serve in the unclassified service. The executive director must have significant knowledge and expertise in health economics and demonstrated experience in health policy.

(b) The attorney general shall provide legal services to the commission.

(c) The commissioner of health shall provide technical assistance to the commission related to data collection, analyzing health care trends and costs, and setting health care spending growth targets.

(d) The commission may employ or contract for professional and technical assistance, including actuarial assistance, as the commission deems necessary to perform the commission's duties.

Subd. 9. **Administration.** The commissioner of health shall provide office space, equipment and supplies, and analytic staff support to the commission and the Health Care Affordability Advisory Council.

Subd. 10. **Duties of the commissioner.** (a) The commissioner, in consultation with the commissioners of commerce and human services, shall provide staff support to the commission, including performing and procuring consulting and analytic services. The commissioner shall:

(1) establish the form and manner of data reporting, including reporting methods and dates, consistent with program design and timelines formalized by the commission;

(2) under the authority in chapter 62J, collect data identified by the commission for use in the program in a form and manner that ensures the collection of high-quality, transparent data;

(3) provide analytical support, including by conducting background research or environmental scans, evaluating the suitability of available data, performing needed analysis and data modeling, calculating performance under the spending trends, and researching drivers of spending growth trends;

(4) assist health care entities subject to the targets with reporting of data, internal analysis of spending growth trends, and, as necessary, methodological issues;

(5) synthesize information and report to the commission; and

(6) make appointments and staff the Health Care Affordability Advisory Council under section 62J.0414.

(b) In carrying out the duties required by this section, the commissioner may contract with entities with expertise in health economic, health finance, and actuarial science.

Subd. 11. **Access to information.** (a) The commission or commissioner may request that a state agency provide the commission with data as defined in sections 62J.04 and 295.52 in a usable format as requested by the commission, at no cost to the commission.

(b) The commission may request from a state agency unique or custom data sets, and the agency may charge the commission for providing the data at the same rate the agency would charge any other public or private entity. The commission may grant the commissioner access to this data.

(c) Any information provided to the commission or commissioner by a state agency must be de-identified. For purposes of this subdivision, "de-identified" means the process used to prevent the identity of a person from being connected with information and ensuring all identifiable information has been removed.

(d) Any data submitted to the commission or the commissioner shall retain their original classification under the Minnesota Data Practices Act in chapter 13.

(e) The commissioner, under the authority of chapter 62J, may collect data necessary for the performance of its duties, and shall collect this data in a form and manner that ensures the collection of high-quality, transparent data.

Sec. 2. **[62J.0412] DUTIES OF THE COMMISSION; GENERAL.**

Subdivision 1. **Health care delivery and payment.** (a) The commission shall monitor the administration and reform of the health care delivery and payment systems in the state. The commission shall:

(1) set health care spending growth targets for the state;

(2) enhance the transparency of provider organizations;

(3) monitor the adoption and effectiveness of alternative payment methodologies;

(4) foster innovative health care delivery and payment models that lower health care cost growth while improving the quality of patient care;

(5) monitor and review the impact of changes within the health care marketplace; and

(6) monitor patient access to necessary health care services.

(b) The commission shall establish goals to reduce health care disparities in racial and ethnic communities and to ensure access to quality care for persons with disabilities or with chronic or complex health conditions.

Subd. 2. **Duties of the commission; market trends.** The commission shall monitor efforts to reform the health care delivery and payment system in Minnesota to understand emerging trends in the commercial health insurance market, including large self-insured employers and the state's public health care programs, in order to identify opportunities for state action to achieve:

(1) improved patient experience of care, including quality and satisfaction;

(2) improved health of all populations, including a reduction in health disparities; and

(3) a reduction in the growth of health care costs.

Subd. 3. **Duties of the commission; recommendations for reform.** The commission shall make recommendations for legislative policy, market, or any other reforms to:

(1) lower the rate of growth in commercial health care costs and public health care program spending in the state;

(2) positively impact the state's rankings in the areas listed in this subdivision and subdivision 2; and

(3) improve the quality and value of care for all Minnesotans, and for specific populations adversely affected by health disparities.

Sec. 3. **[62J.0413] DUTIES OF THE COMMISSION; GROWTH TARGETS.**

Subdivision 1. **Growth target program.** The commission is responsible for the development, establishment, and operation of the health care spending growth target program, determining the health care entities subject to health care spending growth targets, and reporting on progress toward targets to the legislature and the public.

Subd. 2. **Methodologies for growth targets.** (a) The commission shall develop a methodology to establish the health care spending growth targets and identify the economic

indicators to be used in establishing the initial and subsequent growth targets. Growth targets must:

(1) use a clear and operational definition of total health care spending for the state;

(2) promote a predictable and sustainable rate of growth for total health care spending as measured by an established economic indicator, such as the rate of increase of the state's economy or of the personal income of residents of the state, or a combination;

(3) apply to all health care entities, as defined by the commission;

(4) be measurable on a per capita basis, statewide basis, health plan company basis, health plan basis, and health care provider basis;

(5) account for the health status of patients; and

(6) incorporate specific benchmarks related to health equity.

(b) The commission shall establish a methodology for calculating health care cost growth statewide, and for each health care provider and health plan company. In developing this methodology, the commissioner shall:

(1) at the discretion of the commission, account for variability by age and sex;

(2) take into consideration the need for variability in targets across public and private payers;

(3) incorporate health equity considerations; and

(4) consider the impact of targets on health care access and health care disparities.

(c) The commission, when developing this methodology, shall determine which health care entities are subject to targets, and at what level of aggregation.

Subd. 3. **Data on performance.** The commission shall identify the data to be used for tracking performance toward achieving health care spending growth targets, and adopt methods of data collection. In identifying data and methods, the commission shall:

(1) consider the availability, timeliness, quality, and usefulness of existing data;

(2) assess the need for additional investments in data collection, data validation, or analysis capacity to support efficient collection and aggregation of data to support the commission's activities;

(3) limit the reporting burden to the greatest extent possible; and

(4) identify and define the health care entities that are required to report to the commissioner.

Subd. 4. **Reporting requirements.** The commission shall establish requirements for health care providers and health plan companies to report data and other information necessary to calculate health care cost growth. Health care providers and health plans must report data in the form and manner established by the commission.

Subd. 5. **Establishment of growth targets.** (a) The commission, by June 15, 2024, shall establish annual health care spending growth targets consistent with the methodology in subdivision 2 for each of the next five calendar years, with the goal of limiting health care spending growth. The commission may continue to establish annual health care spending growth targets for subsequent years.

(b) The commission shall regularly review all components of the program methodology, including economic indicators and other factors, and, as appropriate, revise established health care spending growth target levels. Any changes to health care spending growth target levels require a two-thirds majority vote of the commission.

Subd. 6. **Additional criteria for growth targets.** (a) In developing the health care spending growth target program, the commission may:

(1) evaluate and ensure that the program does not place a disproportionate burden on communities most impacted by health disparities, the providers who primarily serve communities most impacted by health disparities, or individuals who reside in rural areas or have high health care needs;

(2) consider payment models that help ensure financial sustainability of rural health care delivery systems and the ability to provide population health;

(3) consider the addition of quality of care performance measures or minimum primary care spending goals;

(4) allow setting growth targets that encourage an individual health care entity to serve populations with greater health care risks by incorporating:

(i) a risk factor adjustment reflecting the health status of the entity's patient mix; and

(ii) an equity adjustment accounting for the social determinants of health and other factors related to health equity for the entity's patient mix;

(5) ensure that growth targets:

(i) encourage the growth of the Minnesota health care workforce, including the need to provide competitive wages and benefits;

(ii) do not limit the use of collective bargaining or place a floor or ceiling on health care workforce compensation; and

(iii) promote workforce stability and maintain high-quality health care jobs; and

(6) consult with stakeholders representing patients, health care providers, payers of health care services, and others.

(b) Based on an analysis of drivers of health care spending by the commissioner and evidence from public testimony, the commissioner shall explore strategies and new policies, and future legislative proposals, that can contribute to achieving health care spending growth targets or limiting health care spending growth without increasing disparities in access to health care, including the establishment of accountability mechanisms for health care entities.

Subd. 7. **Reports.** (a) The commission shall submit the reports specified in this section to the chairs and ranking minority members of the legislative committees with primary jurisdiction over health care. These reports must be made available to the public.

(b) The commission shall submit written progress updates about the development and implementation of the health care growth target program by February 15, 2024 and February 15, 2025. The updates must include reporting on commission membership and activities, program design decisions, planned timelines for implementation of the program, progress of implementation, and comprehensive methodological details underlying program design decisions.

(c) The commission shall submit by March 31, 2026, and by March 31 annually thereafter, reports on health care spending trends subject to the health care growth targets. The commission may delegate preparation of the reports to the commissioner, and any contractors the commissioner determines are necessary. The reports must include:

(1) aggregate spending growth for entities subject to health care growth targets relative to established target levels;

(2) findings from the analyses of cost drivers of health care spending growth;

(3) estimates of the impact of health care spending growth on Minnesota residents, including for those communities most impacted by health disparities, including an analysis of Minnesota residents' access to insurance and care, the value of health care, and the state's ability to pursue other spending priorities;

(4) the potential and observed impact of the health care growth targets on the financial viability of the rural health care delivery system;

(5) changes in the health care spending growth methodology under consideration; and

(6) recommended policy changes that may affect health care spending growth trends, including broader and more transparent adoption of value-based payment arrangements.

Sec. 4. **[62J.0414] HEALTH CARE AFFORDABILITY ADVISORY COUNCIL.**

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

(b) "Council" means the Health Care Affordability Advisory Council.

(c) "Commission" means the Health Care Affordability Commission.

Subd. 2. **Establishment; administration.** (a) The commissioner of health shall appoint a 13-member advisory council to provide technical assistance to the commission. Members shall be appointed based on their knowledge and demonstrated expertise in one or more of the following areas:

(1) health care spending trends and drivers;

(2) equitable access to health care services;

(3) health insurance operation and finance;

(4) actuarial science;

(5) the practice of medicine;

(6) patient perspectives;

(7) clinical and health services research; and

(8) the health care marketplace.

(b) The commissioner shall provide administrative and staff support to the advisory council.

Subd. 3. **Membership.** The council's membership shall consist of:

(1) three members representing patients and health care consumers, at least one of whom must have experience working with communities most impacted by health disparities and one of whom must have experience working with persons in the disability community;

(2) the commissioner of health or a designee;

(3) the commissioner of human services or a designee;

(4) one member who is a health services researcher at the University of Minnesota;

(5) two members who represent nonprofit group purchasers;

(6) one member who represents for-profit group purchasers;

(7) two members who represent health care systems;

(8) one member who represents independent health care providers;

(9) two members who represent employee benefit plans, with one representing a public employer; and

(10) one member who represents the Rare Disease Advisory Council.

Subd. 4. **Terms.** (a) The initial appointments to the council shall be made by September 30, 2023. The council members shall serve staggered terms of three or four years determined by lot by the secretary of state. Following the initial appointments, the council members shall serve four-year terms. Members may not serve more than two consecutive terms.

(b) Removal and vacancies of council members are governed by section 15.059.

Subd. 5. **Meetings.** The council must meet publicly on at least a monthly basis until the initial growth targets are established. After the initial growth targets are established, the council shall meet at least quarterly.

Subd. 6. **Duties.** The council shall:

(1) provide technical advice to the commission on the development and implementation of the health care spending growth targets, drivers of health care spending, and other items related to the commission duties;

(2) provide technical input on data sources for measuring health care spending; and

(3) advise the commission on methods to measure the impact of health care spending growth targets on:

(i) communities most impacted by health disparities;

(ii) the providers who primarily serve communities most impacted by health disparities;

(iii) individuals with disabilities;

(iv) individuals with health coverage through medical assistance or MinnesotaCare;

(v) individuals who reside in rural areas; and

(vi) individuals with rare diseases.

Subd. 7. **Expiration.** Notwithstanding section 15.059, subdivision 6, the council does not expire.

Sec. 5. **[62J.0415] NOTICE TO HEALTH CARE ENTITIES.**

Subdivision 1. **Notice.** The commission shall provide notice to all health care entities that have been identified by the commission as exceeding the health care spending growth target for a specified period as determined by the commission.

Subd. 2. **Performance improvement plans.** (a) The commission shall establish and implement procedures to assist health care entities to improve efficiency and reduce cost growth by requiring some or all health care entities provided notice under subdivision 1 to file and implement a performance improvement plan. The commission shall provide written notice of this requirement to health care entities and describe the form and manner in which these plans must be prepared and submitted.

(b) The performance improvement plan must be filed with the commission:

(1) within 45 days of receipt of an initial notice;

(2) if the health care entity has requested a waiver or extension, within 45 days of receipt of a notice that the waiver or extension has been denied; or

(3) if the health care entity has been granted an extension, on the date given in the extension.

(c) The health care entity may file any documentation or supporting evidence with the commission to support the health care entity's application to waive or extend the timeline to file a performance improvement plan. The commission shall require the health care entity to submit any other relevant information it deems necessary in considering the waiver or extension application, provided that this information shall be made public at the discretion of the commission. The commission may waive or delay the requirement for a health care entity to file a performance improvement plan in response to a waiver or extension request in light of all information received from the health care entity, based on a consideration of the following factors:

(1) the costs, price, and utilization trends of the health care entity over time, and any demonstrated improvement in reducing per capita medical expenses adjusted by health status;

(2) any ongoing strategies or investments that the health care entity is implementing to improve future long-term efficiency and reduce cost growth;

(3) whether the factors that led to increased costs for the health care entity can reasonably be considered to be unanticipated and outside of the control of the entity. These factors may include but shall not be limited to age and other health status adjusted factors of the patients served by the health care entity and other cost inputs such as pharmaceutical expenses and medical device expenses;

(4) the overall financial condition of the health care entity; and

(5) any other factors the commission considers relevant.

If the commission declines to waive or extend the requirement for the health care entity to file a performance improvement plan, the commission shall provide written notice to the health care entity that its application for a waiver or extension was denied and the health care entity shall file a performance improvement plan.

(d) A health care entity shall file a performance improvement plan with the commission:

(1) within 45 days of receipt of an initial notice;

(2) if the health care entity has requested a waiver or extension, within 45 days of receipt of a notice that such waiver or extension has been denied; or

(3) if the health care entity is granted an extension, on the date given on the extension.

The performance improvement plan shall identify the causes of the entity's cost growth and shall include but not be limited to specific strategies, adjustments, and action steps the entity proposes to implement to improve cost performance. The proposed performance improvement plan shall include specific identifiable and measurable expected outcomes and a timetable for implementation. The commission may request additional information as needed, in order to approve a proposed performance improvement plan. The timetable for a performance improvement plan must not exceed 18 months.

(e) The commission shall approve any performance improvement plan that it determines is reasonably likely to address the underlying cause of the entity's cost growth and has a reasonable expectation for successful implementation. If the commission determines that the performance improvement plan is unacceptable or incomplete, the commission may provide consultation on the criteria that have not been met and may allow an additional time period of up to 30 calendar days for resubmission. Upon approval of the proposed performance improvement plan, the commission shall notify the health care entity to begin immediate implementation of the performance improvement plan. Public notice shall be

provided by the commission on its website, identifying that the health care entity is implementing a performance improvement plan. All health care entities implementing an approved performance improvement plan shall be subject to additional reporting requirements and compliance monitoring, as determined by the commission. The commission shall provide assistance to the health care entity in the successful implementation of the performance improvement plan.

(f) All health care entities shall in good faith work to implement the performance improvement plan. At any point during the implementation of the performance improvement plan, the health care entity may file amendments to the performance improvement plan, subject to approval of the commission. At the conclusion of the timetable established in the performance improvement plan, the health care entity shall report to the commission regarding the outcome of the performance improvement plan. If the commission determines the performance improvement plan was not implemented successfully, the commission shall:

(1) extend the implementation timetable of the existing performance improvement plan;

(2) approve amendments to the performance improvement plan as proposed by the health care entity;

(3) require the health care entity to submit a new performance improvement plan; or

(4) waive or delay the requirement to file any additional performance improvement plans.

Upon the successful completion of the performance improvement plan, the commission shall remove the identity of the health care entity from the commission's website.

(g) If the commission determines that a health care entity has:

(1) willfully neglected to file a performance improvement plan with the commission within 45 days or as required;

(2) failed to file an acceptable performance improvement plan in good faith with the commission;

(3) failed to implement the performance improvement plan in good faith; or

(4) knowingly failed to provide information required by this subdivision to the commission or knowingly provided false information, the commission may assess a civil penalty to the health care entity of not more than $500,000. The commission shall only impose a civil penalty as a last resort.

Sec. 6. **[62J.0416] IDENTIFY STRATEGIES FOR REDUCTION OF ADMINISTRATIVE SPENDING AND LOW-VALUE CARE.**

(a) The commissioner of health shall develop recommendations for strategies to reduce the volume and growth of administrative spending by health care organizations and group purchasers, and the magnitude of low-value care delivered to Minnesota residents. The commissioner shall:

(1) review the availability of data and identify gaps in the data infrastructure to estimate aggregated and disaggregated administrative spending and low-value care;

(2) based on available data, estimate the volume and change over time of administrative spending and low-value care in Minnesota;

(3) conduct an environmental scan and key informant interviews with experts in health care finance, health economics, health care management or administration, and the administration of health insurance benefits to determine drivers of spending growth for spending on administrative services or the provision of low-value care; and

(4) convene a clinical learning community and an employer task force to review the evidence from clauses (1) to (3) and develop a set of actionable strategies to address administrative spending volume and growth and the magnitude of the volume of low-value care.

(b) By March 31, 2025, the commissioner shall deliver the recommendations to the chairs and ranking minority members of house and senate committees with jurisdiction over health and human services finance and policy.

Sec. 7. **[62J.0417] PAYMENT MECHANISMS IN RURAL HEALTH CARE.**

(a) The commissioner shall develop a plan to assess readiness of rural communities and rural health care providers to adopt value based, global budgeting or alternative payment systems and recommend steps needed to implement them. The commissioner may use the development of case studies and modeling of alternate payment systems to demonstrate value-based payment systems that ensure a baseline level of essential community or regional health services and address population health needs.

(b) The commissioner shall develop recommendations for pilot projects with the aim of ensuring financial viability of rural health care systems in the context of spending growth targets. The commissioner shall share findings with the Minnesota health care cost growth target commission.

Sec. 8. Minnesota Statutes 2022, section 62U.04, subdivision 11, is amended to read:

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

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

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

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

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

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

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

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

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

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

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

(6) to provide technical assistance to the Health Care Affordability Commission to implement sections 62J.0411 to 62J.04125.

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

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

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

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

Sec. 9. Minnesota Statutes 2022, section 62V.05, is amended by adding a subdivision to read:

Subd. 13. **Transitional cost-sharing reductions.** (a) The board shall develop and implement, for the 2024, 2025, and 2026 plan years only, a system to support eligible individuals who choose to enroll in gold level health plans through MNsure.

(b) For purposes of this section, an "eligible individual" is an individual who:

(1) is a resident of Minnesota; and

(2) is enrolled in a gold level health plan offered in the enrollee's county of residence.

(c) Under the system established in this subdivision, the monthly transitional cost-sharing reduction subsidy for an eligible individual is $75.

(d) The board shall establish procedures for determining an individual's eligibility for the subsidy and providing payments to a health carrier for any eligible individuals enrolled in the carrier's gold level health plans.

Sec. 10. **[256.9631] DIRECT PAYMENT SYSTEM FOR MEDICAL ASSISTANCE AND MINNESOTACARE.**

Subdivision 1. **Direct payment system established.** (a) The commissioner shall establish a direct payment system to deliver services to eligible individuals, in order to achieve better health outcomes and reduce the cost of health care for the state. Under this system, eligible individuals shall receive services through the medical assistance fee-for-service system, county-based purchasing plans, or county-owned health maintenance organizations. The commissioner shall implement the direct payment system beginning January 1, 2027.

(b) Persons who do not meet the definition of eligible individual shall continue to receive services from managed care and county-based purchasing plans under sections 256B.69 and 256B.692, subject to the opt-out provision under section 256B.69, subdivision 28, paragraph (c), for persons who are certified as blind or having a disability, and the exemptions from managed care enrollment listed in section 256B.69, subdivision 4, paragraph (b).

Subd. 2. **Definitions.** (a) For purposes of this section, the following definitions apply.

(b) "Eligible individuals" means: (1) qualified medical assistance enrollees, defined as persons eligible for medical assistance as families and children and adults without children eligible under section 256B.055, subdivision 15; and (2) all MinnesotaCare enrollees.

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

Subd. 3. **Managed care service delivery.** (a) In counties that choose to operate a county-based purchasing plan under section 256B.692, the commissioner shall permit those counties, in a timely manner, to establish a new county-based purchasing plan or participate in an existing county-based purchasing plan.

(b) In counties that choose to operate a county-owned health maintenance organization under section 256B.69, the commissioner shall permit those counties to establish a new county-owned and operated health maintenance organization or continue serving enrollees through an existing county-owned and operated health maintenance organization.

(c) County-based purchasing plans and county-owned health maintenance organizations shall be reimbursed at the capitation rate determined under sections 256B.69 and 256B.692, unless the county board or boards elect to receive fee-for-service reimbursement under subdivision 3, paragraph (b).

(d) The commissioner shall allow eligible individuals the opportunity to opt out of enrollment in a county-based purchasing plan or county-owned health maintenance organization.

Subd. 4. **Fee-for-service reimbursement.** (a) The commissioner shall reimburse health care providers directly for all medical assistance and MinnesotaCare covered services provided to eligible individuals, using the fee-for-service payment methods specified in chapters 256, 256B, 256R, and 256S. Payments for services shall be made to individual providers, clinics, and hospitals for the services they provide, and not to hospital systems or networks of providers.

(b) The commissioner, at the election of the county board or boards, shall directly reimburse participating providers of county-based purchasing plans and county-owned health maintenance organizations at the fee-for-service payment rate for services provided to eligible individuals.

(c) The commissioner shall ensure that payments under this section to a qualified hospital provider are equivalent to the payments that would have been received based on managed care direct payment arrangements. If necessary, a qualified hospital provider may use a county-owned health maintenance organization to receive direct payments as described in section 256B.1973.

Subd. 5. **Termination of managed care contracts.** The commissioner shall terminate managed care contracts for eligible individuals under sections 256B.69, 256L.12, and 256L.121 by December 31, 2026, except that the commissioner may continue to contract with county-based purchasing plans and county-owned health maintenance organizations, as provided under this section.

Subd. 6. **System development and administration.** (a) The commissioner, under the direct payment system, shall:

(1) provide benefits management, claims processing, and enrollee support services;

(2) coordinate operation of the direct payment system with county agencies and MNsure, and with service delivery to medical assistance enrollees who are age 65 or older, blind, or have disabilities, or who are exempt from managed care enrollment under section 256B.69, subdivision 4, paragraph (b);

(3) establish and maintain provider payment rates at levels sufficient to ensure high-quality care and enrollee access to covered health care services;

(4) develop and monitor quality measures for health care service delivery; and

(5) develop and implement provider incentives and innovative methods of health care delivery, to ensure the efficient provision of high-quality care and reduce health care disparities.

(b) This section does not prohibit the commissioner from seeking legislative and federal approval for demonstration projects to ensure access to care or improve health care quality.

(c) The commissioner may contract with an administrator to administer the direct payment system.

Subd. 7. **Implementation plan.** (a) The commissioner shall present an implementation plan for the direct payment system to the chairs and ranking minority members of the legislative committees with jurisdiction over health care policy and finance by January 15, 2025. The commissioner may contract for technical assistance in developing the implementation plan and conducting related studies and analysis.

(b) The implementation plan must include:

(1) a timeline for the development and implementation of the direct payment system;

(2) the procedures to be used to ensure continuity of care for enrollees who transition from managed care to fee-for-service;

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

(4) recommendations on providing effective care coordination under the direct payment system for all enrollees, including those with complex medical conditions, who face socioeconomic barriers to receiving care, or who are from underserved populations that experience health disparities;

(5) recommendations on whether the direct payment system should include supplemental payments for care coordination, including:

(i) the provider types eligible for supplemental payments and funding for outreach;

(ii) procedures to coordinate supplemental payments with existing supplemental or cost-based payment methods; and

(iii) procedures to align care coordination initiatives funded through supplemental payments under this section with existing care coordination initiatives;

(6) recommendations on whether the direct payment system should include funding to providers for outreach initiatives to patients who, because of mental illness, homelessness, or other circumstances, are unlikely to obtain needed care and treatment;

(7) recommendations on whether and how the direct payment system should be expanded to deliver services and care coordination under medical assistance to persons who are blind or have a disability, and managed care contracts to deliver services to these individuals;

(8) procedures to compensate providers for any loss of savings from the federal 340B Drug Pricing Program; and

(9) recommendations for statutory changes necessary to implement the direct payment system.

(c) In developing the implementation plan, the commissioner shall:

(1) calculate the projected cost of a direct payment system relative to the cost of the current system;

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

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

(4) estimate the loss in provider financial savings under the federal 340B Drug Pricing Program that would result from the elimination of managed care plan contracts under medical assistance and MinnesotaCare, and develop a method to reimburse providers for these potential losses;

(5) consult with the commissioner of health and the contractor or contractors analyzing the Minnesota Health Plan and other reform models, on plan design and assumptions; and

(6) conduct other analyses necessary to develop the implementation plan.

Sec. 11. Minnesota Statutes 2022, section 256.969, subdivision 9, is amended to read:

Subd. 9. **Disproportionate numbers of low-income patients served.** (a) For admissions occurring on or after July 1, 1993, the medical assistance disproportionate population adjustment shall comply with federal law and shall be paid to a hospital, excluding regional treatment centers and facilities of the federal Indian Health Service, with a medical assistance inpatient utilization rate in excess of the arithmetic mean. The adjustment must be determined as follows:

(1) for a hospital with a medical assistance inpatient utilization rate above the arithmetic mean for all hospitals excluding regional treatment centers and facilities of the federal Indian Health Service but less than or equal to one standard deviation above the mean, the adjustment must be determined by multiplying the total of the operating and property payment rates by the difference between the hospital's actual medical assistance inpatient utilization rate and the arithmetic mean for all hospitals excluding regional treatment centers and facilities of the federal Indian Health Service; and

(2) for a hospital with a medical assistance inpatient utilization rate above one standard deviation above the mean, the adjustment must be determined by multiplying the adjustment that would be determined under clause (1) for that hospital by 1.1. The commissioner shall

report annually on the number of hospitals likely to receive the adjustment authorized by this paragraph. The commissioner shall specifically report on the adjustments received by public hospitals and public hospital corporations located in cities of the first class.

(b) Certified public expenditures made by Hennepin County Medical Center shall be considered Medicaid disproportionate share hospital payments. Hennepin County and Hennepin County Medical Center shall report by June 15, 2007, on payments made beginning July 1, 2005, or another date specified by the commissioner, that may qualify for reimbursement under federal law. Based on these reports, the commissioner shall apply for federal matching funds.

(c) Upon federal approval of the related state plan amendment, paragraph (b) is effective retroactively from July 1, 2005, or the earliest effective date approved by the Centers for Medicare and Medicaid Services.

(d) Effective July 1, 2015, disproportionate share hospital (DSH) payments shall be paid in accordance with a new methodology using 2012 as the base year. Annual payments made under this paragraph shall equal the total amount of payments made for 2012. A licensed children's hospital shall receive only a single DSH factor for children's hospitals. Other DSH factors may be combined to arrive at a single factor for each hospital that is eligible for DSH payments. The new methodology shall make payments only to hospitals located in Minnesota and include the following factors:

(1) a licensed children's hospital with at least 1,000 fee-for-service discharges in the base year shall receive a factor of 0.868. A licensed children's hospital with less than 1,000 fee-for-service discharges in the base year shall receive a factor of 0.7880;

(2) a hospital that has in effect for the initial rate year a contract with the commissioner to provide extended psychiatric inpatient services under section 256.9693 shall receive a factor of 0.0160;

(3) a hospital that has received medical assistance payment for at least 20 transplant services in the base year shall receive a factor of 0.0435;

(4) a hospital that has a medical assistance utilization rate in the base year between 20 percent up to one standard deviation above the statewide mean utilization rate shall receive a factor of 0.0468;

(5) a hospital that has a medical assistance utilization rate in the base year that is at least one standard deviation above the statewide mean utilization rate but is less than two and one-half standard deviations above the mean shall receive a factor of 0.2300; and

(6) a hospital that is a level one trauma center and that has a medical assistance utilization rate in the base year that is at least two and one-half standard deviations above the statewide mean utilization rate shall receive a factor of 0.3711.

(e) For the purposes of determining eligibility for the disproportionate share hospital factors in paragraph (d), clauses (1) to (6), the medical assistance utilization rate and discharge thresholds shall be measured using only one year when a two-year base period is used.

(f) Any payments or portion of payments made to a hospital under this subdivision that are subsequently returned to the commissioner because the payments are found to exceed the hospital-specific DSH limit for that hospital shall be redistributed, proportionate to the number of fee-for-service discharges, to other DSH-eligible non-children's hospitals that have a medical assistance utilization rate that is at least one standard deviation above the mean.

(g) An additional payment adjustment shall be established by the commissioner under this subdivision for a hospital that provides high levels of administering high-cost drugs to enrollees in fee-for-service medical assistance. The commissioner shall consider factors including fee-for-service medical assistance utilization rates and payments made for drugs purchased through the 340B drug purchasing program and administered to fee-for-service enrollees. If any part of this adjustment exceeds a hospital's hospital-specific disproportionate share hospital limit, or if the hospital qualifies for the alternative payment rate described in subdivision 2e, the commissioner shall make a payment to the hospital that equals the nonfederal share of the amount that exceeds the limit. The total nonfederal share of the amount of the payment adjustment under this paragraph shall not exceed ~~$1,500,000~~ $.....

EFFECTIVE DATE. This section is effective January 1, 2026, or the January 1 following certification of the modernized pharmacy claims processing system, whichever is later.

Sec. 12. Minnesota Statutes 2022, section 256B.056, subdivision 7, is amended to read:

Subd. 7. **Period of eligibility.** (a) Eligibility is available for the month of application and for three months prior to application if the person was eligible in those prior months. A redetermination of eligibility must occur every 12 months.

(b) Notwithstanding any other law to the contrary:

(1) a child under 19 years of age who is determined eligible for medical assistance must remain eligible for a period of 12 months;

(2) a child 19 years of age and older but under 21 years of age who is determined eligible for medical assistance must remain eligible for a period of 12 months; and

(3) a child under six years of age who is determined eligible for medical assistance must remain eligible through the month in which the child reaches six years of age.

(c) A child's eligibility under paragraph (b) may be terminated earlier if:

(1) the child or the child's representative requests voluntary termination of eligibility;

(2) the child ceases to be a resident of this state;

(3) the child dies; or

(4) the agency determines eligibility was erroneously granted at the most recent eligibility determination due to agency error or fraud, abuse, or perjury attributed to the child or the child's representative.

~~(b)~~ (d) For a person eligible for an insurance affordability program as defined in section 256B.02, subdivision 19, who reports a change that makes the person eligible for medical assistance, eligibility is available for the month the change was reported and for three months prior to the month the change was reported, if the person was eligible in those prior months.

EFFECTIVE DATE. This section is effective January 1, 2025, or upon federal approval, whichever is later, except that paragraph (b), clause (1), is effective January 1, 2024. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 13. Minnesota Statutes 2022, section 256B.0625, subdivision 18h, is amended to read:

Subd. 18h. **Managed care.** (a) The following subdivisions apply to managed care plans and county-based purchasing plans:

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

(2) subdivision 18; and

(3) subdivision 18a.

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

(c) Managed care plans and county-based purchasing plans shall reimburse pharmacies for drug costs at a level not to exceed the reimbursement rate in subdivision 13e, paragraphs (a), (d), and (f), excluding the 340B drug program ceiling price limit, and shall pay a dispensing fee equal to the fee-for-service dispensing fee in subdivision 13e, paragraph (a), for outpatient drugs dispensed to enrollees. Contracts between managed care plans and county-based purchasing plans and providers to whom this paragraph applies must allow recovery of payments from those providers if capitation rates are adjusted in accordance with this paragraph. Payment recoveries must not exceed an amount equal to any increase in rates that results from this provision. This paragraph shall not be implemented if federal approval is not received for this paragraph, or if federal approval is withdrawn at any time.

EFFECTIVE DATE. This section is effective January 1, 2024, or upon federal approval, whichever is later.

Sec. 14. Minnesota Statutes 2022, section 256B.0631, subdivision 1, is amended to read:

Subdivision 1. **Cost-sharing.** (a) Except as provided in subdivision 2, the medical assistance benefit plan shall include the following cost-sharing for all recipients, effective for services provided ~~on or after~~ from September 1, 2011, to December 31, 2023:

(1) $3 per nonpreventive visit, except as provided in paragraph (b). For purposes of this subdivision, a visit means an episode of service which is required because of a recipient's symptoms, diagnosis, or established illness, and which is delivered in an ambulatory setting by a physician or physician assistant, chiropractor, podiatrist, nurse midwife, advanced practice nurse, audiologist, optician, or optometrist;

(2) $3.50 for nonemergency visits to a hospital-based emergency room, except that this co-payment shall be increased to $20 upon federal approval;

(3) $3 per brand-name drug prescription, $1 per generic drug prescription, and $1 per prescription for a brand-name multisource drug listed in preferred status on the preferred drug list, subject to a $12 per month maximum for prescription drug co-payments. No co-payments shall apply to antipsychotic drugs when used for the treatment of mental illness;

(4) a family deductible equal to $2.75 per month per family and adjusted annually by the percentage increase in the medical care component of the CPI-U for the period of September to September of the preceding calendar year, rounded to the next higher five-cent increment; and

(5) total monthly cost-sharing must not exceed five percent of family income. For purposes of this paragraph, family income is the total earned and unearned income of the

individual and the individual's spouse, if the spouse is enrolled in medical assistance and also subject to the five percent limit on cost-sharing. This paragraph does not apply to premiums charged to individuals described under section 256B.057, subdivision 9.

(b) Recipients of medical assistance are responsible for all co-payments and deductibles in this subdivision.

(c) Notwithstanding paragraph (b), the commissioner, through the contracting process under sections 256B.69 and 256B.692, may allow managed care plans and county-based purchasing plans to waive the family deductible under paragraph (a), clause (4). The value of the family deductible shall not be included in the capitation payment to managed care plans and county-based purchasing plans. Managed care plans and county-based purchasing plans shall certify annually to the commissioner the dollar value of the family deductible.

(d) Notwithstanding paragraph (b), the commissioner may waive the collection of the family deductible described under paragraph (a), clause (4), from individuals and allow long-term care and waivered service providers to assume responsibility for payment.

(e) Notwithstanding paragraph (b), the commissioner, through the contracting process under section 256B.0756 shall allow the pilot program in Hennepin County to waive co-payments. The value of the co-payments shall not be included in the capitation payment amount to the integrated health care delivery networks under the pilot program.

(f) For services provided on or after January 1, 2024, the medical assistance benefit plan must not include cost-sharing or deductibles for any medical assistance recipient or benefit.

Sec. 15. Minnesota Statutes 2022, section 256B.0631, subdivision 3, is amended to read:

Subd. 3. **Collection.** (a) The medical assistance reimbursement to the provider shall be reduced by the amount of the co-payment or deductible, except that reimbursements shall not be reduced:

(1) once a recipient has reached the $12 per month maximum for prescription drug co-payments; or

(2) for a recipient who has met their monthly five percent cost-sharing limit.

(b) The provider collects the co-payment or deductible from the recipient. Providers may not deny services to recipients who are unable to pay the co-payment or deductible.

~~(c) Medical assistance reimbursement to fee-for-service providers and payments to managed care plans shall not be increased as a result of the removal of co-payments or deductibles effective on or after January 1, 2009.~~

EFFECTIVE DATE. This section is effective January 1, 2024.

Sec. 16. Minnesota Statutes 2022, section 256B.69, subdivision 4, is amended to read:

Subd. 4. **Limitation of choice; opportunity to opt out.** (a) The commissioner shall develop criteria to determine when limitation of choice may be implemented in the experimental counties, but shall provide all eligible individuals the opportunity to opt out of enrollment in managed care under this section. The criteria shall ensure that all eligible individuals in the county have continuing access to the full range of medical assistance services as specified in subdivision 6.

(b) The commissioner shall exempt the following persons from participation in the project, in addition to those who do not meet the criteria for limitation of choice:

(1) persons eligible for medical assistance according to section 256B.055, subdivision 1;

(2) persons eligible for medical assistance due to blindness or disability as determined by the Social Security Administration or the state medical review team, unless:

(i) they are 65 years of age or older; or

(ii) they reside in Itasca County or they reside in a county in which the commissioner conducts a pilot project under a waiver granted pursuant to section 1115 of the Social Security Act;

(3) recipients who currently have private coverage through a health maintenance organization;

(4) recipients who are eligible for medical assistance by spending down excess income for medical expenses other than the nursing facility per diem expense;

(5) recipients who receive benefits under the Refugee Assistance Program, established under United States Code, title 8, section 1522(e);

(6) children who are both determined to be severely emotionally disturbed and receiving case management services according to section 256B.0625, subdivision 20, except children who are eligible for and who decline enrollment in an approved preferred integrated network under section 245.4682;

(7) adults who are both determined to be seriously and persistently mentally ill and received case management services according to section 256B.0625, subdivision 20;

(8) persons eligible for medical assistance according to section 256B.057, subdivision 10;

(9) persons with access to cost-effective employer-sponsored private health insurance or persons enrolled in a non-Medicare individual health plan determined to be cost-effective according to section 256B.0625, subdivision 15; and

(10) persons who are absent from the state for more than 30 consecutive days but still deemed a resident of Minnesota, identified in accordance with section 256B.056, subdivision 1, paragraph (b).

Children under age 21 who are in foster placement may enroll in the project on an elective basis. Individuals excluded under clauses (1), (6), and (7) may choose to enroll on an elective basis. The commissioner may enroll recipients in the prepaid medical assistance program for seniors who are (1) age 65 and over, and (2) eligible for medical assistance by spending down excess income.

(c) The commissioner may allow persons with a one-month spenddown who are otherwise eligible to enroll to voluntarily enroll or remain enrolled, if they elect to prepay their monthly spenddown to the state.

(d) The commissioner may require, subject to the opt-out provision under paragraph (a), those individuals to enroll in the prepaid medical assistance program who otherwise would have been excluded under paragraph (b), clauses (1), (3), and (8), and under Minnesota Rules, part 9500.1452, subpart 2, items H, K, and L.

(e) Before limitation of choice is implemented, eligible individuals shall be notified and given the opportunity to opt out of managed care enrollment. After notification, those individuals who choose not to opt out shall be allowed to choose only among demonstration providers. The commissioner may assign an individual with private coverage through a health maintenance organization, to the same health maintenance organization for medical assistance coverage, if the health maintenance organization is under contract for medical assistance in the individual's county of residence. After initially choosing a provider, the recipient is allowed to change that choice only at specified times as allowed by the commissioner. If a demonstration provider ends participation in the project for any reason, a recipient enrolled with that provider must select a new provider but may change providers without cause once more within the first 60 days after enrollment with the second provider.

(f) An infant born to a woman who is eligible for and receiving medical assistance and who is enrolled in the prepaid medical assistance program shall be retroactively enrolled to the month of birth in the same managed care plan as the mother once the child is enrolled

in medical assistance unless the child is determined to be excluded from enrollment in a prepaid plan under this section.

EFFECTIVE DATE. This section is effective January 1, 2024.

Sec. 17. Minnesota Statutes 2022, section 256B.69, subdivision 6d, is amended to read:

Subd. 6d. **Prescription drugs.** The commissioner ~~may~~ shall exclude or modify coverage for outpatient prescription drugs dispensed by a pharmacy to a medical assistance or MinnesotaCare enrollee from the prepaid managed care contracts entered into under this ~~section in order to increase savings to the state by collecting additional prescription drug rebates. The contracts must maintain incentives for the managed care plan to manage drug costs and utilization and may require that the managed care plans maintain an open drug formulary. In order to manage drug costs and utilization, the contracts may authorize the managed care plans to use preferred drug lists and prior authorization. This subdivision is contingent on federal approval of the managed care contract changes and the collection of additional prescription drug rebates~~ chapter and chapter 256L. The commissioner may include, exclude, or modify coverage for prescription drugs administered to a medical assistance or MinnesotaCare enrollee from the prepaid managed care contracts entered into under this chapter and chapter 256L.

EFFECTIVE DATE. This section is effective January 1, 2026, or the January 1 following certification of the modernized pharmacy claims processing system, whichever is later.

Sec. 18. Minnesota Statutes 2022, section 256B.69, subdivision 28, is amended to read:

Subd. 28. **Medicare special needs plans; medical assistance basic health care.** (a) The commissioner may contract with demonstration providers and current or former sponsors of qualified Medicare-approved special needs plans, to provide medical assistance basic health care services to persons with disabilities, including those with developmental disabilities. Basic health care services include:

(1) those services covered by the medical assistance state plan except for ICF/DD services, home and community-based waiver services, case management for persons with developmental disabilities under section 256B.0625, subdivision 20a, and personal care and certain home care services defined by the commissioner in consultation with the stakeholder group established under paragraph (d); and

(2) basic health care services may also include risk for up to 100 days of nursing facility services for persons who reside in a noninstitutional setting and home health services related to rehabilitation as defined by the commissioner after consultation with the stakeholder group.

The commissioner may exclude other medical assistance services from the basic health care benefit set. Enrollees in these plans can access any excluded services on the same basis as other medical assistance recipients who have not enrolled.

(b) The commissioner may contract with demonstration providers and current and former sponsors of qualified Medicare special needs plans, to provide basic health care services under medical assistance to persons who are dually eligible for both Medicare and Medicaid and those Social Security beneficiaries eligible for Medicaid but in the waiting period for Medicare. The commissioner shall consult with the stakeholder group under paragraph (d) in developing program specifications for these services. Payment for Medicaid services provided under this subdivision for the months of May and June will be made no earlier than July 1 of the same calendar year.

(c) ~~Notwithstanding subdivision 4, beginning January 1, 2012,~~ The commissioner shall enroll persons with disabilities in managed care under this section, unless the individual chooses to opt out of enrollment. The commissioner shall establish enrollment and opt out procedures consistent with applicable enrollment procedures under this section.

(d) The commissioner shall establish a state-level stakeholder group to provide advice on managed care programs for persons with disabilities, including both MnDHO and contracts with special needs plans that provide basic health care services as described in paragraphs (a) and (b). The stakeholder group shall provide advice on program expansions under this subdivision and subdivision 23, including:

(1) implementation efforts;

(2) consumer protections; and

(3) program specifications such as quality assurance measures, data collection and reporting, and evaluation of costs, quality, and results.

(e) Each plan under contract to provide medical assistance basic health care services shall establish a local or regional stakeholder group, including representatives of the counties covered by the plan, members, consumer advocates, and providers, for advice on issues that arise in the local or regional area.

(f) The commissioner is prohibited from providing the names of potential enrollees to health plans for marketing purposes. The commissioner shall mail no more than two sets of marketing materials per contract year to potential enrollees on behalf of health plans, at the health plan's request. The marketing materials shall be mailed by the commissioner within 30 days of receipt of these materials from the health plan. The health plans shall cover any costs incurred by the commissioner for mailing marketing materials.

EFFECTIVE DATE. This section is effective January 1, 2024.

Sec. 19. Minnesota Statutes 2022, section 256B.69, subdivision 36, is amended to read:

Subd. 36. **Enrollee support system.** (a) The commissioner shall establish an enrollee support system that provides support to an enrollee before and during enrollment in a managed care plan.

(b) The enrollee support system must:

(1) provide access to counseling for each potential enrollee on choosing a managed care plan or opting out of managed care;

(2) assist an enrollee in understanding enrollment in a managed care plan;

(3) provide an access point for complaints regarding enrollment, covered services, and other related matters;

(4) provide information on an enrollee's grievance and appeal rights within the managed care organization and the state's fair hearing process, including an enrollee's rights and responsibilities; and

(5) provide assistance to an enrollee, upon request, in navigating the grievance and appeals process within the managed care organization and in appealing adverse benefit determinations made by the managed care organization to the state's fair hearing process after the managed care organization's internal appeals process has been exhausted. Assistance does not include providing representation to an enrollee at the state's fair hearing, but may include a referral to appropriate legal representation sources.

(c) Outreach to enrollees through the support system must be accessible to an enrollee through multiple formats, including telephone, Internet, in-person, and, if requested, through auxiliary aids and services.

(d) The commissioner may designate enrollment brokers to assist enrollees on selecting a managed care organization and providing necessary enrollment information. For purposes of this subdivision, "enrollment broker" means an individual or entity that performs choice

counseling or enrollment activities in accordance with Code of Federal Regulations, part 42, section 438.810, or both.

EFFECTIVE DATE. This section is effective January 1, 2024.

Sec. 20. Minnesota Statutes 2022, section 256B.692, subdivision 1, is amended to read:

Subdivision 1. **In general.** County boards or groups of county boards may elect to purchase or provide health care services on behalf of persons eligible for medical assistance who would otherwise be required to or may elect to participate in the prepaid medical assistance program according to section 256B.69, subject to the opt-out provision of section 256B.69, subdivision 4, paragraph (a). Counties that elect to purchase or provide health care under this section must provide all services included in prepaid managed care programs according to section 256B.69, subdivisions 1 to 22. County-based purchasing under this section is governed by section 256B.69, unless otherwise provided for under this section.

EFFECTIVE DATE. This section is effective January 1, 2024.

Sec. 21. Minnesota Statutes 2022, section 256B.75, is amended to read:

256B.75 HOSPITAL OUTPATIENT REIMBURSEMENT.

(a) For outpatient hospital facility fee payments for services rendered on or after October 1, 1992, the commissioner of human services shall pay the lower of (1) submitted charge, or (2) 32 percent above the rate in effect on June 30, 1992, except for those services for which there is a federal maximum allowable payment. Effective for services rendered on or after January 1, 2000, payment rates for nonsurgical outpatient hospital facility fees and emergency room facility fees shall be increased by eight percent over the rates in effect on December 31, 1999, except for those services for which there is a federal maximum allowable payment. Services for which there is a federal maximum allowable payment shall be paid at the lower of (1) submitted charge, or (2) the federal maximum allowable payment. Total aggregate payment for outpatient hospital facility fee services shall not exceed the Medicare upper limit. If it is determined that a provision of this section conflicts with existing or future requirements of the United States government with respect to federal financial participation in medical assistance, the federal requirements prevail. The commissioner may, in the aggregate, prospectively reduce payment rates to avoid reduced federal financial participation resulting from rates that are in excess of the Medicare upper limitations.

(b) (1) Notwithstanding paragraph (a), payment for outpatient, emergency, and ambulatory surgery hospital facility fee services for critical access hospitals designated under section

144.1483, clause (9), shall be paid on a cost-based payment system that is based on the cost-finding methods and allowable costs of the Medicare program. Effective for services provided on or after July 1, 2015, rates established for critical access hospitals under this paragraph for the applicable payment year shall be the final payment and shall not be settled to actual costs. Effective for services delivered on or after the first day of the hospital's fiscal year ending in 2017, the rate for outpatient hospital services shall be computed using information from each hospital's Medicare cost report as filed with Medicare for the year that is two years before the year that the rate is being computed. Rates shall be computed using information from Worksheet C series until the department finalizes the medical assistance cost reporting process for critical access hospitals. After the cost reporting process is finalized, rates shall be computed using information from Title XIX Worksheet D series. The outpatient rate shall be equal to ancillary cost plus outpatient cost, excluding costs related to rural health clinics and federally qualified health clinics, divided by ancillary charges plus outpatient charges, excluding charges related to rural health clinics and federally qualified health clinics.

(2) The rate described in clause (1) shall be increased for hospitals providing high levels of 340B drugs. The rate adjustment shall be based on each hospital's share of the total reimbursement for 340B drugs to all critical access hospitals, but shall not exceed .... percentage points.

(c) Effective for services provided on or after July 1, 2003, rates that are based on the Medicare outpatient prospective payment system shall be replaced by a budget neutral prospective payment system that is derived using medical assistance data. The commissioner shall provide a proposal to the 2003 legislature to define and implement this provision. When implementing prospective payment methodologies, the commissioner shall use general methods and rate calculation parameters similar to the applicable Medicare prospective payment systems for services delivered in outpatient hospital and ambulatory surgical center settings unless other payment methodologies for these services are specified in this chapter.

(d) For fee-for-service services provided on or after July 1, 2002, the total payment, before third-party liability and spenddown, made to hospitals for outpatient hospital facility services is reduced by .5 percent from the current statutory rate.

(e) In addition to the reduction in paragraph (d), the total payment for fee-for-service services provided on or after July 1, 2003, made to hospitals for outpatient hospital facility services before third-party liability and spenddown, is reduced five percent from the current statutory rates. Facilities defined under section 256.969, subdivision 16, are excluded from this paragraph.

(f) In addition to the reductions in paragraphs (d) and (e), the total payment for fee-for-service services provided on or after July 1, 2008, made to hospitals for outpatient hospital facility services before third-party liability and spenddown, is reduced three percent from the current statutory rates. Mental health services and facilities defined under section 256.969, subdivision 16, are excluded from this paragraph.

EFFECTIVE DATE. This section is effective January 1, 2026, or the January 1 following certification of the modernized pharmacy claims processing system, whichever is later.

Sec. 22. Minnesota Statutes 2022, section 256L.04, subdivision 1c, is amended to read:

Subd. 1c. **General requirements.** To be eligible for MinnesotaCare, a person must meet the eligibility requirements of this section. A person eligible for MinnesotaCare ~~shall~~ with a family income of less than or equal to 200 percent of the federal poverty guidelines must not be considered a qualified individual under section 1312 of the Affordable Care Act, and is not eligible for enrollment in a qualified health plan offered through MNsure under chapter 62V.

EFFECTIVE DATE. This section is effective January 1, 2027, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 23. Minnesota Statutes 2022, section 256L.04, subdivision 7a, is amended to read:

Subd. 7a. **Ineligibility.** Adults whose income is greater than the limits established under this section may not enroll in the MinnesotaCare program, except as provided in subdivision 15.

EFFECTIVE DATE. This section is effective January 1, 2027, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 24. Minnesota Statutes 2022, section 256L.04, subdivision 10, is amended to read:

Subd. 10. **Citizenship requirements.** (a) Eligibility for MinnesotaCare is ~~limited~~ available to citizens or nationals of the United States ~~and~~, lawfully present noncitizens as defined in Code of Federal Regulations, title 8, section 103.12~~.~~, and undocumented noncitizens ~~are ineligible for MinnesotaCare~~. For purposes of this subdivision, an undocumented noncitizen is an individual who resides in the United States without the approval or acquiescence of the United States Citizenship and Immigration Services. Families

with children who are citizens or nationals of the United States must cooperate in obtaining satisfactory documentary evidence of citizenship or nationality according to the requirements of the federal Deficit Reduction Act of 2005, Public Law 109-171.

(b) Notwithstanding subdivisions 1 and 7, eligible persons include families and individuals who are ~~lawfully present and~~ ineligible for medical assistance by reason of immigration status and who have incomes equal to or less than 200 percent of federal poverty guidelines.

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

Sec. 25. Minnesota Statutes 2022, section 256L.04, is amended by adding a subdivision to read:

Subd. 15. **Persons eligible for public option.** (a) Families and individuals with income above the maximum income eligibility limit specified in subdivision 1 or 7 but who meet all other MinnesotaCare eligibility requirements are eligible for MinnesotaCare. All other provisions of this chapter apply unless otherwise specified.

(b) Families and individuals may enroll in MinnesotaCare under this subdivision only during an annual open enrollment period or special enrollment period, as designated by MNsure in compliance with Code of Federal Regulations, title 45, parts 155.410 and 155.420.

EFFECTIVE DATE. This section is effective January 1, 2027, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 26. Minnesota Statutes 2022, section 256L.07, subdivision 1, is amended to read:

Subdivision 1. **General requirements.** Individuals enrolled in MinnesotaCare under section 256L.04, subdivision 1, and individuals enrolled in MinnesotaCare under section 256L.04, subdivision 7, whose income increases above 200 percent of the federal poverty guidelines~~,~~ are no longer eligible for the program and ~~shall~~ must be disenrolled by the commissioner, unless the individuals continue MinnesotaCare enrollment through the public option under section 256L.04, subdivision 15. For persons disenrolled under this subdivision, MinnesotaCare coverage terminates the last day of the calendar month in which the commissioner sends advance notice according to Code of Federal Regulations, title 42, section 431.211, that indicates the income of a family or individual exceeds program income limits.

EFFECTIVE DATE. This section is effective January 1, 2027, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 27. Minnesota Statutes 2022, section 256L.15, subdivision 2, is amended to read:

Subd. 2. **Sliding fee scale; monthly individual or family income.** (a) The commissioner shall establish a sliding fee scale to determine the percentage of monthly individual or family income that households at different income levels must pay to obtain coverage through the MinnesotaCare program. The sliding fee scale must be based on the enrollee's monthly individual or family income.

~~(b) Beginning January 1, 2014, MinnesotaCare enrollees shall pay premiums according to the premium scale specified in paragraph (d).~~

~~(c)~~ (b) Paragraph ~~(b)~~ (a) does not apply to~~:~~

~~(1)~~ children 20 years of age or younger~~; and~~

~~(2) individuals with household incomes below 35 percent of the federal poverty guidelines~~.

~~(d) The following premium scale is established for each individual in the household who is 21 years of age or older and enrolled in MinnesotaCare:~~

~~**Federal Poverty Guideline Greater than or Equal to**~~	~~**Less than**~~	~~**Individual Premium Amount**~~
~~35%~~	~~55%~~	~~$4~~
~~55%~~	~~80%~~	~~$6~~
~~80%~~	~~90%~~	~~$8~~
~~90%~~	~~100%~~	~~$10~~
~~100%~~	~~110%~~	~~$12~~
~~110%~~	~~120%~~	~~$14~~
~~120%~~	~~130%~~	~~$15~~
~~130%~~	~~140%~~	~~$16~~
~~140%~~	~~150%~~	~~$25~~
~~150%~~	~~160%~~	~~$37~~
~~160%~~	~~170%~~	~~$44~~
~~170%~~	~~180%~~	~~$52~~
~~180%~~	~~190%~~	~~$61~~
~~190%~~	~~200%~~	~~$71~~
~~200%~~		~~$80~~

~~(c)~~ (c) Beginning January 1, ~~2021~~ 2024, the commissioner shall continue to charge premiums in accordance with the simplified premium scale established to comply with the American Rescue Plan Act of 2021, in effect from January 1, 2021, through December 31, 2025, for families and individuals eligible under section 256L.04, subdivisions 1 and 7. The commissioner shall adjust the premium scale ~~established under paragraph (d)~~ as needed to ensure that premiums do not exceed the amount that an individual would have been required to pay if the individual was enrolled in an applicable benchmark plan in accordance with the Code of Federal Regulations, title 42, section 600.505 (a)(1).

(d) The commissioner shall establish a sliding premium scale for persons eligible through the public option under section 256L.04, subdivision 15. Beginning January 1, 2027, persons eligible through the public option shall pay premiums according to this premium scale. Persons eligible through the public option who are 20 years of age or younger are exempt from paying premiums.

EFFECTIVE DATE. This section is effective January 1, 2024, except that paragraph (d) is effective January 1, 2027, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 28. **TRANSITION TO MINNESOTACARE PUBLIC OPTION.**

(a) The commissioner of human services shall continue to administer MinnesotaCare as a basic health program in accordance with Minnesota Statutes, section 256L.02, subdivision 5.

(b) The commissioner shall present an implementation plan for the MinnesotaCare public option under Minnesota Statutes, section 256L.04, subdivision 15, to the chairs and ranking minority members of the legislative committees with jurisdiction over health care policy and finance by January 15, 2025. The plan must include:

(1) recommendations for any changes to the MinnesotaCare public option necessary to continue federal basic health program funding or to receive other federal funding;

(2) recommendations for ensuring sufficient provider participation in MinnesotaCare;

(3) estimates of state costs related to the MinnesotaCare public option;

(4) a description of the proposed premium scale for persons eligible through the public option, including an analysis of the extent to which the proposed premium scale:

(i) ensures affordable premiums for persons across the income spectrum enrolled under the public option; and

(ii) avoids premium cliffs for persons transitioning to and enrolled under the public option; and

(5) draft legislation that includes any additional policy and conforming changes necessary to implement the MinnesotaCare public option and the implementation plan recommendations.

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

Sec. 29. **REQUEST FOR FEDERAL APPROVAL.**

(a) The commissioner of human services shall seek any federal waivers, approvals, and law changes necessary to implement this act, including but not limited to those waivers, approvals, and law changes necessary to allow the state to:

(1) continue receiving federal basic health program payments for basic health program-eligible MinnesotaCare enrollees and to receive other federal funding for the MinnesotaCare public option;

(2) receive federal payments equal to the value of premium tax credits and cost-sharing reductions that MinnesotaCare enrollees with household incomes greater than 200 percent of the federal poverty guidelines would otherwise have received; and

(3) receive federal payments equal to the value of emergency medical assistance that would otherwise have been paid to the state for covered services provided to eligible enrollees.

(b) In implementing this section, the commissioner of human services shall consult with the commissioner of commerce and the Board of Directors of MNsure and may contract for technical and actuarial assistance.

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

Sec. 30. **ANALYSIS OF BENEFITS AND COSTS OF UNIVERSAL HEALTH CARE SYSTEM REFORM MODELS.**

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

(b) "All necessary care" means the full range of services listed in the proposed Minnesota Health Plan legislation, including medical, dental, vision and hearing, mental health, chemical

dependency treatment, reproductive and sexual health, prescription drugs, medical equipment and supplies, long-term care, home care, and coordination of care.

(c) "Direct payment system" means the health care delivery system authorized by Minnesota Statutes, section 256.9631.

(d) "MinnesotaCare public option" means the MinnesotaCare expansion to cover individuals eligible under Minnesota Statutes, section 256L.04, subdivision 15.

(e) "Other reform models" means alternative models of health care reform, that may include changes to health system administration, payments, or benefits, and may be comprehensive or specific to selected market segments or populations.

(f) "Total public and private health care spending" means:

(1) spending on all medical care including but not limited to dental, vision and hearing, mental health, chemical dependency treatment, prescription drugs, medical equipment and supplies, long-term care, and home care, whether paid through premiums, co-pays and deductibles, other out-of-pocket payments, or other funding from government, employers, or other sources; and

(2) the costs associated with administering, delivering, and paying for the care. The costs of administering, delivering, and paying for the care includes all expenses by insurers, providers, employers, individuals, and government to select, negotiate, purchase, and administer insurance and care including but not limited to coverage for health care, dental, long-term care, prescription drugs, and the medical expense portions of workers compensation and automobile insurance, and the cost of administering and paying for all health care products and services that are not covered by insurance.

Subd. 2. **Initial assumptions.** (a) When calculating administrative savings under the universal health proposal, the analysts shall recognize that simple, direct payment of medical services avoids the need for provider networks, eliminates prior authorization requirements, and eliminates administrative complexity of other payment schemes along with the need for creating risk adjustment mechanisms, and measuring, tracking, and paying under those risk adjusted or nonrisk adjusted payment schemes by both providers and payors.

(b) The analysts shall assume that, under the universal health proposal, while gross provider payments may be reduced to reflect reduced administrative costs, net provider income would remain similar to the current system. However, they shall not assume that payment rate negotiations will track current Medicaid, Medicare, or market payment rates or a combination of those rates, because provider compensation, after adjusting for reduced

administrative costs, would not be universally raised or lowered but would be negotiated based on market needs, so provider compensation might be raised in an underserved area such as mental health but lowered in other areas.

Subd. 3. **Contract for analysis of proposals; analytic tool.** (a) The commissioner of health shall contract with one or more independent entities to:

(1) conduct an analysis of the benefits and costs of a legislative proposal for a universal health care financing system, based on the legislative proposal known as the Minnesota Health Plan (Regular Session 2022, Senate File No. 2740/House File No. 2798) and a similar analysis of the current health care financing system to assist the state in comparing the proposal to the current system; and

(2) conduct an analysis of the MinnesotaCare public option, the direct payment system, and other reform models, and a similar analysis of the current health care financing system to assist the state in comparing the models to the current system.

(b) In conducting these analyses, the contractor or contractors shall develop and use an analytic tool that meets the requirements in subdivision 4, and shall also make this analytic tool available for use by the commissioner.

(c) The commissioner shall issue a request for information. Based on responses to the request for information, the commissioner shall issue a request for proposals that specifies requirements for the design, analysis, and deliverables, and shall select one or more contractors based on responses to the request for proposals. The commissioner shall consult with the chief authors of this act in implementing this paragraph.

Subd. 4. **Requirements for analytic tool.** (a) The analytic tool must be able to assess and model the impact of the Minnesota Health Plan, the direct payment system, the MinnesotaCare public option, and other reform models on the following:

(1) coverage: the number of people who are uninsured versus the number of people who are insured;

(2) benefit completeness: adequacy of coverage measured by the completeness of the coverage and the number of people lacking coverage for key necessary care elements such as dental, long-term care, medical equipment or supplies, vision and hearing, or other health services that are not covered, if any. The analysis must take into account the vast variety of benefit designs in the commercial market and report the extent of coverage in each area;

(3) underinsurance: whether people with coverage can afford the care they need or whether cost prevents them from accessing care. This includes affordability in terms of premiums, deductibles, and out-of-pocket expenses;

(4) system capacity: the timeliness and appropriateness of the care received and whether people turn to inappropriate care such as emergency rooms because of a lack of proper care in accordance with clinical guidelines; and

(5) health care spending: total public and private health care spending in Minnesota, including all spending by individuals, businesses, and government. Where relevant, the analysis shall be broken out by key necessary care areas, such as medical, dental, and mental health. The analysis of total health care spending shall examine whether there are savings or additional costs under the legislative proposal compared to the existing system due to:

(i) changes in cost of insurance, billing, underwriting, marketing, evaluation, and other administrative functions for all entities involved in the health care system, including savings from global budgeting for hospitals and institutional care instead of billing for individual services provided;

(ii) changed prices on medical services and products, including pharmaceuticals, due to price negotiations under the proposal;

(iii) impact on utilization, health outcomes, and workplace absenteeism due to prevention, early intervention, and health-promoting activities;

(iv) shortages or excess capacity of medical facilities, equipment, and personnel, including caregivers and staff, under either the current system or the proposal, including capacity of clinics, hospitals, and other appropriate care sites versus inappropriate emergency room usage. The analysis shall break down capacity by geographic differences such as rural versus metro, and disparate access by population group;

(v) the impact on state, local, and federal government non-health-care expenditures. This may include areas such as reduced crime and out-of-home placement costs due to mental health or chemical dependency coverage. Additional definition may further develop hypotheses for other impacts that warrant analysis;

(vi) job losses or gains within the health care system; specifically, in health care delivery, health billing, and insurance administration;

(vii) job losses or gains elsewhere in the economy under the proposal due to implementation of the resulting reduction of insurance and administrative burdens on businesses; and

(viii) impacts on disparities in health care access and outcomes.

(b) The analytic tool must:

(1) have the capacity to conduct interactive microsimulations;

(2) allow comparisons between the Minnesota Health Plan, the direct payment system, the MinnesotaCare public option, the current delivery system, and other reform models, on the relative impact of these delivery approaches on the variables described in paragraph (a); and

(3) allow comparisons based on differing assumptions about the characteristics and operation of the delivery approaches.

Subd. 5. **Analyses by the commissioner.** The commissioner, in cooperation with the commissioners of human services and commerce, and the legislature, may use the analytic tool to assist in the development, design, and analysis of reform models under consideration by the legislature and state agencies, and to supplement the analyses of the Minnesota Health Plan, the MinnesotaCare public option, and the direct payment system conducted by the contractor or contractors under this section.

Subd. 6. **Report and delivery of analytic tool.** (a) The contractor or contractors, by January 15, 2026, shall report findings and recommendations to the commissioner, and to the chairs and ranking minority members of the legislative committees with jurisdiction over health care and commerce, on the design and implementation of the Minnesota Health Plan, the MinnesotaCare public option, and the direct payment system. The findings and recommendations must address the feasibility and affordability of the proposals, and the projected impact of the proposals on the variables listed in subdivision 4.

(b) The contractor or contractors shall make the analytic tool available to the commissioner by January 15, 2026.

ARTICLE 3
DEPARTMENT OF HEALTH

Section 1. Minnesota Statutes 2022, section 12A.08, subdivision 3, is amended to read:

Subd. 3. **Implementation.** To implement the requirements of this section, the commissioner may cooperate with private health care providers and facilities, Tribal nations, and community health boards as defined in section 145A.02~~,~~; provide grants to assist community health boards~~,~~ and Tribal nations; use volunteer services of individuals qualified

to provide public health services~~,~~; and enter into cooperative or mutual aid agreements to provide public health services.

Sec. 2. Minnesota Statutes 2022, section 13.3805, subdivision 1, is amended to read:

Subdivision 1. **Health data generally.** (a) **Definitions.** As used in this subdivision:

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

(2) "Health data" are data on individuals created, collected, received, or maintained by the Department of Health, political subdivisions, or statewide systems relating to the identification, description, prevention, and control of disease or as part of an epidemiologic investigation the commissioner designates as necessary to analyze, describe, or protect the public health.

(b) **Data on individuals.** (1) Health data are private data on individuals. Notwithstanding section 13.05, subdivision 9, health data may not be disclosed except as provided in this subdivision and section 13.04.

(2) The commissioner or a community health board as defined in section 145A.02, subdivision 5, may disclose health data to the data subject's physician as necessary to locate or identify a case, carrier, or suspect case, to establish a diagnosis, to provide treatment, to identify persons at risk of illness, or to conduct an epidemiologic investigation.

(3) With the approval of the commissioner, health data may be disclosed to the extent necessary to assist the commissioner to locate or identify a case, carrier, or suspect case, to alert persons who may be threatened by illness as evidenced by epidemiologic data, to control or prevent the spread of serious disease, or to diminish an imminent threat to the public health.

~~(c) **Health summary data.** Summary data derived from data collected under section 145.413 may be provided under section 13.05, subdivision 7.~~

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

Sec. 3. Minnesota Statutes 2022, section 16A.151, subdivision 2, is amended to read:

Subd. 2. **Exceptions.** (a) If a state official litigates or settles a matter on behalf of specific injured persons or entities, this section does not prohibit distribution of money to the specific injured persons or entities on whose behalf the litigation or settlement efforts were initiated. If money recovered on behalf of injured persons or entities cannot reasonably be distributed to those persons or entities because they cannot readily be located or identified or because

the cost of distributing the money would outweigh the benefit to the persons or entities, the money must be paid into the general fund.

(b) Money recovered on behalf of a fund in the state treasury other than the general fund may be deposited in that fund.

(c) This section does not prohibit a state official from distributing money to a person or entity other than the state in litigation or potential litigation in which the state is a defendant or potential defendant.

(d) State agencies may accept funds as directed by a federal court for any restitution or monetary penalty under United States Code, title 18, section 3663(a)(3), or United States Code, title 18, section 3663A(a)(3). Funds received must be deposited in a special revenue account and are appropriated to the commissioner of the agency for the purpose as directed by the federal court.

(e) Tobacco settlement revenues as defined in section 16A.98, subdivision 1, paragraph (t), may be deposited as provided in section 16A.98, subdivision 12.

(f) Any money received by the state resulting from a settlement agreement or an assurance of discontinuance entered into by the attorney general of the state, or a court order in litigation brought by the attorney general of the state, on behalf of the state or a state agency, related to alleged violations of consumer fraud laws in the marketing, sale, or distribution of opioids in this state or other alleged illegal actions that contributed to the excessive use of opioids, must be deposited in the settlement account established in the opiate epidemic response fund under section 256.043, subdivision 1. This paragraph does not apply to attorney fees and costs awarded to the state or the Attorney General's Office, to contract attorneys hired by the state or Attorney General's Office, or to other state agency attorneys.

(g) Notwithstanding paragraph (f), if money is received from a settlement agreement or an assurance of discontinuance entered into by the attorney general of the state or a court order in litigation brought by the attorney general of the state on behalf of the state or a state agency against a consulting firm working for an opioid manufacturer or opioid wholesale drug distributor, the commissioner shall deposit any money received into the settlement account established within the opiate epidemic response fund under section 256.042, subdivision 1. Notwithstanding section 256.043, subdivision 3a, paragraph (a), any amount deposited into the settlement account in accordance with this paragraph shall be appropriated to the commissioner of human services to award as grants as specified by the opiate epidemic response advisory council in accordance with section 256.043, subdivision 3a, paragraph (d).

(h) Any money received by the state resulting from a settlement agreement or an assurance of discontinuance entered into by the attorney general of the state, or a court order in litigation brought by the attorney general of the state on behalf of the state or a state agency related to alleged violations of consumer fraud laws in the marketing, sale, or distribution of electronic nicotine delivery systems in this state or other alleged illegal actions that contributed to the exacerbation of youth nicotine use, must be deposited in the settlement account established in the tobacco use prevention account under section 144.398. This paragraph does not apply to: (1) attorney fees and costs awarded or paid to the state or the Attorney General's Office; (2) contract attorneys hired by the state or Attorney General's Office; or (3) other state agency attorneys.

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

Sec. 4. Minnesota Statutes 2022, section 62J.17, subdivision 5a, is amended to read:

Subd. 5a. **Retrospective review.** (a) The commissioner shall retrospectively review each major spending commitment and ~~notify the provider of the results of the review. The commissioner shall~~ determine whether the major spending commitment was appropriate. In making the determination, the commissioner may consider the following criteria: the major spending commitment's impact on the cost, access, and quality of health care; the clinical effectiveness and cost-effectiveness of the major spending commitment; and the alternatives available to the provider. If the major expenditure is determined not to be appropriate, the commissioner shall notify the provider.

(b) The commissioner may not prevent or prohibit a major spending commitment subject to retrospective review. However, if the provider fails the retrospective review, any major spending commitments by that provider for the five-year period following the commissioner's decision are subject to prospective review under subdivision 6a.

Sec. 5. **[62J.571] STATEWIDE HEALTH CARE PROVIDER DIRECTORY.**

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

(b) "Health care provider directory" means an electronic catalog and index that supports management of health care provider information, both individual and organizational, in a directory structure for public use to find available providers and networks and support state agency responsibilities.

(c) "Health care provider" means a practicing provider that accepts reimbursement from a group purchaser.

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

Subd. 2. **Health care provider directory.** (a) The commissioner shall assess the feasibility and stakeholder commitment to develop, manage, and maintain a statewide electronic directory of health care providers. The assessment must take into consideration consumer information needs; state agency applications; stakeholder needs; technical requirements; alignment with national standards; governance; operations; legal and policy considerations; and existing directories.

Subd. 3. **Consultation.** The commissioner shall assess the feasibility of the directory in consultation with stakeholders, including but not limited to consumers, group purchasers, health care providers, community health boards, and state agencies.

Sec. 6. **[62J.811] PROVIDER BALANCE BILLING REQUIREMENTS.**

Subdivision 1. **Billing requirements.** (a) Each health care provider and health facility shall comply with Consolidated Appropriations Act, 2021, Division BB also known as the "No Surprises Act," including any federal regulations adopted under that act.

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

Subd. 2. **Investigations and compliance.** (a) The commissioner shall, to the extent practicable, seek the cooperation of health care providers and facilities, and may provide any support and assistance as available, in obtaining compliance with this section.

(b) The commissioner shall determine the manner and processes for fulfilling any responsibilities and taking any of the actions in paragraphs (c) to (f).

(c) A person who believes a health care provider or facility has not complied with the requirements of the No Surprises Act or this section may file a complaint with the commissioner in the manner determined by the commissioner.

(d) The commissioner shall conduct compliance reviews and investigate complaints filed under this section in the manner determined by the commissioner to ascertain whether health care providers and facilities are complying with this section.

(e) The commissioner may report violations under this section to other relevant federal and state departments and jurisdictions as appropriate, including the attorney general and

relevant health-related licensing boards, and may also coordinate investigations and enforcement of this section with other relevant federal and state departments and jurisdictions as appropriate, including the attorney general and relevant health-related licensing boards.

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

(g) Any data collected by the commissioner as part of an active investigation or active compliance review under this section are classified as protected nonpublic data pursuant to section 13.02, subdivision 13, in the case of data not on individuals and confidential pursuant to section 13.02, subdivision 3, in the case of data on individuals. Data describing the final disposition of an investigation or compliance review are classified as public.

Subd. 3. **Civil penalty.** (a) The commissioner, in monitoring and enforcing this section, may levy a civil monetary penalty against each health care provider or facility found to be in violation of up to $100 for each violation, but the penalties levied under this subdivision may not exceed $25,000 for identical violations during a calendar year.

(b) No civil monetary penalty shall be imposed under this section for violations that occur prior to January 1, 2024.

Sec. 7. Minnesota Statutes 2022, section 62J.84, subdivision 2, is amended to read:

Subd. 2. **Definitions.** (a) For purposes of this section, the terms defined in this subdivision have the meanings given.

(b) "Biosimilar" means a drug that is produced or distributed pursuant to a biologics license application approved under United States Code, title 42, section 262(K)(3).

(c) "Brand name drug" means a drug that is produced or distributed pursuant to:

(1) ~~an original,~~ a new drug application approved under United States Code, title 21, section 355(c), except for a generic drug as defined under Code of Federal Regulations, title 42, section 447.502; or

(2) a biologics license application approved under United States Code, title ~~45~~ 42, section 262(a)(c).

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

(e) "Generic drug" means a drug that is marketed or distributed pursuant to:

(1) an abbreviated new drug application approved under United States Code, title 21, section 355(j);

(2) an authorized generic as defined under Code of Federal Regulations, title ~~45~~ 42, section 447.502; or

(3) a drug that entered the market the year before 1962 and was not originally marketed under a new drug application.

(f) "Manufacturer" means a drug manufacturer licensed under section 151.252.

(g) "New prescription drug" or "new drug" means a prescription drug approved for marketing by the United States Food and Drug Administration (FDA) for which no previous wholesale acquisition cost has been established for comparison.

(h) "Patient assistance program" means a program that a manufacturer offers to the public in which a consumer may reduce the consumer's out-of-pocket costs for prescription drugs by using coupons, discount cards, prepaid gift cards, manufacturer debit cards, or by other means.

(i) "Prescription drug" or "drug" has the meaning provided in section 151.441, subdivision 8.

(j) "Price" means the wholesale acquisition cost as defined in United States Code, title 42, section 1395w-3a(c)(6)(B).

(k) "30-day supply" means the total daily dosage units of a prescription drug recommended by the prescribing label approved by the FDA for 30 days. If the FDA-approved prescribing label includes more than one recommended daily dosage, the 30-day supply is based on the maximum recommended daily dosage on the FDA-approved prescribing label.

(l) "Course of treatment" means the total dosage of a single prescription for a prescription drug recommended by the FDA-approved prescribing label. If the FDA-approved prescribing label includes more than one recommended dosage for a single course of treatment, the course of treatment is the maximum recommended dosage on the FDA-approved prescribing label.

(m) "Drug product family" means a group of one or more prescription drugs that share a unique generic drug description or nontrade name and dosage form.

(n) "National drug code" means the three-segment code maintained by the federal Food and Drug Administration that includes a labeler code, a product code, and a package code

for a drug product and that has been converted to an 11-digit format consisting of five digits in the first segment, four digits in the second segment, and two digits in the third segment. A three-segment code shall be considered converted to an 11-digit format when, as necessary, at least one "0" has been added to the front of each segment containing less than the specified number of digits such that each segment contains the specified number of digits.

(o) "Pharmacy" or "pharmacy provider" means a place of business licensed by the Board of Pharmacy under section 151.19 in which prescription drugs are prepared, compounded, or dispensed under the supervision of a pharmacist.

(p) "Pharmacy benefit manager" or "PBM" means an entity licensed to act as a pharmacy benefit manager under section 62W.03.

(q) "Pricing unit" means the smallest dispensable amount of a prescription drug product that could be dispensed.

(r) "Reporting entity" means any manufacturer, pharmacy, pharmacy benefit manager, wholesale drug distributor, or any other entity required to submit data under this section.

(s) "Wholesale drug distributor" or "wholesaler" means an entity that:

(1) is licensed to act as a wholesale drug distributor under section 151.47; and

(2) distributes prescription drugs, of which it is not the manufacturer, to persons or entities, or both, other than a consumer or patient in the state.

Sec. 8. Minnesota Statutes 2022, section 62J.84, subdivision 3, is amended to read:

Subd. 3. **Prescription drug price increases reporting.** (a) Beginning January 1, 2022, a drug manufacturer must submit to the commissioner the information described in paragraph (b) for each prescription drug for which the price was $100 or greater for a 30-day supply or for a course of treatment lasting less than 30 days and:

(1) for brand name drugs where there is an increase of ten percent or greater in the price over the previous 12-month period or an increase of 16 percent or greater in the price over the previous 24-month period; and

(2) for generic or biosimilar drugs where there is an increase of 50 percent or greater in the price over the previous 12-month period.

(b) For each of the drugs described in paragraph (a), the manufacturer shall submit to the commissioner no later than 60 days after the price increase goes into effect, in the form and manner prescribed by the commissioner, the following information, if applicable:

(1) the ~~name~~ description and price of the drug and the net increase, expressed as a percentage~~;~~, with the following listed separately:

(i) the national drug code;

(ii) the product name;

(iii) the dosage form;

(iv) the strength;

(v) the package size;

(2) the factors that contributed to the price increase;

(3) the name of any generic version of the prescription drug available on the market;

(4) the introductory price of the prescription drug when it was ~~approved for marketing by the Food and Drug Administration and the net yearly increase, by calendar year, in the price of the prescription drug during the previous five years~~ introduced for sale in the United States and the price of the drug on the last day of each of the five calendar years preceding the price increase;

(5) the direct costs incurred during the previous 12-month period by the manufacturer that are associated with the prescription drug, listed separately:

(i) to manufacture the prescription drug;

(ii) to market the prescription drug, including advertising costs; and

(iii) to distribute the prescription drug;

(6) the total sales revenue for the prescription drug during the previous 12-month period;

(7) the manufacturer's net profit attributable to the prescription drug during the previous 12-month period;

(8) the total amount of financial assistance the manufacturer has provided through patient prescription assistance programs during the previous 12-month period, if applicable;

(9) any agreement between a manufacturer and another entity contingent upon any delay in offering to market a generic version of the prescription drug;

(10) the patent expiration date of the prescription drug if it is under patent;

(11) the name and location of the company that manufactured the drug; ~~and~~

(12) if a brand name prescription drug, the ~~ten~~ highest ~~prices~~ price paid for the prescription drug during the previous calendar year in ~~any country other than~~ the ten

countries, excluding the United States~~.~~, that charged the highest single price for the prescription drug; and

(13) if the prescription drug was acquired by the manufacturer during the previous 12-month period, all of the following information:

(i) price at acquisition;

(ii) price in the calendar year prior to acquisition;

(iii) name of the company from which the drug was acquired;

(iv) date of acquisition; and

(v) acquisition price.

(c) The manufacturer may submit any documentation necessary to support the information reported under this subdivision.

Sec. 9. Minnesota Statutes 2022, section 62J.84, subdivision 4, is amended to read:

Subd. 4. **New prescription drug price reporting.** (a) Beginning January 1, 2022, no later than 60 days after a manufacturer introduces a new prescription drug for sale in the United States that is a new brand name drug with a price that is greater than the tier threshold established by the Centers for Medicare and Medicaid Services for specialty drugs in the Medicare Part D program for a 30-day supply or for a course of treatment lasting fewer than 30 days or a new generic or biosimilar drug with a price that is greater than the tier threshold established by the Centers for Medicare and Medicaid Services for specialty drugs in the Medicare Part D program for a 30-day supply or for a course of treatment lasting fewer than 30 days and is not at least 15 percent lower than the referenced brand name drug when the generic or biosimilar drug is launched, the manufacturer must submit to the commissioner, in the form and manner prescribed by the commissioner, the following information, if applicable:

(1) the description of the drug, with the following listed separately:

(i) the national drug code;

(ii) the product name;

(iii) the dosage form;

(iv) the strength;

(v) the package size;

~~(1)~~ (2) the price of the prescription drug;

~~(2)~~ (3) whether the Food and Drug Administration granted the new prescription drug a breakthrough therapy designation or a priority review;

~~(3)~~ (4) the direct costs incurred by the manufacturer that are associated with the prescription drug, listed separately:

(i) to manufacture the prescription drug;

(ii) to market the prescription drug, including advertising costs; and

(iii) to distribute the prescription drug; and

~~(4)~~ (5) the patent expiration date of the drug if it is under patent.

(b) The manufacturer may submit documentation necessary to support the information reported under this subdivision.

Sec. 10. Minnesota Statutes 2022, section 62J.84, subdivision 6, is amended to read:

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

(1) a list of the prescription drugs reported under subdivisions 3, 4, and ~~5,~~ 11 to 14 and the manufacturers of those prescription drugs; and

(2) information reported to the commissioner under subdivisions 3, 4, and ~~5~~ 11 to 14.

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

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

to withhold information from public disclosure, the commissioner shall provide the manufacturer written notice that the information will be publicly posted 30 days after the date of the notice.

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

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

Sec. 11. Minnesota Statutes 2022, section 62J.84, subdivision 7, is amended to read:

Subd. 7. **Consultation.** (a) The commissioner may consult with a private entity or consortium that satisfies the standards of section 62U.04, subdivision 6, the University of Minnesota, or the commissioner of commerce, as appropriate, in issuing the form and format of the information reported under this section; in posting information pursuant to subdivision 6; and in taking any other action for the purpose of implementing this section.

(b) The commissioner may consult with representatives of the ~~manufacturers~~ reporting entities to establish a standard format for reporting information under this section and may use existing reporting methodologies to establish a standard format to minimize administrative burdens to the state and ~~manufacturers~~ reporting entities.

Sec. 12. Minnesota Statutes 2022, section 62J.84, subdivision 8, is amended to read:

Subd. 8. **Enforcement and penalties.** (a) A ~~manufacturer~~ reporting entity may be subject to a civil penalty, as provided in paragraph (b), for:

(1) failing to register under subdivision 15;

~~(1)~~ (2) failing to submit timely reports or notices as required by this section;

~~(2)~~ (3) failing to provide information required under this section; or

~~(3)~~ (4) providing inaccurate or incomplete information under this section.

(b) The commissioner shall adopt a schedule of civil penalties, not to exceed $10,000 per day of violation, based on the severity of each violation.

(c) The commissioner shall impose civil penalties under this section as provided in section 144.99, subdivision 4.

(d) The commissioner may remit or mitigate civil penalties under this section upon terms and conditions the commissioner considers proper and consistent with public health and safety.

(e) Civil penalties collected under this section shall be deposited in the health care access fund.

Sec. 13. Minnesota Statutes 2022, section 62J.84, subdivision 9, is amended to read:

Subd. 9. **Legislative report.** (a) No later than May 15, 2022, and by January 15 of each year thereafter, the commissioner shall report to the chairs and ranking minority members of the legislative committees with jurisdiction over commerce and health and human services policy and finance on the implementation of this section, including but not limited to the effectiveness in addressing the following goals:

(1) promoting transparency in pharmaceutical pricing for the state and other payers;

(2) enhancing the understanding on pharmaceutical spending trends; and

(3) assisting the state and other payers in the management of pharmaceutical costs.

(b) The report must include a summary of the information submitted to the commissioner under subdivisions 3, 4, and ~~5~~ 11 to 14.

Sec. 14. Minnesota Statutes 2022, section 62J.84, is amended by adding a subdivision to read:

Subd. 10. **Notice of prescription drugs of substantial public interest.** (a) No later than January 31, 2024, and quarterly thereafter, the commissioner shall produce and post on the department's website a list of prescription drugs that the department determines to represent a substantial public interest and for which the department intends to request data under subdivisions 11 to 14, subject to paragraph (c). The department shall base its inclusion of prescription drugs on any information the department determines is relevant to providing greater consumer awareness of the factors contributing to the cost of prescription drugs in the state, and the department shall consider drug product families that include prescription drugs:

(1) that triggered reporting under subdivision 3 or 4 during the previous calendar quarter;

(2) for which average claims paid amounts exceeded 125 percent of the price as of the claim incurred date during the most recent calendar quarter for which claims paid amounts are available; or

(3) that are identified by members of the public during a public comment period process.

(b) Not sooner than 30 days after publicly posting the list of prescription drugs under paragraph (a), the department shall notify, via email, reporting entities registered with the department of the requirement to report under subdivisions 11 to 14.

(c) No more than 500 prescription drugs may be designated as having a substantial public interest in any one notice.

Sec. 15. Minnesota Statutes 2022, section 62J.84, is amended by adding a subdivision to read:

Subd. 11. **Manufacturer prescription drug substantial public interest reporting.** (a) Beginning January 1, 2024, a manufacturer must submit to the commissioner the information described in paragraph (b) for any prescription drug:

(1) included in a notification to report issued to the manufacturer by the department under subdivision 10;

(2) which the manufacturer manufactures or repackages;

(3) for which the manufacturer sets the wholesale acquisition cost; and

(4) for which the manufacturer has not submitted data under subdivision 3 during the 120-day period prior to the date of the notification to report.

(b) For each of the drugs described in paragraph (a), the manufacturer shall submit to the commissioner no later than 60 days after the date of the notification to report, in the form and manner prescribed by the commissioner, the following information, if applicable:

(1) a description of the drug with the following listed separately:

(i) the national drug code;

(ii) the product name;

(iii) the dosage form;

(iv) the strength; and

(v) the package size;

(2) the price of the drug product on the later of:

(i) the day one year prior to the date of the notification to report;

(ii) the introduced to market date; or

(iii) the acquisition date;

(3) the price of the drug product on the date of the notification to report;

(4) the introductory price of the prescription drug when it was introduced for sale in the United States and the price of the drug on the last day of each of the five calendar years preceding the date of the notification to report;

(5) the direct costs incurred during the 12-month period prior to the date of the notification to report by the manufacturers that are associated with the prescription drug, listed separately:

(i) to manufacture the prescription drug;

(ii) to market the prescription drug, including advertising costs; and

(iii) to distribute the prescription drug;

(6) the number of units of the prescription drug sold during the 12-month period prior to the date of the notification to report;

(7) the total sales revenue for the prescription drug during the 12-month period prior to the date of the notification to report;

(8) the total rebate payable amount accrued for the prescription drug during the 12-month period prior to the date of the notification to report;

(9) the manufacturer's net profit attributable to the prescription drug during the 12-month period prior to the date of the notification to report;

(10) the total amount of financial assistance the manufacturer has provided through patient prescription assistance programs during the 12-month period prior to the date of the notification to report, if applicable;

(11) any agreement between a manufacturer and another entity contingent upon any delay in offering to market a generic version of the prescription drug;

(12) the patent expiration date of the prescription drug if the prescription drug is under patent;

(13) the name and location of the company that manufactured the drug;

(14) if the prescription drug is a brand name prescription drug, the ten countries other than the United States that paid the highest prices for the prescription drug during the previous calendar year and their prices; and

(15) if the prescription drug was acquired by the manufacturer within a 12-month period prior to the date of the notification to report, all of the following information:

(i) the price at acquisition;

(ii) the price in the calendar year prior to acquisition;

(iii) the name of the company from which the drug was acquired;

(iv) the date of acquisition; and

(v) the acquisition price.

(c) The manufacturer may submit any documentation necessary to support the information reported under this subdivision.

Sec. 16. Minnesota Statutes 2022, section 62J.84, is amended by adding a subdivision to read:

Subd. 12. **Pharmacy prescription drug substantial public interest reporting.** (a) Beginning January 1, 2024, a pharmacy must submit to the commissioner the information described in paragraph (b) for any prescription drug included in a notification to report issued to the pharmacy by the department under subdivision 10.

(b) For each of the drugs described in paragraph (a), the pharmacy shall submit to the commissioner no later than 60 days after the date of the notification to report, in the form and manner prescribed by the commissioner, the following information, if applicable:

(1) a description of the drug with the following listed separately:

(i) the national drug code;

(ii) the product name;

(iii) the dosage form;

(iv) the strength; and

(v) the package size;

(2) the number of units of the drug acquired during the 12-month period prior to the date of the notification to report;

(3) the total spent before rebates by the pharmacy to acquire the drug during the 12-month period prior to the date of the notification to report;

(4) the total rebate receivable amount accrued by the pharmacy for the drug during the 12-month period prior to the date of the notification to report;

(5) the number of pricing units of the drug dispensed by the pharmacy during the 12-month period prior to the date of the notification to report;

(6) the total payment receivable by the pharmacy for dispensing the drug including ingredient cost, dispensing fee, and administrative fees during the 12-month period prior to the date of the notification to report;

(7) the total rebate payable amount accrued by the pharmacy for the drug during the 12-month period prior to the date of the notification to report; and

(8) the average cash price paid by consumers per pricing unit for prescriptions dispensed where no claim was submitted to a health care service plan or health insurer during the 12-month period prior to the date of the notification to report.

(c) The pharmacy may submit any documentation necessary to support the information reported under this subdivision.

Sec. 17. Minnesota Statutes 2022, section 62J.84, is amended by adding a subdivision to read:

Subd. 13. **PBM prescription drug substantial public interest reporting.** (a) Beginning January 1, 2024, a PBM must submit to the commissioner the information described in paragraph (b) for any prescription drug included in a notification to report issued to the PBM by the department under subdivision 10.

(b) For each of the drugs described in paragraph (a), the PBM shall submit to the commissioner no later than 60 days after the date of the notification to report, in the form and manner prescribed by the commissioner, the following information, if applicable:

(1) a description of the drug with the following listed separately:

(i) the national drug code;

(ii) the product name;

(iii) the dosage form;

(iv) the strength; and

(v) the package size;

(2) the number of pricing units of the drug product filled for which the PBM administered claims during the 12-month period prior to the date of the notification to report;

(3) the total reimbursement amount accrued and payable to pharmacies for pricing units of the drug product filled for which the PBM administered claims during the 12-month period prior to the date of the notification to report;

(4) the total reimbursement or administrative fee amount, or both, accrued and receivable from payers for pricing units of the drug product filled for which the PBM administered claims during the 12-month period prior to the date of the notification to report;

(5) the total rebate receivable amount accrued by the PBM for the drug product during the 12-month period prior to the date of the notification to report; and

(6) the total rebate payable amount accrued by the PBM for the drug product during the 12-month period prior to the date of the notification to report.

(c) The PBM may submit any documentation necessary to support the information reported under this subdivision.

Sec. 18. Minnesota Statutes 2022, section 62J.84, is amended by adding a subdivision to read:

Subd. 14. **Wholesaler prescription drug substantial public interest reporting.** (a) Beginning January 1, 2024, a wholesaler must submit to the commissioner the information described in paragraph (b) for any prescription drug included in a notification to report issued to the wholesaler by the department under subdivision 10.

(b) For each of the drugs described in paragraph (a), the wholesaler shall submit to the commissioner no later than 60 days after the date of the notification to report, in the form and manner prescribed by the commissioner, the following information, if applicable:

(1) a description of the drug with the following listed separately:

(i) the national drug code;

(ii) the product name;

(iii) the dosage form;

(iv) the strength; and

(v) the package size;

(2) the number of units of the drug product acquired by the wholesale drug distributor during the 12-month period prior to the date of the notification to report;

(3) the total spent before rebates by the wholesale drug distributor to acquire the drug product during the 12-month period prior to the date of the notification to report;

(4) the total rebate receivable amount accrued by the wholesale drug distributor for the drug product during the 12-month period prior to the date of the notification to report;

(5) the number of units of the drug product sold by the wholesale drug distributor during the 12-month period prior to the date of the notification to report;

(6) gross revenue from sales in the United States generated by the wholesale drug distributor for this drug product during the 12-month period prior to the date of the notification to report; and

(7) total rebate payable amount accrued by the wholesale drug distributor for the drug product during the 12-month period prior to the date of the notification to report.

(c) The wholesaler may submit any documentation necessary to support the information reported under this subdivision.

Sec. 19. Minnesota Statutes 2022, section 62J.84, is amended by adding a subdivision to read:

Subd. 15. **Registration requirements.** Beginning January 1, 2024, a reporting entity subject to this chapter shall register with the department in a form and manner prescribed by the commissioner.

Sec. 20. Minnesota Statutes 2022, section 62J.84, is amended by adding a subdivision to read:

Subd. 16. **Rulemaking.** For the purposes of this section, the commissioner may use the expedited rulemaking process under section 14.389.

Sec. 21. Minnesota Statutes 2022, section 62Q.01, is amended by adding a subdivision to read:

Subd. 6b. **No Surprises Act.** "No Surprises Act" means Division BB of the Consolidated Appropriations Act, 2021, which amended Title XXVII of the Public Health Service Act, Public Law 116-260, and any amendments to and any federal guidance or regulations issued under this act.

Sec. 22. Minnesota Statutes 2022, section 62Q.021, is amended by adding a subdivision to read:

Subd. 3. **Compliance with 2021 federal law.** Each health plan company, health provider, and health facility shall comply with the No Surprises Act, including any federal regulations adopted under the act, to the extent that the act imposes requirements that apply in this state but are not required under the laws of this state. This subdivision does not require compliance with any provision of the No Surprises Act before the effective date provided for that provision in the No Surprises Act. The commissioner shall enforce this subdivision.

Sec. 23. Minnesota Statutes 2022, section 62Q.55, subdivision 5, is amended to read:

Subd. 5. **Coverage restrictions or limitations.** If emergency services are provided by a nonparticipating provider, with or without prior authorization, the health plan company shall not impose coverage restrictions or limitations that are more restrictive than apply to emergency services received from a participating provider. Cost-sharing requirements that apply to emergency services received out-of-network must be the same as the cost-sharing requirements that apply to services received in-network and shall count toward the in-network deductible. All coverage and charges for emergency services must comply with the No Surprises Act.

Sec. 24. Minnesota Statutes 2022, section 62Q.556, is amended to read:

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

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

(1) ~~from~~ a nonparticipating provider at a participating hospital or ambulatory surgical center, ~~when the services are rendered:~~ as described by the No Surprises Act, including any federal regulations adopted under that act;

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

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

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

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

(3) a nonparticipating provider or facility providing emergency services as defined in section 62Q.55, subdivision 3, and other services as described in the requirements of the No Surprises Act.

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

~~(c)~~ (b) The services described in paragraph (a), ~~clause (2)~~ clauses (1), (2), and (3), as defined in the No Surprises Act, and any federal regulations adopted under that act, are ~~not unauthorized provider services~~ subject to balance billing if the enrollee ~~gives advance written~~ provides informed consent ~~to~~ prior to receiving services from the nonparticipating provider acknowledging that the use of a provider, or the services to be rendered, may result in costs not covered by the health plan. The informed consent must comply with all requirements of the No Surprises Act, including any federal regulations adopted under that act.

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

(b) A health plan company must attempt to negotiate the reimbursement, less any applicable enrollee cost sharing under paragraph (a), for the ~~unauthorized~~ nonparticipating provider services with the nonparticipating provider. If ~~a health plan company's and nonparticipating provider's attempts~~ the attempt to negotiate reimbursement for the ~~health care~~ nonparticipating provider services ~~do~~ does not result in a resolution, ~~the health plan company or provider may elect to refer the matter for binding arbitration, chosen in accordance with paragraph (c). A nondisclosure agreement must be executed by both parties prior to engaging an arbitrator in accordance with this section. The cost of arbitration must be shared equally between the parties.~~ either party may initiate the federal independent

dispute resolution process pursuant to the No Surprises Act, including any federal regulations adopted under that act.

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

~~(d) The arbitrator must consider relevant information, including the health plan company's payments to other nonparticipating providers for the same services, the circumstances and complexity of the particular case, and the usual and customary rate for the service based on information available in a database in a national, independent, not-for-profit corporation, and similar fees received by the provider for the same services from other health plans in which the provider is nonparticipating, in reaching a decision.~~

Subd. 3. **Annual data reporting.** (a) Beginning April 1, 2024, a health plan company must report annually to the commissioner of health:

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

(2) the total number of enrollee complaints received regarding the rights and protections established by the No Surprises Act in the prior calendar year.

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

Subd. 4. **Enforcement.** (a) Any provider or facility, including a health care provider or facility pursuant to section 62A.63, subdivision 2, or 62J.03, subdivision 8, that is subject to the relevant provisions of the No Surprises Act is subject to the requirements of this section and section 62J.811.

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

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

Sec. 25. Minnesota Statutes 2022, section 62Q.56, subdivision 2, is amended to read:

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

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

(i) an acute condition;

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

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

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

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

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

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

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

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

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

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

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

Sec. 26. Minnesota Statutes 2022, section 62Q.73, subdivision 1, is amended to read:

Subdivision 1. **Definition.** For purposes of this section, "adverse determination" means:

(1) for individual health plans, a complaint decision relating to a health care service or claim that is partially or wholly adverse to the complainant;

(2) an individual health plan that is grandfathered plan coverage may instead apply the definition of adverse determination for group coverage in clause (3);

(3) for group health plans, a complaint decision relating to a health care service or claim that has been appealed in accordance with section 62Q.70 and the appeal decision is partially or wholly adverse to the complainant;

(4) any adverse determination, as defined in section 62M.02, subdivision 1a, that has been appealed in accordance with section 62M.06 and the appeal did not reverse the adverse determination;

(5) a decision relating to a health care service made by a health plan company licensed under chapter 60A that denies the service on the basis that the service was not medically necessary; ~~or~~

(6) the enrollee has met the requirements of subdivision 6, paragraph (e)~~.~~<u>; or</u>

<u>(7) a decision relating to a health plan's coverage of nonparticipating provider services as described in and subject to section 62Q.556, subdivision 1, paragraph (a).</u>

An adverse determination does not include complaints relating to fraudulent marketing practices or agent misrepresentation.

Sec. 27. Minnesota Statutes 2022, section 62Q.73, subdivision 7, is amended to read:

Subd. 7. **Standards of review.** (a) For an external review of any issue in an adverse determination that does not require a medical necessity determination, the external review must be based on whether the adverse determination was in compliance with the enrollee's health benefit plan <u>or section 62Q.556, subdivision 1, paragraph (a)</u>.

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

(c) For an external review of any issue in an adverse determination by a health plan company, other than a health plan company licensed under chapter 62D, that requires a medical necessity determination, the external review must determine whether the adverse determination was consistent with the definition of medically necessary care in section 62Q.53, subdivision 2.

(d) For an external review of an adverse determination involving experimental or investigational treatment, the external review entity must base its decision on all documents submitted by the health plan company and enrollee, including:

(1) medical records;

(2) the recommendation of the attending physician, advanced practice registered nurse, physician assistant, or health care professional;

(3) consulting reports from health care professionals;

(4) the terms of coverage;

(5) federal Food and Drug Administration approval; and

(6) medical or scientific evidence or evidence-based standards.

Sec. 28. Minnesota Statutes 2022, section 62U.04, subdivision 4, is amended to read:

Subd. 4. **Encounter data.** (a) All health plan companies, dental 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, data on contractual value-based payments, 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) the data must include enrollee race and ethnicity, to the extent available; and

~~(3)~~ (4) except for the ~~identifier~~ data described in ~~clause~~ clauses (2) and (3), the data must not include information that is not included in a health care claim, dental 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 definition of summary data in section 13.02, subdivision 19, summary data prepared under this subdivision may be derived from nonpublic data.~~ Notwithstanding the data classifications in this paragraph, data on providers collected under this subdivision may be released or published as authorized in subdivision 11. 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.

EFFECTIVE DATE. Paragraph (a), clause (3), is effective retroactively from January 1, 2023, and applies to claims incurred on or after that date.

Sec. 29. Minnesota Statutes 2022, section 62U.04, subdivision 5, is amended to read:

Subd. 5. **Pricing data.** (a) All health plan companies, dental plan companies, and third-party administrators shall submit, on a monthly basis, data on their contracted prices with health care providers and dental care providers to a private entity designated by the commissioner of health for the purposes of performing the analyses required under this subdivision. Data on contracted prices submitted under this paragraph must include data on supplemental contractual value-based payments paid to health care providers. 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 definition of summary data in section 13.02, subdivision 19, summary data prepared under this section may be derived from nonpublic data. Notwithstanding the data classifications in this paragraph, data on providers collected under this subdivision may be released or published as authorized in subdivision 11. The commissioner shall establish procedures and safeguards to protect the integrity and confidentiality of any data that it maintains.

Sec. 30. Minnesota Statutes 2022, section 62U.04, subdivision 5a, is amended to read:

Subd. 5a. **Self-insurers.** (a) The commissioner shall not require a self-insurer governed by the federal Employee Retirement Income Security Act of 1974 (ERISA) to comply with this section.

(b) A third-party administrator must annually notify the self-insurers whose health plans are administered by the third-party administrator that the self-insurer may elect to have the third-party administrator submit encounter data and data on contracted prices under subdivisions 4 and 5 from the self-insurer's health plan for the upcoming plan year. This notice must be provided in a form and manner specified by the commissioner. After receiving responses from self-insurers, a third-party administrator must, in a form and manner specified by the commissioner, report to the commissioner:

(1) the self-insurers that elected to have the third-party administrator submit encounter data and data on contracted prices from the self-insurer's health plan for the upcoming plan year;

(2) the self-insurers that declined to have the third-party administrator submit encounter data and data on contracted prices from the self-insurer's health plan for the upcoming plan year; and

(3) data deemed necessary by the commissioner to identify and track the status of reporting of data from self-insured health plans.

Sec. 31. Minnesota Statutes 2022, section 62U.04, is amended by adding a subdivision to read:

Subd. 5b. **Nonclaims-based payments.** (a) Beginning January 1, 2025, all health plan companies and third-party administrators shall submit to a private entity designated by the commissioner of health all nonclaims-based payments made to health care providers. The data shall be submitted in a form, manner, and frequency specified by the commissioner. Nonclaims-based payments are payments to health care providers designed to pay for value of health care services over volume of health care services and include alternative payment models or incentives, payments for infrastructure expenditures or investments, and payments for workforce expenditures or investments. Nonclaims-based payments submitted under this subdivision must, to the extent possible, be attributed to a health care provider in the same manner in which claims-based data are attributed to a health care provider and, where appropriate, must be combined with data collected under subdivisions 4 and 5 in analyses of health care spending.

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

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

Sec. 32. Minnesota Statutes 2022, 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, 5a, and 5b for the ~~following~~ purposes authorized in this subdivision and in subdivision 13:

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

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

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

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

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

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

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

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

(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.~~

(6) to conduct analyses of the impact of health care transactions on health care costs, market consolidation, and quality under section 144.593, subdivision 6.

(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.~~

~~(c) 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. 33. Minnesota Statutes 2022, section 62U.04, is amended by adding a subdivision to read:

Subd. 13. **Expanded access to and use of the all-payer claims data.** (a) The commissioner or the commissioner's designee shall make the data submitted under subdivisions 4, 5, 5a, and 5b available to individuals and organizations engaged in research on, or efforts to effect transformation in, health care outcomes, access, quality, disparities, or spending, provided the use of the data serves a public benefit. Data made available under this subdivision may not be used to:

(1) create an unfair market advantage for any participant in the health care market in Minnesota, including health plan companies, payers, and providers;

(2) reidentify or attempt to reidentify an individual in the data; or

(3) publicly report contract details between a health plan company and provider and derived from the data.

(b) To implement paragraph (a), the commissioner shall:

(1) establish detailed requirements for data access; a process for data users to apply to access and use the data; legally enforceable data use agreements to which data users must consent; a clear and robust oversight process for data access and use, including a data management plan, that ensures compliance with state and federal data privacy laws; agreements for state agencies and the University of Minnesota to ensure proper and efficient use and security of data; and technical assistance for users of the data and for stakeholders;

(2) develop a fee schedule to support the cost of expanded access to and use of the data, provided the fees charged under the schedule do not create a barrier to access or use for those most affected by disparities; and

(3) create a research advisory group to advise the commissioner on applications for data use under this subdivision, including an examination of the rigor of the research approach, the technical capabilities of the proposed user, and the ability of the proposed user to successfully safeguard the data.

Sec. 34. **[115.7411] ADVISORY COUNCIL ON WATER SUPPLY SYSTEMS AND WASTEWATER TREATMENT FACILITIES.**

Subdivision 1. **Purpose; membership.** The Advisory Council on Water Supply Systems and Wastewater Treatment Facilities shall advise the commissioners of health and the Pollution Control Agency regarding classification of water supply systems and wastewater treatment facilities, qualifications and competency evaluation of water supply system operators and wastewater treatment facility operators, and additional laws, rules, and procedures that may be desirable for regulating the operation of water supply systems and of wastewater treatment facilities. The advisory council is composed of 11 voting members, of whom:

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

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

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

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

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

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

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

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

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

Sec. 35. Minnesota Statutes 2022, section 121A.335, subdivision 3, is amended to read:

Subd. 3. **Frequency of testing.** ~~(a)~~ The plan under subdivision 2 must include a testing schedule for every building serving prekindergarten through grade 12 students. The schedule must require that each building be tested at least once every five years. A school district or charter school must begin testing school buildings by July 1, 2018, and complete testing of all buildings that serve students within five years.

~~(b) A school district or charter school that finds lead at a specific location providing cooking or drinking water within a facility must formulate, make publicly available, and implement a plan that is consistent with established guidelines and recommendations to ensure that student exposure to lead is minimized. This includes, when a school district or charter school finds the presence of lead at a level where action should be taken as set by the guidance in any water source that can provide cooking or drinking water, immediately shutting off the water source or making it unavailable until the hazard has been minimized.~~

Sec. 36. Minnesota Statutes 2022, section 121A.335, subdivision 5, is amended to read:

Subd. 5. **Reporting.** (a) A school district or charter school that has tested its buildings for the presence of lead shall make the results of the testing available to the public for review and must directly notify parents annually of the availability of the information. School districts and charter schools must follow the actions outlined in guidance from the commissioners of health and education. ~~If a test conducted under subdivision 3, paragraph (a), reveals the presence of lead above a level where action should be taken as set by the guidance, the school district or charter school must, within 30 days of receiving the test result, either remediate the presence of lead to below the level set in guidance, verified by retest, or directly notify parents of the test result. The school district or charter school must make the water source unavailable until the hazard has been minimized.~~

(b) Results of testing, and any planned remediation steps, shall be made available within 30 days of receiving results.

(c) A school district or charter school that has tested for lead in drinking water shall report the results of testing and any planned remediation steps to the school board at the next available school board meeting or within 30 days of receiving results, whichever is sooner.

(d) The school district or charter school shall maintain lead testing in drinking water records electronically or by paper copy for at least 15 years.

(e) Beginning July 1, 2024, school districts and charter schools must report their test results and remediation activities to the commissioner of health on or before July 1 of each year.

Sec. 37. Minnesota Statutes 2022, section 121A.335, is amended by adding a subdivision to read:

Subd. 6. **Remediation.** (a) A school district or charter school that finds lead above five parts per billion at a specific location providing cooking or drinking water within a facility must formulate, make publicly available, and implement a plan to remediate the lead in drinking water. The plan must be consistent with established guidelines and recommendations to ensure exposure to lead is remediated.

(b) When lead is found above five parts per billion the water fixture shall immediately be shut off or made unavailable for consumption until the hazard has been minimized as verified by a test.

(c) If the school district or charter school receives water from a public water supply that has an action level in exceedance of the federal Lead and Copper Rule, it may delay remediation activities until the public water system meets state and federal requirements in the Lead and Copper Rule. If the school district or charter school receives water from a lead service line or other lead infrastructure owned by the public water supply, the school district may delay remediation of fixtures until the lead service line is fully replaced. The school must ensure that any fixture testing above five parts per billion is not used for consumption until remediation activities are complete.

Sec. 38. **[144.0526] MINNESOTA ONE HEALTH ANTIMICROBIAL STEWARDSHIP COLLABORATIVE.**

Subdivision 1. **Establishment.** The commissioner of health shall establish the Minnesota One Health Antimicrobial Stewardship Collaborative. The commissioner shall appoint a director to execute operations, conduct health education, and provide technical assistance.

Subd. 2. **Commissioner's duties.** The commissioner of health shall oversee a program to:

(1) maintain the position of director of One Health Antimicrobial Stewardship to lead state antimicrobial stewardship initiatives across human, animal, and environmental health;

(2) communicate to professionals and the public the interconnectedness of human, animal, and environmental health, especially related to preserving the efficacy of antibiotic medications, which are a shared resource;

(3) leverage new and existing partnerships. The commissioner of health shall consult and collaborate with organizations and agencies in fields including but not limited to health care, veterinary medicine, animal agriculture, academic institutions, and industry and community organizations to inform strategies for education, practice improvement, and research in all settings where antimicrobial products are used;

(4) ensure that veterinary settings have education and strategies needed to practice appropriate antibiotic prescribing, implement clinical antimicrobial stewardship programs, and prevent transmission of antimicrobial-resistant microbes; and

(5) support collaborative research and programmatic initiatives to improve the understanding of the impact of antimicrobial use and resistance in the natural environment.

Sec. 39. **[144.0528] COMPREHENSIVE DRUG OVERDOSE AND MORBIDITY PREVENTION ACT.**

Subdivision 1. **Definition.** For the purpose of this section, "drug overdose and morbidity" means health problems that people experience after inhaling, ingesting, or injecting medicines in quantities that exceed prescription status; medicines taken that are prescribed to a different person; medicines that have been adulterated or adjusted by contaminants intentionally or unintentionally; or nonprescription drugs in amounts that result in morbidity or mortality.

Subd. 2. **Establishment.** (a) The commissioner of health shall establish a comprehensive drug overdose and morbidity program to conduct comprehensive drug overdose and morbidity prevention activities, epidemiologic investigations and surveillance, and evaluation to monitor, address, and prevent drug overdoses statewide through integrated strategies that include the following:

(1) advance access to evidence-based nonnarcotic pain management services;

(2) implement culturally specific interventions and prevention programs with population and community groups in greatest need, including those who are pregnant and their infants;

(3) enhance overdose prevention and supportive services for people experiencing homelessness. This strategy includes funding for emergency and short-term housing subsidies through the homeless overdose prevention hub and expanding support for syringe services programs serving people experiencing homelessness statewide;

(4) equip employers to promote health and well-being of employees by addressing substance misuse and drug overdose;

(5) improve outbreak detection and identification of substances involved in overdoses through the expansion of the Minnesota Drug Overdose and Substance Use Surveillance Activity (MNDOSA);

(6) implement Tackling Overdose With Networks (TOWN) community prevention programs;

(7) identify, address, and respond to drug overdose and morbidity in those who are pregnant or have just given birth through multitiered approaches that may:

(i) promote medication-assisted treatment options;

(ii) support programs that provide services in accord with evidence-based care models for mental health and substance abuse disorder;

(iii) collaborate with interdisciplinary and professional organizations that focus on quality improvement initiatives related to substance use disorder; and

(iv) implement substance use disorder-related recommendations from the maternal mortality review committee, as appropriate; and

(8) design a system to assess, address, and prevent the impacts of drug overdose and morbidity on those who are pregnant, their infants, and children. Specifically, the commissioner of health may:

(i) systematically collect data to identify, analyze, and interpret the impact, incidence, incidence trends, conditions, treatments, and health, educational, and developmental outcomes associated with prenatal exposure to harmful substances through maternal substance use;

(ii) collect data, including on diagnosis, management, interventions, and outcomes, from relevant sources identified by the commissioner, including hospitals, clinics, laboratory settings, and other entities and providers involved in the care or treatment of infants, children, and those who are pregnant. This data may be collected in collaboration with other prenatal, newborn, and child-related public health data collection systems;

(iii) inform health care providers and the public of the prevalence, risks, conditions, and treatments associated with substance use disorders involving or affecting pregnancies, infants, and children; and

(iv) identify communities, families, infants, and children affected by substance use disorder in order to recommend focused interventions, prevention, and services.

(b) Individually identifiable data collected or maintained by the Department of Health under this subdivision is subject to the provisions of subdivision 9, paragraph (a).

Subd. 3. **Partnerships.** The commissioner of health may consult with sovereign Tribal nations, the Minnesota Departments of Human Services, Corrections, Public Safety, and Education, local public health agencies, care providers and insurers, community organizations that focus on substance abuse risks and recovery, individuals affected by substance use disorders, and any other individuals, entities, and organizations as necessary to carry out the goals of this section.

Subd. 4. **Grants authorized.** (a) The commissioner of health may award grants, as funding allows, to entities and organizations focused on addressing and preventing the negative impacts of drug overdose and morbidity. Examples of activities the commissioner may consider for these grant awards include:

(1) developing, implementing, or promoting drug overdose and morbidity prevention programs and activities;

(2) community outreach and other efforts addressing the root causes of drug overdose and morbidity;

(3) identifying risk and protective factors relating to drug overdose and morbidity that contribute to identification, development, or improvement of prevention strategies and community outreach;

(4) developing or providing trauma-informed drug overdose and morbidity prevention and services;

(5) developing or providing culturally and linguistically appropriate drug overdose and morbidity prevention and services, and programs that target and serve historically underserved communities;

(6) working collaboratively with educational institutions, including school districts, to implement drug overdose and morbidity prevention strategies for students, teachers, and administrators;

(7) working collaboratively with sovereign Tribal nations, care providers, nonprofit organizations, for-profit organizations, government entities, community-based organizations, and other entities to implement substance misuse and drug overdose prevention strategies within their communities; and

(8) creating or implementing quality improvement initiatives to improve drug overdose and morbidity treatment and outcomes.

(b) Any organization or government entity receiving grant money under this section must collect and make available to the commissioner of health aggregate data related to the activity funded by the program under this section. The commissioner of health shall use the information and data from the program evaluation to inform the administration of existing Department of Health programming and the development of Department of Health policies, programs, and procedures.

Subd. 5. **Promotion; administration.** In fiscal years 2026 and beyond, the commissioner may spend up to 25 percent of the total funding appropriated to the comprehensive drug overdose and morbidity program in each fiscal year to promote, administer, support, and evaluate the programs authorized under this section and to provide technical assistance to program grantees.

Subd. 6. **External contributions.** The commissioner may accept contributions from governmental and nongovernmental sources and may apply for grants to supplement state appropriations for the programs authorized under this section. Contributions and grants received from the sources identified in this subdivision to advance the purpose of this section are appropriated to the commissioner for the comprehensive drug overdose and morbidity program.

Subd. 7. **Program evaluation.** Beginning February 28, 2024, the commissioner of health shall report every even-numbered year to the legislative committees with jurisdiction over health detailing the expenditures of funds authorized under this section. The commissioner shall use the data to evaluate the effectiveness of the program. The commissioner must include in the report:

(1) the number of organizations receiving grant money under this section;

(2) the number of individuals served by the grant programs;

(3) a description and analysis of the practices implemented by program grantees; and

(4) best practices recommendations to prevent drug overdose and morbidity, including culturally relevant best practices and recommendations focused on historically underserved communities.

Subd. 8. **Measurement.** Notwithstanding any law to the contrary, the commissioner of health shall assess and evaluate grants and contracts awarded using available data sources, including but not limited to the Minnesota All Payer Claims Database (MN APCD), the Minnesota Behavioral Risk Factor Surveillance System (BRFSS), the Minnesota Student

Survey, vital records, hospitalization data, syndromic surveillance, and the Minnesota Electronic Health Record Consortium.

Subd. 9. **Classification of data.** (a) Individually identifiable data collected or maintained by the comprehensive drug overdose and morbidity program under subdivision 2, paragraph (a), clause (8), are classified as private data on individuals, as defined in section 13.02, subdivision 3.

(b) Private data identified in paragraph (a) shall not be introduced into evidence in any administrative, civil, or criminal proceeding, or disclosed in response to discovery requests, subpoenas, or investigative demands. These disclosure and evidentiary restrictions only apply to data collected or maintained by the comprehensive drug overdose and morbidity program and do not apply to data obtained from alternative sources.

Sec. 40. **[144.0752] CULTURAL COMMUNICATIONS.**

Subdivision 1. **Establishment.** The commissioner of health shall establish:

(1) a cultural communications program that advances culturally and linguistically appropriate communication services for communities most impacted by health disparities which includes limited English proficient (LEP) populations, African American populations, LGBTQ+ populations, and people with disabilities; and

(2) a position that works with department leadership and division to ensure that the department follows the National Standards for Culturally and Linguistically Appropriate Services (CLAS) Standards.

Subd. 2. **Commissioner's duties.** The commissioner of health shall oversee a program to:

(1) align the department services, policies, procedures, and governance with the National CLAS Standards, establish culturally and linguistically appropriate goals, policies, and management accountability, and apply them throughout the organization's planning and operations;

(2) ensure the department services respond to the cultural and linguistic diversity of Minnesotans and that the department partners with the community to design, implement, and evaluate policies, practices, and services that are aligned with the national cultural and linguistic appropriateness standard; and

(3) ensure the department leadership, workforce, and partners embed culturally and linguistically appropriate policies and practices into leadership and public health program planning, intervention, evaluation, and dissemination.

Subd. 3. **Eligible contractors.** The commissioner may enter into contracts to implement this section. Organizations eligible to receive contract funding under this section include:

(1) master contractors that are selected through the state to provide language and communication services; and

(2) organizations that are able to provide services for languages that master contractors are unable to cover.

Sec. 41. **[144.0754] OFFICE OF AFRICAN AMERICAN HEALTH; DUTIES.**

Subdivision 1. **Establishment.** The commissioner shall establish the Office of African American Health to address the unique public health needs of African American Minnesotans and work to develop solutions and systems to address identified health disparities of African American Minnesotans arising from a context of cumulative and historical discrimination and disadvantages in multiple systems, including but not limited to housing, education, employment, gun violence, incarceration, environmental factors, and health care discrimination.

Subd. 2. **Duties of the office.** The office shall:

(1) convene the African American Health State Advisory Council (AAHSAC) under section 144.0755 to advise the commissioner on issues and to develop specific, targeted policy solutions to improve the health of African American Minnesotans, with a focus on United States-born African Americans;

(2) based upon input from and collaboration with the AAHSAC, health indicators, and identified disparities, conduct analysis and develop policy and program recommendations and solutions targeted at improving African American health outcomes;

(3) coordinate and conduct community engagement across multiple systems, sectors, and communities to address racial disparities in labor force participation, educational achievement, and involvement with the criminal justice system that impact African American health and well-being;

(4) conduct data analysis and research to support policy goals and solutions;

(5) award and administer African American health special emphasis grants to health and community-based organizations to plan and develop programs targeted at improving African

American health outcomes, based upon needs identified by the council, health indicators, and identified disparities and addressing historical trauma and systems of United States-born African American Minnesotans; and

(6) develop and administer Department of Health immersion experiences for students in secondary education and community colleges to improve diversity of the public health workforce and introduce career pathways that contribute to reducing health disparities.

Sec. 42. **[144.0755] AFRICAN AMERICAN HEALTH STATE ADVISORY COUNCIL.**

Subdivision 1. **Establishment; purpose.** The commissioner of health shall establish and administer the African American Health State Advisory Council to advise the commissioner on implementing specific strategies to reduce health inequities and disparities that particularly affect African Americans in Minnesota.

Subd. 2. **Members.** (a) The council shall include no fewer than 12 or more than 20 members from any of the following groups:

(1) representatives of community-based organizations serving or advocating for African American citizens;

(2) at-large community leaders or elders, as nominated by other council members;

(3) African American individuals who provide and receive health care services;

(4) African American secondary or college students;

(5) health or human service professionals serving African American communities or clients;

(6) representatives with research or academic expertise in racial equity; and

(7) other members that the commissioner deems appropriate to facilitate the goals and duties of the council.

(b) The commissioner shall make recommendations for council membership and, after considering recommendations from the council, shall appoint a chair or chairs of the council. Council members shall be appointed by the governor.

Subd. 3. **Terms.** A term shall be for two years and appointees may be reappointed to serve two additional terms. The commissioner shall recommend appointments to replace members vacating their positions in a timely manner, no more than three months after the council reviews panel recommendations.

Subd. 4. **Duties of commissioner.** The commissioner or commissioner's designee shall:

(1) maintain and actively engage with the council established in this section;

(2) based on recommendations of the council, review identified department or other related policies or practices that maintain health inequities and disparities that particularly affect African Americans in Minnesota;

(3) in partnership with the council, recommend or implement action plans and resources necessary to address identified disparities and advance African American health equity;

(4) support interagency collaboration to advance African American health equity; and

(5) support member participation in the council, including participation in educational and community engagement events across Minnesota that specifically address African American health equity.

Subd. 5. **Duties of council.** The council shall:

(1) identify health disparities found in African American communities and contributing factors;

(2) recommend to the commissioner for review any statutes, rules, or administrative policies or practices that would address African American health disparities;

(3) recommend policies and strategies to the commissioner of health to address disparities specifically affecting African American health;

(4) form work groups of council members who are persons who provide and receive services and representatives of advocacy groups;

(5) provide the work groups with clear guidelines, standardized parameters, and tasks for the work groups to accomplish; and

(6) annually submit to the commissioner a report that summarizes the activities of the council, identifies disparities specially affecting the health of African American Minnesotans, and makes recommendations to address identified disparities.

Subd. 6. **Duties of council members.** The members of the council shall:

(1) attend scheduled meetings with no more than three absences per year, participate in scheduled meetings, and prepare for meetings by reviewing meeting notes;

(2) maintain open communication channels with respective constituencies;

(3) identify and communicate issues and risks that may impact the timely completion of tasks;

(4) participate in any activities the council or commissioner deems appropriate and necessary to facilitate the goals and duties of the council; and

(5) participate in work groups to carry out council duties.

Subd. 7. **Staffing; office space; equipment.** The commissioner shall provide the advisory council with staff support, office space, and access to office equipment and services.

Subd. 8. **Reimbursement.** Compensation and reimbursement for travel and expenses incurred for council activities are governed by section 15.059, subdivision 3.

Sec. 43. **[144.0756] AFRICAN AMERICAN HEALTH SPECIAL EMPHASIS GRANT PROGRAM.**

Subdivision 1. **Establishment.** The commissioner of health shall establish the African American health special emphasis grant program administered by the Office of African American Health. The purposes of the program are to:

(1) identify disparities impacting African American health arising from cumulative and historical discrimination and disadvantages in multiple systems, including but not limited to housing, education, employment, gun violence, incarceration, environmental factors, and health care discrimination; and

(2) develop community-based solutions that incorporate a multisector approach to addressing identified disparities impacting African American health.

Subd. 2. **Requests for proposals; accountability; data collection.** As directed by the commissioner of health, the Office of African American Health shall:

(1) develop a request for proposals for an African American health special emphasis grant program in consultation with community stakeholders;

(2) provide outreach, technical assistance, and program development guidance to potential qualifying organizations or entities;

(3) review responses to requests for proposals in consultation with community stakeholders and award grants under this section;

(4) establish a transparent and objective accountability process in consultation with community stakeholders, focused on outcomes that grantees agree to achieve;

(5) provide grantees with access to summary and other public data to assist grantees in establishing and implementing effective community-led solutions; and

(6) collect and maintain data on outcomes reported by grantees.

Subd. 3. **Eligible grantees.** Organizations eligible to receive grant funding under this section include nonprofit organizations or entities that work with African American communities or are focused on addressing disparities impacting the health of African American communities.

Subd. 4. **Strategic consideration and priority of proposals; grant awards.** In developing the requests for proposals and awarding the grants, the commissioner and the Office of African American Health shall consider building upon the existing capacity of communities and on developing capacity where it is lacking. Proposals shall focus on addressing health equity issues specific to United States-born African American communities; addressing the health impact of historical trauma; and reducing health disparities experienced by United States-born African American communities; and incorporating a multisector approach to addressing identified disparities.

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

Sec. 44. **[144.0757] OFFICE OF AMERICAN INDIAN HEALTH.**

Subdivision 1. **Duties.** The Office of American Indian Health is established to address unique public health needs of American Indian Tribal communities in Minnesota, and shall:

(1) coordinate with Minnesota's Tribal Nations and urban American Indian community-based organizations to identify underlying causes of health disparities, address unique health needs of Minnesota's Tribal communities, and develop public health approaches to achieve health equity;

(2) strengthen capacity of American Indian and community-based organizations and Tribal Nations to address identified health disparities and needs;

(3) administer state and federal grant funding opportunities targeted to improve the health of American Indians;

(4) provide overall leadership for targeted development of holistic health and wellness strategies to improve health and to support Tribal and urban American Indian public health leadership and self-sufficiency;

(5) provide technical assistance to Tribal and American Indian urban community leaders to develop culturally appropriate activities to address public health emergencies;

(6) develop and administer the department immersion experiences for American Indian students in secondary education and community colleges to improve diversity of the public

health workforce and introduce career pathways that contribute to reducing health disparities; and

(7) identify and promote workforce development strategies for Department of Health staff to work with the American Indian population and Tribal Nations more effectively in Minnesota.

Subd. 2. **Grants and contracts.** To carry out these duties, the office may contract with or provide grants to qualifying entities.

Sec. 45. **[144.0758] AMERICAN INDIAN HEALTH SPECIAL EMPHASIS GRANTS.**

Subdivision 1. **Establishment.** The commissioner of health shall establish the American Indian health special emphasis grant program. The purposes of the program are to:

(1) plan and develop programs targeted to address continuing and persistent health disparities of Minnesota's American Indian population and improve American Indian health outcomes based upon needs identified by health indicators and identified disparities;

(2) identify disparities in American Indian health arising from cumulative and historical discrimination; and

(3) plan and develop community-based solutions with a multisector approach to addressing identified disparities in American Indian health.

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

(1) develop a request for proposals for an American Indian health special emphasis grant program in consultation with Minnesota's Tribal Nations and urban American Indian community-based organizations based upon needs identified by the community, health indicators, and identified disparities;

(2) provide outreach, technical assistance, and program development guidance to potential qualifying organizations or entities;

(3) review responses to requests for proposals in consultation with community stakeholders and award grants under this section;

(4) establish a transparent and objective accountability process in consultation with community stakeholders focused on outcomes that grantees agree to achieve;

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

(6) collect and maintain data on outcomes reported by grantees.

Subd. 3. **Eligible grantees.** Organizations eligible to receive grant funding under this section are Minnesota's Tribal Nations and urban American Indian community-based organizations.

Subd. 4. **Strategic consideration and priority of proposals; grant awards.** In developing the proposals and awarding the grants, the commissioner shall consider building upon the existing capacity of Minnesota's Tribal Nations and urban American Indian community-based organizations and on developing capacity where it is lacking. Proposals may focus on addressing health equity issues specific to Tribal and urban American Indian communities; addressing the health impact of historical trauma; reducing health disparities experienced by American Indian communities; and incorporating a multisector approach to addressing identified disparities.

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

Sec. 46. Minnesota Statutes 2022, section 144.122, is amended to read:

144.122 LICENSE, PERMIT, AND SURVEY FEES.

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

(b) The commissioner may charge a fee for voluntary certification of medical laboratories and environmental laboratories, and for environmental and medical laboratory services provided by the department, without complying with paragraph (a) or chapter 14. Fees

charged for environment and medical laboratory services provided by the department must be approximately equal to the costs of providing the services.

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

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

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

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

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

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

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

Prospective payment surveys for hospitals	$ 900
Swing bed surveys for nursing homes	$ 1,200
Psychiatric hospitals	$ 1,400
Rural health facilities	$ 1,100
Portable x-ray providers	$ 500

Home health agencies	$	1,800
Outpatient therapy agencies	$	800
End stage renal dialysis providers	$	2,100
Independent therapists	$	800
Comprehensive rehabilitation outpatient facilities	$	1,200
Hospice providers	$	1,700
Ambulatory surgical providers	$	1,800
Hospitals	$	4,200
Other provider categories or additional resurveys required to complete initial certification	Actual surveyor costs: average surveyor cost x number of hours for the survey process.	

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

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

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

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

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

(g) The commissioner shall charge hospitals an annual licensing base fee of $1,826 per hospital, plus an additional $23 per licensed bed or bassinet fee. Revenue shall be deposited

to the state government special revenue fund and credited toward trauma hospital designations under sections 144.605 and 144.6071.

Sec. 47. Minnesota Statutes 2022, section 144.1481, subdivision 1, is amended to read:

Subdivision 1. **Establishment; membership.** The commissioner of health shall establish a ~~16-member~~ 21-member Rural Health Advisory Committee. The committee shall consist of the following members, all of whom must reside outside the seven-county metropolitan area, as defined in section 473.121, subdivision 2:

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

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

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

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

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

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

(7) a dentist licensed under chapter 150A or other oral health professional if a dentist is not available to participate;

(8) ~~a midlevel practitioner~~ an advanced practice professional;

(9) a registered nurse or licensed practical nurse;

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

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

(12) a member of a Tribal nation;

(13) a representative of a local public health agency or community health board;

(14) a health professional or advocate with experience working with people with mental illness;

(15) a representative of a community organization that works with individuals experiencing health disparities;

(16) an individual with expertise in economic development, or an employer working outside the seven-county metropolitan area; and

~~(12)~~ (17) three consumers, at least one of whom must be ~~an advocate for persons who are mentally ill or developmentally disabled~~ from a community experiencing health disparities.

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

Sec. 48. Minnesota Statutes 2022, 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.

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

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

(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.

(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.

(h) "Hospital nurse" means an individual who is licensed as a registered nurse and who is providing direct patient care in a nonprofit hospital setting.

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

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

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

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

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

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

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

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

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

(r) "PSLF program" means the federal Public Service Loan Forgiveness program established under Code of Federal Regulations, title 34, section 685.219.

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

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

~~(s)~~ (u) "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. 49. Minnesota Statutes 2022, section 144.1501, subdivision 2, is amended to read:

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

(1) for medical residents, mental health professionals, and alcohol and drug counselors agreeing to practice in designated rural areas or 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~~.~~; and

(7) for nurses who are enrolled in the PSLF program, employed as a hospital nurse by a nonprofit hospital that is an eligible employer under the PSLF program, and providing direct care to patients at the nonprofit hospital.

(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. 50. Minnesota Statutes 2022, 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. Nurses applying under subdivision 2, paragraph (a), clause (7), must also include proof that the applicant is enrolled in the PSLF program and confirmation that the applicant is employed as a hospital nurse.

(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:

(1) 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.;

(2) a nurse selected under subdivision 2, paragraph (a), clause (7), who must agree to continue as a hospital nurse for the repayment period of the participant's eligible loan under the PSLF program; and

(3) a nurse who agrees to teach according to subdivision 2, paragraph (a), clause (3), who must sign a contract to agree to teach for a minimum of two years.

Sec. 51. Minnesota Statutes 2022, section 144.1501, subdivision 4, is amended to read:

Subd. 4. **Loan forgiveness.** (a) The commissioner of health may select applicants each year for participation in the loan forgiveness program, within the limits of available funding. In considering applications, the commissioner shall give preference to applicants who document diverse cultural competencies. The commissioner shall distribute available funds

for loan forgiveness proportionally among the eligible professions according to the vacancy rate for each profession in the required geographic area, facility type, teaching area, patient group, or specialty type specified in subdivision 2, except for hospital nurses. The commissioner shall allocate funds for physician loan forgiveness so that 75 percent of the funds available are used for rural physician loan forgiveness and 25 percent of the funds available are used for underserved urban communities and pediatric psychiatry loan forgiveness. If the commissioner does not receive enough qualified applicants each year to use the entire allocation of funds for any eligible profession, the remaining funds may be allocated proportionally among the other eligible professions according to the vacancy rate for each profession in the required geographic area, patient group, or facility type specified in subdivision 2. Applicants are responsible for securing their own qualified educational loans. The commissioner shall select participants based on their suitability for practice serving the required geographic area or facility type specified in subdivision 2, as indicated by experience or training. The commissioner shall give preference to applicants closest to completing their training. Except as specified in paragraphs (b) and (c), for each year that a participant meets the service obligation required under subdivision 3, up to a maximum of four years, the commissioner shall make annual disbursements directly to the participant equivalent to 15 percent of the average educational debt for indebted graduates in their profession in the year closest to the applicant's selection for which information is available, not to exceed the balance of the participant's qualifying educational loans. Before receiving loan repayment disbursements and as requested, the participant must complete and return to the commissioner a confirmation of practice form provided by the commissioner verifying that the participant is practicing as required under subdivisions 2 and 3. The participant must provide the commissioner with verification that the full amount of loan repayment disbursement received by the participant has been applied toward the designated loans. After each disbursement, verification must be received by the commissioner and approved before the next loan repayment disbursement is made. Participants who move their practice remain eligible for loan repayment as long as they practice as required under subdivision 2.

(b) For hospital nurses, the commissioner of health shall select applicants each year for participation in the hospital nursing education loan forgiveness program, within limits of available funding for hospital nurses. Applicants are responsible for applying for and maintaining eligibility for the PSLF program. For each year that a participant meets the eligibility requirements described in subdivision 3, the commissioner shall make an annual disbursement directly to the participant in an amount equal to the minimum loan payments required to be paid by the participant under the participant's repayment plan established for

the participant under the PSLF program for the previous loan year. Before receiving the annual loan repayment disbursement, the participant must complete and return to the commissioner a confirmation of practice form provided by the commissioner, verifying that the participant continues to meet the eligibility requirements under subdivision 3. The participant must provide the commissioner with verification that the full amount of loan repayment disbursement received by the participant has been applied toward the loan for which forgiveness is sought under the PSLF program.

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

Sec. 52. Minnesota Statutes 2022, section 144.1501, subdivision 5, is amended to read:

Subd. 5. **Penalty for nonfulfillment.** If a participant does not fulfill the required minimum commitment of service according to subdivision 3, or for hospital nurses, if the secretary of education determines that the participant does not meet eligibility requirements for the PSLF, the commissioner of health shall collect from the participant the total amount paid to the participant under the loan forgiveness program plus interest at a rate established according to section 270C.40. The commissioner shall deposit the money collected in the health care access fund to be credited to the health professional education loan forgiveness program account established in subdivision 2. The commissioner shall allow waivers of all or part of the money owed the commissioner as a result of a nonfulfillment penalty if emergency circumstances prevented fulfillment of the minimum service commitment, or for hospital nurses, if the PSLF program is discontinued before the participant's service commitment is fulfilled.

Sec. 53. **[144.1504] EMPLOYEE RECRUITMENT EDUCATION LOAN FORGIVENESS PROGRAM.**

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

(b) "Designated rural area" means a statutory or 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.

(c) "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.

(d) "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.

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

(f) "Physician assistant" means a person licensed under chapter 147A.

(g) "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.

Subd. 2. **Creation of account.** (a) A health professional employee education loan forgiveness program account is established. The commissioner of health shall use money from the account to make grants to eligible providers for a loan forgiveness recruitment and retention program. Nominations for loan forgiveness through a grant shall be available to employees who are nurse practitioners, physicians, or physician assistants who agree to practice in designated rural areas that are included in a health profession's shortage area, where the provider rate per 10,000 population is less than ten and the vacancy rate has reached a level determined by the commissioner.

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

Subd. 3. **Eligibility.** (a) Eligible providers must provide services in designated rural areas that are included in a health profession's shortage area where the provider rate per 10,000 population is less than ten and the vacancy rate has reached a level determined by the commissioner for nurse practitioners, physicians, or physician assistants.

(b) Employees, as described in subdivision 2, paragraph (a), selected to receive loan forgiveness must agree to work a minimum average of 30 hours per week for a minimum of five years for a qualifying provider organization to maintain eligibility for loan forgiveness under this section.

Subd. 4. **Request for proposals.** The commissioner shall publish request for proposals that specify qualifying provider eligibility requirements; criteria for a qualifying employee

loan forgiveness recruitment program; provider selection criteria; documentation required for program participation; maximum number of loan forgiveness slots available per eligible provider; and methods of evaluation. The commissioner must publish additional requests for proposals each year in which funding is available for this purpose.

Subd. 5. **Application requirements.** (a) Eligible providers seeking loan forgiveness for employees shall submit an application to the commissioner. Applications from eligible providers must contain a complete description of the employee loan forgiveness program being proposed by the applicant, the process for determining which employees are eligible for loan forgiveness, and any special circumstances related to the provider that make it difficult to recruit and retain qualified employees. Eligible providers must submit the names of their employees to be considered for loan forgiveness.

(b) An employee whose name has been submitted to the commissioner and who wishes to apply for loan forgiveness must submit an application to the commissioner that must include employee practice site information and verification of employee qualified educational loan debt. The employee is responsible for securing the employee's qualified educational loans.

Subd. 6. **Selection process.** The commissioner shall determine a maximum number of loan forgiveness slots available per eligible provider and shall make selections based on the information provided in the grant application, including the demonstrated need for an applicant provider to enhance the retention of its workforce, the proposed employee loan forgiveness selection process, and other criteria as determined by the commissioner.

Subd. 7. **Reporting requirements.** (a) Participating providers whose employees receive loan forgiveness shall submit a report to the commissioner on a schedule determined by the commissioner and on a form supplied by the commissioner. The report must include the number of employees receiving loan forgiveness and, for each employee receiving loan forgiveness, the employee's name, current position, and average number of hours worked per week. During the loan forgiveness period, the commissioner may require and collect from participating providers and employees receiving loan forgiveness other information necessary to evaluate the program and ensure ongoing eligibility.

(b) Before receiving loan repayment disbursements, the employee must complete and return to the commissioner a confirmation of practice form provided by the commissioner verifying that the employee is practicing as required in subdivision 3. The employee must provide the commissioner with verification that the full amount of loan repayment disbursement received by the employee has been applied toward the designated loans. After

each disbursement, verification must be received by the commissioner and approved before the next loan repayment disbursement is made. Employees who move to a different eligible provider remain eligible for loan repayment as long as they practice as required in subdivision 3.

Subd. 8. **Penalty for nonfulfillment.** If an employee does not fulfill the required minimum service commitment in subdivision 3, the commissioner shall collect from the employee the total amount paid to the employee under the loan forgiveness program, plus interest at a rate established according to section 270C.40. The commissioner shall deposit the money collected in an account in the special revenue fund and money in that account is annually appropriated to the commissioner for purposes of this section. The commissioner may allow waivers of all or part of the money owed to the commissioner as a result of a nonfulfillment penalty if emergency circumstances prevented fulfillment of the minimum service commitment.

Subd. 9. **Rules.** The commissioner may adopt rules to implement this section.

Sec. 54. Minnesota Statutes 2022, section 144.1505, is amended to read:

144.1505 HEALTH PROFESSIONALS CLINICAL TRAINING EXPANSION AND RURAL AND UNDERSERVED CLINICAL ROTATIONS GRANT ~~PROGRAM~~ PROGRAMS.

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

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

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

(i) approved by the Board of Dentistry; or

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

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

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

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

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

(7) "eligible physician training program" means a physician residency training program located in Minnesota and that is currently accredited by the accrediting body or has presented a credible plan as a candidate for accreditation;

(8) "eligible dental program" means a dental education program or a dental residency training program located in Minnesota and that is currently accredited by the accrediting body or has presented a credible plan as a candidate for accreditation; and

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

Subd. 2. ~~**Program**~~ **Programs.** (a) For advanced practice provider clinical training expansion grants, the commissioner of health shall award health professional training site grants to eligible physician assistant, advanced practice registered nurse, pharmacy, dental therapy, and mental health professional programs to plan and implement expanded clinical training. A planning grant shall not exceed $75,000, and a training grant shall not exceed $150,000 for the first year, $100,000 for the second year, and $50,000 for the third year per program.

(b) For health professional rural and underserved clinical rotations grants, the commissioner of health shall award health professional training site grants to eligible physician, physician assistant, advanced practice registered nurse, pharmacy, dentistry, dental therapy, and mental health professional programs to augment existing clinical training programs to add rural and underserved rotations or clinical training experiences, such as credential or certificate rural tracks or other specialized training. For physician and dentist training, the expanded training must include rotations in primary care settings such as community clinics, hospitals, health maintenance organizations, or practices in rural communities.

~~(b)~~ (c) Funds may be used for:

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

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

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

(4) travel and lodging for students;

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

(6) development and implementation of cultural competency training;

(7) evaluations;

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

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

Subd. 3. **Applications.** Eligible physician assistant, advanced practice registered nurse, pharmacy, dental therapy, and mental health professional programs and physician and dental programs seeking a grant shall apply to the commissioner. Applications must include a description of the number of additional students who will be trained using grant funds; attestation that funding will be used to support an increase in the number of clinical training slots; a description of the problem that the proposed project will address; a description of the project, including all costs associated with the project, sources of funds for the project, detailed uses of all funds for the project, and the results expected; and a plan to maintain or operate any component included in the project after the grant period. The applicant must describe achievable objectives, a timetable, and roles and capabilities of responsible individuals in the organization. Applicants applying under subdivision 2, paragraph (b), must include information about length of training and training site settings, geographic location of rural sites, and rural populations expected to be served.

Subd. 4. **Consideration of applications.** The commissioner shall review each application to determine whether or not the application is complete and whether the program and the project are eligible for a grant. In evaluating applications, the commissioner shall score each application based on factors including, but not limited to, the applicant's clarity and

thoroughness in describing the project and the problems to be addressed, the extent to which the applicant has demonstrated that the applicant has made adequate provisions to ensure proper and efficient operation of the training program once the grant project is completed, the extent to which the proposed project is consistent with the goal of increasing access to primary care and mental health services for rural and underserved urban communities, the extent to which the proposed project incorporates team-based primary care, and project costs and use of funds.

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

Sec. 55. **[144.1507] PRIMARY CARE RESIDENCY TRAINING GRANT PROGRAM.**

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

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

(1) is located in Minnesota;

(2) trains medical residents in the specialties of family medicine, general internal medicine, general pediatrics, psychiatry, geriatrics, or general surgery in rural residency training programs or in community-based ambulatory care centers that primarily serve the underserved; and

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

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

(d) "Community-based ambulatory care centers" means federally qualified health centers, community mental health centers, rural health clinics, health centers operated by the Indian

Health Service, an Indian Tribe or Tribal organization, or an urban American Indian organization or an entity receiving funds under Title X of the Public Health Service Act.

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

Subd. 2. **Rural residency training program.** (a) The commissioner of health shall award rural residency training program grants to eligible programs to plan, implement, and sustain rural residency training programs. A rural residency training program grant shall not exceed $250,000 per year for up to three years for planning and development, and $225,000 per resident per year for each year thereafter to sustain the program.

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

(1) planning related to establishing accredited rural residency training programs;

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

(3) establishing new rural residency training programs;

(4) recruitment, training, and retention of new residents and faculty related to the new rural residency training program;

(5) travel and lodging for new residents;

(6) faculty, new resident, and preceptor salaries related to new rural residency training programs;

(7) training site improvements, fees, equipment, and supplies required for new rural residency training programs; and

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

Subd. 3. **Applications for rural residency training program grants.** Eligible programs seeking a grant shall apply to the commissioner. Applications must include the number of new primary care rural residency training program slots planned, under development or under contract; a description of the training program, including location of the established residency program and rural training sites; a description of the project, including all costs associated with the project; all sources of funds for the project; detailed uses of all funds for the project; the results expected; proof of eligibility for federal graduate medical education funding, if applicable; and a plan to seek the funding. The applicant must describe achievable objectives, a timetable, and the roles and capabilities of responsible individuals in the organization.

Subd. 4. **Consideration of grant applications.** The commissioner shall review each application to determine if the residency program application is complete, if the proposed rural residency program and residency slots are eligible for a grant, and if the program is eligible for federal graduate medical education funding, and when the funding is available. If eligible programs are not eligible for federal graduate medical education funding, the commissioner may award continuation funding to the eligible program beyond the initial grant period. The commissioner shall award grants to support training programs in family medicine, general internal medicine, general pediatrics, psychiatry, geriatrics, general surgery, and other primary care focus areas.

Subd. 5. **Program oversight.** During the grant period, the commissioner may require and collect from grantees any information necessary to evaluate the program. Notwithstanding section 16A.28, subdivision 6, encumbrances for grants under this section issued by June 30 of each year may be certified for a period of up to three years beyond the year in which the funds were originally appropriated.

Sec. 56. **[144.1508] CLINICAL HEALTH CARE TRAINING.**

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

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

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

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

(e) "Eligible entity" means an organization that is located in Minnesota, provides a clinical medical education experience, and hosts students, residents, or other trainee types

as determined by the commissioner, and is from an accredited Minnesota teaching program and institution.

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

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

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

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

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

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

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

(b) An entity hosting a clinical medical education program for advanced practice nursing is eligible for funds under subdivision 3, if the program meets the eligibility requirements in paragraph (a), clauses (1) to (3), and is sponsored by the University of Minnesota Academic Health Center, the Mayo Foundation, or an institution that is part of the Minnesota State Colleges and Universities system or members of the Minnesota Private College Council.

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

(1) the official name and address and the site addresses of the clinical medical education programs where eligible trainees are hosted;

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

(3) for each applicant, the type and specialty orientation of trainees in the program; the name, entity address, medical assistance provider number, and national provider identification number of each training site used in the program, as appropriate; the federal tax identification number of each training site, where available; the total number of eligible trainee FTEs at each site; and

(4) other supporting information the commissioner deems necessary.

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

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

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

Subd. 4. **Report.** (a) Teaching institutions receiving funds under this section must sign and submit a medical education grant verification report (GVR) to verify funding was distributed as specified in the GVR. If the teaching institution fails to submit the GVR by the stated deadline, the teaching institution is required to return the full amount of funds received to the commissioner within 30 days of receiving notice from the commissioner. The commissioner shall distribute returned funds to the appropriate training sites in accordance with the commissioner's approval letter.

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

Sec. 57. Minnesota Statutes 2022, section 144.2151, is amended to read:

144.2151 FETAL DEATH RECORD AND CERTIFICATE OF BIRTH RESULTING IN STILLBIRTH.

Subdivision 1. ~~**Filing**~~ **Registration.** A fetal death record ~~of birth for each birth resulting in a stillbirth in this state, on or after August 1, 2005,~~ must be established for ~~which a~~ each fetal death ~~report is required~~ reported and registered under section 144.222, subdivision 1~~, shall be filed with the state registrar within five days after the birth if the parent or parents of the stillbirth request to have a record of birth resulting in stillbirth prepared~~.

Subd. 2. **Information to parents.** The party responsible for filing a fetal death report under section 144.222, subdivision 1, shall advise the parent or parents of a stillbirth:

~~(1) that they may request preparation of a record of birth resulting in stillbirth;~~

~~(2) that preparation of the record is optional; and~~

~~(3) how to obtain a certified copy of the record if one is requested and prepared.~~

(1) that the parent or parents may choose to provide a full name or provide only a last name for the record;

(2) that the parent or parents may request a certificate of birth resulting in stillbirth after the fetal death record is established;

(3) that the parent who gave birth may request an informational copy of the fetal death record; and

(4) that the parent or parents named on the fetal death record and the party responsible for reporting the fetal death may correct or amend the record to protect the integrity and accuracy of vital records.

Subd. 3. ~~**Preparation**~~ **Responsibilities of the state registrar.** ~~(a) Within five days after delivery of a stillbirth, the parent or parents of the stillbirth may prepare and file the record with the state registrar if the parent or parents of the stillbirth, after being advised as provided in subdivision 2, request to have a record of birth resulting in stillbirth prepared.~~

~~(b) If the parent or parents of the stillbirth do not choose to provide a full name for the stillbirth, the parent or parents may choose to file only a last name.~~

~~(c) Either parent of the stillbirth or, if neither parent is available, another person with knowledge of the facts of the stillbirth shall attest to the accuracy of the personal data entered on the record in time to permit the filing of the record within five days after delivery.~~

The state registrar shall:

(1) prescribe the process to:

(i) register a fetal death;

(ii) request the certificate of birth resulting in stillbirth; and

(iii) request the informational copy of a fetal death record;

(2) prescribe a standardized format for the certificate of birth resulting in stillbirth, which shall integrate security features and be as similar as possible to a birth certificate;

(3) issue a certificate of birth resulting in stillbirth or a statement of no vital record found to the parent or parents named on the fetal death record upon the parent's proper completion of an attestation provided by the commissioner and payment of the required fee;

(4) correct or amend the fetal death record upon a request from the parent who gave birth, parents, or the person who registered the fetal death or filed the report; and

(5) refuse to amend or correct the fetal death record when an applicant does not submit the minimum documentation required to amend the record or when the state registrar has cause to question the validity or completeness of the applicant's statements or any documentary evidence and the deficiencies are not corrected. The state registrar shall advise the applicant of the reason for this action and shall further advise the applicant of the right of appeal to a court with competent jurisdiction over the Department of Health.

Subd. 4. **~~Retroactive application~~ Delayed registration.** ~~Notwithstanding subdivisions 1 to 3,~~ If a ~~birth that~~ fetal death occurred in this state at any time ~~resulted in a stillbirth~~ for which a fetal death report was required under section 144.222, subdivision 1, but a ~~record of birth resulting in stillbirth was not prepared under subdivision 3, a parent of the stillbirth may submit to the state registrar, on or after August 1, 2005, a written request for preparation of a record of birth resulting in stillbirth and evidence of the facts of the stillbirth in the form and manner specified by the state registrar. The state registrar shall prepare and file the record of birth resulting in stillbirth within 30 days after receiving satisfactory evidence of the facts of the stillbirth.~~ fetal death was not registered and a record was not established, a person responsible for registering the fetal death, the medical examiner or coroner with jurisdiction, or a parent may submit to the state registrar a written request to register the fetal death and submit the evidence to support the request.

~~Subd. 5. **Responsibilities of state registrar.** The state registrar shall:~~

~~(1) prescribe the form of and information to be included on a record of birth resulting in stillbirth, which shall be as similar as possible to the form of and information included on a record of birth;~~

~~(2) prescribe the form of and information to be provided by the parent of a stillbirth requesting a record of birth resulting in stillbirth under subdivisions 3 and 4 and make this form available on the Department of Health's website;~~

~~(3) issue a certified copy of a record of birth resulting in stillbirth to a parent of the stillbirth that is the subject of the record if:~~

~~(i) a record of birth resulting in stillbirth has been prepared and filed under subdivision 3 or 4; and~~

~~(ii) the parent requesting a certified copy of the record submits the request in writing; and~~

~~(4) create and implement a process for entering, preparing, and handling stillbirth records identical or as close as possible to the processes for birth and fetal death records when feasible, but no later than the date on which the next reprogramming of the Department of Health's database for vital records is completed.~~

Sec. 58. Minnesota Statutes 2022, section 144.222, is amended to read:

144.222 FETAL DEATH REPORTS ~~OF FETAL OR INFANT DEATH~~ AND REGISTRATION.

Subdivision 1. **Fetal death report required.** A fetal death ~~report~~ must be ~~filed~~ registered or reported within five days of the death of a fetus for whom 20 or more weeks of gestation have elapsed, except for abortions defined under section 145.4241. A fetal death ~~report must be prepared~~ must be registered or reported in a format prescribed by the state registrar and filed in accordance with Minnesota Rules, parts 4601.0100 to 4601.2600 by:

(1) a person in charge of an institution or that person's authorized designee if a fetus is delivered in the institution or en route to the institution;

(2) a physician, certified nurse midwife, or other licensed medical personnel in attendance at or immediately after the delivery if a fetus is delivered outside an institution; or

(3) a parent or other person in charge of the disposition of the remains if a fetal death occurred without medical attendance at or immediately after the delivery.

~~Subd. 2. **Sudden infant death.** Each infant death which is diagnosed as sudden infant death syndrome shall be reported within five days to the state registrar.~~

Sec. 59. Minnesota Statutes 2022, section 144.222, subdivision 1, is amended to read:

Subdivision 1. **Fetal death report required.** A fetal death report must be filed within five days of the death of a fetus for whom 20 or more weeks of gestation have elapsed, except for abortions defined under section ~~145.4241~~ 145.411, subdivision 5. A fetal death report must be prepared in a format prescribed by the state registrar and filed in accordance with Minnesota Rules, parts 4601.0100 to 4601.2600 by:

(1) a person in charge of an institution or that person's authorized designee if a fetus is delivered in the institution or en route to the institution;

(2) a physician, certified nurse midwife, or other licensed medical personnel in attendance at or immediately after the delivery if a fetus is delivered outside an institution; or

(3) a parent or other person in charge of the disposition of the remains if a fetal death occurred without medical attendance at or immediately after the delivery.

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

Sec. 60. Minnesota Statutes 2022, section 144.226, subdivision 3, is amended to read:

Subd. 3. **Birth record surcharge.** (a) In addition to any fee prescribed under subdivision 1, there shall be a nonrefundable surcharge of $3 for each certified birth or stillbirth record and for a certification that the vital record cannot be found. The state registrar or local issuance office shall forward this amount to the commissioner of management and budget each month following the collection of the surcharge for deposit into the account for the children's trust fund for the prevention of child abuse established under section 256E.22. This surcharge shall not be charged under those circumstances in which no fee for a certified birth or stillbirth record is permitted under subdivision 1, paragraph (b). Upon certification by the commissioner of management and budget that the assets in that fund exceed $20,000,000, this surcharge shall be discontinued.

(b) In addition to any fee prescribed under subdivision 1, there shall be a nonrefundable surcharge of $10 for each certified birth record. The state registrar or local issuance office shall forward this amount to the commissioner of management and budget each month following the collection of the surcharge for deposit in the general fund.

Sec. 61. Minnesota Statutes 2022, section 144.226, subdivision 4, is amended to read:

Subd. 4. **Vital records surcharge.** In addition to any fee prescribed under subdivision 1, there is a nonrefundable surcharge of $4 for each certified and noncertified birth, stillbirth, or death record, and for a certification that the record cannot be found. The local issuance

office or state registrar shall forward this amount to the commissioner of management and budget each month following the collection of the surcharge to be deposited into the state government special revenue fund.

Sec. 62. **[144.3431] NONRESIDENTIAL MENTAL HEALTH SERVICES.**

A minor who is age 16 or older may give effective consent for nonresidential mental health services, and the consent of no other person is required. For purposes of this section, "nonresidential mental health services" means outpatient services as defined in section 245.4871, subdivision 29, provided to a minor who is not residing in a hospital, inpatient unit, or licensed residential treatment facility or program.

Sec. 63. Minnesota Statutes 2022, section 144.382, is amended by adding a subdivision to read:

Subd. 2a. **Connector.** "Connector" means gooseneck, pigtail, and other service line connectors. A connector is typically a short section of piping not exceeding two feet that can be bent and used for connections between rigid service piping.

Sec. 64. Minnesota Statutes 2022, section 144.382, is amended by adding a subdivision to read:

Subd. 3a. **Galvanized requiring replacement.** "Galvanized requiring replacement" means a galvanized service line that is or was at any time connected to a lead service line or lead status unknown service line, or is currently or was previously affixed to a lead connector. The majority of galvanized service lines fall under this category.

Sec. 65. Minnesota Statutes 2022, section 144.382, is amended by adding a subdivision to read:

Subd. 3b. **Galvanized service line.** "Galvanized service line" means a service line made of iron or piping that has been dipped in zinc to prevent corrosion and rusting.

Sec. 66. Minnesota Statutes 2022, section 144.382, is amended by adding a subdivision to read:

Subd. 3c. **Lead connector.** "Lead connector" means a connector made of lead.

Sec. 67. Minnesota Statutes 2022, section 144.382, is amended by adding a subdivision to read:

Subd. 3d. **Lead service line.** "Lead service line" means a portion of pipe that is made of lead, which connects the water main to the building inlet. A lead service line may be owned by the water system, by the property owner, or both.

Sec. 68. Minnesota Statutes 2022, section 144.382, is amended by adding a subdivision to read:

Subd. 3e. **Lead status unknown service line or unknown service line.** "Lead status unknown service line" or "unknown service line" means a service line that has not been demonstrated to meet or does not meet the definition of lead free in section 1417 of the Safe Drinking Water Act.

Sec. 69. Minnesota Statutes 2022, section 144.382, is amended by adding a subdivision to read:

Subd. 3f. **Nonlead service line.** "Nonlead service line" means a service line determined through an evidence-based record, method, or technique not to be a lead service line or galvanized service line requiring replacement. Most nonlead service lines are made of copper or plastic.

Sec. 70. Minnesota Statutes 2022, section 144.382, is amended by adding a subdivision to read:

Subd. 4a. **Service line.** "Service line" means a portion of pipe that connects the water main to the building inlet. A service line may be owned by the water system, by the property owner, or both. A service line may be made of many materials, such as lead, copper, galvanized steel, or plastic.

Sec. 71. **[144.3853] CLASSIFICATION OF SERVICE LINES.**

Subdivision 1. **Classification of lead status of service line.** (a) A water system may classify the actual material of a service line, such as copper or plastic, as an alternative to classifying the service line as a nonlead service line, for the purpose of the lead service line inventory.

(b) It is not necessary to physically verify the material composition, such as copper or plastic, of a service line for its lead status to be identified. For example, if records demonstrate

the service line was installed after a municipal, state, or federal ban on the installation of lead service lines, the service line may be classified as a nonlead service line.

Subd. 2. **Lead connector.** For the purposes of the lead service line inventory and lead service line replacement plan, if a service line has a lead connector, the service line shall be classified as a lead service line or a galvanized service line requiring replacement.

Subd. 3. **Galvanized service line.** A galvanized service line may only be classified as a nonlead service line if there is documentation verifying it was never connected to a lead service line or lead connector. Rarely will a galvanized service line be considered a nonlead service line.

Sec. 72. **[144.398] TOBACCO USE PREVENTION ACCOUNT; ESTABLISHMENT AND USES.**

Subdivision 1. **Definitions.** (a) As used in this section, the terms in this subdivision have the meanings given.

(b) "Electronic delivery device" has the meaning given in section 609.685, subdivision 1, paragraph (c).

(c) "Nicotine delivery product" has the meaning given in section 609.6855, subdivision 1, paragraph (c).

(d) "Tobacco" has the meaning given in section 609.685, subdivision 1, paragraph (a).

(e) "Tobacco-related devices" has the meaning given in section 609.685, subdivision 1, paragraph (b).

Subd. 2. **Account created.** A tobacco use prevention account is created in the special revenue fund. Pursuant to section 16A.151, subdivision 2, paragraph (h), the commissioner of management and budget shall deposit into the account any money received by the state resulting from a settlement agreement or an assurance of discontinuance entered into by the attorney general of the state, or a court order in litigation brought by the attorney general of the state on behalf of the state or a state agency related to alleged violations of consumer fraud laws in the marketing, sale, or distribution of electronic nicotine delivery systems in this state or other alleged illegal actions that contributed to the exacerbation of youth nicotine use.

Subd. 3. **Appropriations from tobacco use prevention account.** (a) Each fiscal year, the amount of money in the tobacco use prevention account is appropriated to the commissioner of health for:

(1) tobacco and electronic delivery device use prevention and cessation projects consistent with the duties specified in section 144.392;

(2) a public information program under section 144.393;

(3) the development of health promotion and health education materials about tobacco and electronic delivery device use prevention and cessation;

(4) tobacco and electronic delivery device use prevention activities under section 144.396; and

(5) statewide tobacco cessation services under section 144.397.

(b) In activities funded under this subdivision, the commissioner of health must:

(1) prioritize preventing persons under the age of 21 from using commercial tobacco, electronic delivery devices, tobacco-related devices, and nicotine delivery products;

(2) promote racial and health equity; and

(3) use strategies that are evidence-based or based on promising practices.

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

Sec. 73. Minnesota Statutes 2022, section 144.55, subdivision 3, is amended to read:

Subd. 3. **Standards for licensure.** (a) Notwithstanding the provisions of section 144.56, for the purpose of hospital licensure, the commissioner of health shall use as minimum standards the hospital certification regulations promulgated pursuant to title XVIII of the Social Security Act, United States Code, title 42, section 1395, et seq. The commissioner may use as minimum standards changes in the federal hospital certification regulations promulgated after May 7, 1981, if the commissioner finds that such changes are reasonably necessary to protect public health and safety. ~~The commissioner shall also promulgate in rules additional minimum standards for new construction.~~

(b) Hospitals must meet the applicable provisions of the 2022 edition of the Facility Guidelines Institute *Guidelines for Design and Construction of Hospitals*. This minimum design standard must be met for all new licenses, new construction, change of use, or change of occupancy for which plan review packages are received on or after January 1, 2024.

(c) If the commissioner decides to update the edition of the guidelines specified in paragraph (b) for purposes of this subdivision, the commissioner must notify the chairs and ranking minority members of the legislative committees with jurisdiction over health care and public safety of the planned update by January 15 of the year in which the new edition

will become effective. Following notice from the commissioner, the new edition shall become effective for hospitals beginning August 1 of that year, unless otherwise provided in law. The commissioner shall, by publication in the State Register, specify a date by which hospitals must comply with the updated edition. The date by which hospitals must comply shall not be sooner than 12 months after publication of the commissioner's notice in the State Register and shall apply only to plan review packages received on or after that date.

(d) Hospitals shall be in compliance with all applicable state and local governing laws, regulations, standards, ordinances, and codes for fire safety, building, and zoning requirements.

~~(b)~~ (e) Each hospital and outpatient surgical center shall establish policies and procedures to prevent the transmission of human immunodeficiency virus and hepatitis B virus to patients and within the health care setting. The policies and procedures shall be developed in conformance with the most recent recommendations issued by the United States Department of Health and Human Services, Public Health Service, Centers for Disease Control. The commissioner of health shall evaluate a hospital's compliance with the policies and procedures according to subdivision 4.

~~(c)~~ (f) An outpatient surgical center must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines.

~~(d)~~ (g) Written compliance with this subdivision must be maintained by the outpatient surgical center.

EFFECTIVE DATE. This section is effective January 1, 2024.

Sec. 74. Minnesota Statutes 2022, section 144.566, is amended to read:

144.566 VIOLENCE AGAINST HEALTH CARE WORKERS.

Subdivision 1. **Definitions.** (a) The following definitions apply to this section and have the meanings given.

(b) "Act of violence" means an act by a patient or visitor against a health care worker that includes kicking, scratching, urinating, sexually harassing, or any act defined in sections 609.221 to 609.2241.

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

(d) "Health care worker" means any person, whether licensed or unlicensed, employed by, volunteering in, or under contract with a hospital, who has direct contact with a patient of the hospital for purposes of either medical care or emergency response to situations potentially involving violence.

(e) "Hospital" means any facility licensed as a hospital under section 144.55.

(f) "Incident response" means the actions taken by hospital administration and health care workers during and following an act of violence.

(g) "Interfere" means to prevent, impede, discourage, or delay a health care worker's ability to report acts of violence, including by retaliating or threatening to retaliate against a health care worker.

(h) "Preparedness" means the actions taken by hospital administration and health care workers to prevent a single act of violence or acts of violence generally.

(i) "Retaliate" means to discharge, discipline, threaten, otherwise discriminate against, or penalize a health care worker regarding the health care worker's compensation, terms, conditions, location, or privileges of employment.

(j) "Workplace violence hazards" means locations and situations where violent incidents are more likely to occur, including, as applicable, but not limited to locations isolated from other health care workers; health care workers working alone; health care workers working in remote locations; health care workers working late night or early morning hours; locations where an assailant could prevent entry of responders or other health care workers into a work area; locations with poor illumination; locations with poor visibility; lack of physical barriers between health care workers and persons at risk of committing workplace violence; lack of effective escape routes; obstacles and impediments to accessing alarm systems; locations within the facility where alarm systems are not operational; entryways where unauthorized entrance may occur, such as doors designated for staff entrance or emergency exits; presence, in the areas where patient contact activities are performed, of furnishings or objects that could be used as weapons; and locations where high-value items, currency, or pharmaceuticals are stored.

Subd. 2. **~~Hospital duties~~ Action plans and action plan reviews required.** ~~(a)~~ All hospitals must design and implement preparedness and incident response action plans to acts of violence by January 15, 2016, and review and update the plan at least annually thereafter. The plan must be in writing; specific to the workplace violence hazards and corrective measures for the units, services, or operations of the hospital; and available to health care workers at all times.

Subd. 3. **Action plan committees.** ~~(b)~~ A hospital shall designate a committee of representatives of health care workers employed by the hospital, including nonmanagerial health care workers, nonclinical staff, administrators, patient safety experts, and other appropriate personnel to develop preparedness and incident response action plans to acts of violence. The hospital shall, in consultation with the designated committee, implement the plans under ~~paragraph (a)~~ subdivision 2. Nothing in this ~~paragraph~~ subdivision shall require the establishment of a separate committee solely for the purpose required by this subdivision.

Subd. 4. **Required elements of action plans; generally.** The preparedness and incident response action plans to acts of violence must include:

(1) effective procedures to obtain the active involvement of health care workers and their representatives in developing, implementing, and reviewing the plan, including their participation in identifying, evaluating, and correcting workplace violence hazards, designing and implementing training, and reporting and investigating incidents of workplace violence;

(2) names or job titles of the persons responsible for implementing the plan; and

(3) effective procedures to ensure that supervisory and nonsupervisory health care workers comply with the plan.

Subd. 5. **Required elements of action plans; evaluation of risk factors.** (a) The preparedness and incident response action plans to acts of violence must include assessment procedures to identify and evaluate workplace violence hazards for each facility, unit, service, or operation, including community-based risk factors and areas surrounding the facility, such as employee parking areas and other outdoor areas. Procedures shall specify the frequency with which such environmental assessments will take place.

(b) The preparedness and incident response action plans to acts of violence must include assessment tools, environmental checklists, or other effective means to identify workplace violence hazards.

Subd. 6. **Required elements of action plans; review of workplace violence incidents.** The preparedness and incident response action plans to acts of violence must include procedures for reviewing all workplace violence incidents that occurred in the facility, unit, service, or operation within the previous year, whether or not an injury occurred.

Subd. 7. **Required elements of action plans; reporting workplace violence.** The preparedness and incident response action plans to acts of violence must include:

(1) effective procedures for health care workers to document information regarding conditions that may increase the potential for workplace violence incidents and communicate that information without fear of reprisal to other health care workers, shifts, or units;

(2) effective procedures for health care workers to report a violent incident, threat, or other workplace violence concern without fear of reprisal;

(3) effective procedures for the hospital to accept and respond to reports of workplace violence and to prohibit retaliation against a health care worker who makes such a report;

(4) a policy statement stating the hospital will not prevent a health care worker from reporting workplace violence or take punitive or retaliatory action against a health care worker for doing so;

(5) effective procedures for investigating health care worker concerns regarding workplace violence or workplace violence hazards;

(6) procedures for informing health care workers of the results of the investigation arising from a report of workplace violence or from a concern about a workplace violence hazard and of any corrective actions taken;

(7) effective procedures for obtaining assistance from the appropriate law enforcement agency or social service agency during all work shifts. The procedure may establish a central coordination procedure; and

(8) a policy statement stating the hospital will not prevent a health care worker from seeking assistance and intervention from local emergency services or law enforcement when a violent incident occurs or take punitive or retaliatory action against a health care worker for doing so.

Subd. 8. **Required elements of action plans; coordination with other employers.** The preparedness and incident response action plans to acts of violence must include methods the hospital will use to coordinate implementation of the plan with other employers whose employees work in the same health care facility, unit, service, or operation and to ensure that those employers and their employees understand their respective roles as provided in

the plan. These methods must ensure that all employees working in the facility, unit, service, or operation are provided the training required by subdivision 11 and that workplace violence incidents involving any employee are reported, investigated, and recorded.

Subd. 9. **Required elements of action plans; white supremacist affiliation and support prohibited.** (a) The preparedness and incident response action plans to acts of violence must include a policy statement stating that security personnel employed by the hospital or assigned to the hospital by a contractor are prohibited from affiliating with, supporting, or advocating for white supremacist groups, causes, or ideologies or participating in, or actively promoting, an international or domestic extremist group that the Federal Bureau of Investigation has determined supports or encourages illegal, violent conduct.

(b) For purposes of this subdivision, white supremacist groups, causes, or ideologies include organizations and associations and ideologies that promote white supremacy and the idea that white people are superior to Black, Indigenous, and people of color (BIPOC); promote religious and racial bigotry; seek to exacerbate racial and ethnic tensions between BIPOC and non-BIPOC; or engage in patently hateful and inflammatory speech, intimidation, and violence against BIPOC as means of promoting white supremacy.

Subd. 10. **Required elements of action plans; training.** (a) The preparedness and incident response action plans to acts of violence must include:

(1) procedures for developing and providing the training required in subdivision 11 that permits health care workers and their representatives to participate in developing the training; and

(2) a requirement for cultural competency training and equity, diversity, and inclusion training.

(b) The preparedness and incident response action plans to acts of violence must include procedures to communicate with health care workers regarding workplace violence matters, including:

(1) how health care workers will document and communicate to other health care workers and between shifts and units information regarding conditions that may increase the potential for workplace violence incidents;

(2) how health care workers can report a violent incident, threat, or other workplace violence concern;

(3) how health care workers can communicate workplace violence concerns without fear of reprisal; and

(4) how health care worker concerns will be investigated, and how health care workers will be informed of the results of the investigation and any corrective actions to be taken.

Subd. 11. **Training required.** ~~(c)~~ A hospital ~~shall~~ must provide training to all health care workers employed or contracted with the hospital on safety during acts of violence. Each health care worker must receive safety training ~~annually and upon hire~~ during the health care worker's orientation and before the health care worker completes a shift independently, and annually thereafter. Training must, at a minimum, include:

(1) safety guidelines for response to and de-escalation of an act of violence;

(2) ways to identify potentially violent or abusive situations, including aggression and violence predicting factors; ~~and~~

(3) the hospital's ~~incident response reaction plan and violence prevention plan~~ preparedness and incident response action plans for acts of violence, including how the health care worker may report concerns about workplace violence within each hospital's reporting structure without fear of reprisal, how the hospital will address workplace violence incidents, and how the health care worker can participate in reviewing and revising the plan; and

(4) any resources available to health care workers for coping with incidents of violence, including but not limited to critical incident stress debriefing or employee assistance programs.

Subd. 12. **Annual review and update of action plans.** ~~(d)~~ (a) As part of its annual review of preparedness and incident response action plans required under ~~paragraph (a)~~ subdivision 2, the hospital must review with the designated committee:

(1) the effectiveness of its preparedness and incident response action plans, including the sufficiency of security systems, alarms, emergency responses, and security personnel availability;

(2) security risks associated with specific units, areas of the facility with uncontrolled access, late night shifts, early morning shifts, and areas surrounding the facility such as employee parking areas and other outdoor areas;

(3) the most recent gap analysis as provided by the commissioner; ~~and~~

~~(3)~~ (4) the number of acts of violence that occurred in the hospital during the previous year, including injuries sustained, if any, and the unit in which the incident occurred~~.~~;

(5) evaluations of staffing, including staffing patterns and patient classification systems that contribute to, or are insufficient to address, the risk of violence; and

(6) any reports of discrimination or abuse that arise from security resources, including from the behavior of security personnel.

(b) As part of the annual update of preparedness and incident response action plans required under subdivision 2, the hospital must incorporate corrective actions into the action plan to address workplace violence hazards identified during the annual action plan review, reports of workplace violence, reports of workplace violence hazards, and reports of discrimination or abuse that arise from the security resources.

Subd. 13. **Action plan updates.** Following the annual review of the action plan, a hospital must update the action plans to reflect the corrective actions the hospital will implement to mitigate the hazards and vulnerabilities identified during the annual review.

Subd. 14. **Requests for additional staffing.** A hospital shall create and implement a procedure for a health care worker to officially request of hospital supervisors or administration that additional staffing be provided. The hospital must document all requests for additional staffing made because of a health care worker's concern over a risk of an act of violence. If the request for additional staffing to reduce the risk of violence is denied, the hospital must provide the health care worker who made the request a written reason for the denial and must maintain documentation of that communication with the documentation of requests for additional staffing. A hospital must make documentation regarding staffing requests available to the commissioner for inspection at the commissioner's request. The commissioner may use documentation regarding staffing requests to inform the commissioner's determination on whether the hospital is providing adequate staffing and security to address acts of violence, and may use documentation regarding staffing requests if the commissioner imposes a penalty under subdivision 18.

Subd. 15. **Disclosure of action plans.** ~~(c)~~ (a) A hospital ~~shall~~ must make its most recent action plans and ~~the information listed in paragraph (d)~~ most recent action plan reviews available to ~~local law enforcement~~ all direct care staff and, if any of its workers are represented by a collective bargaining unit, to the exclusive bargaining representatives of those collective bargaining units.

(b) A hospital must also annually submit to the commissioner its most recent action plan and the results of the most recent annual review conducted under subdivision 12.

Subd. 16. **Legislative report required.** (a) The commissioner must compile the information into a single annual report and submit the report to the chairs and ranking

minority members of the legislative committees with jurisdiction over health care by January 15 of each year.

(b) This subdivision does not expire.

Subd. 17. **Interference prohibited.** ~~(f)~~ A hospital, including any individual, partner, association, or any person or group of persons acting directly or indirectly in the interest of the hospital, ~~shall~~ must not interfere with or discourage a health care worker if the health care worker wishes to contact law enforcement or the commissioner regarding an act of violence.

Subd. 18. **Penalties.** ~~(g)~~ Notwithstanding section 144.653, subdivision 6, the commissioner may impose ~~an administrative~~ a fine of up to ~~$250~~ $10,000 for failure to comply with the requirements of this ~~subdivision~~ section. The commissioner must allow the hospital at least 30 calendar days to correct a violation of this section before assessing a fine.

Sec. 75. **[144.587] REQUIREMENTS FOR SCREENING FOR ELIGIBILITY FOR HEALTH COVERAGE OR ASSISTANCE.**

Subdivision 1. **Definitions.** (a) The terms defined in this subdivision apply to this section and sections 144.588 to 144.589.

(b) "Charity care" means the provision of free or discounted care to a patient according to a hospital's financial assistance policies.

(c) "Hospital" means a private, nonprofit, or municipal hospital licensed under sections 144.50 to 144.56.

(d) "Minnesota attorney general/hospital agreement" means the agreement between the attorney general and certain Minnesota hospitals that is filed in Ramsey County District Court and that establishes requirements for hospital litigation practices, garnishments, use of collection agencies, central billing office practices, and practices for billing uninsured patients.

(e) "Most favored insurer" means the nongovernmental third-party payor that provided the most revenue to the provider during the previous calendar year.

(f) "Navigator" has the meaning given in section 62V.02, subdivision 9.

(g) "Premium tax credit" means a tax credit or premium subsidy under the federal Patient Protection and Affordable Care Act, Public Law 111-148, as amended, including the federal

Health Care and Education Reconciliation Act of 2010, Public Law 111-152, and any amendments to and federal guidance and regulations issued under these acts.

(h) "Presumptive eligibility" has the meaning given in section 256B.057, subdivision 12.

(i) "Revenue recapture" means the use of the procedures in chapter 270A to collect debt.

(j) "Uninsured service or treatment" means any service or treatment that is not covered by: (1) a health plan, contract, or policy that provides health coverage to a patient; or (2) any other type of insurance coverage, including but not limited to no-fault automobile coverage, workers' compensation coverage, or liability coverage.

(k) "Unreasonable burden" includes requiring a patient to apply for enrollment in a state or federal program for which the patient is obviously or categorically ineligible or has been found to be ineligible in the previous 12 months.

Subd. 2. **Screening.** A hospital must screen a patient who is uninsured or whose insurance coverage status is not known by the hospital for: eligibility for charity care from the hospital; eligibility for state or federal public health care programs using presumptive eligibility or another similar process; and eligibility for a premium tax credit. The hospital must attempt to complete this screening process in person or by telephone within 30 days after the patient receives services at the hospital or at the emergency department associated with the hospital.

Subd. 3. **Charity care.** (a) Upon completion of the screening process in subdivision 2, the hospital must either assist the patient with applying for charity care and refer the patient to the appropriate department in the hospital for follow-up or make a determination that the patient is ineligible for charity care. A hospital may initiate one or more of the following steps only after the hospital determines that the patient is ineligible for charity care and may not initiate any of the following steps while the patient's application for charity care is pending:

(1) offering to enroll or enrolling the patient in a payment plan;

(2) changing the terms of a patient's payment plan;

(3) offering the patient a loan or line of credit, application materials for a loan or line of credit, or assistance with applying for a loan or line of credit, for the payment of medical debt;

(4) referring a patient's debt for collections, including in-house collections, third-party collections, revenue recapture, or any other process for the collection of debt;

(5) denying health care services to the patient or any member of the patient's household because of outstanding medical debt, regardless of whether the services are deemed necessary or may be available from another provider; or

(6) accepting a credit card payment of over $500 for the medical debt owed to the hospital.

(b) A hospital may not impose application procedures for charity care that place an unreasonable burden on the individual patient, taking into account the individual patient's physical, mental, intellectual, or sensory deficiencies or language barriers that may hinder the patient's ability to comply with application procedures.

(c) When a hospital evaluates a patient's eligibility for charity care, hospital requests to the responsible party for verification of assets or income shall be limited to:

(1) information that is reasonably necessary and readily available to determine eligibility; and

(2) facts that are relevant to determine eligibility.

A hospital must not demand duplicate forms of verification of assets.

Subd. 4. **Public health care program; premium tax credit.** (a) If a patient is presumptively eligible for a public health care program, the hospital must assist the patient in completing an insurance affordability program application, help the patient schedule an appointment with a navigator organization, or provide the patient with contact information for the nearest available navigator or certified application counselor services.

(b) If a patient is eligible for a premium tax credit, the hospital may schedule an appointment for the patient with a navigator or a MNsure-certified insurance broker organization or provide the patient with contact information for the nearest available navigator services or a MNsure-certified insurance broker.

Subd. 5. **Patient may decline services.** A patient may decline to participate in the screening process, to apply for charity care, to complete an insurance affordability program application, to schedule an appointment with a navigator organization, or to accept information about navigator services.

Subd. 6. **Notice.** (a) A hospital must post notice of the availability of charity care from the hospital in at least the following locations: (1) areas of the hospital where patients are admitted or registered; (2) emergency departments; and (3) the portion of the hospital's financial services or billing department that is accessible to patients. The posted notice must be in all languages spoken by more than five percent of the population in the hospital's service area.

(b) A hospital must make available on the hospital's website, the current version of the hospital's charity care policy, a plain-language summary of the policy, and the hospital's charity care application form. The summary and application form must be available in all languages spoken by more than five percent of the population in the hospital's service area.

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

Sec. 76. **[144.588] CERTIFICATION OF EXPERT REVIEW.**

Subdivision 1. **Requirement; referral to third-party debt collection agency.** (a) In order to refer a patient's account to a third-party debt collection agency, a hospital must complete an affidavit of expert review certifying that the hospital:

(1) confirmed the information required of the hospital in the most recent version of the Minnesota attorney general/hospital agreement for referral of a specific patient's account to a third-party debt collection agency; and

(2) unless the patient declined to participate, complied with the requirements in section 144.587 to conduct a patient screening and, as applicable, assist the patient in applying for charity care, assist the patient with completing an insurance affordability program application, or refer the patient to a navigator organization.

(b) The affidavit of expert review must be completed by a designated employee of the hospital seeking to refer the patient's account to a third-party debt collection agency.

Subd. 2. **Penalty for noncompliance.** Failure to comply with subdivision 1 shall subject a hospital to a fine assessed by the commissioner of health.

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

Sec. 77. **[144.589] BILLING OF UNINSURED PATIENTS.**

A hospital shall not charge a patient whose annual household income is less than $125,000 for any uninsured service or treatment in an amount that exceeds the total amount the provider would be reimbursed for that service or treatment from its most favored insurer. The total amount the provider would be reimbursed for that service or treatment from its most favored insurer includes both the amount the provider would be reimbursed directly from its most favored insurer, and the amount the provider would be reimbursed from the insured's policyholder under any applicable co-payments, deductibles, and coinsurance.

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

Sec. 78. **[144.593] REQUIREMENTS FOR CERTAIN HEALTH CARE ENTITY TRANSACTIONS.**

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

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

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

(d) "Health care entity" means:

(1) a hospital;

(2) a hospital system;

(3) a captive professional entity;

(4) a medical foundation;

(5) a health care provider group practice;

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

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

(e) "Health care provider" means a physician licensed under chapter 147, a physician assistant licensed under chapter 147A, or an advanced practice registered nurse as defined in section 148.171, subdivision 3, who provides health care services, including but not limited to medical care, consultation, diagnosis, or treatment.

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

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

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

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

An entity that otherwise meets the definition of health care provider group practice in this paragraph shall be considered a health care provider group practice even if its shareholders, partners, or owners include single-health care provider professional corporations, limited liability companies formed to render professional services, or other entities in which beneficial owners are individual health care providers.

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

(h) "Medical foundation" means a nonprofit legal entity through which physicians or other health care providers perform research or provide medical services.

(i) "Transaction" means a single action, or a series of actions within a five-year period, that constitutes:

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

(2) the sale, lease, or transfer of 30 percent or more of the assets of a health care entity to another entity;

(3) the granting of a security interest of 30 percent or more of the property and assets of a health care entity to another entity;

(4) the transfer of 30 percent or more of the shares or other ownership of the health care entity to another entity;

(5) an addition or substitution of one or more members of the health care entity's governing body that effectively transfers control, responsibility for, or governance of the health care entity to another entity;

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

(7) substantial investment of 30 percent or more in a health care entity that results in sharing of revenues without a change in ownership or voting shares.

Subd. 2. **Notice required.** (a) This subdivision applies to all transactions where:

(1) the health care entity involved in the transaction has average revenue of at least $10,000,000 per year; or

(2) an entity created by the transaction is projected to have average revenue of at least $10,000,000 per year once the entity is operating at full capacity.

(b) A health care entity must provide notice to the attorney general and the commissioner and comply with this subdivision before entering into a transaction. Notice must be provided at least 180 days before the proposed completion date for the transaction.

(c) As part of the notice required under this subdivision, at least 180 days before the proposed completion date of the transaction, a health care entity must affirmatively disclose the following to the attorney general and the commissioner:

(1) the entities involved in the transaction;

(2) the leadership of the entities involved in the transaction, including all directors, board members, and officers;

(3) the services provided by each entity and the attributed revenue for each entity by location;

(4) the primary service area for each location;

(5) the proposed service area for each location;

(6) the current relationships between the entities and the health care providers and practices affected, the locations of affected health care providers and practices, the services provided by affected health care providers and practices, and the proposed relationships between the entities and the health care providers and practices affected;

(7) the terms of the transaction agreement or agreements;

(8) the acquisition price;

(9) markets in which the entities expect postmerger synergies to produce a competitive advantage;

(10) potential areas of expansion, whether in existing markets or new markets;

(11) plans to close facilities, reduce workforce, or reduce or eliminate services;

(12) the experts and consultants used to evaluate the transaction;

(13) the number of full-time equivalent positions at each location before and after the transaction by job category, including administrative and contract positions; and

(14) any other information requested by the attorney general or commissioner.

(d) As part of the notice required under this subdivision, at least 180 days before the proposed completion date of the transaction, a health care entity must affirmatively produce the following to the attorney general and the commissioner:

(1) the current governing documents for all entities involved in the transaction and any amendments to these documents;

(2) the transaction agreement or agreements and all related agreements;

(3) any collateral agreements related to the principal transaction, including leases, management contracts, and service contracts;

(4) all expert or consultant reports or valuations conducted in evaluating the transaction, including any valuation of the assets that are subject to the transaction prepared within three years preceding the anticipated transaction completion date and any reports of financial or economic analysis conducted in anticipation of the transaction;

(5) the results of any projections or modeling of health care utilization or financial impacts related to the transaction, including but not limited to copies of reports by appraisers, accountants, investment bankers, actuaries, and other experts;

(6) a financial and economic analysis and report prepared by an independent expert or consultant on the effects of the transaction;

(7) an impact analysis report prepared by an independent expert or consultant on the effects of the transaction on communities and the workforce, including any changes in availability or accessibility of services;

(8) all documents reflecting the purposes of or restrictions on any related nonprofit entity's charitable assets;

(9) copies of all filings submitted to federal regulators, including any Hart-Scott-Rodino filing the entities submitted to the Federal Trade Commission in connection with the transaction;

(10) a certification sworn under oath by each board member and chief executive officer for any nonprofit entity involved in the transaction containing the following: an explanation of how the completed transaction is in the public interest, addressing the factors in subdivision 5, paragraph (a); a disclosure of each declarant's compensation and benefits relating to the transaction for the three years following the transaction's anticipated completion date; and a disclosure of any conflicts of interest;

(11) audited and unaudited financial statements from all entities involved in the transaction and tax filings for all entities involved in the transaction covering the preceding five fiscal years; and

(12) any other information or documents requested by the attorney general or commissioner.

(e) The commissioner may adopt rules to implement this section, and may alter, amend, suspend, or repeal any of such rules. The requirements of section 14.125 do not apply to the adoption of rules under this paragraph.

(f) The attorney general may extend the notice and waiting period required under paragraph (b) for an additional 90 days by notifying the health care entity in writing of the extension.

(g) The attorney general may waive all or any part of the notice and waiting period required under paragraph (b).

(h) The attorney general or the commissioner may hold public listening sessions or forums to obtain input on the transaction from providers or community members who may be impacted by the transaction.

(i) The attorney general or the commissioner may bring an action in district court to compel compliance with the notice requirements in this subdivision.

Subd. 3. **Prohibited transactions.** No health care entity may enter into a transaction that will:

(1) substantially lessen competition; or

(2) tend to create a monopoly or monopsony.

Subd. 4. **Additional requirements for nonprofit health care entities.** A health care entity that is incorporated under chapter 317A or organized under section 322C.1101, or that is a subsidiary of any such entity, must, before entering into a transaction, ensure that:

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

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

(3) the nonprofit health care entity will receive full and fair value for its public benefit assets;

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

(5) the proceeds of the transaction will be used in a manner consistent with the public benefit for which the assets are held by the nonprofit health care entity;

(6) the transaction will not result in a breach of fiduciary duty; and

(7) there are procedures and policies in place to prohibit any officer, director, trustee, or other executive of the nonprofit health care entity from directly or indirectly benefiting from the transaction.

Subd. 5. **Attorney general enforcement and supplemental authority.** (a) The attorney general may bring an action in district court to enjoin or unwind a transaction or seek other equitable relief necessary to protect the public interest if a health care entity or transaction violates this section, if the transaction is contrary to the public interest, or if both a health care entity or transaction violates this section and the transaction is contrary to the public interest. Factors informing whether a transaction is contrary to the public interest include but are not limited to whether the transaction:

(1) will harm public health;

(2) will reduce the affected community's continued access to affordable and quality care and to the range of services historically provided by the entities or will prevent members in the affected community from receiving a comparable or better patient experience;

(3) will have a detrimental impact on competing health care options within primary and dispersed service areas;

(4) will reduce delivery of health care to disadvantaged, uninsured, underinsured, and underserved populations and to populations enrolled in public health care programs;

(5) will have a substantial negative impact on medical education and teaching programs, health care workforce training, or medical research;

(6) will have a negative impact on the market for health care services, health insurance services, or skilled health care workers;

(7) will increase health care costs for patients; or

(8) will adversely impact provider cost trends and containment of total health care spending.

(b) The attorney general may enforce this section under section 8.31.

(c) Failure of the entities involved in a transaction to provide timely information as required by the attorney general or the commissioner shall be an independent and sufficient ground for a court to enjoin the transaction or provide other equitable relief, provided the

attorney general notified the entities of the inadequacy of the information provided and provided the entities with a reasonable opportunity to remedy the inadequacy.

(d) The attorney general shall consult with the commissioner to determine whether a transaction is contrary to the public interest. Any information exchanged between the attorney general and the commissioner according to this subdivision is confidential data on individuals as defined in section 13.02, subdivision 3, or protected nonpublic data as defined in section 13.02, subdivision 13. The commissioner may share with the attorney general, according to section 13.05, subdivision 9, any not public data, as defined in section 13.02, subdivision 8a, held by the Department of Health to aid in the investigation and review of the transaction, and the attorney general must maintain this data with the same classification according to section 13.03, subdivision 4, paragraph (d).

Subd. 6. **Supplemental authority of commissioner.** (a) Notwithstanding any law to the contrary, the commissioner may use data or information submitted under this section, section 62U.04, and sections 144.695 to 144.705 to conduct analyses of the aggregate impact of health care transactions on access to or the cost of health care services, health care market consolidation, and health care quality.

(b) The commissioner shall issue periodic public reports on the number and types of transactions subject to this section and on the aggregate impact of transactions on health care cost, quality, and competition in Minnesota.

Subd. 7. **Relation to other law.** (a) The powers and authority under this section are in addition to, and do not affect or limit, all other rights, powers, and authority of the attorney general or the commissioner under chapter 8, 309, 317A, 325D, 501B, or other law.

(b) Nothing in this section shall suspend any obligation imposed under chapter 8, 309, 317A, 325D, 501B, or other law on the entities involved in a transaction.

EFFECTIVE DATE. This section is effective the day following final enactment and applies to transactions completed on or after that date. In determining whether a transaction was completed on or after the effective date, any actions or series of actions necessary to the completion of the transaction that occurred prior to the effective date must be considered.

Sec. 79. Minnesota Statutes 2022, section 144.608, subdivision 1, is amended to read:

Subdivision 1. **Trauma Advisory Council established.** (a) A Trauma Advisory Council is established to advise, consult with, and make recommendations to the commissioner on the development, maintenance, and improvement of a statewide trauma system.

(b) The council shall consist of the following members:

(1) a trauma surgeon certified by the American Board of Surgery or the American Osteopathic Board of Surgery who practices in a level I or II trauma hospital;

(2) a general surgeon certified by the American Board of Surgery or the American Osteopathic Board of Surgery whose practice includes trauma and who practices in a designated rural area as defined under section 144.1501, subdivision 1~~, paragraph (e)~~;

(3) a neurosurgeon certified by the American Board of Neurological Surgery who practices in a level I or II trauma hospital;

(4) a trauma program nurse manager or coordinator practicing in a level I or II trauma hospital;

(5) an emergency physician certified by the American Board of Emergency Medicine or the American Osteopathic Board of Emergency Medicine whose practice includes emergency room care in a level I, II, III, or IV trauma hospital;

(6) a trauma program manager or coordinator who practices in a level III or IV trauma hospital;

(7) a physician certified by the American Board of Family Medicine or the American Osteopathic Board of Family Practice whose practice includes emergency department care in a level III or IV trauma hospital located in a designated rural area as defined under section 144.1501, subdivision 1~~, paragraph (e)~~;

(8) a nurse practitioner, as defined under section 144.1501, subdivision 1~~, paragraph (l)~~, or a physician assistant, as defined under section 144.1501, subdivision 1~~, paragraph (o)~~, whose practice includes emergency room care in a level IV trauma hospital located in a designated rural area as defined under section 144.1501, subdivision 1~~, paragraph (e)~~;

(9) a physician certified in pediatric emergency medicine by the American Board of Pediatrics or certified in pediatric emergency medicine by the American Board of Emergency Medicine or certified by the American Osteopathic Board of Pediatrics whose practice primarily includes emergency department medical care in a level I, II, III, or IV trauma hospital, or a surgeon certified in pediatric surgery by the American Board of Surgery whose practice involves the care of pediatric trauma patients in a trauma hospital;

(10) an orthopedic surgeon certified by the American Board of Orthopaedic Surgery or the American Osteopathic Board of Orthopedic Surgery whose practice includes trauma and who practices in a level I, II, or III trauma hospital;

(11) the state emergency medical services medical director appointed by the Emergency Medical Services Regulatory Board;

(12) a hospital administrator of a level III or IV trauma hospital located in a designated rural area as defined under section 144.1501, subdivision 1~~, paragraph (e)~~;

(13) a rehabilitation specialist whose practice includes rehabilitation of patients with major trauma injuries or traumatic brain injuries and spinal cord injuries as defined under section 144.661;

(14) an attendant or ambulance director who is an EMT, EMT-I, or EMT-P within the meaning of section 144E.001 and who actively practices with a licensed ambulance service in a primary service area located in a designated rural area as defined under section 144.1501, subdivision 1~~, paragraph (e)~~; and

(15) the commissioner of public safety or the commissioner's designee.

Sec. 80. Minnesota Statutes 2022, section 144.615, subdivision 7, is amended to read:

Subd. 7. **Limitations of services.** (a) The following limitations apply to the services performed at a birth center:

(1) surgical procedures must be limited to those normally accomplished during an uncomplicated birth, including episiotomy and repair; and

~~(2) no abortions may be administered; and~~

~~(3)~~ (2) no general or regional anesthesia may be administered.

(b) Notwithstanding paragraph (a), local anesthesia may be administered at a birth center if the administration of the anesthetic is performed within the scope of practice of a health care professional.

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

Sec. 81. Minnesota Statutes 2022, section 144.651, is amended by adding a subdivision to read:

Subd. 10a. **Designated support person for pregnant patient.** (a) A health care provider and a health care facility must allow, at a minimum, one designated support person of a pregnant patient's choosing to be physically present while the patient is receiving health care services including during a hospital stay.

(b) For purposes of this subdivision, "designated support person" means any person necessary to provide comfort to the patient including but not limited to the patient's spouse, partner, family member, or another person related by affinity. Certified doulas and traditional midwives may not be counted toward the limit of one designated support person.

Sec. 82. Minnesota Statutes 2022, section 144.653, subdivision 5, is amended to read:

Subd. 5. **Correction orders.** Whenever a duly authorized representative of the state commissioner of health finds upon inspection of a facility required to be licensed under the provisions of sections 144.50 to 144.58 that the licensee of such facility is not in compliance with sections 144.411 to 144.417, 144.50 to 144.58, 144.651, 144.7051 to 144.7058, or 626.557, or the applicable rules promulgated under those sections, a correction order shall be issued to the licensee. The correction order shall state the deficiency, cite the specific rule violated, and specify the time allowed for correction.

Sec. 83. Minnesota Statutes 2022, section 144.6535, subdivision 1, is amended to read:

Subdivision 1. **Request for variance or waiver.** A hospital may request that the commissioner grant a variance or waiver from the provisions of ~~Minnesota Rules, chapter 4640 or 4645~~ section 144.55, subdivision 3, paragraph (b). A request for a variance or waiver must be submitted to the commissioner in writing. Each request must contain:

(1) the specific ~~rule or rules~~ requirement for which the variance or waiver is requested;

(2) the reasons for the request;

(3) the alternative measures that will be taken if a variance or waiver is granted;

(4) the length of time for which the variance or waiver is requested; and

(5) other relevant information deemed necessary by the commissioner to properly evaluate the request for the variance or waiver.

EFFECTIVE DATE. This section is effective January 1, 2024.

Sec. 84. Minnesota Statutes 2022, section 144.6535, subdivision 2, is amended to read:

Subd. 2. **Criteria for evaluation.** The decision to grant or deny a variance or waiver must be based on the commissioner's evaluation of the following criteria:

(1) whether the variance or waiver will adversely affect the health, treatment, comfort, safety, or well-being of a patient;

(2) whether the alternative measures to be taken, if any, are equivalent to or superior to those prescribed in ~~Minnesota Rules, chapter 4640 or 4645~~ section 144.55, subdivision 3, paragraph (b); and

(3) whether compliance with the ~~rule or rules~~ requirements would impose an undue burden upon the applicant.

EFFECTIVE DATE. This section is effective January 1, 2024.

Sec. 85. Minnesota Statutes 2022, section 144.6535, subdivision 4, is amended to read:

Subd. 4. **Effect of alternative measures or conditions.** (a) Alternative measures or conditions attached to a variance or waiver have the same force and effect as the ~~rules~~ requirement under ~~Minnesota Rules, chapter 4640 or 4645~~ section 144.55, subdivision 3, paragraph (b), and are subject to the issuance of correction orders and penalty assessments in accordance with section 144.55.

(b) Fines for a violation of this section shall be in the same amount as that specified for the particular ~~rule~~ requirement for which the variance or waiver was requested.

EFFECTIVE DATE. This section is effective January 1, 2024.

Sec. 86. Minnesota Statutes 2022, section 144.69, is amended to read:

144.69 CLASSIFICATION OF DATA ON INDIVIDUALS.

Subdivision 1. **Data collected by the cancer reporting system.** Notwithstanding any law to the contrary, including section 13.05, subdivision 9, data collected on individuals by the cancer ~~surveillance~~ reporting system, including the names and personal identifiers of persons required in section 144.68 to report, shall be private and may only be used for the purposes set forth in this section and sections 144.671, 144.672, and 144.68. Any disclosure other than is provided for in this section and sections 144.671, 144.672, and 144.68, is declared to be a misdemeanor and punishable as such. Except as provided by rule, and as part of an epidemiologic investigation, an officer or employee of the commissioner of health may interview patients named in any such report, or relatives of any such patient, only after ~~the consent of~~ notifying the attending physician, advanced practice registered nurse, physician assistant, or surgeon ~~is obtained~~. Research protections for patients must be consistent with section 13.04, subdivision 2, and Code of Federal Regulations, title 45, part 46.

Subd. 2. **Transfers of information to state cancer registries and federal government agencies.** (a) Information containing personal identifiers of a non-Minnesota resident collected by the cancer reporting system may be provided to the statewide cancer registry of the nonresident's home state solely for the purposes consistent with this section and sections 144.671, 144.672, and 144.68, provided that the other state agrees to maintain the classification of the information as provided under subdivision 1.

(b) Information, excluding direct identifiers such as name, Social Security number, telephone number, and street address, collected by the cancer reporting system may be

provided to the Centers for Disease Control and Prevention's National Program of Cancer Registries and the National Cancer Institute's Surveillance, Epidemiology, and End Results Program registry.

Sec. 87. **[144.7051] DEFINITIONS.**

Subdivision 1. **Applicability.** For the purposes of sections 144.7051 to 144.7058, the terms defined in this section have the meanings given.

Subd. 2. **Concern for safe staffing form.** "Concern for safe staffing form" means a standard uniform form developed by the commissioner that may be used by any individual to report unsafe staffing situations while maintaining the privacy of patients.

Subd. 3. **Commissioner.** "Commissioner" means the commissioner of health.

Subd. 4. **Daily staffing schedule.** "Daily staffing schedule" means the actual number of full-time equivalent nonmanagerial care staff assigned to an inpatient care unit and providing care in that unit during a 24-hour period and the actual number of patients assigned to each direct care registered nurse present and providing care in the unit.

Subd. 5. **Direct-care registered nurse.** "Direct-care registered nurse" means a registered nurse, as defined in section 148.171, subdivision 20, who is nonsupervisory and nonmanagerial and who directly provides nursing care to patients more than 60 percent of the time.

Subd. 6. **Hospital.** "Hospital" means any setting that is licensed under this chapter as a hospital.

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

Sec. 88. **[144.7053] HOSPITAL NURSE STAFFING COMMITTEE.**

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

(b) The commissioner is not required to verify compliance with this section by an on-site visit.

Subd. 2. **Staffing committee membership.** (a) At least 35 percent of the hospital nurse staffing committee's membership must be direct care registered nurses typically assigned

to a specific unit for an entire shift and at least 15 percent of the committee's membership must be other direct care workers typically assigned to a specific unit for an entire shift. Direct care registered nurses and other direct care workers who are members of a collective bargaining unit shall be appointed or elected to the committee according to the guidelines of the applicable collective bargaining agreement. If there is no collective bargaining agreement, direct care registered nurses shall be elected to the committee by direct care registered nurses employed by the hospital and other direct care workers shall be elected to the committee by other direct care workers employed by the hospital.

(b) The hospital shall appoint 50 percent of the hospital nurse staffing committee's membership.

Subd. 3. **Staffing committee compensation.** A hospital must treat participation in the hospital nurse staffing committee meetings by any hospital employee as scheduled work time and compensate each committee member at the employee's existing rate of pay. A hospital must relieve all direct care registered nurse members of the hospital nurse staffing committee of other work duties during the times when the committee meets.

Subd. 4. **Staffing committee meeting frequency.** Each hospital nurse staffing committee must meet at least quarterly.

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

(b) Each hospital nurse staffing committee must:

(1) establish a secure, uniform, and easily accessible method for any hospital employee, patient, or patient family member to submit directly to the committee a concern for safe staffing form;

(2) review each concern for safe staffing form;

(3) forward a copy of all concern for safe staffing forms to the relevant hospital nurse workload committee;

(4) review the documentation of compliance maintained by the hospital under section 144.7056, subdivision 10;

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

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

(7) submit a nurse staffing report to the commissioner;

(8) assist the commissioner in compiling data for the Nursing Workforce Report by encouraging participation in the commissioner's independent study on reasons licensed registered nurses are leaving the profession; and

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

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

Sec. 89. **[144.7054] HOSPITAL NURSE WORKLOAD COMMITTEE.**

Subdivision 1. **Hospital nurse workload committee required.** (a) Each hospital must establish and maintain functioning hospital nurse workload committees for each unit.

(b) The commissioner is not required to verify compliance with this section by an on-site visit.

Subd. 2. **Workload committee membership.** (a) At least 35 percent of each workload committee's membership must be direct care registered nurses typically assigned to the unit for an entire shift and at least 15 percent of the committee's membership must be other direct care workers typically assigned to the unit for an entire shift. Direct care registered nurses and other direct care workers who are members of a collective bargaining unit shall be appointed or elected to the committee according to the guidelines of the applicable collective bargaining agreement. If there is no collective bargaining agreement, direct care registered nurses shall be elected to the committee by direct care registered nurses typically assigned to the unit for an entire shift and other direct care workers shall be elected to the committee by other direct care workers typically assigned to the unit for an entire shift.

(b) The hospital shall appoint 50 percent of each unit's nurse workload committee's membership.

(c) Notwithstanding paragraphs (a) and (b), if a hospital has established a staffing committee through collective bargaining, then the composition of that committee prevails.

Subd. 3. **Workload committee compensation.** A hospital must treat participation in a hospital nurse workload committee meeting by any hospital employee as scheduled work time and compensate each committee member at the employee's existing rate of pay. A

hospital must relieve all direct care registered nurse members of a hospital nurse workload committee of other work duties during the times when the committee meets.

Subd. 4. **Workload committee meeting frequency.** Each hospital nurse workload committee must meet at least monthly whenever the committee is in receipt of an unresolved concern for safe staffing form.

Subd. 5. **Workload committee duties.** (a) Each hospital nurse workload committee must create, implement, and maintain dispute resolution procedures to guide the committee's development and implementation of solutions to the staffing concerns raised in concern for safe staffing forms that have been forwarded to the committee. The dispute resolution procedures must include an expedited arbitration process with an arbitrator who has expertise in patient care. The committee must use the expedited arbitration process for any complaint that remains unresolved 30 days after the submission of the concern for safe staffing form that gave rise to the complaint.

(b) Each hospital nurse workload committee must attempt to expeditiously resolve staffing issues the committee determines arise from a violation of the hospital's core staffing plan.

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

Sec. 90. Minnesota Statutes 2022, section 144.7055, is amended to read:

144.7055 HOSPITAL CORE STAFFING PLAN ~~REPORTS~~.

Subdivision 1. **Definitions.** (a) For the purposes of ~~this section~~ sections 144.7051 to 144.7058, the following terms have the meanings given.

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

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

(d) "Inpatient care unit" or "unit" means a designated inpatient area for assigning patients and staff for which a ~~distinct staffing plan~~ daily staffing schedule exists and that operates

24 hours per day, seven days per week in a hospital setting. Inpatient care unit does not include any hospital-based clinic, long-term care facility, or outpatient hospital department.

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

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

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

(b) The commissioner is not required to verify compliance with this section by an on-site visit.

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

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

(2) the maximum number of patients on each inpatient care unit for whom a direct care nurse can typically safely care;

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

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

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

(6) strategies to enable direct care registered nurses to take breaks they are entitled to under law or under an applicable collective bargaining agreement; and

(7) strategies to eliminate patient boarding in emergency departments that do not rely on requiring direct care registered nurses to work additional hours to provide care.

~~(c)~~ (d) Core staffing plans must ensure that:

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

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

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

(4) a light duty direct care registered nurse is given appropriate assignments;

(5) a charge nurse does not have patient assignments; and

(6) daily staffing schedules do not interfere with applicable collective bargaining agreements.

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

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

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

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

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

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

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

(6) the stress that direct-care nurses experience when required to work extreme amounts of overtime, such as shifts in excess of 12 hours or multiple consecutive double shifts;

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

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

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

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

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

Subd. 2b. **Failure to develop hospital core staffing plans.** If a hospital nurse staffing committee cannot approve a hospital core staffing plan by a majority vote, the members of the nurse staffing committee must enter an expedited arbitration process with an arbitrator who understands patient care needs.

Subd. 2c. **Objections to hospital core staffing plans.** (a) If hospital management objects to a core staffing plan approved by a majority vote of the hospital nurse staffing committee, the hospital may elect to attempt to amend the core staffing plan through arbitration.

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

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

Subd. 2d. **Mandatory submission of core staffing plan to commissioner.** Each hospital must submit to the commissioner the core staffing plans approved by the hospital's nurse staffing committee. A hospital must submit any substantial updates to any previously

approved plan, including any amendments to the plan resulting from arbitration, within 30 calendar days of approval of the update by the committee or the conclusion of arbitration.

Subd. 3. **Standard electronic reporting developed.** ~~(a) Hospitals must submit the core staffing plans to the Minnesota Hospital Association by January 1, 2014. The Minnesota Hospital Association shall include each reporting hospital's core staffing plan on the Minnesota Hospital Association's Minnesota Hospital Quality Report website by April 1, 2014. any substantial changes to the core staffing plan shall be updated within 30 days.~~

~~(b)~~ The Minnesota Hospital Association shall include on its website for each reporting hospital on a quarterly basis the actual direct patient care hours per patient and per unit. Hospitals must submit the direct patient care report to the Minnesota Hospital Association by July 1, 2014, and quarterly thereafter.

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

Sec. 91. **[144.7056] IMPLEMENTATION OF HOSPITAL CORE STAFFING PLANS.**

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

(b) The commissioner is not required to verify compliance with this section by on-site visits during routine hospital surveys.

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

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

Subd. 4. **Posting of compliance in patient rooms.** A hospital must post on a whiteboard in a patient's room or make available through a television in a patient's room both the number of patients a nurse on the patient's unit should be assigned under the relevant core staffing plan and the number of patients actually assigned to a nurse during the current shift.

Subd. 5. **Deviations from core staffing plans.** (a) Before hospital management lowers the staffing level of any unit, management must consult with and receive agreement from at least 50 percent of the direct care registered nurses staffing the unit.

(b) Deviation from a core staffing plan with the agreement of at least 50 percent of the direct care registered nurses staffing the unit does not constitute compliance with the core staffing plan.

Subd. 6. **Public posting of emergency department wait times.** A hospital must maintain on its website and publicly display in its emergency department the approximate wait time for patients who are not in critical need of emergency care. The approximate wait time must be updated at least hourly.

Subd. 7. **Disclosure of staffing plan upon admission.** A hospital must provide an explanation of its core staffing plan to each patient upon admission.

Subd. 8. **Public distribution of core staffing plan and notice of compliance.** (a) A hospital must include with the posted materials described in subdivisions 2 and 3 a statement that individual copies of the posted materials are available upon request to any patient on the unit or to any visitor of a patient on the unit. The statement must include specific instructions for obtaining copies of the posted materials.

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

Subd. 9. **Reporting noncompliance.** (a) Any hospital employee, patient, or patient family member may submit a concern for safe staffing form to report an instance of noncompliance with a hospital's core staffing plan, to object to the contents of a core staffing plan, or to challenge the process of the hospital nurse staffing committee.

(b) A hospital must not interfere with or retaliate against a hospital employee for submitting a concern for safe staffing form.

(c) The commissioner of labor and industry may investigate any report of retaliation against a hospital employee for submitting a concern for safe staffing form. The commissioner of labor and industry may fine a hospital up to $250,000 for each instance of substantiated retaliation against a hospital employee for submitting a concern for safe staffing form.

Subd. 10. **Documentation of compliance.** Each hospital must document compliance with its core nursing plans and maintain records demonstrating compliance for each inpatient

care unit for five years. Each hospital must provide to its nurse staffing committee access to all documentation required under this subdivision.

EFFECTIVE DATE. This section is effective October 1, 2025.

Sec. 92. **[144.7057] HOSPITAL NURSE STAFFING REPORTS.**

Subdivision 1. **Nurse staffing report required.** Each hospital nurse staffing committee must submit quarterly nurse staffing reports to the commissioner. Reports must be submitted within 60 days of the end of the quarter.

Subd. 2. **Nurse staffing report.** Nurse staffing reports submitted to the commissioner by a hospital nurse staffing committee must:

(1) identify any suspected incidents of the hospital failing during the reporting quarter to meet the standards of one of its core staffing plans;

(2) identify each occurrence of the hospital accepting an elective surgery at a time when the unit performing the surgery is out of compliance with its core staffing plan;

(3) identify problems of insufficient staffing, including but not limited to:

(i) inappropriate number of direct care registered nurses scheduled in a unit;

(ii) inappropriate number of direct care registered nurses present and delivering care in a unit;

(iii) inappropriately experienced direct care registered nurses scheduled for a particular unit;

(iv) inappropriately experienced direct care registered nurses present and delivering care in a unit;

(v) inability for nurse supervisors to adjust daily nursing schedules for increased patient acuity or nursing intensity in a unit; and

(vi) chronically unfilled direct care positions within the hospital;

(4) identify any units that pose a risk to patient safety due to inadequate staffing;

(5) propose solutions to solve insufficient staffing;

(6) propose solutions to reduce risks to patient safety in inadequately staffed units; and

(7) describe staffing trends within the hospital.

Subd. 3. **Public posting of nurse staffing reports.** The commissioner must include on its website each quarterly nurse staffing report submitted to the commissioner under subdivision 1.

Subd. 4. **Standardized reporting.** The commissioner shall develop and provide to each hospital nurse staffing committee a uniform format or standard form the committee must use to comply with the nurse staffing reporting requirements under this section. The format or form developed by the commissioner must present the reported information in a manner allowing patients and the public to clearly understand and compare staffing patterns and actual levels of staffing across reporting hospitals. The commissioner must include, in the uniform format or on the standardized form, space to allow the reporting hospital to include a description of additional resources available to support unit-level patient care and a description of the hospital.

Subd. 5. **Penalties.** Notwithstanding section 144.653, subdivisions 5 and 6, the commissioner may impose an immediate fine of up to $5,000 for each instance of a failure to report an elective surgery requiring reporting under subdivision 2, clause (2). The facility may request a hearing on the immediate fine under section 144.653, subdivision 8.

EFFECTIVE DATE. This section is effective October 1, 2025.

Sec. 93. **[144.7058] GRADING OF COMPLIANCE WITH CORE STAFFING PLANS.**

Subdivision 1. **Grading compliance with core staffing plans.** By January 1, 2026, the commissioner must develop a uniform annual grading system that evaluates each hospital's compliance with its own core staffing plan. The commissioner must assign each hospital a compliance grade based on a review of the hospital's nurse staffing report submitted under section 144.7057. The commissioner must assign a failing compliance grade to any hospital that has not been in compliance with its staffing plan for six or more months during the reporting year.

Subd. 2. **Grading factors.** When grading a hospital's compliance with its core staffing plan, the commissioner must consider at least the following factors:

(1) the number of assaults and injuries occurring in the hospital involving patients;

(2) the prevalence of infections, pressure ulcers, and falls among patients;

(3) emergency department wait times;

(4) readmissions;

(5) use of restraints and other behavior interventions;

(6) employment turnover rates among direct care registered nurses and other direct care health care workers;

(7) prevalence of overtime among direct care registered nurses and other direct care health care workers;

(8) prevalence of missed shift breaks among direct care registered nurses and other direct care health care workers;

(9) frequency of incidents of being out of compliance with a core staffing plan; and

(10) the extent of noncompliance with a core staffing plan.

Subd. 3. **Public disclosure of compliance grades.** Beginning January 1, 2027, the commissioner must publish a compliance grade for each hospital on the department website with a link to the hospital's core staffing plan, the hospital's nurse staffing reports, and an accessible and easily understandable explanation of what the compliance grade means.

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

Sec. 94. **[144.7059] RETALIATION AGAINST NURSES PROHIBITED.**

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

(b) "Emergency" means a period when replacement staff are not able to report for duty for the next shift, or a period of increased patient need, because of unusual, unpredictable, or unforeseen circumstances, including but not limited to an act of terrorism, a disease outbreak, adverse weather conditions, or a natural disaster, that impacts continuity of patient care.

(c) "Nurse" has the meaning given in section 148.171, subdivision 9, and includes nurses employed by the state.

(d) "Taking action against" means discharging, disciplining, threatening, reporting to the Board of Nursing, discriminating against, or penalizing regarding compensation, terms, conditions, location, or privileges of employment.

Subd. 2. **Prohibited actions.** Except as provided in subdivision 5, a hospital or other entity licensed under sections 144.50 to 144.58, and its agent, or other health care facility licensed by the commissioner of health, and the facility's agent, is prohibited from taking action against a nurse solely on the ground that the nurse fails to accept an assignment of one or more additional patients because the nurse determines that accepting an additional patient assignment, in the nurse's judgment, may create an unnecessary danger to a patient's

life, health, or safety or may otherwise constitute a ground for disciplinary action under section 148.261. This subdivision does not apply to a nursing facility, an intermediate care facility for persons with developmental disabilities, or a licensed boarding care home.

Subd. 3. **State nurses.** Subdivision 2 applies to nurses employed by the state regardless of the type of facility where the nurse is employed and regardless of the facility's license, if the nurse is involved in resident or patient care.

Subd. 4. **Collective bargaining rights.** This section does not diminish or impair the rights of a person under any collective bargaining agreement.

Subd. 5. **Emergency.** A nurse may be required to accept an additional patient assignment in an emergency.

Subd. 6. **Enforcement.** The commissioner of labor and industry shall enforce this section. The commissioner of labor and industry may assess a fine of up to $5,000 for each violation of this section.

Sec. 95. Minnesota Statutes 2022, section 144.7067, subdivision 1, is amended to read:

Subdivision 1. **Establishment of reporting system.** (a) The commissioner shall establish an adverse health event reporting system designed to facilitate quality improvement in the health care system. The reporting system shall not be designed to punish errors by health care practitioners or health care facility employees.

(b) The reporting system shall consist of:

(1) mandatory reporting by facilities of 27 adverse health care events;

(2) mandatory reporting by facilities of whether the unit where an adverse event occurred was in compliance with the core staffing plan for the unit at the time of the adverse event;

(3) mandatory completion of a root cause analysis and a corrective action plan by the facility and reporting of the findings of the analysis and the plan to the commissioner or reporting of reasons for not taking corrective action;

~~(3)~~ (4) analysis of reported information by the commissioner to determine patterns of systemic failure in the health care system and successful methods to correct these failures;

~~(4)~~ (5) sanctions against facilities for failure to comply with reporting system requirements; and

~~(5)~~ (6) communication from the commissioner to facilities, health care purchasers, and the public to maximize the use of the reporting system to improve health care quality.

(c) The commissioner is not authorized to select from or between competing alternate acceptable medical practices.

EFFECTIVE DATE. This section is effective October 1, 2025.

Sec. 96. Minnesota Statutes 2022, section 144.9501, subdivision 9, is amended to read:

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

Sec. 97. Minnesota Statutes 2022, section 144.9501, subdivision 17, is amended to read:

Subd. 17. **Lead hazard reduction.** (a) "Lead hazard reduction" means abatement, swab team services, or interim controls undertaken to make a residence, child care facility, school, playground, or other location where lead hazards are identified lead-safe by complying with the lead standards and methods adopted under section 144.9508.

(b) Lead hazard reduction does not include renovation activity that is primarily intended to remodel, repair, or restore a given structure or dwelling rather than abate or control lead-based paint hazards.

(c) Lead hazard reduction does not include activities that disturb painted surfaces that total:

(1) less than 20 square feet (two square meters) on exterior surfaces; or

(2) less than two square feet (0.2 square meters) in an interior room.

Sec. 98. Minnesota Statutes 2022, section 144.9501, subdivision 26a, is amended to read:

Subd. 26a. **Regulated lead work.** ~~(a)~~ "Regulated lead work" means:

(1) abatement;

(2) interim controls;

(3) a clearance inspection;

(4) a lead hazard screen;

(5) a lead inspection;

(6) a lead risk assessment;

(7) lead project designer services;

(8) lead sampling technician services;

(9) swab team services;

(10) renovation activities; ~~or~~

(11) lead hazard reduction; or

~~(11)~~ (12) activities performed to comply with lead orders issued by ~~a community health board~~ an assessing agency.

~~(b) Regulated lead work does not include abatement, interim controls, swab team services, or renovation activities that disturb painted surfaces that total no more than:~~

~~(1) 20 square feet (two square meters) on exterior surfaces; or~~

~~(2) six square feet (0.6 square meters) in an interior room.~~

Sec. 99. Minnesota Statutes 2022, section 144.9501, subdivision 26b, is amended to read:

Subd. 26b. **Renovation.** (a) "Renovation" means the modification of any pre-1978 affected property for compensation that results in the disturbance of known or presumed lead-containing painted surfaces defined under section 144.9508, unless that activity is performed as lead hazard reduction. A renovation performed for the purpose of converting a building or part of a building into an affected property is a renovation under this subdivision.

(b) Renovation does not include minor repair and maintenance activities described in this paragraph. All activities that disturb painted surfaces and are performed within 30 days of other activities that disturb painted surfaces in the same room must be considered a single project when applying the criteria below. Unless the activity involves window replacement or demolition of a painted surface, building component, or portion of a structure, for purposes of this paragraph, "minor repair and maintenance" means activities that disturb painted surfaces totaling:

(1) less than 20 square feet (two square meters) on exterior surfaces; or

(2) less than six square feet (0.6 square meters) in an interior room.

(c) Renovation does not include total demolition of a freestanding structure. For purposes of this paragraph, "total demolition" means demolition and disposal of all interior and exterior painted surfaces, including windows. Unpainted foundation building components remaining after total demolition may be reused.

Sec. 100. Minnesota Statutes 2022, section 144.9501, is amended by adding a subdivision to read:

Subd. 33. **Compensation.** "Compensation" means money or other mutually agreed upon form of payment given or received for regulated lead work, including rental payments, rental income, or salaries derived from rental payments.

Sec. 101. Minnesota Statutes 2022, section 144.9501, is amended by adding a subdivision to read:

Subd. 34. **Individual.** "Individual" means a natural person.

Sec. 102. Minnesota Statutes 2022, section 144.9505, subdivision 1, is amended to read:

Subdivision 1. **Licensing, certification, and permitting.** (a) Fees collected under this section shall be deposited into the state treasury and credited to the state government special revenue fund.

(b) Persons shall not advertise or otherwise present themselves as lead supervisors, lead workers, lead inspectors, lead risk assessors, lead sampling technicians, lead project designers, renovation firms, or lead firms unless they have licenses or certificates issued by the commissioner under this section.

(c) The fees required in this section for inspectors, risk assessors, and certified lead firms are waived for state or local government employees performing services for or as an assessing agency.

(d) ~~An individual who is the owner of property on which regulated lead work is to be performed or an adult individual who is related to the property owner, as defined under section 245A.02, subdivision 13, is exempt from the requirements to obtain a license and pay a fee according to this section.~~ Individual residential property owners who perform regulated lead work on their own residence are exempt from the licensure and firm certification requirements of this section. Notwithstanding the provisions of paragraphs (a) to (c), this exemption does not apply when the regulated lead work is a renovation performed for compensation, when a child with an elevated blood level has been identified in the residence or the building in which the residence is located, or when the residence is occupied by one or more individuals who are not related to the property owner, as defined under section 245A.02, subdivision 13.

~~(e) A person that employs individuals to perform regulated lead work outside of the person's property must obtain certification as a certified lead firm. An individual who~~

~~performs lead hazard reduction, lead hazard screens, lead inspections, lead risk assessments, clearance inspections, lead project designer services, lead sampling technician services, swab team services, and activities performed to comply with lead orders must be employed by a certified lead firm, unless the individual is a sole proprietor and does not employ any other individuals, the individual is employed by a person that does not perform regulated lead work outside of the person's property, or the individual is employed by an assessing agency.~~

Sec. 103. Minnesota Statutes 2022, section 144.9505, subdivision 1g, is amended to read:

Subd. 1g. **Certified lead firm.** A person who performs or employs individuals to perform regulated lead work, with the exception of renovation, ~~outside of the person's property~~ must obtain certification as a lead firm. The certificate must be in writing, contain an expiration date, be signed by the commissioner, and give the name and address of the person to whom it is issued. A lead firm certificate is valid for one year. The certification fee is $100, is nonrefundable, and must be submitted with each application. The lead firm certificate or a copy of the certificate must be readily available at the worksite for review by the contracting entity, the commissioner, and other public health officials charged with the health, safety, and welfare of the state's citizens.

Sec. 104. Minnesota Statutes 2022, section 144.9505, subdivision 1h, is amended to read:

Subd. 1h. **Certified renovation firm.** A person who performs or employs individuals to perform renovation ~~activities outside of the person's property~~ for compensation must obtain certification as a renovation firm. The certificate must be in writing, contain an expiration date, be signed by the commissioner, and give the name and address of the person to whom it is issued. A renovation firm certificate is valid for two years. The certification fee is $100, is nonrefundable, and must be submitted with each application. The renovation firm certificate or a copy of the certificate must be readily available at the worksite for review by the contracting entity, the commissioner, and other public health officials charged with the health, safety, and welfare of the state's citizens.

Sec. 105. Minnesota Statutes 2022, section 144.9508, subdivision 2, is amended to read:

Subd. 2. **Regulated lead work standards and methods.** (a) The commissioner shall adopt rules establishing regulated lead work standards and methods in accordance with the provisions of this section, for lead in paint, dust, drinking water, and soil in a manner that protects public health and the environment for all residences, including residences also used for a commercial purpose, child care facilities, playgrounds, and schools.

(b) In the rules required by this section, the commissioner shall require lead hazard reduction of intact paint only if the commissioner finds that the intact paint is on a chewable or lead-dust producing surface that is a known source of actual lead exposure to a specific individual. The commissioner shall prohibit methods that disperse lead dust into the air that could accumulate to a level that would exceed the lead dust standard specified under this section. The commissioner shall work cooperatively with the commissioner of administration to determine which lead hazard reduction methods adopted under this section may be used for lead-safe practices including prohibited practices, preparation, disposal, and cleanup. The commissioner shall work cooperatively with the commissioner of the Pollution Control Agency to develop disposal procedures. In adopting rules under this section, the commissioner shall require the best available technology for regulated lead work methods, paint stabilization, and repainting.

(c) The commissioner of health shall adopt regulated lead work standards and methods for lead in bare soil in a manner to protect public health and the environment. The commissioner shall adopt a maximum standard of 100 parts of lead per million in bare soil. The commissioner shall set a soil replacement standard not to exceed 25 parts of lead per million. Soil lead hazard reduction methods shall focus on erosion control and covering of bare soil.

(d) The commissioner shall adopt regulated lead work standards and methods for lead in dust in a manner to protect the public health and environment. Dust standards shall use a weight of lead per area measure and include dust on the floor, on the window sills, and on window wells. Lead hazard reduction methods for dust shall focus on dust removal and other practices which minimize the formation of lead dust from paint, soil, or other sources.

(e) The commissioner shall adopt lead hazard reduction standards and methods for lead in drinking water both at the tap and public water supply system or private well in a manner to protect the public health and the environment. The commissioner may adopt the rules for controlling lead in drinking water as contained in Code of Federal Regulations, title 40, part 141. Drinking water lead hazard reduction methods may include an educational approach of minimizing lead exposure from lead in drinking water.

(f) The commissioner of the Pollution Control Agency shall adopt rules to ensure that removal of exterior lead-based coatings from residences and steel structures by abrasive blasting methods is conducted in a manner that protects health and the environment.

(g) All regulated lead work standards shall provide reasonable margins of safety that are consistent with more than a summary review of scientific evidence and an emphasis on overprotection rather than underprotection when the scientific evidence is ambiguous.

(h) No unit of local government shall have an ordinance or regulation governing regulated lead work standards or methods for lead in paint, dust, drinking water, or soil that require a different regulated lead work standard or method than the standards or methods established under this section.

(i) Notwithstanding paragraph (h), the commissioner may approve the use by a unit of local government of an innovative lead hazard reduction method which is consistent in approach with methods established under this section.

(j) The commissioner shall adopt rules for issuing lead orders required under section 144.9504, rules for notification of abatement or interim control activities requirements, and other rules necessary to implement sections 144.9501 to 144.9512.

(k) The commissioner shall adopt rules consistent with section 402(c)(3) of the Toxic Substances Control Act and all regulations adopted thereunder to ensure that renovation in a pre-1978 affected property ~~where a child or pregnant female resides~~ is conducted in a manner that protects health and the environment. Notwithstanding sections 14.125 and 14.128, the authority to adopt these rules does not expire.

(l) The commissioner shall adopt rules consistent with sections 406(a) and 406(b) of the Toxic Substances Control Act. Notwithstanding sections 14.125 and 14.128, the authority to adopt these rules does not expire.

Sec. 106. Minnesota Statutes 2022, section 144A.06, subdivision 2, is amended to read:

Subd. 2. **New license required; change of ownership.** (a) The commissioner of health by rule shall prescribe procedures for licensure under this section.

(b) A new license is required and the prospective licensee must apply for a license prior to operating a currently licensed nursing home. The licensee must change whenever one of the following events occur:

(1) the form of the licensee's legal entity structure is converted or changed to a different type of legal entity structure;

(2) the licensee dissolves, consolidates, or merges with another legal organization and the licensee's legal organization does not survive;

(3) within the previous 24 months, 50 percent or more of the licensee's ownership interest is transferred, whether by a single transaction or multiple transactions to:

(i) a different person or multiple different persons; or

(ii) a person or multiple persons who had less than a five percent ownership interest in the facility at the time of the first transaction; or

(4) any other event or combination of events that results in a substitution, elimination, or withdrawal of the licensee's responsibility for the facility.

Sec. 107. Minnesota Statutes 2022, section 144A.071, subdivision 2, is amended to read:

Subd. 2. **Moratorium.** (a) The commissioner of health, in coordination with the commissioner of human services, shall deny each request for new licensed or certified nursing home or certified boarding care beds except as provided in subdivision 3 or 4a, or section 144A.073. "Certified bed" means a nursing home bed or a boarding care bed certified by the commissioner of health for the purposes of the medical assistance program, under United States Code, title 42, sections 1396 et seq. Certified beds in facilities which do not allow medical assistance intake shall be deemed to be decertified for purposes of this section only.

(b) The commissioner of human services, in coordination with the commissioner of health, shall deny any request to issue a license under section 252.28 and chapter 245A to a nursing home or boarding care home, if that license would result in an increase in the medical assistance reimbursement amount.

(c) In addition, the commissioner of health must not approve any construction project whose cost exceeds $1,000,000, unless:

~~(a)~~ (1) any construction costs exceeding $1,000,000 are not added to the facility's appraised value and are not included in the facility's payment rate for reimbursement under the medical assistance program; or

~~(b)~~ (2) the project:

~~(1)~~ (i) has been approved through the process described in section 144A.073;

~~(2)~~ (ii) meets an exception in subdivision 3 or 4a;

~~(3)~~ (iii) is necessary to correct violations of state or federal law issued by the commissioner of health;

~~(4)~~ (iv) is necessary to repair or replace a portion of the facility that was damaged by fire, lightning, ground shifts, or other such hazards, including environmental hazards, provided that the provisions of subdivision 4a, clause (a), are met; or

~~(5)~~ (v) is being proposed by a licensed nursing facility that is not certified to participate in the medical assistance program and will not result in new licensed or certified beds.

(d) Prior to the final plan approval of any construction project, the commissioners of health and human services shall be provided with an itemized cost estimate for the project construction costs. If a construction project is anticipated to be completed in phases, the total estimated cost of all phases of the project shall be submitted to the commissioners and shall be considered as one construction project. Once the construction project is completed and prior to the final clearance by the commissioners, the total project construction costs for the construction project shall be submitted to the commissioners. If the final project construction cost exceeds the dollar threshold in this subdivision, the commissioner of human services shall not recognize any of the project construction costs or the related financing costs in excess of this threshold in establishing the facility's property-related payment rate.

(e) The dollar thresholds for construction projects are as follows: for construction projects other than those authorized in ~~clauses (1) to (6)~~ paragraph (c), clause (2), items (i) to (v), the dollar threshold is $1,000,000. For projects authorized after July 1, 1993, under ~~clause (1)~~ paragraph (c), clause (2), item (i), the dollar threshold is the cost estimate submitted with a proposal for an exception under section 144A.073, plus inflation as calculated according to section 256B.431, subdivision 3f, paragraph (a). For projects authorized under ~~clauses (2) to (4)~~ paragraph (c), clause (2), items (ii) to (iv), the dollar threshold is the itemized estimate project construction costs submitted to the commissioner of health at the time of final plan approval, plus inflation as calculated according to section 256B.431, subdivision 3f, paragraph (a).

(f) The commissioner of health shall adopt rules to implement this section or to amend the emergency rules for granting exceptions to the moratorium on nursing homes under section 144A.073.

(g) All construction projects approved through section 144A.073, subdivision 3, after March 1, 2020, are subject to the fair rental value property rate as described in section 256R.26.

EFFECTIVE DATE. This section is effective retroactively from March 1, 2020.

Sec. 108. Minnesota Statutes 2022, section 144A.073, subdivision 3b, is amended to read:

Subd. 3b. **Amendments to approved projects.** (a) Nursing facilities that have received approval ~~on or after July 1, 1993,~~ for exceptions to the moratorium on nursing homes through the process described in this section may request amendments to the designs of the projects by writing the commissioner within 15 months of receiving approval. Applicants shall submit supporting materials that demonstrate how the amended projects meet the criteria described in paragraph (b).

(b) The commissioner shall approve requests for amendments for projects approved ~~on or after July 1, 1993,~~ according to the following criteria:

(1) the amended project designs must provide solutions to all of the problems addressed by the original application that are at least as effective as the original solutions;

(2) the amended project designs may not reduce the space in each resident's living area or in the total amount of common space devoted to resident and family uses by more than five percent;

(3) the costs ~~recognized for reimbursement~~ of amended project designs shall be ~~the threshold amount of the original proposal as identified according to section 144A.071, subdivision 2~~ the cost estimate associated with the project as originally approved, except under conditions described in clause (4); and

(4) total costs ~~up to ten percent greater than the cost identified in clause (3) may be recognized for reimbursement if~~ of the amendment are no greater than ten percent of the cost estimate associated with the project as initially approved if the proposer can document that one of the following circumstances is true:

(i) changes are needed due to a natural disaster;

(ii) conditions that affect the safety or durability of the project that could not have reasonably been known prior to approval are discovered;

(iii) state or federal law require changes in project design; or

(iv) documentable circumstances occur that are beyond the control of the owner and require changes in the design.

(c) Approval of a request for an amendment does not alter the expiration of approval of the project according to subdivision 3.

(d) Reimbursement for amendments to approved projects is independent of the actual construction costs and based on the allowable appraised value of the completed project. An approved project may not be amended to reduce the scope of an approved project.

EFFECTIVE DATE. This section is effective retroactively from March 1, 2020.

Sec. 109. Minnesota Statutes 2022, section 144A.474, subdivision 3, is amended to read:

Subd. 3. **Survey process.** The survey process for core surveys shall include the following as applicable to the particular licensee and setting surveyed:

(1) presurvey review of pertinent documents and notification to the ombudsman for long-term care;

(2) an entrance conference with available staff;

(3) communication with managerial officials or the registered nurse in charge, if available, and ongoing communication with key staff throughout the survey regarding information needed by the surveyor, clarifications regarding home care requirements, and applicable standards of practice;

(4) presentation of written contact information to the provider about the survey staff conducting the survey, the supervisor, and the process for requesting a reconsideration of the survey results;

(5) a brief tour of ~~a sample of~~ the ~~housing with services establishments~~ establishment in which the provider is providing home care services;

(6) a sample selection of home care clients;

(7) information-gathering through client and staff observations, client and staff interviews, and reviews of records, policies, procedures, practices, and other agency information;

(8) interviews of clients' family members, if available, with clients' consent when the client can legally give consent;

(9) except for complaint surveys conducted by the Office of Health Facilities Complaints, an ~~on-site~~ exit conference~~,~~ with preliminary findings ~~shared and~~ discussed with the provider within one business day after completion of survey activities, ~~documentation that an exit conference occurred,~~ and with written information provided on the process for requesting a reconsideration of the survey results; and

(10) postsurvey analysis of findings and formulation of survey results, including correction orders when applicable.

Sec. 110. Minnesota Statutes 2022, section 144A.474, subdivision 9, is amended to read:

Subd. 9. **Follow-up surveys.** For providers that have Level 3 or Level 4 violations under subdivision 11, ~~or any violations determined to be widespread,~~ the department shall conduct a follow-up survey within 90 calendar days of the survey. When conducting a follow-up survey, the surveyor will focus on whether the previous violations have been corrected and may also address any new violations that are observed while evaluating the corrections that have been made.

Sec. 111. Minnesota Statutes 2022, section 144A.474, subdivision 12, is amended to read:

Subd. 12. **Reconsideration.** (a) The commissioner shall make available to home care providers a correction order reconsideration process. This process may be used to challenge the correction order issued, including the level and scope described in subdivision 11, and any fine assessed. During the correction order reconsideration request, the issuance for the correction orders under reconsideration are not stayed, but the department shall post information on the website with the correction order that the licensee has requested a reconsideration and that the review is pending.

(b) A licensed home care provider may request from the commissioner, in writing, a correction order reconsideration regarding any correction order issued to the provider. The written request for reconsideration must be received by the commissioner within 15 ~~calendar~~ business days of the correction order receipt date. The correction order reconsideration shall not be reviewed by any surveyor, investigator, or supervisor that participated in the writing or reviewing of the correction order being disputed. The correction order reconsiderations may be conducted in person, by telephone, by another electronic form, or in writing, as determined by the commissioner. The commissioner shall respond in writing to the request from a home care provider for a correction order reconsideration within 60 days of the date the provider requests a reconsideration. The commissioner's response shall identify the commissioner's decision regarding each citation challenged by the home care provider.

(c) The findings of a correction order reconsideration process shall be one or more of the following:

(1) supported in full, the correction order is supported in full, with no deletion of findings to the citation;

(2) supported in substance, the correction order is supported, but one or more findings are deleted or modified without any change in the citation;

(3) correction order cited an incorrect home care licensing requirement, the correction order is amended by changing the correction order to the appropriate statutory reference;

(4) correction order was issued under an incorrect citation, the correction order is amended to be issued under the more appropriate correction order citation;

(5) the correction order is rescinded;

(6) fine is amended, it is determined that the fine assigned to the correction order was applied incorrectly; or

(7) the level or scope of the citation is modified based on the reconsideration.

(d) If the correction order findings are changed by the commissioner, the commissioner shall update the correction order website.

(e) This subdivision does not apply to temporary licensees.

Sec. 112. Minnesota Statutes 2022, section 144A.4791, subdivision 10, is amended to read:

Subd. 10. **Termination of service plan.** (a) If a home care provider terminates a service plan with a client, and the client continues to need home care services, the home care provider shall provide the client and the client's representative, if any, with a written notice of termination which includes the following information:

(1) the effective date of termination;

(2) the reason for termination;

(3) a statement that the client may contact the Office of Ombudsman for Long-Term Care to request an advocate to assist regarding the termination and contact information for the office, including the office's central telephone number;

~~(3)~~ (4) a list of known licensed home care providers in the client's immediate geographic area;

~~(4)~~ (5) a statement that the home care provider will participate in a coordinated transfer of care of the client to another home care provider, health care provider, or caregiver, as required by the home care bill of rights, section 144A.44, subdivision 1, clause (17);

~~(5)~~ (6) the name and contact information of a person employed by the home care provider with whom the client may discuss the notice of termination; and

~~(6)~~ (7) if applicable, a statement that the notice of termination of home care services does not constitute notice of termination of ~~the housing with services contract with a housing with services establishment~~ any housing contract.

(b) When the home care provider voluntarily discontinues services to all clients, the home care provider must notify the commissioner, lead agencies, and ombudsman for long-term care about its clients and comply with the requirements in this subdivision.

Sec. 113. Minnesota Statutes 2022, section 144G.16, subdivision 7, is amended to read:

Subd. 7. **Fines and penalties.** (a) The ~~fee~~ fine for failure to comply with the notification requirements in section 144G.52, subdivision 7, is $1,000.

(b) Fines and penalties collected under this section shall be deposited in a dedicated special revenue account. On an annual basis, the balance in the special revenue account shall be appropriated to the commissioner to implement the recommendations of the advisory council established in section 144A.4799.

Sec. 114. Minnesota Statutes 2022, section 144G.18, is amended to read:

144G.18 NOTIFICATION OF CHANGES IN INFORMATION.

Subdivision 1. **Notification.** A provisional licensee or licensee shall notify the commissioner in writing prior to a change in the manager or authorized agent and within 60 calendar days after any change in the information required in section 144G.12, subdivision 1, clause (1), (3), (4), (17), or (18).

Subd. 2. **Fines and penalties.** (a) The fine for failure to comply with the notification requirements of this section is $1,000.

(b) Fines and penalties collected under this subdivision shall be deposited in a dedicated special revenue account. On an annual basis, the balance in the special revenue account shall be appropriated to the commissioner to implement the recommendations of the advisory council established in section 144A.4799.

Sec. 115. Minnesota Statutes 2022, section 144G.57, subdivision 8, is amended to read:

Subd. 8. ~~**Fine**~~ **Fines and penalties.** (a) The commissioner may impose a fine for failure to follow the requirements of this section.

(b) The fine for failure to comply with this section is $1,000.

(c) Fines and penalties collected under this section shall be deposited in a dedicated special revenue account. On an annual basis, the balance in the special revenue account shall be appropriated to the commissioner to implement the recommendations of the advisory council established in section 144A.4799.

Sec. 116. Minnesota Statutes 2022, section 145.411, subdivision 1, is amended to read:

Subdivision 1. **Terms.** As used in sections 145.411 to ~~145.416~~ 145.414, the terms defined in this section have the meanings given to them.

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

Sec. 117. Minnesota Statutes 2022, section 145.411, subdivision 5, is amended to read:

Subd. 5. **Abortion.** "Abortion" includes an act, procedure or use of any instrument, medicine or drug which is supplied or prescribed for or administered to ~~a pregnant woman~~ an individual with the intention of terminating, and which results in the termination of, pregnancy.

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

Sec. 118. Minnesota Statutes 2022, section 145.423, subdivision 1, is amended to read:

Subdivision 1. **Recognition; ~~medical~~ care.** ~~A born alive~~ An infant ~~as a result of an abortion~~ who is born alive shall be fully recognized as a human person, and accorded immediate protection under the law. All reasonable measures consistent with good medical practice, including the compilation of appropriate medical records, shall be taken by the responsible medical personnel to ~~preserve the life and health of the born alive infant~~ care for the infant who is born alive.

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

Sec. 119. **[145.561] 988 SUICIDE AND CRISIS LIFELINE.**

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

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

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

(d) "988" means the universal telephone number designated as the universal telephone number within the United States for the purpose of the national suicide prevention and

mental health crisis hotline system operating through the 988 Suicide and Crisis Lifeline, or its successor, maintained by the Assistant Secretary for Mental Health and Substance Use under section 520E-3 of the Public Health Service Act (United States Code, title 42, sections 290bb-36c).

(e) "988 administrator" means the administrator of the national 988 Suicide and Crisis Lifeline maintained by the Assistant Secretary for Mental Health and Substance Use under section 520E-3 of the Public Health Service Act.

(f) "988 contact" means a communication with the 988 Suicide and Crisis Lifeline system within the United States via modalities offered including call, chat, or text.

(g) "988 Lifeline Center" means a state-identified center that is a member of the Suicide and Crisis Lifeline network that responds to statewide or regional 988 contacts.

(h) "988 Suicide and Crisis Lifeline" or "988 Lifeline" means the national suicide prevention and mental health crisis hotline system maintained by the Assistant Secretary for Mental Health and Substance Use under section 520E-3 of the Public Health Service Act (United States Code, title 42, sections 290bb-36c).

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

Subd. 2. **988 Lifeline.** (a) The commissioner shall administer the designation of and oversight for a 988 Lifeline center or a network of 988 Lifeline centers to answer contacts from individuals accessing the Suicide and Crisis Lifeline from any jurisdiction within the state 24 hours per day, seven days per week.

(b) The designated 988 Lifeline Center must:

(1) have an active agreement with the 988 Suicide and Crisis Lifeline program for participation in the network and the department;

(2) meet the 988 Lifeline program requirements and best practice guidelines for operational and clinical standards;

(3) provide data and reports, and participate in evaluations and related quality improvement activities as required by the 988 Lifeline program and the department;

(4) identify or adapt technology that is demonstrated to be interoperable across Mobile Crisis and Public Safety Answering Points used in the state for the purpose of crisis care coordination;

(5) facilitate crisis and outgoing services, including mobile crisis teams in accordance with guidelines established by the 988 Lifeline program and the department;

(6) actively collaborate and coordinate service linkages with mental health and substance use disorder treatment providers, local community mental health centers including certified community behavioral health clinics and community behavioral health centers, mobile crisis teams, and community based and hospital emergency departments;

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

(8) meet the requirements set by the 988 Lifeline program and the department for serving at-risk and specialized populations.

(c) The department shall adopt rules and regulations to allow appropriate information sharing and communication between and across crisis and emergency response systems.

(d) The department, having primary oversight of suicide prevention, shall work with the 988 Lifeline program, veterans crisis line, and other SAMHSA-approved networks for the purpose of ensuring consistency of public messaging about 988 services. The department may use funds under this section or provide grants to organizations in order to publicize and raise awareness about 988 services.

(e) The department shall work with representatives from 988 Lifeline Centers and public safety answering points, other public safety agencies, and the commissioner of public safety to facilitate the development of protocols and procedures for interactions between 988 and 911 services across Minnesota. Protocols and procedures shall be developed following available national standards and guidelines.

(f) The department shall provide an annual report of the 988 Lifeline usage including answer rates, abandoned calls, and referrals to 911 emergency response.

Subd. 3. **988 special revenue account established.** (a) There is established a dedicated account in the special revenue fund to create and maintain a statewide 988 suicide and crisis lifeline system pursuant to the National Suicide Hotline Designation Act of 2020, the Federal Communications Commission's rules adopted July 16, 2020, and national guidelines for crisis care.

(b) The account shall consist of:

(1) a 988 telecommunications fee imposed under this section;

(2) a prepaid wireless 988 fee imposed under section 403.161;

(3) appropriations made by the state legislature;

(4) grants and gifts intended for deposit;

(5) interest, premiums, gains, or other earnings on the account; and

(6) money from any other source that is deposited in or transferred to the account.

(c) The account shall be administered by the department, and money in the account shall be expended to offset costs that are or can be reasonably attributed to:

(1) implementing, maintaining, and improving the 988 suicide and crisis lifeline including staffing and technological infrastructure enhancements necessary to achieve operational standards and best practices set by the 988 lifeline and the department;

(2) personnel for 988 lifeline centers;

(3) data collection, reporting, participation in evaluations, public promotion, and related quality improvement activities as required by the 988 administrator and the department; and

(4) administration, oversight, and evaluation of the account.

(d) Money in the fund:

(1) does not revert at the end of any state fiscal year but remains available for the purposes of the account in subsequent state fiscal years;

(2) is not subject to transfer to any other fund or to transfer, assignment, or reassignment for any other use or purpose; and

(3) is continuously appropriated to the commissioner for the purposes of the account.

(e) An annual report of funds, deposits, and expenditures shall be made to the Federal Communications Commission.

Subd. 4. **988 telecommunication fee.** (a) In compliance with the National Suicide Hotline Designation Act of 2020, the department shall impose a monthly statewide fee on each subscriber of a wireline, wireless, and IP-enabled voice service at a rate that provides for the robust creation, operation, and maintenance of a statewide 988 suicide prevention and crisis system.

(b) The commissioner shall annually recommend to the Public Utilities Commission an adequate and appropriate fee to implement this section. The commissioner shall provide telecommunication service providers and carriers a minimum of 30 days' notice of each fee change.

(c) The amount of the 988 telecommunication fee must not be less than 12 cents and no more than 25 cents a month on or after January 1, 2024, for each consumer access line, including trunk equivalents as designated by the commission pursuant to section 403.11, subdivision 1. The 988 telecommunication fee must be the same for all subscribers.

(d) Each wireline, wireless, and IP-enabled voice telecommunications service provider shall collect the 988 telecommunication fee and transfer the amounts collected to the commissioner of public safety in the same manner as provided in section 403.11, subdivision 1, paragraph (d).

(e) The commissioner of public safety shall deposit the money collected from the 988 telecommunication fee to the 988 account to be expended only in support of 988 services, or enhancements of such services.

(f) Consistent with United States Code, title 47, section 251(a), the revenue generated by a 988 telecommunication fee must only be used to offset costs that are or will be reasonably attributed to:

(1) ensuring the efficient and effective routing and handling of calls, chats, and texts made to the 988 Lifeline centers including staffing and technological infrastructure enhancements necessary to achieve operational, performance, and clinical standards and best practices set by the 988 Lifeline program and the department; and

(2) personnel and providing acute mental health and crisis outreach services by directly responding to the 988 Suicide and Crisis Lifeline.

(g) All 988 telecommunication fee revenue must be used to supplement, not supplant, any federal, state, or local funding for suicide prevention.

(h) The 988 telecommunication fee amount shall be adjusted as needed to provide for continuous operation, volume increases, and maintenance of the 988 service.

(i) The commissioner shall report on revenue generated by the 988 telecommunication fee to the Federal Communications Commission.

Subd. 5. **988 fee for prepaid wireless telecommunications services.** (a) The 988 telecommunication fee established in subdivision 4 does not apply to prepaid wireless telecommunications services. Prepaid wireless telecommunications services are subject to the prepaid wireless 988 fee established in section 403.161, subdivision 1, paragraph (c).

(b) Collection, remittance, and deposit of prepaid wireless 988 fees are governed by sections 403.161 and 403.162.

Sec. 120. Minnesota Statutes 2022, section 145.87, subdivision 4, is amended to read:

Subd. 4. ~~**Administrative costs**~~ **Administration.** 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.

Sec. 121. **[145.875] HOME VISITING FOR PRIORITY POPULATIONS.**

Subdivision 1. **Establishment; priority populations.** The commissioner of health shall administer a program to expand home visiting services for priority populations. The commissioner shall determine priority populations based on the most recent maternal and child health data, including the statewide Maternal, Infant, and Early Childhood Home Visiting needs assessment.

Subd. 2. **Grants.** The commissioner shall award competitive grants under this section to community health boards, Tribal governments, and nonprofit organizations. Grant funds must be used to start up or expand home visiting programs in the county, reservation, or region to serve families in priority populations. Grant recipients must prioritize provision of services to priority populations such as parents at high risk or with high needs, parents with a history of mental illness, domestic abuse, or substance abuse, children with special health care needs, and families experiencing or at risk for homelessness. Priority for grants may be given to programs enrolling families with a child aged two to four years old.

Subd. 3. **Technical assistance and evaluation.** The commissioner shall provide technical assistance and training to grant recipients on promising practices and shall evaluate results.

Sec. 122. **[145.903] SCHOOL-BASED HEALTH CENTERS.**

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

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

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

(1) health care providers;

(2) community clinics;

(3) hospitals;

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

(5) health care foundations or nonprofit organizations;

(6) higher education institutions; or

(7) local health departments.

Subd. 2. **Expansion of Minnesota school-based health centers.** (a) The commissioner of health shall administer a program to provide grants to school districts and school-based health centers to support existing centers and facilitate the growth of school-based health centers in Minnesota.

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

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

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

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

(c) The commissioner of health shall administer a grant to a nonprofit organization to facilitate a community of practice among school-based health centers to improve quality, equity, and sustainability of care delivered through school-based health centers; encourage cross-sharing among school-based health centers; support existing clinics; and expand school-based health centers in new communities in Minnesota.

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

(e) The commissioners of health and of education shall coordinate the projects and initiatives funded under this section with other efforts at the local, state, or national level to avoid duplication and promote coordinated efforts.

Subd. 3. **School-based health center services.** Services provided by a school-based health center may include but are not limited to:

(1) preventive health care;

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

(3) mental health care and crisis management;

(4) acute care for illness and injury;

(5) oral health care;

(6) vision care;

(7) nutritional counseling;

(8) substance abuse counseling;

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

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

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

Subd. 4. **Sponsoring organizations.** A sponsoring organization that agrees to operate a school-based health center must enter into a memorandum of agreement with the school or school district. The memorandum of agreement must require the sponsoring organization to be financially responsible for the operation of school-based health centers in the school or school district and must identify the costs that are the responsibility of the school or school district, such as Internet access, custodial services, utilities, and facility maintenance. To the greatest extent possible, a sponsoring organization must bill private insurers, medical assistance, and other public programs for services provided in the school-based health centers in order to maintain the financial sustainability of school-based health centers.

Sec. 123. Minnesota Statutes 2022, section 145.924, is amended to read:

145.924 ~~AIDS~~ HIV PREVENTION GRANTS.

(a) The commissioner may award grants to community health boards as defined in section 145A.02, subdivision 5, state agencies, state councils, or nonprofit corporations to provide evaluation and counseling services to populations at risk for acquiring human immunodeficiency virus infection, including, but not limited to, ~~minorities~~ communities of color, adolescents, ~~intravenous drug users~~ women, people who inject drugs, and ~~homosexual men~~ gay, bisexual, and transgender individuals.

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

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

(d) The commissioner shall administer a grant program to provide funds to organizations, including Tribal health agencies, to assist with HIV/AIDS outbreaks.

Sec. 124. Minnesota Statutes 2022, section 145.925, is amended to read:

145.925 ~~FAMILY PLANNING~~ SEXUAL AND REPRODUCTIVE HEALTH SERVICES GRANTS.

Subdivision 1. **~~Eligible organizations; purpose~~ Goal and establishment.** ~~The commissioner of health may make special grants to cities, counties, groups of cities or counties, or nonprofit corporations to provide prepregnancy family planning services.~~ (a) It is the goal of the state to increase access to sexual and reproductive health services for people who experience barriers, whether geographic, cultural, financial, or other, in access to such services. The commissioner of health shall administer grants to facilitate access to sexual and reproductive health services for people of reproductive age, particularly those from populations that experience barriers to these services.

(b) The commissioner of health shall coordinate with other efforts at the local, state, or national level to avoid duplication and promote complementary efforts in sexual and reproductive health service promotion among people of reproductive age.

~~Subd. 1a. **Family planning services; defined.** "Family planning services" means counseling by trained personnel regarding family planning; distribution of information~~

~~relating to family planning, referral to licensed physicians or local health agencies for consultation, examination, medical treatment, genetic counseling, and prescriptions for the purpose of family planning; and the distribution of family planning products, such as charts, thermometers, drugs, medical preparations, and contraceptive devices. For purposes of sections 145A.01 to 145A.14, family planning shall mean voluntary action by individuals to prevent or aid conception but does not include the performance, or make referrals for encouragement of voluntary termination of pregnancy.~~

~~Subd. 2.~~ **~~Prohibition.~~** ~~The commissioner shall not make special grants pursuant to this section to any nonprofit corporation which performs abortions. No state funds shall be used under contract from a grantee to any nonprofit corporation which performs abortions. This provision shall not apply to hospitals licensed pursuant to sections 144.50 to 144.56, or health maintenance organizations certified pursuant to chapter 62D.~~

Subd. 2a. **Sexual and reproductive health services defined.** For purposes of this section, "sexual and reproductive health services" means services that promote a state of complete physical, mental, and social well-being in relation to sexuality and reproduction, and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and its functions and processes, and to sexuality. These services must be provided in accord with nationally recognized standards and include but are not limited to sexual and reproductive health counseling, voluntary and informed decision-making on sexual and reproductive health, information on and provision of contraceptive methods, sexual and reproductive health screenings and treatment, pregnancy testing and counseling, and other preconception services.

Subd. 3. ~~**Minors**~~ **Grants authorized.** ~~No funds provided by grants made pursuant to this section shall be used to support any family planning services for any unemancipated minor in any elementary or secondary school building.~~ (a) The commissioner of health shall award grants to eligible community organizations, including nonprofit organizations, community health boards, and Tribal communities in rural and metropolitan areas of the state to support, sustain, expand, or implement reproductive and sexual health programs for people of reproductive age to increase access to and availability of medically accurate sexual and reproductive health services.

(b) The commissioner of health shall establish application scoring criteria in the evaluation of applications submitted for award under this section. These criteria shall include but are not limited to the degree to which applicants' programming responds to demographic factors relevant to subdivision 1, paragraph (a), and paragraph (f).

(c) When determining whether to award a grant or the amount of a grant under this section, the commissioner of health may identify and stratify geographic regions based on the region's need for sexual and reproductive health services. In this stratification, the commissioner may consider data on the prevalence of poverty and other factors relevant to a geographic region's need for sexual and reproductive health services.

(d) The commissioner of health may consider geographic and Tribal communities' representation in the award of grants.

(e) Current recipients of funding under this section shall not be afforded priority over new applicants.

(f) Grant funds shall be used to support new or existing sexual and reproductive health programs that provide person-centered, accessible services; that are culturally and linguistically appropriate, inclusive of all people, and trauma-informed; that protect the dignity of the individual; and that ensure equitable, quality services consistent with nationally recognized standards of care. These services shall include:

(1) education and outreach on medically accurate sexual and reproductive health information;

(2) contraceptive counseling, provision of contraceptive methods, and follow-up;

(3) screening, testing, and treatment of sexually transmitted infections and other sexual or reproductive concerns; and

(4) referral and follow-up for medical, financial, mental health, and other services in accord with a service recipient's needs.

~~Subd. 4. **Parental notification.** Except as provided in sections 144.341 and 144.342, any person employed to provide family planning services who is paid in whole or in part from funds provided under this section who advises an abortion or sterilization to any unemancipated minor shall, following such a recommendation, so notify the parent or guardian of the reasons for such an action.~~

~~Subd. 5. **Rules.** The commissioner of health shall promulgate rules for approval of plans and budgets of prospective grant recipients, for the submission of annual financial and statistical reports, and the maintenance of statements of source and application of funds by grant recipients. The commissioner of health may not require that any home rule charter or statutory city or county apply for or receive grants under this subdivision as a condition for the receipt of any state or federal funds unrelated to family planning services.~~

Subd. 6. **Public services; individual ~~and employee~~ rights.** The request of any person for ~~family planning~~ sexual and reproductive health services or the refusal to accept any service shall in no way affect the right of the person to receive public assistance, public health services, or any other public service. Nothing in this section shall abridge the right of the ~~individual~~ person to make decisions concerning ~~family planning~~ sexual and reproductive health, nor shall any ~~individual~~ person be required to state a reason for refusing any offer of ~~family planning~~ sexual and reproductive health services.

~~Any employee of the agencies engaged in the administration of the provisions of this section may refuse to accept the duty of offering family planning services to the extent that the duty is contrary to personal beliefs. A refusal shall not be grounds for dismissal, suspension, demotion, or any other discrimination in employment. The directors or supervisors of the agencies shall reassign the duties of employees in order to carry out the provisions of this section.~~

All information gathered by any agency, entity, or individual conducting programs in ~~family planning~~ sexual and reproductive health is private data on individuals within the meaning of section 13.02, subdivision 12. For any person or entity meeting the definition of a "provider" under section 144.291, subdivision 2, paragraph (i), all sexual and reproductive health services information provided to, gathered about, or received from a person under this section is also subject to the Minnesota Health Records Act, in sections 144.291 to 144.298.

~~Subd. 7. **Family planning services; information required.** A grant recipient shall inform any person requesting counseling on family planning methods or procedures of:~~

~~(1) Any methods or procedures which may be followed, including identification of any which are experimental or any which may pose a health hazard to the person;~~

~~(2) A description of any attendant discomforts or risks which might reasonably be expected;~~

~~(3) A fair explanation of the likely results, should a method fail;~~

~~(4) A description of any benefits which might reasonably be expected of any method;~~

~~(5) A disclosure of appropriate alternative methods or procedures;~~

~~(6) An offer to answer any inquiries concerning methods of procedures; and~~

~~(7) An instruction that the person is free either to decline commencement of any method or procedure or to withdraw consent to a method or procedure at any reasonable time.~~

~~Subd. 8. **Coercion; penalty.** Any person who receives compensation for services under any program receiving financial assistance under this section, who coerces or endeavors to coerce any person to undergo an abortion or sterilization procedure by threatening the person with the loss of or disqualification for the receipt of any benefit or service under a program receiving state or federal financial assistance shall be guilty of a misdemeanor.~~

~~Subd. 9. **Amount of grant; rules.** Notwithstanding any rules to the contrary, including rules proposed in the State Register on April 1, 1991, the commissioner, in allocating grant funds for family planning special projects, shall not limit the total amount of funds that can be allocated to an organization. The commissioner shall allocate to an organization receiving grant funds on July 1, 1997, at least the same amount of grant funds for the 1998 to 1999 grant cycle as the organization received for the 1996 to 1997 grant cycle, provided the organization submits an application that meets grant funding criteria. This subdivision does not affect any procedure established in rule for allocating special project money to the different regions. The commissioner shall revise the rules for family planning special project grants so that they conform to the requirements of this subdivision. In adopting these revisions, the commissioner is not subject to the rulemaking provisions of chapter 14, but is bound by section 14.386, paragraph (a), clauses (1) and (3). Section 14.386, paragraph (b), does not apply to these rules.~~

Sec. 125. **[145.9257] COMMUNITY SOLUTIONS FOR HEALTHY CHILD DEVELOPMENT GRANT PROGRAM.**

Subdivision 1. **Establishment.** The commissioner of health shall establish a grant program to improve child development outcomes and the well-being of children of color and American Indian children from prenatal to grade 3 and their families. The purposes of the program are to:

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

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

(3) promote racial and geographic equity.

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

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

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

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

(4) ensure communication with the ethnic councils, Minnesota Indian Affairs Council, and the State Advisory Council on Early Childhood Education and Care on the request for proposal process;

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

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

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

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

Subd. 3. **Community solutions advisory council; establishment; duties; compensation.** (a) No later than October 1, 2023, the commissioner shall have convened a 12-member community solutions advisory council as follows:

(1) two members representing the African Heritage community;

(2) two members representing the Latino community;

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

(4) two members representing the American Indian community;

(5) two parents of children who are under nine years of age and are Black, nonwhite people of color, or American Indian;

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

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

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

(c) The community solutions advisory council shall:

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

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

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

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

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

(d) Each advisory council member shall be compensated in accordance with section 15.059, subdivision 3.

Subd. 4. **Eligible grantees.** Organizations eligible to receive grant funding under this section include: (1) organizations or entities that work with Black, non-white communities of color, and American Indian communities;

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

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

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

are Black, nonwhite people of color, or American Indian from prenatal to grade 3 and their families.

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

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

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

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

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

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

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

The advisory council may recommend additional strategic considerations and priorities to the commissioner.

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

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

Sec. 126. **[145.9272] LEAD REMEDIATION IN SCHOOL AND CHILD CARE SETTINGS GRANT PROGRAM.**

Subdivision 1. **Establishment; purpose.** The commissioner of health shall develop a grant program for the purpose of remediating identified sources of lead in drinking water in schools and licensed child care settings.

Subd. 2. **Grants authorized.** The commissioner shall award grants through a request for proposals process to schools and licensed child care settings. Priority shall be given to

schools and licensed child care settings with higher levels of lead detected in water samples, evidence of lead service lines, or lead plumbing materials and school districts that serve disadvantaged communities.

Subd. 3. **Grant allocation.** Grantees must use the funds to address sources of lead contamination in their facilities including but not limited to service connections and premise plumbing, and to implement best practices for water management within the building.

Sec. 127. **[145.9273] TESTING FOR LEAD IN DRINKING WATER IN CHILD CARE SETTINGS.**

Subdivision 1. **Requirement to test.** By July 1, 2024, licensed child care providers must develop a plan to accurately and efficiently test for the presence of lead in drinking water in child care facilities following either the Department of Health's document "Reducing Lead in Drinking Water: A Technical Guidance for Minnesota's School and Child Care Facilities" or the Environmental Protection Agency's "3Ts: Training, Testing, Taking Action" guidance materials.

Subd. 2. **Scope and frequency of testing.** The plan under subdivision 1 must include testing every building serving children and all water fixtures used for consumption of water, including water used in food preparation. All taps must be tested at least once every five years. A licensed child care provider must begin testing in buildings by July 1, 2024, and complete testing in all buildings that serve students within five years.

Subd. 3. **Remediation of lead in drinking water.** The plan under subdivision 1 must include steps to remediate if lead is present in drinking water. A licensed child care provider that finds lead at concentrations at or exceeding five parts per billion at a specific location providing water to children within its facilities must take action to reduce lead exposure following guidance and verify the success of remediation by retesting the location for lead. Remediation actions are actions that reduce lead levels from the drinking water fixture as demonstrated by testing. This includes using certified filters, implementing, and documenting a building-wide flushing program, and replacing or removing fixtures with elevated lead levels.

Subd. 4. **Reporting results.** (a) A licensed child care provider that tested its buildings for the presence of lead shall make the results of the testing and any remediation steps taken available to parents and staff and notify them of the availability of results. Reporting shall occur no later than 30 days from receipt of results and annually thereafter.

(b) Beginning July 1, 2024, a licensed child care provider must report the provider's test results and remediation activities to the commissioner of health annually on or before July 1 of each year.

Sec. 128. **[145.987] HEALTH EQUITY ADVISORY AND LEADERSHIP (HEAL) COUNCIL.**

Subdivision 1. **Establishment; composition of advisory council.** The commissioner shall establish and appoint a health equity advisory and leadership (HEAL) council to provide guidance to the commissioner of health regarding strengthening and improving the health of communities most impacted by health inequities across the state. The council shall consist of 18 members who will provide representation from the following groups:

(1) African American and African heritage communities;

(2) Asian American and Pacific Islander communities;

(3) Latina/o/x communities;

(4) American Indian communities and Tribal governments and nations;

(5) disability communities;

(6) lesbian, gay, bisexual, transgender, and queer (LGBTQ) communities; and

(7) representatives who reside outside the seven-county metropolitan area.

Subd. 2. **Organization and meetings.** The advisory council shall be organized and administered under section 15.059. Meetings shall be held at least quarterly and hosted by the department. Subcommittees may be convened as necessary. Advisory council meetings are subject to the open meeting law under chapter 13D.

Subd. 3. **Duties.** The advisory council shall:

(1) advise the commissioner on health equity issues and the health equity priorities and concerns of the populations specified in subdivision 1;

(2) assist the agency in efforts to advance health equity, including consulting on specific agency policies and programs, providing ideas and input about potential budget and policy proposals, and recommending review of agency policies, standards, or procedures that may create or perpetuate health inequities; and

(3) assist the agency in developing and monitoring meaningful performance measures related to advancing health equity.

Subd. 4. **Expiration.** The advisory council shall remain in existence until health inequities in the state are eliminated. Health inequities will be considered eliminated when race, ethnicity, income, gender, gender identity, geographic location, or other identity or social marker will no longer be predictors of health outcomes in the state. Section 145.928 describes nine health disparities that must be considered when determining whether health inequities have been eliminated in the state.

Sec. 129. Minnesota Statutes 2022, section 145A.131, subdivision 1, is amended to read:

Subdivision 1. **Funding formula for community health boards.** (a) Base funding for each community health board eligible for a local public health grant under section 145A.03, subdivision 7, shall be determined by each community health board's fiscal year 2003 allocations, prior to unallotment, for the following grant programs: community health services subsidy; state and federal maternal and child health special projects grants; family home visiting grants; TANF MN ENABL grants; TANF youth risk behavior grants; and available women, infants, and children grant funds in fiscal year 2003, prior to unallotment, distributed based on the proportion of WIC participants served in fiscal year 2003 within the CHS service area.

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

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

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

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

(f) Funding for foundational public health responsibilities must be distributed based on a formula determined by the commissioner in consultation with the State Community Health Services Advisory Committee. A portion of these funds may be used to fund new organizational models, including multijurisdictional and regional partnerships. These funds shall be used in accordance with subdivision 5.

Sec. 130. Minnesota Statutes 2022, section 145A.131, subdivision 5, is amended to read:

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

(b) Funding for foundational public health responsibilities as outlined in subdivision 1, paragraph (f), must be used to fulfill foundational public health responsibilities as defined by the commissioner in consultation with the State Community Health Services Advisory Committee unless a community health board can demonstrate fulfillment of foundational public health responsibilities. If a community health board can demonstrate foundational public health responsibilities are fulfilled, funds may be used for local priorities developed through the community health assessment and community health improvement planning process.

(c) By July 1, 2028, all local public health grant funds must be used first to fulfill foundational public health responsibilities. Once a community health board can demonstrate foundational public health responsibilities are fulfilled, funds can be used for local priorities developed through the community health assessment and community health improvement planning process.

Sec. 131. Minnesota Statutes 2022, section 145A.14, is amended by adding a subdivision to read:

Subd. 2b. **Grants to Tribes.** The commissioner shall distribute grants to Tribal governments for foundational public health responsibilities as defined by each Tribal government.

Sec. 132. Minnesota Statutes 2022, section 147A.08, is amended to read:

147A.08 EXEMPTIONS.

(a) This chapter does not apply to, control, prevent, or restrict the practice, service, or activities of persons listed in section 147.09, clauses (1) to (6) and (8) to (13)~~,~~; persons

regulated under section 214.01, subdivision 2~~,~~; or ~~persons~~ midlevel practitioners, nurses, or nurse-midwives as defined in section 144.1501, subdivision 1~~, paragraphs (i), (k), and (l)~~.

(b) Nothing in this chapter shall be construed to require licensure of:

(1) a physician assistant student enrolled in a physician assistant educational program accredited by the Accreditation Review Commission on Education for the Physician Assistant or by its successor agency approved by the board;

(2) a physician assistant employed in the service of the federal government while performing duties incident to that employment; or

(3) technicians, other assistants, or employees of physicians who perform delegated tasks in the office of a physician but who do not identify themselves as a physician assistant.

Sec. 133. Minnesota Statutes 2022, section 148.261, subdivision 1, is amended to read:

Subdivision 1. **Grounds listed.** The board may deny, revoke, suspend, limit, or condition the license and registration of any person to practice advanced practice, professional, or practical nursing under sections 148.171 to 148.285, or to otherwise discipline a licensee or applicant as described in section 148.262. The following are grounds for disciplinary action:

(1) Failure to demonstrate the qualifications or satisfy the requirements for a license contained in sections 148.171 to 148.285 or rules of the board. In the case of a person applying for a license, the burden of proof is upon the applicant to demonstrate the qualifications or satisfaction of the requirements.

(2) Employing fraud or deceit in procuring or attempting to procure a permit, license, or registration certificate to practice advanced practice, professional, or practical nursing or attempting to subvert the licensing examination process. Conduct that subverts or attempts to subvert the licensing examination process includes, but is not limited to:

(i) conduct that violates the security of the examination materials, such as removing examination materials from the examination room or having unauthorized possession of any portion of a future, current, or previously administered licensing examination;

(ii) conduct that violates the standard of test administration, such as communicating with another examinee during administration of the examination, copying another examinee's answers, permitting another examinee to copy one's answers, or possessing unauthorized materials; or

(iii) impersonating an examinee or permitting an impersonator to take the examination on one's own behalf.

(3) Conviction of a felony or gross misdemeanor reasonably related to the practice of professional, advanced practice registered, or practical nursing. Conviction as used in this subdivision includes a conviction of an offense that if committed in this state would be considered a felony or gross misdemeanor without regard to its designation elsewhere, or a criminal proceeding where a finding or verdict of guilt is made or returned but the adjudication of guilt is either withheld or not entered.

(4) Revocation, suspension, limitation, conditioning, or other disciplinary action against the person's professional or practical nursing license or advanced practice registered nursing credential, in another state, territory, or country; failure to report to the board that charges regarding the person's nursing license or other credential are pending in another state, territory, or country; or having been refused a license or other credential by another state, territory, or country.

(5) Failure to or inability to perform professional or practical nursing as defined in section 148.171, subdivision 14 or 15, with reasonable skill and safety, including failure of a registered nurse to supervise or a licensed practical nurse to monitor adequately the performance of acts by any person working at the nurse's direction.

(6) Engaging in unprofessional conduct, including, but not limited to, a departure from or failure to conform to board rules of professional or practical nursing practice that interpret the statutory definition of professional or practical nursing as well as provide criteria for violations of the statutes, or, if no rule exists, to the minimal standards of acceptable and prevailing professional or practical nursing practice, or any nursing practice that may create unnecessary danger to a patient's life, health, or safety. Actual injury to a patient need not be established under this clause.

(7) Failure of an advanced practice registered nurse to practice with reasonable skill and safety or departure from or failure to conform to standards of acceptable and prevailing advanced practice registered nursing.

(8) Delegating or accepting the delegation of a nursing function or a prescribed health care function when the delegation or acceptance could reasonably be expected to result in unsafe or ineffective patient care.

(9) Actual or potential inability to practice nursing with reasonable skill and safety to patients by reason of illness, use of alcohol, drugs, chemicals, or any other material, or as a result of any mental or physical condition.

(10) Adjudication as mentally incompetent, mentally ill, a chemically dependent person, or a person dangerous to the public by a court of competent jurisdiction, within or without this state.

(11) Engaging in any unethical conduct, including, but not limited to, conduct likely to deceive, defraud, or harm the public, or demonstrating a willful or careless disregard for the health, welfare, or safety of a patient. Actual injury need not be established under this clause.

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

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

(14) Revealing a privileged communication from or relating to a patient except when otherwise required or permitted by law.

(15) Engaging in abusive or fraudulent billing practices, including violations of federal Medicare and Medicaid laws or state medical assistance laws.

(16) Improper management of patient records, including failure to maintain adequate patient records, to comply with a patient's request made pursuant to sections 144.291 to 144.298, or to furnish a patient record or report required by law.

(17) Knowingly aiding, assisting, advising, or allowing an unlicensed person to engage in the unlawful practice of advanced practice, professional, or practical nursing.

(18) Violating a rule adopted by the board, an order of the board, or a state or federal law relating to the practice of advanced practice, professional, or practical nursing, or a state or federal narcotics or controlled substance law.

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

(20) Aiding suicide or aiding attempted suicide in violation of section 609.215 as established by any of the following:

(i) a copy of the record of criminal conviction or plea of guilty for a felony in violation of section 609.215, subdivision 1 or 2;

(ii) a copy of the record of a judgment of contempt of court for violating an injunction issued under section 609.215, subdivision 4;

(iii) a copy of the record of a judgment assessing damages under section 609.215, subdivision 5; or

(iv) a finding by the board that the person violated section 609.215, subdivision 1 or 2. The board shall investigate any complaint of a violation of section 609.215, subdivision 1 or 2.

(21) Practicing outside the scope of practice authorized by section 148.171, subdivision 5, 10, 11, 13, 14, 15, or 21.

(22) Making a false statement or knowingly providing false information to the board, failing to make reports as required by section 148.263, or failing to cooperate with an investigation of the board as required by section 148.265.

(23) Engaging in false, fraudulent, deceptive, or misleading advertising.

(24) Failure to inform the board of the person's certification or recertification status as a certified registered nurse anesthetist, certified nurse-midwife, certified nurse practitioner, or certified clinical nurse specialist.

(25) Engaging in clinical nurse specialist practice, nurse-midwife practice, nurse practitioner practice, or registered nurse anesthetist practice without a license and current certification or recertification by a national nurse certification organization acceptable to the board.

~~(26) Engaging in conduct that is prohibited under section 145.412.~~

~~(27)~~ (26) Failing to report employment to the board as required by section 148.211, subdivision 2a, or knowingly aiding, assisting, advising, or allowing a person to fail to report as required by section 148.211, subdivision 2a.

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

Sec. 134. Minnesota Statutes 2022, section 148.512, subdivision 10a, is amended to read:

Subd. 10a. **Hearing aid.** "Hearing aid" means ~~an instrument~~ a prescribed aid, or any of its parts, worn in the ear canal and designed to or represented as being able to aid ~~or enhance~~ human hearing. "Hearing aid" includes the aid's parts, attachments, or accessories, including, but not limited to, ear molds and behind the ear (BTE) devices with or without an ear mold. Batteries and cords are not parts, attachments, or accessories of a hearing aid. Surgically

implanted hearing aids, and assistive listening devices not worn within the ear canal, are not hearing aids.

Sec. 135. Minnesota Statutes 2022, section 148.512, subdivision 10b, is amended to read:

Subd. 10b. **Hearing aid dispensing.** "Hearing aid dispensing" means making ear mold impressions, prescribing~~, or recommending~~ a hearing aid, assisting the consumer in prescription aid selection~~, selling hearing aids at retail~~, or testing human hearing in connection with these activities regardless of whether the person conducting these activities has a monetary interest in the dispensing of prescription hearing aids to the consumer. Hearing aid dispensing does not include selling over-the-counter hearing aids.

Sec. 136. Minnesota Statutes 2022, section 148.512, is amended by adding a subdivision to read:

Subd. 10c. **Over-the-counter hearing aid or OTC hearing aid.** "Over-the-counter hearing aid" or "OTC hearing aid" has the meaning given to that term in Code of Federal Regulations, title 21, section 800.30(b).

Sec. 137. Minnesota Statutes 2022, section 148.512, is amended by adding a subdivision to read:

Subd. 13a. **Prescription hearing aid.** "Prescription hearing aid" means a hearing aid requiring a prescription from a certified hearing aid dispenser or licensed audiologist that is not an OTC hearing aid.

Sec. 138. Minnesota Statutes 2022, section 148.513, is amended by adding a subdivision to read:

Subd. 4. **Over-the-counter hearing aids.** Nothing in sections 148.511 to 148.5198 shall preclude licensed audiologists from dispensing or selling over-the-counter hearing aids.

Sec. 139. Minnesota Statutes 2022, section 148.515, subdivision 6, is amended to read:

Subd. 6. **Dispensing audiologist examination requirements.** (a) Audiologists are exempt from the written examination requirement in section 153A.14, subdivision 2h, paragraph (a), clause (1).

(b) After July 31, 2005, all applicants for audiologist licensure under sections 148.512 to 148.5198 must achieve a passing score on the practical tests of proficiency described in

section 153A.14, subdivision 2h, paragraph (a), clause (2), within the time period described in section 153A.14, subdivision 2h, paragraph (c).

(c) In order to dispense prescription hearing aids as a sole proprietor, member of a partnership, or for a limited liability company, corporation, or any other entity organized for profit, a licensee who obtained audiologist licensure under sections 148.512 to 148.5198, before August 1, 2005, and who is not certified to dispense prescription hearing aids under chapter 153A, must achieve a passing score on the practical tests of proficiency described in section 153A.14, subdivision 2h, paragraph (a), clause (2), within the time period described in section 153A.14, subdivision 2h, paragraph (c). All other audiologist licensees who obtained licensure before August 1, 2005, are exempt from the practical tests.

(d) An applicant for an audiology license who obtains a temporary license under section 148.5175 may dispense prescription hearing aids only under supervision of a licensed audiologist who dispenses prescription hearing aids.

Sec. 140. Minnesota Statutes 2022, section 148.5175, is amended to read:

148.5175 TEMPORARY LICENSURE.

(a) The commissioner shall issue temporary licensure as a speech-language pathologist, an audiologist, or both, to an applicant who:

(1) submits a signed and dated affidavit stating that the applicant is not the subject of a disciplinary action or past disciplinary action in this or another jurisdiction and is not disqualified on the basis of section 148.5195, subdivision 3; and

(2) either:

(i) provides a copy of a current credential as a speech-language pathologist, an audiologist, or both, held in the District of Columbia or a state or territory of the United States; or

(ii) provides a copy of a current certificate of clinical competence issued by the American Speech-Language-Hearing Association or board certification in audiology by the American Board of Audiology.

(b) A temporary license issued to a person under this subdivision expires 90 days after it is issued or on the date the commissioner grants or denies licensure, whichever occurs first.

(c) Upon application, a temporary license shall be renewed twice to a person who is able to demonstrate good cause for failure to meet the requirements for licensure within the initial temporary licensure period and who is not the subject of a disciplinary action or

disqualified on the basis of section 148.5195, subdivision 3. Good cause includes but is not limited to inability to take and complete the required practical exam for dispensing prescription hearing ~~instruments~~ aids.

(d) Upon application, a temporary license shall be issued to a person who meets the requirements of section 148.515, subdivisions 2a and 4, but has not completed the requirement in section 148.515, subdivision 6.

Sec. 141. Minnesota Statutes 2022, section 148.5195, subdivision 3, is amended to read:

Subd. 3. **Grounds for disciplinary action by commissioner.** The commissioner may take any of the disciplinary actions listed in subdivision 4 on proof that the individual has:

(1) intentionally submitted false or misleading information to the commissioner or the advisory council;

(2) failed, within 30 days, to provide information in response to a written request by the commissioner or advisory council;

(3) performed services of a speech-language pathologist or audiologist in an incompetent or negligent manner;

(4) violated sections 148.511 to 148.5198;

(5) failed to perform services with reasonable judgment, skill, or safety due to the use of alcohol or drugs, or other physical or mental impairment;

(6) violated any state or federal law, rule, or regulation, and the violation is a felony or misdemeanor, an essential element of which is dishonesty, or which relates directly or indirectly to the practice of speech-language pathology or audiology. Conviction for violating any state or federal law which relates to speech-language pathology or audiology is necessarily considered to constitute a violation, except as provided in chapter 364;

(7) aided or abetted another person in violating any provision of sections 148.511 to 148.5198;

(8) been or is being disciplined by another jurisdiction, if any of the grounds for the discipline is the same or substantially equivalent to those under sections 148.511 to 148.5198;

(9) not cooperated with the commissioner or advisory council in an investigation conducted according to subdivision 1;

(10) advertised in a manner that is false or misleading;

(11) engaged in conduct likely to deceive, defraud, or harm the public; or demonstrated a willful or careless disregard for the health, welfare, or safety of a client;

(12) failed to disclose to the consumer any fee splitting or any promise to pay a portion of a fee to any other professional other than a fee for services rendered by the other professional to the client;

(13) engaged in abusive or fraudulent billing practices, including violations of federal Medicare and Medicaid laws, Food and Drug Administration regulations, or state medical assistance laws;

(14) obtained money, property, or services from a consumer through the use of undue influence, high pressure sales tactics, harassment, duress, deception, or fraud;

(15) performed services for a client who had no possibility of benefiting from the services;

(16) failed to refer a client for medical evaluation or to other health care professionals when appropriate or when a client indicated symptoms associated with diseases that could be medically or surgically treated;

(17) had the certification required by chapter 153A denied, suspended, or revoked according to chapter 153A;

(18) used the term doctor of audiology, doctor of speech-language pathology, AuD, or SLPD without having obtained the degree from an institution accredited by the North Central Association of Colleges and Secondary Schools, the Council on Academic Accreditation in Audiology and Speech-Language Pathology, the United States Department of Education, or an equivalent;

(19) failed to comply with the requirements of section 148.5192 regarding supervision of speech-language pathology assistants; or

(20) if the individual is an audiologist or certified hearing ~~instrument~~ aid dispenser:

(i) prescribed ~~or otherwise recommended~~ to a consumer or potential consumer the use of a prescription hearing ~~instrument~~ aid, unless the prescription from a physician ~~or recommendation from~~, an audiologist, or a certified dispenser is in writing, is based on an audiogram that is delivered to the consumer or potential consumer when the prescription ~~or recommendation~~ is made, and bears the following information in all capital letters of 12-point or larger boldface type: "THIS PRESCRIPTION ~~OR RECOMMENDATION~~ MAY BE FILLED BY, AND PRESCRIPTION HEARING ~~INSTRUMENTS~~ AIDS MAY BE PURCHASED FROM, THE LICENSED AUDIOLOGIST OR CERTIFIED DISPENSER OF YOUR CHOICE";

(ii) failed to give a copy of the audiogram, upon which the prescription ~~or recommendation~~ is based, to the consumer when the consumer requests a copy;

(iii) failed to provide the consumer rights brochure required by section 148.5197, subdivision 3;

(iv) failed to comply with restrictions on sales of prescription hearing ~~instruments~~ aids in sections 148.5197, subdivision 3, and 148.5198;

(v) failed to return a consumer's prescription hearing ~~instrument~~ aid used as a trade-in or for a discount in the price of a new prescription hearing ~~instrument~~ aid when requested by the consumer upon cancellation of the purchase agreement;

(vi) failed to follow Food and Drug Administration or Federal Trade Commission regulations relating to dispensing prescription hearing ~~instruments~~ aids;

(vii) failed to dispense a prescription hearing ~~instrument~~ aid in a competent manner or without appropriate training;

(viii) delegated prescription hearing ~~instrument~~ aid dispensing authority to a person not authorized to dispense a prescription hearing ~~instrument~~ aid under this chapter or chapter 153A;

(ix) failed to comply with the requirements of an employer or supervisor of a hearing ~~instrument~~ aid dispenser trainee;

(x) violated a state or federal court order or judgment, including a conciliation court judgment, relating to the activities of the individual's prescription hearing ~~instrument~~ aid dispensing; or

(xi) failed to include on the audiogram the practitioner's printed name, credential type, credential number, signature, and date.

Sec. 142. Minnesota Statutes 2022, section 148.5196, subdivision 1, is amended to read:

Subdivision 1. **Membership.** The commissioner shall appoint 12 persons to a Speech-Language Pathologist and Audiologist Advisory Council. The 12 persons must include:

(1) three public members, as defined in section 214.02. Two of the public members shall be either persons receiving services of a speech-language pathologist or audiologist, or family members of or caregivers to such persons, and at least one of the public members shall be either a hearing ~~instrument~~ aid user or an advocate of one;

(2) three speech-language pathologists licensed under sections 148.511 to 148.5198, one of whom is currently and has been, for the five years immediately preceding the appointment, engaged in the practice of speech-language pathology in Minnesota and each of whom is employed in a different employment setting including, but not limited to, private practice, hospitals, rehabilitation settings, educational settings, and government agencies;

(3) one speech-language pathologist licensed under sections 148.511 to 148.5198, who is currently and has been, for the five years immediately preceding the appointment, employed by a Minnesota public school district or a Minnesota public school district consortium that is authorized by Minnesota Statutes and who is licensed in speech-language pathology by the Professional Educator Licensing and Standards Board;

(4) three audiologists licensed under sections 148.511 to 148.5198, two of whom are currently and have been, for the five years immediately preceding the appointment, engaged in the practice of audiology and the dispensing of prescription hearing ~~instruments~~ aids in Minnesota and each of whom is employed in a different employment setting including, but not limited to, private practice, hospitals, rehabilitation settings, educational settings, industry, and government agencies;

(5) one nonaudiologist hearing ~~instrument~~ aid dispenser recommended by a professional association representing hearing ~~instrument~~ aid dispensers; and

(6) one physician licensed under chapter 147 and certified by the American Board of Otolaryngology, Head and Neck Surgery.

Sec. 143. Minnesota Statutes 2022, section 148.5197, is amended to read:

148.5197 HEARING AID DISPENSING.

Subdivision 1. **Content of contracts.** Oral statements made by an audiologist or certified dispenser regarding the provision of warranties, refunds, and service on the prescription hearing aid or aids dispensed must be written on, and become part of, the contract of sale, specify the item or items covered, and indicate the person or business entity obligated to provide the warranty, refund, or service.

Subd. 2. **Required use of license number.** The audiologist's license number or certified dispenser's certificate number must appear on all contracts, bills of sale, and receipts used in the sale of prescription hearing aids.

Subd. 3. **Consumer rights information.** An audiologist or certified dispenser shall, at the time of the ~~recommendation or~~ prescription, give a consumer rights brochure, prepared by the commissioner and containing information about legal requirements pertaining to

dispensing of prescription hearing aids, to each potential consumer of a prescription hearing aid. The brochure must contain information about the consumer information center described in section 153A.18. A contract for a prescription hearing aid must note the receipt of the brochure by the consumer, along with the consumer's signature or initials.

Subd. 4. **Liability for contracts.** Owners of entities in the business of dispensing prescription hearing aids, employers of audiologists or persons who dispense prescription hearing aids, supervisors of trainees or audiology students, and hearing aid dispensers conducting the transaction at issue are liable for satisfying all terms of contracts, written or oral, made by their agents, employees, assignees, affiliates, or trainees, including terms relating to products, repairs, warranties, service, and refunds. The commissioner may enforce the terms of prescription hearing aid contracts against the principal, employer, supervisor, or dispenser who conducted the transaction and may impose any remedy provided for in this chapter.

Sec. 144. Minnesota Statutes 2022, section 148.5198, is amended to read:

148.5198 RESTRICTION ON SALE OF PRESCRIPTION HEARING AIDS.

Subdivision 1. **45-calendar-day guarantee and buyer right to cancel.** (a) An audiologist or certified dispenser dispensing a prescription hearing aid in this state must comply with paragraphs (b) and (c).

(b) The audiologist or certified dispenser must provide the buyer with a 45-calendar-day written money-back guarantee. The guarantee must permit the buyer to cancel the purchase for any reason within 45 calendar days after receiving the prescription hearing aid by giving or mailing written notice of cancellation to the audiologist or certified dispenser. If the buyer mails the notice of cancellation, the 45-calendar-day period is counted using the postmark date, to the date of receipt by the audiologist or certified dispenser. If the prescription hearing aid must be repaired, remade, or adjusted during the 45-calendar-day money-back guarantee period, the running of the 45-calendar-day period is suspended one day for each 24-hour period that the prescription hearing aid is not in the buyer's possession. A repaired, remade, or adjusted prescription hearing aid must be claimed by the buyer within three business days after notification of availability, after which time the running of the 45-calendar-day period resumes. The guarantee must entitle the buyer, upon cancellation, to receive a refund of payment within 30 days of return of the prescription hearing aid to the audiologist or certified dispenser. The audiologist or certified dispenser may retain as a cancellation fee no more than $250 of the buyer's total purchase price of the prescription hearing aid.

(c) The audiologist or certified dispenser shall provide the buyer with a contract written in plain English, that contains uniform language and provisions that meet the requirements under the Plain Language Contract Act, sections 325G.29 to 325G.36. The contract must include, but is not limited to, the following: in immediate proximity to the space reserved for the signature of the buyer, or on the first page if there is no space reserved for the signature of the buyer, a clear and conspicuous disclosure of the following specific statement in all capital letters of no less than 12-point boldface type: "MINNESOTA STATE LAW GIVES THE BUYER THE RIGHT TO CANCEL THIS PURCHASE FOR ANY REASON AT ANY TIME PRIOR TO MIDNIGHT OF THE 45TH CALENDAR DAY AFTER RECEIPT OF THE PRESCRIPTION HEARING AID(S). THIS CANCELLATION MUST BE IN WRITING AND MUST BE GIVEN OR MAILED TO THE AUDIOLOGIST OR CERTIFIED DISPENSER. IF THE BUYER DECIDES TO RETURN THE PRESCRIPTION HEARING AID(S) WITHIN THIS 45-CALENDAR-DAY PERIOD, THE BUYER WILL RECEIVE A REFUND OF THE TOTAL PURCHASE PRICE OF THE AID(S) FROM WHICH THE AUDIOLOGIST OR CERTIFIED DISPENSER MAY RETAIN AS A CANCELLATION FEE NO MORE THAN $250."

Subd. 2. **Itemized repair bill.** Any audiologist, certified dispenser, or company who agrees to repair a prescription hearing aid must provide the owner of the prescription hearing aid, or the owner's representative, with a bill that describes the repair and services rendered. The bill must also include the repairing audiologist's, certified dispenser's, or company's name, address, and telephone number.

This subdivision does not apply to an audiologist, certified dispenser, or company that repairs a prescription hearing aid pursuant to an express warranty covering the entire prescription hearing aid and the warranty covers the entire cost, both parts and labor, of the repair.

Subd. 3. **Repair warranty.** Any guarantee of prescription hearing aid repairs must be in writing and delivered to the owner of the prescription hearing aid, or the owner's representative, stating the repairing audiologist's, certified dispenser's, or company's name, address, telephone number, length of guarantee, model, and serial number of the prescription hearing aid and all other terms and conditions of the guarantee.

Subd. 4. **Misdemeanor.** A person found to have violated this section is guilty of a misdemeanor.

Subd. 5. **Additional.** In addition to the penalty provided in subdivision 4, a person found to have violated this section is subject to the penalties and remedies provided in section 325F.69, subdivision 1.

Subd. 6. **Estimates.** Upon the request of the owner of a prescription hearing aid or the owner's representative for a written estimate and prior to the commencement of repairs, a repairing audiologist, certified dispenser, or company shall provide the customer with a written estimate of the price of repairs. If a repairing audiologist, certified dispenser, or company provides a written estimate of the price of repairs, it must not charge more than the total price stated in the estimate for the repairs. If the repairing audiologist, certified dispenser, or company after commencing repairs determines that additional work is necessary to accomplish repairs that are the subject of a written estimate and if the repairing audiologist, certified dispenser, or company did not unreasonably fail to disclose the possible need for the additional work when the estimate was made, the repairing audiologist, certified dispenser, or company may charge more than the estimate for the repairs if the repairing audiologist, certified dispenser, or company immediately provides the owner or owner's representative a revised written estimate pursuant to this section and receives authorization to continue with the repairs. If continuation of the repairs is not authorized, the repairing audiologist, certified dispenser, or company shall return the prescription hearing aid as close as possible to its former condition and shall release the prescription hearing aid to the owner or owner's representative upon payment of charges for repairs actually performed and not in excess of the original estimate.

Sec. 145. Minnesota Statutes 2022, section 151.37, subdivision 12, is amended to read:

Subd. 12. **Administration of opiate antagonists for drug overdose.** (a) A licensed physician, a licensed advanced practice registered nurse authorized to prescribe drugs pursuant to section 148.235, or a licensed physician assistant may authorize the following individuals to administer opiate antagonists, as defined in section 604A.04, subdivision 1:

(1) an emergency medical responder registered pursuant to section 144E.27;

(2) a peace officer as defined in section 626.84, subdivision 1, paragraphs (c) and (d);

(3) correctional employees of a state or local political subdivision;

(4) staff of community-based health disease prevention or social service programs;

(5) a volunteer firefighter; and

(6) a ~~licensed school~~ nurse or ~~certified public health nurse~~ any other personnel employed by, or under contract with, a ~~school board under section 121A.21~~ charter, public, or private school.

(b) For the purposes of this subdivision, opiate antagonists may be administered by one of these individuals only if:

(1) the licensed physician, licensed physician assistant, or licensed advanced practice registered nurse has issued a standing order to, or entered into a protocol with, the individual; and

(2) the individual has training in the recognition of signs of opiate overdose and the use of opiate antagonists as part of the emergency response to opiate overdose.

(c) Nothing in this section prohibits the possession and administration of naloxone pursuant to section 604A.04.

(d) Notwithstanding section 148.235, subdivisions 8 and 9, a licensed practical nurse is authorized to possess and administer according to this subdivision an opiate antagonist in a school setting.

Sec. 146. Minnesota Statutes 2022, section 153A.13, subdivision 3, is amended to read:

Subd. 3. **Hearing ~~instrument~~ aid.** "Hearing ~~instrument~~ aid" means an instrument~~, or any of its parts, worn in the ear canal and designed to or represented as being able to aid or enhance human hearing. "Hearing instrument" includes the instrument's parts, attachments, or accessories, including, but not limited to, ear molds and behind the ear (BTE) devices with or without an ear mold. Batteries and cords are not parts, attachments, or accessories of a hearing instrument. Surgically implanted hearing instruments, and assistive listening devices not worn within the ear canal, are not hearing instruments.~~ as defined in section 148.512, subdivision 10a.

Sec. 147. Minnesota Statutes 2022, section 153A.13, subdivision 4, is amended to read:

Subd. 4. **Hearing ~~instrument~~ aid dispensing.** "Hearing ~~instrument~~ aid dispensing" ~~means making ear mold impressions, prescribing, or recommending a hearing instrument, assisting the consumer in instrument selection, selling hearing instruments at retail, or testing human hearing in connection with these activities regardless of whether the person conducting these activities has a monetary interest in the sale of hearing instruments to the consumer.~~ has the meaning given in section 148.512, subdivision 10b.

Sec. 148. Minnesota Statutes 2022, section 153A.13, subdivision 5, is amended to read:

Subd. 5. **Dispenser of hearing ~~instruments~~ aids.** "Dispenser of hearing ~~instruments~~ aids" means a natural person who engages in prescription hearing ~~instrument~~ aid dispensing, whether or not certified by the commissioner of health or licensed by an existing health-related board, except that a person described as follows is not a dispenser of hearing ~~instruments~~ aids:

(1) a student participating in supervised field work that is necessary to meet requirements of an accredited educational program if the student is designated by a title which clearly indicates the student's status as a student trainee; or

(2) a person who helps a dispenser of hearing ~~instruments~~ aids in an administrative or clerical manner and does not engage in prescription hearing ~~instrument~~ aid dispensing.

A person who offers to dispense a prescription hearing ~~instrument~~ aid, or a person who advertises, holds out to the public, or otherwise represents that the person is authorized to dispense prescription hearing ~~instruments~~ aids, must be certified by the commissioner except when the person is an audiologist as defined in section 148.512.

Sec. 149. Minnesota Statutes 2022, section 153A.13, subdivision 6, is amended to read:

Subd. 6. **Advisory council.** "Advisory council" means the Minnesota Hearing ~~Instrument~~ Aid Dispenser Advisory Council, or a committee of ~~it~~ the council, established under section 153A.20.

Sec. 150. Minnesota Statutes 2022, section 153A.13, subdivision 7, is amended to read:

Subd. 7. **ANSI.** "ANSI" means ~~ANSI S3.6-1989,~~ American National Standard Specification for Audiometers ~~from the American National Standards Institute. This document is available through the Minitex interlibrary loan system~~ as defined in the United States Food and Drug Administration, Code of Federal Regulations, title 21, section 874.1050.

Sec. 151. Minnesota Statutes 2022, section 153A.13, subdivision 9, is amended to read:

Subd. 9. **Supervision.** "Supervision" means monitoring activities of, and accepting responsibility for, the prescription hearing ~~instrument~~ aid dispensing activities of a trainee.

Sec. 152. Minnesota Statutes 2022, section 153A.13, subdivision 10, is amended to read:

Subd. 10. **Direct supervision or directly supervised.** "Direct supervision" or "directly supervised" means the on-site and contemporaneous location of a supervisor and trainee, when the supervisor observes the trainee engaging in prescription hearing ~~instrument~~ aid dispensing with a consumer.

Sec. 153. Minnesota Statutes 2022, section 153A.13, subdivision 11, is amended to read:

Subd. 11. **Indirect supervision or indirectly supervised.** "Indirect supervision" or "indirectly supervised" means the remote and independent performance of prescription hearing ~~instrument~~ aid dispensing by a trainee when authorized under section 153A.14, subdivision 4a, paragraph (b).

Sec. 154. Minnesota Statutes 2022, section 153A.13, is amended by adding a subdivision to read:

Subd. 12. **Over-the-counter hearing aid or OTC hearing aid.** "Over-the-counter hearing aid" or "OTC hearing aid" has the meaning given in section 148.512, subdivision 10c.

Sec. 155. Minnesota Statutes 2022, section 153A.13, is amended by adding a subdivision to read:

Subd. 13. **Prescription hearing aid.** "Prescription hearing aid" has the meaning given in section 148.512, subdivision 13a.

Sec. 156. Minnesota Statutes 2022, section 153A.14, subdivision 1, is amended to read:

Subdivision 1. **Application for certificate.** An applicant must:

(1) be 21 years of age or older;

(2) apply to the commissioner for a certificate to dispense prescription hearing ~~instruments~~ aids on application forms provided by the commissioner;

(3) at a minimum, provide the applicant's name, Social Security number, business address and phone number, employer, and information about the applicant's education, training, and experience in testing human hearing and fitting prescription hearing ~~instruments~~ aids;

(4) include with the application a statement that the statements in the application are true and correct to the best of the applicant's knowledge and belief;

(5) include with the application a written and signed authorization that authorizes the commissioner to make inquiries to appropriate regulatory agencies in this or any other state where the applicant has sold prescription hearing ~~instruments~~ aids;

(6) submit certification to the commissioner that the applicant's audiometric equipment has been calibrated to meet current ANSI standards within 12 months of the date of the application;

(7) submit evidence of continuing education credits, if required;

(8) submit all fees as required under section 153A.17; and

(9) consent to a fingerprint-based criminal history records check required under section 144.0572, pay all required fees, and cooperate with all requests for information. An applicant must complete a new criminal background check if more than one year has elapsed since the applicant last applied for a license.

Sec. 157. Minnesota Statutes 2022, section 153A.14, subdivision 2, is amended to read:

Subd. 2. **Issuance of certificate.** (a) The commissioner shall issue a certificate to each dispenser of hearing ~~instruments~~ aids who applies under subdivision 1 if the commissioner determines that the applicant is in compliance with this chapter, has passed an examination administered by the commissioner, has met the continuing education requirements, if required, and has paid the fee set by the commissioner. The commissioner may reject or deny an application for a certificate if there is evidence of a violation or failure to comply with this chapter.

(b) The commissioner shall not issue a certificate to an applicant who refuses to consent to a criminal history background check as required by section 144.0572 within 90 days after submission of an application or fails to submit fingerprints to the Department of Human Services. Any fees paid by the applicant to the Department of Health shall be forfeited if the applicant refuses to consent to the background study.

Sec. 158. Minnesota Statutes 2022, section 153A.14, subdivision 2h, is amended to read:

Subd. 2h. **Certification by examination.** An applicant must achieve a passing score, as determined by the commissioner, on an examination according to paragraphs (a) to (c).

(a) The examination must include, but is not limited to:

(1) A written examination approved by the commissioner covering the following areas as they pertain to prescription hearing ~~instrument~~ aid selling:

(i) basic physics of sound;

(ii) the anatomy and physiology of the ear;

(iii) the function of prescription hearing ~~instruments~~ aids; and

(iv) the principles of prescription hearing ~~instrument~~ aid selection.

(2) Practical tests of proficiency in the following techniques as they pertain to prescription hearing ~~instrument~~ aid selling:

(i) pure tone audiometry, including air conduction testing and bone conduction testing;

(ii) live voice or recorded voice speech audiometry including speech recognition (discrimination) testing, most comfortable loudness level, and uncomfortable loudness measurements of tolerance thresholds;

(iii) masking when indicated;

(iv) recording and evaluation of audiograms and speech audiometry to determine proper selection and fitting of a prescription hearing ~~instrument~~ aid;

(v) taking ear mold impressions;

(vi) using an otoscope for the visual observation of the entire ear canal; and

(vii) state and federal laws, rules, and regulations.

(b) The practical examination shall be administered by the commissioner at least twice a year.

(c) An applicant must achieve a passing score on all portions of the examination within a two-year period. An applicant who does not achieve a passing score on all portions of the examination within a two-year period must retake the entire examination and achieve a passing score on each portion of the examination. An applicant who does not apply for certification within one year of successful completion of the examination must retake the examination and achieve a passing score on each portion of the examination. An applicant may not take any part of the practical examination more than three times in a two-year period.

Sec. 159. Minnesota Statutes 2022, section 153A.14, subdivision 2i, is amended to read:

Subd. 2i. **Continuing education requirement.** On forms provided by the commissioner, each certified dispenser must submit with the application for renewal of certification evidence of completion of ten course hours of continuing education earned within the 12-month period of November 1 to October 31, between the effective and expiration dates of

certification. Continuing education courses must be directly related to prescription hearing ~~instrument~~ aid dispensing and approved by the International Hearing Society, the American Speech-Language-Hearing Association, or the American Academy of Audiology. Evidence of completion of the ten course hours of continuing education must be submitted by December 1 of each year. This requirement does not apply to dispensers certified for less than one year.

Sec. 160. Minnesota Statutes 2022, section 153A.14, subdivision 2j, is amended to read:

Subd. 2j. **Required use of certification number.** The certification holder must use the certification number on all contracts, bills of sale, and receipts used in the sale of prescription hearing ~~instruments~~ aids.

Sec. 161. Minnesota Statutes 2022, section 153A.14, subdivision 4, is amended to read:

Subd. 4. **Dispensing of prescription hearing ~~instruments~~ aids without certificate.** Except as provided in subdivisions 4a and 4c, and in sections 148.512 to 148.5198, it is unlawful for any person not holding a valid certificate to dispense a prescription hearing ~~instrument~~ aid as defined in section 153A.13, subdivision 3. A person who dispenses a prescription hearing ~~instrument~~ aid without the certificate required by this section is guilty of a gross misdemeanor.

Sec. 162. Minnesota Statutes 2022, section 153A.14, subdivision 4a, is amended to read:

Subd. 4a. **Trainees.** (a) A person who is not certified under this section may dispense prescription hearing ~~instruments~~ aids as a trainee for a period not to exceed 12 months if the person:

(1) submits an application on forms provided by the commissioner;

(2) is under the supervision of a certified dispenser meeting the requirements of this subdivision;

(3) meets all requirements for certification except passage of the examination required by this section; and

(4) uses the title "dispenser trainee" in contacts with the patients, clients, or consumers.

(b) A certified hearing ~~instrument~~ aid dispenser may not supervise more than two trainees at the same time and may not directly supervise more than one trainee at a time. The certified dispenser is responsible for all actions or omissions of a trainee in connection with the dispensing of prescription hearing ~~instruments~~ aids. A certified dispenser may not supervise

a trainee if there are any commissioner, court, or other orders, currently in effect or issued within the last five years, that were issued with respect to an action or omission of a certified dispenser or a trainee under the certified dispenser's supervision.

Until taking and passing the practical examination testing the techniques described in subdivision 2h, paragraph (a), clause (2), trainees must be directly supervised in all areas described in subdivision 4b, and the activities tested by the practical examination. Thereafter, trainees may dispense prescription hearing ~~instruments~~ aids under indirect supervision until expiration of the trainee period. Under indirect supervision, the trainee must complete two monitored activities a week. Monitored activities may be executed by correspondence, telephone, or other telephonic devices, and include, but are not limited to, evaluation of audiograms, written reports, and contracts. The time spent in supervision must be recorded and the record retained by the supervisor.

Sec. 163. Minnesota Statutes 2022, section 153A.14, subdivision 4b, is amended to read:

Subd. 4b. **Prescription hearing testing protocol.** A dispenser when conducting a hearing test for the purpose of prescription hearing ~~instrument~~ aid dispensing must:

(1) comply with the United States Food and Drug Administration warning regarding potential medical conditions required by Code of Federal Regulations, title 21, section ~~801.420~~ 801.422;

(2) complete a case history of the client's hearing;

(3) inspect the client's ears with an otoscope; and

(4) conduct the following tests on both ears of the client and document the results, and if for any reason one of the following tests cannot be performed pursuant to the United States Food and Drug Administration guidelines, an audiologist shall evaluate the hearing and the need for a prescription hearing ~~instrument~~ aid:

(i) air conduction at 250, 500, 1,000, 2,000, 4,000, and 8,000 Hertz. When a difference of 20 dB or more occurs between adjacent octave frequencies the interoctave frequency must be tested;

(ii) bone conduction at 500, 1,000, 2,000, and 4,000 Hertz for any frequency where the air conduction threshold is greater than 15 dB HL;

(iii) monaural word recognition (discrimination), with a minimum of 25 words presented for each ear; and

(iv) loudness discomfort level, monaural, for setting a prescription hearing ~~instrument's~~ aid's maximum power output; and

(5) include masking in all tests whenever necessary to ensure accurate results.

Sec. 164. Minnesota Statutes 2022, section 153A.14, subdivision 4c, is amended to read:

Subd. 4c. **Reciprocity.** (a) A person who has dispensed prescription hearing ~~instruments~~ aids in another jurisdiction may dispense prescription hearing ~~instruments~~ aids as a trainee under indirect supervision if the person:

(1) satisfies the provisions of subdivision 4a, paragraph (a);

(2) submits a signed and dated affidavit stating that the applicant is not the subject of a disciplinary action or past disciplinary action in this or another jurisdiction and is not disqualified on the basis of section 153A.15, subdivision 1; and

(3) provides a copy of a current credential as a hearing ~~instrument~~ aid dispenser held in the District of Columbia or a state or territory of the United States.

(b) A person becoming a trainee under this subdivision who fails to take and pass the practical examination described in subdivision 2h, paragraph (a), clause (2), when next offered must cease dispensing prescription hearing ~~instruments~~ aids unless under direct supervision.

Sec. 165. Minnesota Statutes 2022, section 153A.14, subdivision 4e, is amended to read:

Subd. 4e. **Prescription hearing aids; enforcement.** Costs incurred by the Minnesota Department of Health for conducting investigations of unlicensed prescription hearing aid ~~dispensers~~ dispensing shall be apportioned between all licensed or credentialed professions that dispense prescription hearing aids.

Sec. 166. Minnesota Statutes 2022, section 153A.14, subdivision 6, is amended to read:

Subd. 6. **Prescription hearing ~~instruments~~ aids to comply with federal and state requirements.** The commissioner shall ensure that prescription hearing ~~instruments~~ aids are dispensed in compliance with state requirements and the requirements of the United States Food and Drug Administration. Failure to comply with state or federal regulations may be grounds for enforcement actions under section 153A.15, subdivision 2.

Sec. 167. Minnesota Statutes 2022, section 153A.14, subdivision 9, is amended to read:

Subd. 9. **Consumer rights.** A hearing ~~instrument~~ aid dispenser shall comply with the requirements of sections 148.5195, subdivision 3, clause (20); 148.5197; and 148.5198.

Sec. 168. Minnesota Statutes 2022, section 153A.14, subdivision 11, is amended to read:

Subd. 11. **Requirement to maintain current information.** A dispenser must notify the commissioner in writing within 30 days of the occurrence of any of the following:

(1) a change of name, address, home or business telephone number, or business name;

(2) the occurrence of conduct prohibited by section 153A.15;

(3) a settlement, conciliation court judgment, or award based on negligence, intentional acts, or contractual violations committed in the dispensing of prescription hearing ~~instruments~~ aids by the dispenser; and

(4) the cessation of prescription hearing ~~instrument~~ aid dispensing activities as an individual or a business.

Sec. 169. Minnesota Statutes 2022, section 153A.14, is amended by adding a subdivision to read:

Subd. 12. **Over-the-counter hearing aids.** Nothing in this chapter shall preclude certified hearing aid dispensers from dispensing or selling over-the-counter hearing aids.

Sec. 170. Minnesota Statutes 2022, section 153A.15, subdivision 1, is amended to read:

Subdivision 1. **Prohibited acts.** The commissioner may take enforcement action as provided under subdivision 2 against a dispenser of prescription hearing ~~instruments~~ aids for the following acts and conduct:

(1) dispensing a prescription hearing ~~instrument~~ aid to a minor person 18 years or younger unless evaluated by an audiologist for hearing evaluation and prescription hearing aid evaluation;

(2) being disciplined through a revocation, suspension, restriction, or limitation by another state for conduct subject to action under this chapter;

(3) presenting advertising that is false or misleading;

(4) providing the commissioner with false or misleading statements of credentials, training, or experience;

(5) engaging in conduct likely to deceive, defraud, or harm the public; or demonstrating a willful or careless disregard for the health, welfare, or safety of a consumer;

(6) splitting fees or promising to pay a portion of a fee to any other professional other than a fee for services rendered by the other professional to the client;

(7) engaging in abusive or fraudulent billing practices, including violations of federal Medicare and Medicaid laws, Food and Drug Administration regulations, or state medical assistance laws;

(8) obtaining money, property, or services from a consumer through the use of undue influence, high pressure sales tactics, harassment, duress, deception, or fraud;

(9) performing the services of a certified hearing ~~instrument~~ aid dispenser in an incompetent or negligent manner;

(10) failing to comply with the requirements of this chapter as an employer, supervisor, or trainee;

(11) failing to provide information in a timely manner in response to a request by the commissioner, commissioner's designee, or the advisory council;

(12) being convicted within the past five years of violating any laws of the United States, or any state or territory of the United States, and the violation is a felony, gross misdemeanor, or misdemeanor, an essential element of which relates to prescription hearing ~~instrument~~ aid dispensing, except as provided in chapter 364;

(13) failing to cooperate with the commissioner, the commissioner's designee, or the advisory council in any investigation;

(14) failing to perform prescription hearing ~~instrument~~ aid dispensing with reasonable judgment, skill, or safety due to the use of alcohol or drugs, or other physical or mental impairment;

(15) failing to fully disclose actions taken against the applicant or the applicant's legal authorization to dispense prescription hearing ~~instruments~~ aids in this or another state;

(16) violating a state or federal court order or judgment, including a conciliation court judgment, relating to the activities of the applicant in prescription hearing ~~instrument~~ aid dispensing;

(17) having been or being disciplined by the commissioner of the Department of Health, or other authority, in this or another jurisdiction, if any of the grounds for the discipline are the same or substantially equivalent to those in sections 153A.13 to 153A.18;

(18) misrepresenting the purpose of hearing tests, or in any way communicating that the hearing test or hearing test protocol required by section 153A.14, subdivision 4b, is a medical evaluation, a diagnostic hearing evaluation conducted by an audiologist, or is other than a test to select a prescription hearing ~~instrument~~ aid, except that the hearing ~~instrument~~ aid dispenser can determine the need for or recommend the consumer obtain a medical evaluation consistent with requirements of the United States Food and Drug Administration;

(19) violating any of the provisions of sections 148.5195, subdivision 3, clause (20); 148.5197; 148.5198; and 153A.13 to 153A.18; and

(20) aiding or abetting another person in violating any of the provisions of sections 148.5195, subdivision 3, clause (20); 148.5197; 148.5198; and 153A.13 to 153A.18.

Sec. 171. Minnesota Statutes 2022, section 153A.15, subdivision 2, is amended to read:

Subd. 2. **Enforcement actions.** When the commissioner finds that a dispenser of prescription hearing ~~instruments~~ aids has violated one or more provisions of this chapter, the commissioner may do one or more of the following:

(1) deny or reject the application for a certificate;

(2) revoke the certificate;

(3) suspend the certificate;

(4) impose, for each violation, a civil penalty that deprives the dispenser of any economic advantage gained by the violation and that reimburses the Department of Health for costs of the investigation and proceeding resulting in disciplinary action, including the amount paid for services of the Office of Administrative Hearings, the amount paid for services of the Office of the Attorney General, attorney fees, court reporters, witnesses, reproduction of records, advisory council members' per diem compensation, department staff time, and expenses incurred by advisory council members and department staff;

(5) censure or reprimand the dispenser;

(6) revoke or suspend the right to supervise trainees;

(7) revoke or suspend the right to be a trainee;

(8) impose a civil penalty not to exceed $10,000 for each separate violation; or

(9) any other action reasonably justified by the individual case.

Sec. 172. Minnesota Statutes 2022, section 153A.15, subdivision 4, is amended to read:

Subd. 4. **Penalties.** Except as provided in section 153A.14, subdivision 4, a person violating this chapter is guilty of a misdemeanor. The commissioner may impose an automatic civil penalty equal to one-fourth the renewal fee on each hearing ~~instrument seller~~ aid dispenser who fails to renew the certificate required in section 153A.14 by the renewal deadline.

Sec. 173. Minnesota Statutes 2022, section 153A.17, is amended to read:

153A.17 EXPENSES; FEES.

(a) The expenses for administering the certification requirements, including the complaint handling system for hearing aid dispensers in sections 153A.14 and 153A.15, and the Consumer Information Center under section 153A.18, must be paid from initial application and examination fees, renewal fees, penalties, and fines. The commissioner shall only use fees collected under this section for the purposes of administering this chapter. The legislature must not transfer money generated by these fees from the state government special revenue fund to the general fund. ~~Surcharges collected by the commissioner of health under section 16E.22 are not subject to this paragraph.~~

(b) The fees are as follows:

(1) the initial certification application fee is $772.50;

(2) the annual renewal certification application fee is $750;

(3) the initial examination fee for the practical portion is $1,200, and $600 for each time it is taken, thereafter; for individuals meeting the requirements of section 148.515, subdivision 2, the fee for the practical portion of the prescription hearing ~~instrument~~ aid dispensing examination is $600 each time it is taken;

(4) the trainee application fee is $230;

(5) the penalty fee for late submission of a renewal application is $260; and

(6) the fee for verification of certification to other jurisdictions or entities is $25.

(c) The commissioner may prorate the certification fee for new applicants based on the number of quarters remaining in the annual certification period.

(d) All fees are nonrefundable. All fees, penalties, and fines received must be deposited in the state government special revenue fund.

(e) Hearing instrument dispensers who were certified before January 1, 2018, shall pay a onetime surcharge of $22.50 to renew their certification when it expires after October 31, 2020. The surcharge shall cover the commissioner's costs associated with criminal background checks.

Sec. 174. Minnesota Statutes 2022, section 153A.175, is amended to read:

153A.175 PENALTY FEES.

(a) The penalty fee for holding oneself out as a hearing ~~instrument~~ aid dispenser without a current certificate after the credential has expired and before it is renewed is one-half the amount of the certificate renewal fee for any part of the first day, plus one-half the certificate renewal fee for any part of any subsequent days up to 30 days.

(b) The penalty fee for applicants who hold themselves out as hearing ~~instrument~~ aid dispensers after expiration of the trainee period and before being issued a certificate is one-half the amount of the certificate application fee for any part of the first day, plus one-half the certificate application fee for any part of any subsequent days up to 30 days. This paragraph does not apply to applicants not qualifying for a certificate who hold themselves out as hearing ~~instrument~~ aid dispensers.

(c) The penalty fee for practicing prescription hearing ~~instrument~~ aid dispensing and failing to submit a continuing education report by the due date with the correct number or type of hours in the correct time period is $200 plus $200 for each missing clock hour. "Missing" means not obtained between the effective and expiration dates of the certificate, the one-month period following the certificate expiration date, or the 30 days following notice of a penalty fee for failing to report all continuing education hours. The certificate holder must obtain the missing number of continuing education hours by the next reporting due date.

(d) Civil penalties and discipline incurred by certificate holders prior to August 1, 2005, for conduct described in paragraph (a), (b), or (c) shall be recorded as nondisciplinary penalty fees. Payment of a penalty fee does not preclude any disciplinary action reasonably justified by the individual case.

Sec. 175. Minnesota Statutes 2022, section 153A.18, is amended to read:

153A.18 CONSUMER INFORMATION CENTER.

The commissioner shall establish a Consumer Information Center to assist actual and potential purchasers of prescription hearing aids by providing them with information

regarding prescription hearing ~~instrument~~ aid sales. The Consumer Information Center shall disseminate information about consumers' legal rights related to prescription hearing ~~instrument~~ aid sales, provide information relating to complaints about dispensers of prescription hearing ~~instruments~~ aids, and provide information about outreach and advocacy services for consumers of prescription hearing ~~instruments~~ aids. In establishing the center and developing the information, the commissioner shall consult with representatives of hearing ~~instrument~~ aid dispensers, audiologists, physicians, and consumers.

Sec. 176. Minnesota Statutes 2022, section 153A.20, is amended to read:

153A.20 HEARING ~~INSTRUMENT~~ AID DISPENSER ADVISORY COUNCIL.

Subdivision 1. **Membership.** (a) The commissioner shall appoint seven persons to a Hearing ~~Instrument~~ Aid Dispenser Advisory Council.

(b) The seven persons must include:

(1) three public members, as defined in section 214.02. At least one of the public members shall be a prescription hearing ~~instrument~~ aid user and one of the public members shall be either a prescription hearing ~~instrument~~ aid user or an advocate of one;

(2) three hearing ~~instrument~~ aid dispensers certified under sections 153A.14 to 153A.20, each of whom is currently, and has been for the five years immediately preceding their appointment, engaged in prescription hearing ~~instrument~~ aid dispensing in Minnesota and who represent the occupation of prescription hearing ~~instrument~~ aid dispensing and who are not audiologists; and

(3) one audiologist licensed as an audiologist under chapter 148 who dispenses prescription hearing ~~instruments~~ aids, recommended by a professional association representing audiologists and speech-language pathologists.

(c) The factors the commissioner may consider when appointing advisory council members include, but are not limited to, professional affiliation, geographical location, and type of practice.

(d) No two members of the advisory council shall be employees of, or have binding contracts requiring sales exclusively for, the same prescription hearing ~~instrument~~ aid manufacturer or the same employer.

Subd. 2. **Organization.** The advisory council shall be organized and administered according to section 15.059. The council may form committees to carry out its duties.

Subd. 3. **Duties.** At the commissioner's request, the advisory council shall:

(1) advise the commissioner regarding hearing ~~instrument~~ aid dispenser certification standards;

(2) provide for distribution of information regarding hearing ~~instrument~~ aid dispenser certification standards;

(3) review investigation summaries of competency violations and make recommendations to the commissioner as to whether the allegations of incompetency are substantiated; and

(4) perform other duties as directed by the commissioner.

Sec. 177. Minnesota Statutes 2022, section 256B.434, subdivision 4f, is amended to read:

Subd. 4f. **Construction project rate adjustments effective October 1, 2006.** (a) Effective October 1, 2006, facilities reimbursed under this section may receive a property rate adjustment for construction projects exceeding the threshold in section 256B.431, subdivision 16, and below the threshold in section 144A.071, subdivision 2, ~~clause (a)~~ paragraph (c), clause (1). For these projects, capital assets purchased shall be counted as construction project costs for a rate adjustment request made by a facility if they are: (1) purchased within 24 months of the completion of the construction project; (2) purchased after the completion date of any prior construction project; and (3) are not purchased prior to July 14, 2005. Except as otherwise provided in this subdivision, the definitions, rate calculation methods, and principles in sections 144A.071 and 256B.431 and Minnesota Rules, parts 9549.0010 to 9549.0080, shall be used to calculate rate adjustments for allowable construction projects under this subdivision and section 144A.073. Facilities completing construction projects between October 1, 2005, and October 1, 2006, are eligible to have a property rate adjustment effective October 1, 2006. Facilities completing projects after October 1, 2006, are eligible for a property rate adjustment effective on the first day of the month following the completion date. Facilities completing projects after January 1, 2018, are eligible for a property rate adjustment effective on the first day of the month of January or July, whichever occurs immediately following the completion date.

(b) Notwithstanding subdivision 18, as of July 14, 2005, facilities with rates set under section 256B.431 and Minnesota Rules, parts 9549.0010 to 9549.0080, that commenced a construction project on or after October 1, 2004, and do not have a contract under subdivision 3 by September 30, 2006, are eligible to request a rate adjustment under section 256B.431, subdivision 10, through September 30, 2006. If the request results in the commissioner determining a rate adjustment is allowable, the rate adjustment is effective on the first of the month following project completion. These facilities shall be allowed to accumulate construction project costs for the period October 1, 2004, to September 30, 2006.

(c) Facilities shall be allowed construction project rate adjustments no sooner than 12 months after completing a previous construction project. Facilities must request the rate adjustment according to section 256B.431, subdivision 10.

(d) Capacity days shall be computed according to Minnesota Rules, part 9549.0060, subpart 11. For rate calculations under this section, the number of licensed beds in the nursing facility shall be the number existing after the construction project is completed and the number of days in the nursing facility's reporting period shall be 365.

(e) The value of assets to be recognized for a total replacement project as defined in section 256B.431, subdivision 17d, shall be computed as described in clause (1). The value of assets to be recognized for all other projects shall be computed as described in clause (2).

(1) Replacement-cost-new limits under section 256B.431, subdivision 17e, and the number of beds allowed under subdivision 3a, paragraph (c), shall be used to compute the maximum amount of assets allowable in a facility's property rate calculation. If a facility's current request for a rate adjustment results from the completion of a construction project that was previously approved under section 144A.073, the assets to be used in the rate calculation cannot exceed the lesser of the amount determined under sections 144A.071, subdivision 2, and 144A.073, subdivision 3b, or the actual allowable costs of the construction project. A current request that is not the result of a project under section 144A.073 cannot exceed the limit under section 144A.071, subdivision 2, paragraph ~~(a)~~ (c), clause (1). Applicable credits must be deducted from the cost of the construction project.

(2)(i) Replacement-cost-new limits under section 256B.431, subdivision 17e, and the number of beds allowed under section 256B.431, subdivision 3a, paragraph (c), shall be used to compute the maximum amount of assets allowable in a facility's property rate calculation.

(ii) The value of a facility's assets to be compared to the amount in item (i) begins with the total appraised value from the last rate notice a facility received when its rates were set under section 256B.431 and Minnesota Rules, parts 9549.0010 to 9549.0080. This value shall be indexed by the factor in section 256B.431, subdivision 3f, paragraph (a), for each rate year the facility received an inflation factor on its property-related rate when its rates were set under this section. The value of assets listed as previous capital additions, capital additions, and special projects on the facility's base year rate notice and the value of assets related to a construction project for which the facility received a rate adjustment when its rates were determined under this section shall be added to the indexed appraised value.

(iii) The maximum amount of assets to be recognized in computing a facility's rate adjustment after a project is completed is the lesser of the aggregate replacement-cost-new limit computed in (i) minus the assets recognized in (ii) or the actual allowable costs of the construction project.

(iv) If a facility's current request for a rate adjustment results from the completion of a construction project that was previously approved under section 144A.073, the assets to be added to the rate calculation cannot exceed the lesser of the amount determined under sections 144A.071, subdivision 2, and 144A.073, subdivision 3b, or the actual allowable costs of the construction project. A current request that is not the result of a project under section 144A.073 cannot exceed the limit stated in section 144A.071, subdivision 2, paragraph ~~(a)~~ (c), clause (1). Assets disposed of as a result of a construction project and applicable credits must be deducted from the cost of the construction project.

(f) For construction projects approved under section 144A.073, allowable debt may never exceed the lesser of the cost of the assets purchased, the threshold limit in section 144A.071, subdivision 2, or the replacement-cost-new limit less previously existing capital debt.

(g) For construction projects that were not approved under section 144A.073, allowable debt is limited to the lesser of the threshold in section 144A.071, subdivision 2, for such construction projects or the applicable limit in paragraph (e), clause (1) or (2), less previously existing capital debt. Amounts of debt taken out that exceed the costs of a construction project shall not be allowed regardless of the use of the funds.

For all construction projects being recognized, interest expense and average debt shall be computed based on the first 12 months following project completion. "Previously existing capital debt" means capital debt recognized on the last rate determined under section 256B.431 and Minnesota Rules, parts 9549.0010 to 9549.0080, and the amount of debt recognized for a construction project for which the facility received a rate adjustment when its rates were determined under this section.

For a total replacement project as defined in section 256B.431, subdivision 17d, the value of previously existing capital debt shall be zero.

(h) In addition to the interest expense allowed from the application of paragraph (f), the amounts allowed under section 256B.431, subdivision 17a, paragraph (a), clauses (2) and (3), will be added to interest expense.

(i) The equity portion of the construction project shall be computed as the allowable assets in paragraph (e), less the average debt in paragraph (f). The equity portion must be

multiplied by 5.66 percent and the allowable interest expense in paragraph (f) must be added. This sum must be divided by 95 percent of capacity days to compute the construction project rate adjustment.

(j) For projects that are not a total replacement of a nursing facility, the amount in paragraph (i) is adjusted for nonreimbursable areas and then added to the current property payment rate of the facility.

(k) For projects that are a total replacement of a nursing facility, the amount in paragraph (i) becomes the new property payment rate after being adjusted for nonreimbursable areas. Any amounts existing in a facility's rate before the effective date of the construction project for equity incentives under section 256B.431, subdivision 16; capital repairs and replacements under section 256B.431, subdivision 15; or refinancing incentives under section 256B.431, subdivision 19, shall be removed from the facility's rates.

(l) No additional equipment allowance is allowed under Minnesota Rules, part 9549.0060, subpart 10, as the result of construction projects under this section. Allowable equipment shall be included in the construction project costs.

(m) Capital assets purchased after the completion date of a construction project shall be counted as construction project costs for any future rate adjustment request made by a facility under section 144A.071, subdivision 2, ~~clause (a)~~ paragraph (c), clause (1), if they are purchased within 24 months of the completion of the future construction project.

(n) In subsequent rate years, the property payment rate for a facility that results from the application of this subdivision shall be the amount inflated in subdivision 4.

(o) Construction projects are eligible for an equity incentive under section 256B.431, subdivision 16. When computing the equity incentive for a construction project under this subdivision, only the allowable costs and allowable debt related to the construction project shall be used. The equity incentive shall not be a part of the property payment rate and not inflated under subdivision 4. Effective October 1, 2006, all equity incentives for nursing facilities reimbursed under this section shall be allowed for a duration determined under section 256B.431, subdivision 16, paragraph (c).

Sec. 178. Minnesota Statutes 2022, section 256B.692, subdivision 2, is amended to read:

Subd. 2. **Duties of commissioner of health.** (a) Notwithstanding chapters 62D and 62N, a county that elects to purchase medical assistance in return for a fixed sum without regard to the frequency or extent of services furnished to any particular enrollee is not required to obtain a certificate of authority under chapter 62D or 62N. The county board of

commissioners is the governing body of a county-based purchasing program. In a multicounty arrangement, the governing body is a joint powers board established under section 471.59.

(b) A county that elects to purchase medical assistance services under this section must satisfy the commissioner of health that the requirements for assurance of consumer protection, provider protection, and fiscal solvency of chapter 62D, applicable to health maintenance organizations will be met according to the following schedule:

(1) for a county-based purchasing plan approved on or before June 30, 2008, the plan must have in reserve:

(i) at least 50 percent of the minimum amount required under chapter 62D as of January 1, 2010;

(ii) at least 75 percent of the minimum amount required under chapter 62D as of January 1, 2011;

(iii) at least 87.5 percent of the minimum amount required under chapter 62D as of January 1, 2012; and

(iv) at least 100 percent of the minimum amount required under chapter 62D as of January 1, 2013; and

(2) for a county-based purchasing plan first approved after June 30, 2008, the plan must have in reserve:

(i) at least 50 percent of the minimum amount required under chapter 62D at the time the plan begins enrolling enrollees;

(ii) at least 75 percent of the minimum amount required under chapter 62D after the first full calendar year;

(iii) at least 87.5 percent of the minimum amount required under chapter 62D after the second full calendar year; and

(iv) at least 100 percent of the minimum amount required under chapter 62D after the third full calendar year.

(c) Until a plan is required to have reserves equaling at least 100 percent of the minimum amount required under chapter 62D, the plan may demonstrate its ability to cover any losses by satisfying the requirements of chapter 62N. A county-based purchasing plan must also assure the commissioner of health that the requirements of sections 62J.041; 62J.48; 62J.71 to 62J.73; all applicable provisions of chapter 62Q, including sections 62Q.075; 62Q.1055;

62Q.106; 62Q.12; 62Q.135; 62Q.14; ~~62Q.145;~~ 62Q.19; 62Q.23, paragraph (c); 62Q.43; 62Q.47; 62Q.50; 62Q.52 to 62Q.56; 62Q.58; 62Q.68 to 62Q.72; and 72A.201 will be met.

(d) All enforcement and rulemaking powers available under chapters 62D, 62J, 62N, and 62Q are hereby granted to the commissioner of health with respect to counties that purchase medical assistance services under this section.

(e) The commissioner, in consultation with county government, shall develop administrative and financial reporting requirements for county-based purchasing programs relating to sections 62D.041, 62D.042, 62D.045, 62D.08, 62N.28, 62N.29, and 62N.31, and other sections as necessary, that are specific to county administrative, accounting, and reporting systems and consistent with other statutory requirements of counties.

(f) The commissioner shall collect from a county-based purchasing plan under this section the following fees:

(1) fees attributable to the costs of audits and other examinations of plan financial operations. These fees are subject to the provisions of Minnesota Rules, part 4685.2800, subpart 1, item F; and

(2) an annual fee of $21,500, to be paid by June 15 of each calendar year.

All fees collected under this paragraph shall be deposited in the state government special revenue fund.

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

Sec. 179. Minnesota Statutes 2022, section 403.161, is amended to read:

403.161 PREPAID WIRELESS FEES IMPOSED; COLLECTION; REMITTANCE.

Subdivision 1. **Fees imposed.** (a) A prepaid wireless E911 fee of 80 cents per retail transaction is imposed on prepaid wireless telecommunications service until the fee is adjusted as an amount per retail transaction under subdivision 7.

(b) A prepaid wireless telecommunications access Minnesota fee, in the amount of the monthly charge provided for in section 237.52, subdivision 2, is imposed on each retail transaction for prepaid wireless telecommunications service until the fee is adjusted as an amount per retail transaction under subdivision 7.

(c) A prepaid wireless 988 fee, in the amount of the monthly charge, is imposed on each retail transaction for prepaid wireless telecommunications service until the fee is adjusted as an amount per retail transaction under subdivision 7.

Subd. 2. **Exemption.** The fees established under subdivision 1 are not imposed on a minimal amount of prepaid wireless telecommunications service that is sold with a prepaid wireless device and is charged a single nonitemized price, and a seller may not apply the fees to such a transaction. For purposes of this subdivision, a minimal amount of service means an amount of service denominated as either ten minutes or less or $5 or less.

Subd. 3. **Fee collected.** The prepaid wireless E911 ~~and~~, telecommunications access Minnesota, and 988 fees must be collected by the seller from the consumer for each retail transaction occurring in this state. The amount of each fee must be combined into one amount, which must be separately stated on an invoice, receipt, or other similar document that is provided to the consumer by the seller.

Subd. 4. **Sales and use tax treatment.** For purposes of this section, a retail transaction conducted in person by a consumer at a business location of the seller must be treated as occurring in this state if that business location is in this state, and any other retail transaction must be treated as occurring in this state if the retail transaction is treated as occurring in this state for purposes of the sales and use tax as specified in section 297A.669, subdivision 3, paragraph (c).

Subd. 5. **Remittance.** The prepaid wireless E911 ~~and~~, telecommunications access Minnesota, and 988 fees are the liability of the consumer and not of the seller or of any provider, except that the seller is liable to remit all fees as provided in section 403.162.

Subd. 6. **Exclusion for calculating other charges.** The combined amount of the prepaid wireless E911 ~~and~~, telecommunications access Minnesota, and 988 fees collected by a seller from a consumer must not be included in the base for measuring any tax, fee, surcharge, or other charge that is imposed by this state, any political subdivision of this state, or any intergovernmental agency.

Subd. 7. **Fee changes.** (a) The prepaid wireless E911 ~~and~~, telecommunications access Minnesota ~~fee~~, and 988 fees must be proportionately increased or reduced upon any change to the fee imposed under section 403.11, subdivision 1, paragraph (c), after July 1, 2013, ~~or~~ the fee imposed under section 237.52, subdivision 2, or the fee imposed under section 145.561, subdivision 4, as applicable.

(b) The department shall post notice of any fee changes on its website at least 30 days in advance of the effective date of the fee changes. It is the responsibility of sellers to monitor the department's website for notice of fee changes.

(c) Fee changes are effective 60 days after the first day of the first calendar month after the commissioner of public safety or the Public Utilities Commission, as applicable, changes the fee.

Sec. 180. Minnesota Statutes 2022, section 403.162, is amended to read:

403.162 ADMINISTRATION OF PREPAID WIRELESS E911 FEES.

Subdivision 1. **Remittance.** Prepaid wireless E911 ~~and~~, telecommunications access Minnesota, and 988 fees collected by sellers must be remitted to the commissioner of revenue at the times and in the manner provided by chapter 297A with respect to the general sales and use tax. The commissioner of revenue shall establish registration and payment procedures that substantially coincide with the registration and payment procedures that apply in chapter 297A.

Subd. 2. **Seller's fee retention.** A seller may deduct and retain three percent of prepaid wireless E911 ~~and~~, telecommunications access Minnesota, and 988 fees collected by the seller from consumers.

Subd. 3. **Department of Revenue provisions.** The audit, assessment, appeal, collection, refund, penalty, interest, enforcement, and administrative provisions of chapters 270C and 289A that are applicable to the taxes imposed by chapter 297A apply to any fee imposed under section 403.161.

Subd. 4. **Procedures for resale transactions.** The commissioner of revenue shall establish procedures by which a seller of prepaid wireless telecommunications service may document that a sale is not a retail transaction. These procedures must substantially coincide with the procedures for documenting sale for resale transactions as provided in chapter 297A.

Subd. 5. **Fees deposited.** (a) The commissioner of revenue shall, based on the relative proportion of the prepaid wireless E911 fee ~~and~~, the prepaid wireless telecommunications access Minnesota fee, and the prepaid wireless 988 fee, imposed per retail transaction, divide the fees collected in corresponding proportions. Within 30 days of receipt of the collected fees, the commissioner shall:

(1) deposit the proportion of the collected fees attributable to the prepaid wireless E911 fee in the 911 emergency telecommunications service account in the special revenue fund; ~~and~~

(2) deposit the proportion of collected fees attributable to the prepaid wireless telecommunications access Minnesota fee in the telecommunications access fund established in section 237.52, subdivision 1~~.~~; and

(3) deposit the proportion of the collected fees attributable to the prepaid wireless 988 fee in the 988 special revenue account established.

(b) The commissioner of revenue may deduct and deposit in a special revenue account an amount not to exceed two percent of collected fees. Money in the account is annually appropriated to the commissioner of revenue to reimburse its direct costs of administering the collection and remittance of prepaid wireless E911 fees, ~~and~~ prepaid wireless telecommunications access Minnesota fees~~.~~, and prepaid wireless 988 fees.

Sec. 181. Minnesota Statutes 2022, section 518A.39, subdivision 2, is amended to read:

Subd. 2. **Modification.** (a) The terms of an order respecting maintenance or support may be modified upon a showing of one or more of the following, any of which makes the terms unreasonable and unfair: (1) substantially increased or decreased gross income of an obligor or obligee; (2) substantially increased or decreased need of an obligor or obligee or the child or children that are the subject of these proceedings; (3) receipt of assistance under the AFDC program formerly codified under sections 256.72 to 256.87 or 256B.01 to ~~256B.40~~ 256B.39, or chapter 256J or 256K; (4) a change in the cost of living for either party as measured by the federal Bureau of Labor Statistics; (5) extraordinary medical expenses of the child not provided for under section 518A.41; (6) a change in the availability of appropriate health care coverage or a substantial increase or decrease in health care coverage costs; (7) the addition of work-related or education-related child care expenses of the obligee or a substantial increase or decrease in existing work-related or education-related child care expenses; or (8) upon the emancipation of the child, as provided in subdivision 5.

(b) It is presumed that there has been a substantial change in circumstances under paragraph (a) and the terms of a current support order shall be rebuttably presumed to be unreasonable and unfair if:

(1) the application of the child support guidelines in section 518A.35, to the current circumstances of the parties results in a calculated court order that is at least 20 percent and at least $75 per month higher or lower than the current support order or, if the current support order is less than $75, it results in a calculated court order that is at least 20 percent per month higher or lower;

(2) the medical support provisions of the order established under section 518A.41 are not enforceable by the public authority or the obligee;

(3) health coverage ordered under section 518A.41 is not available to the child for whom the order is established by the parent ordered to provide;

(4) the existing support obligation is in the form of a statement of percentage and not a specific dollar amount;

(5) the gross income of an obligor or obligee has decreased by at least 20 percent through no fault or choice of the party; or

(6) a deviation was granted based on the factor in section 518A.43, subdivision 1, clause (4), and the child no longer resides in a foreign country or the factor is otherwise no longer applicable.

(c) A child support order is not presumptively modifiable solely because an obligor or obligee becomes responsible for the support of an additional nonjoint child, which is born after an existing order. Section 518A.33 shall be considered if other grounds are alleged which allow a modification of support.

(d) If child support was established by applying a parenting expense adjustment or presumed equal parenting time calculation under previously existing child support guidelines and there is no parenting plan or order from which overnights or overnight equivalents can be determined, there is a rebuttable presumption that the established adjustment or calculation will continue after modification so long as the modification is not based on a change in parenting time. In determining an obligation under previously existing child support guidelines, it is presumed that the court shall:

(1) if a 12 percent parenting expense adjustment was applied, multiply the obligor's share of the combined basic support obligation calculated under section 518A.34, paragraph (b), clause (5), by 0.88; or

(2) if the parenting time was presumed equal but the parents' parental incomes for determining child support were not equal:

(i) multiply the combined basic support obligation under section 518A.34, paragraph (b), clause (5), by 0.75;

(ii) prorate the amount under item (i) between the parents based on each parent's proportionate share of the combined PICS; and

(iii) subtract the lower amount from the higher amount.

(e) On a motion for modification of maintenance, including a motion for the extension of the duration of a maintenance award, the court shall apply, in addition to all other relevant factors, the factors for an award of maintenance under section 518.552 that exist at the time of the motion. On a motion for modification of support, the court:

(1) shall apply section 518A.35, and shall not consider the financial circumstances of each party's spouse, if any; and

(2) shall not consider compensation received by a party for employment in excess of a 40-hour work week, provided that the party demonstrates, and the court finds, that:

(i) the excess employment began after entry of the existing support order;

(ii) the excess employment is voluntary and not a condition of employment;

(iii) the excess employment is in the nature of additional, part-time employment, or overtime employment compensable by the hour or fractions of an hour;

(iv) the party's compensation structure has not been changed for the purpose of affecting a support or maintenance obligation;

(v) in the case of an obligor, current child support payments are at least equal to the guidelines amount based on income not excluded under this clause; and

(vi) in the case of an obligor who is in arrears in child support payments to the obligee, any net income from excess employment must be used to pay the arrearages until the arrearages are paid in full.

(f) A modification of support or maintenance, including interest that accrued pursuant to section 548.091, may be made retroactive only with respect to any period during which the petitioning party has pending a motion for modification but only from the date of service of notice of the motion on the responding party and on the public authority if public assistance is being furnished or the county attorney is the attorney of record, unless the court adopts an alternative effective date under paragraph (l). The court's adoption of an alternative effective date under paragraph (l) shall not be considered a retroactive modification of maintenance or support.

(g) Except for an award of the right of occupancy of the homestead, provided in section 518.63, all divisions of real and personal property provided by section 518.58 shall be final, and may be revoked or modified only where the court finds the existence of conditions that justify reopening a judgment under the laws of this state, including motions under section 518.145, subdivision 2. The court may impose a lien or charge on the divided property at any time while the property, or subsequently acquired property, is owned by the parties or

either of them, for the payment of maintenance or support money, or may sequester the property as is provided by section 518A.71.

(h) The court need not hold an evidentiary hearing on a motion for modification of maintenance or support.

(i) Sections 518.14 and 518A.735 shall govern the award of attorney fees for motions brought under this subdivision.

(j) An enactment, amendment, or repeal of law constitutes a substantial change in the circumstances for purposes of modifying a child support order when it meets the standards for modification in this section.

(k) On the first modification following implementation of amended child support guidelines, the modification of basic support may be limited if the amount of the full variance would create hardship for either the obligor or the obligee. Hardship includes, but is not limited to, eligibility for assistance under chapter 256J.

(l) The court may select an alternative effective date for a maintenance or support order if the parties enter into a binding agreement for an alternative effective date.

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

Sec. 182. Laws 2017, First Special Session chapter 6, article 5, section 11, as amended by Laws 2019, First Special Session chapter 9, article 8, section 20, is amended to read:

Sec. 11. **MORATORIUM ON CONVERSION TRANSACTIONS.**

(a) Notwithstanding Laws 2017, chapter 2, article 2, a nonprofit ~~health~~ service plan corporation operating under Minnesota Statutes, chapter 62C, or a nonprofit health maintenance organization operating under Minnesota Statutes, chapter 62D, as of January 1, 2017, may only merge or consolidate with; convert; or transfer, as part of a single transaction or a series of transactions within a 24-month period, all or a material amount of its assets to an entity that is a corporation organized under Minnesota Statutes, chapter 317A; or to a Minnesota nonprofit hospital within the same integrated health system as the health maintenance organization. For purposes of this section, "material amount" means the lesser of ten percent of such an entity's total admitted net assets as of December 31 of the previous year, or $50,000,000.

(b) Paragraph (a) does not apply if the nonprofit service plan corporation or nonprofit health maintenance organization files an intent to dissolve due to insolvency of the

corporation in accordance with Minnesota Statutes, chapter 317A, or insolvency proceedings are commenced under Minnesota Statutes, chapter 60B.

(c) Nothing in this section shall be construed to authorize a nonprofit health maintenance organization or a nonprofit service plan corporation to engage in any transaction or activities not otherwise permitted under state law.

(d) This section expires July 1, ~~2023~~ 2026.

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

Sec. 183. Laws 2022, chapter 99, article 1, section 46, is amended to read:

Sec. 46. **MENTAL HEALTH GRANTS FOR HEALTH CARE PROFESSIONALS.**

Subdivision 1. **Grants authorized.** (a) The commissioner of health shall develop a grant program to award grants to health care entities, including but not limited to health care systems, hospitals, nursing facilities, community health clinics or consortium of clinics, federally qualified health centers, rural health clinics, or health professional associations for the purpose of establishing or expanding programs focused on improving the mental health of health care professionals.

(b) Grants shall be awarded for programs that are evidenced-based or evidenced-informed and are focused on addressing the mental health of health care professionals by:

(1) identifying and addressing the barriers to and stigma among health care professionals associated with seeking self-care, including mental health and substance use disorder services;

(2) encouraging health care professionals to seek support and care for mental health and substance use disorder concerns;

(3) identifying risk factors associated with suicide and other mental health conditions; ~~or~~

(4) developing and making available resources to support health care professionals with self-care and resiliency~~.~~; or

(5) identifying and modifying structural barriers in health care delivery that create unnecessary stress in the workplace.

Subd. 2. **Allocation of grants.** (a) To receive a grant, a health care entity must submit an application to the commissioner by the deadline established by the commissioner. An application must be on a form and contain information as specified by the commissioner and at a minimum must contain:

(1) a description of the purpose of the program for which the grant funds will be used;

(2) a description of the achievable objectives of the program and how these objectives will be met; and

(3) a process for documenting and evaluating the results of the program.

(b) The commissioner shall give priority to programs that involve peer-to-peer support.

Subd. 2a. **Grant term.** Notwithstanding Minnesota Statutes, section 16A.28, subdivision 6, encumbrances for grants under this section issued by June 30 of each year may be certified for a period of up to three years beyond the year in which the funds were originally appropriated.

Subd. 3. **Evaluation.** The commissioner shall evaluate the overall effectiveness of the grant program by conducting a periodic evaluation of the impact and outcomes of the grant program on health care professional burnout and retention. The commissioner shall submit the results of the evaluation and any recommendations for improving the grant program to the chairs and ranking minority members of the legislative committees with jurisdiction over health care policy and finance by October 15, 2024.

Sec. 184. Laws 2022, chapter 99, article 3, section 9, is amended to read:

Sec. 9. **APPROPRIATION; MENTAL HEALTH GRANTS FOR HEALTH CARE PROFESSIONALS.**

$1,000,000 in fiscal year 2023 is appropriated from the general fund to the commissioner of health for the health care professionals mental health grant program. This is a onetime appropriation and is available until June 30, 2027.

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

Sec. 185. **ADOLESCENT MENTAL HEALTH PROMOTION; GRANTS AUTHORIZED.**

Subdivision 1. **Goal and establishment.** (a) It is the goal of the state to increase protective factors for mental well-being and decrease disparities in rates of mental health issues among adolescent populations. The commissioner of health shall administer grants to community-based organizations to facilitate mental health promotion programs for adolescents, particularly those from populations that report higher rates of specific mental health needs.

(b) The commissioner of health shall coordinate with other efforts at the local, state, or national level to avoid duplication and promote complementary efforts in mental health promotion among adolescents.

Subd. 2. **Grants authorized.** (a) The commissioner of health shall award grants to eligible community organizations, including nonprofit organizations, community health boards, and Tribal public health entities, to implement community-based mental health promotion programs for adolescents in community settings to improve adolescent mental health and reduce disparities between adolescent populations in reported rates of mental health needs.

(b) The commissioner of health, in collaboration with community and professional stakeholders, shall establish criteria for review of applications received under this subdivision to ensure funded programs operate using best practices such as trauma-informed care and positive youth development principles.

(c) Grant funds distributed under this subdivision shall be used to support new or existing community-based mental health promotion programs that include but are not limited to:

(1) training community-based members to facilitate discussions or courses on adolescent mental health promotion skills;

(2) training trusted community members to model positive mental health skills and practices in their existing roles;

(3) training and supporting adolescents to provide peer support; and

(4) supporting community dialogue on mental health promotion and collective stress or trauma.

Subd. 3. **Evaluation.** The commissioner shall conduct an evaluation of the community-based grant programs funded under this section. Grant recipients shall cooperate with the commissioner in the evaluation, and at the direction of the commissioner, shall provide the commissioner with the information needed to conduct the evaluation.

Sec. 186. **ADVANCING HEALTH EQUITY THROUGH CAPACITY BUILDING AND RESOURCE ALLOCATION.**

Subdivision 1. **Establishment of grant program.** The commissioner of health shall:

(1) establish an annual grant program to award infrastructure capacity building grants to help metro and rural community and faith-based organizations serving populations of color, American Indians, LGBTQIA+ communities, and those with disabilities in Minnesota

who have been disproportionately impacted by health and other inequities to be better equipped and prepared for success in procuring grants and contracts at the department and addressing inequities; and

(2) create a framework at the department to maintain equitable practices in grantmaking to ensure that internal grantmaking and procurement policies and practices prioritize equity, transparency, and accessibility to include:

(i) a tracking system for the department to better monitor and evaluate equitable procurement and grantmaking processes and their impacts; and

(ii) technical assistance and coaching to department leadership in grantmaking and procurement processes and programs and providing tools and guidance to ensure equitable and transparent competitive grantmaking processes and award distribution across communities most impacted by inequities and develop measures to track progress over time.

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

(1) in consultation with community stakeholders, community health boards, and Tribal nations, develop a request for proposals for an infrastructure capacity building grant program to help community-based organizations, including faith-based organizations, to be better equipped and prepared for success in procuring grants and contracts at the department and beyond;

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

(3) in consultation with community stakeholders, review responses to requests for proposals and award grants under this section;

(4) ensure communication with the ethnic councils, Minnesota Indian Affairs Council, Minnesota Council on Disability, and the governor's office on the request for proposal process;

(5) in consultation with community stakeholders, establish a transparent and objective accountability process focused on outcomes that grantees agree to achieve;

(6) maintain data on outcomes reported by grantees; and

(7) establish a process or mechanism to evaluate the success of the capacity building grant program and to build the evidence base for effective community-based organizational capacity building in reducing disparities.

Subd. 3. **Eligible grantees.** Organizations eligible to receive grant funding under this section include: organizations or entities that work with diverse communities such as populations of color, American Indians, LGBTQIA+ communities, and those with disabilities in metro and rural communities.

Subd. 4. **Strategic consideration and priority of proposals; eligible populations; grant awards.** (a) The commissioner, in consultation with community stakeholders, shall develop a request for proposals for equity in procurement and grantmaking capacity building grant program to help community-based organizations, including faith-based organizations to be better equipped and prepared for success in procuring grants and contracts at the department and addressing inequities.

(b) In awarding the grants, the commissioner shall provide strategic consideration and give priority to proposals from organizations or entities led by populations of color or American Indians, and those serving communities of color, American Indians, LGBTQIA+ communities, and disability communities.

Subd. 5. **Geographic distribution of grants.** The commissioner shall ensure that grant funds are prioritized and awarded to organizations and entities that are within counties that have a higher proportion of Black or African American, nonwhite Latino(a), LGBTQIA+, and disability communities to the extent possible.

Subd. 6. **Report.** Grantees must report grant program outcomes to the commissioner on the forms and according to the timelines established by the commissioner.

Sec. 187. **CRITICAL ACCESS DENTAL INFRASTRUCTURE PROGRAM.**

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

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

(c) "Critical access dental provider" means a critical access dental provider as defined in Minnesota Statutes, section 256B.76, subdivision 4.

(d) "Dental infrastructure" means:

(1) physical infrastructure of a dental setting, including but not limited to the operations and clinical spaces in a dental clinic; associated heating, ventilation, and air conditioning

infrastructure and other mechanical infrastructure; and dental equipment needed to operate a dental clinic; or

(2) mobile dental equipment or other equipment needed to provide dental services via a hub-and-spoke service delivery model or via teledentistry.

Subd. 2. **Grant and loan program established.** The commissioner shall make grants and forgivable loans to critical access dental providers for eligible dental infrastructure projects.

Subd. 3. **Eligible projects.** In order to be eligible for a grant or forgivable loan under this section, a dental infrastructure project must be proposed by a critical access dental provider and must allow the provider to maintain or expand the provider's capacity to serve Minnesota health care program enrollees.

Subd. 4. **Application.** (a) The commissioner must develop forms and procedures for soliciting and reviewing applications for grants and forgivable loans under this section and for awarding grants and forgivable loans. Critical access dental providers seeking a grant or forgivable loan under this section must apply to the commissioner in a time and manner specified by the commissioner. In evaluating applications for grants or forgivable loans for eligible projects, the commissioner must review applications for completeness and must determine the extent to which:

(1) the project would ensure that the critical access dental provider is able to continue to serve Minnesota health care program enrollees in a manner that would not be possible but for the project; or

(2) the project would increase the number of Minnesota health care program enrollees served by the provider or the clinical complexity of the Minnesota health care program enrollees served by the provider.

(b) The commissioner must award grants and forgivable loans based on the information provided in the grant application.

Subd. 5. **Program oversight.** The commissioner may require and collect from grant and loan recipients any information needed to evaluate the program.

Sec. 188. **DIRECTION TO COMMISSIONER OF HEALTH; DEVELOPMENT OF ANALYTICAL TOOLS.**

(a) The commissioner of health, in consultation with the Minnesota Nurses Association and other professional nursing organizations, must develop a means of analyzing available

adverse event data, available staffing data, and available data from concern for safe staffing forms to examine potential causal links between adverse events and understaffing.

(b) The commissioner must develop an initial means of conducting the analysis described in paragraph (a) by January 1, 2025, and publish a public report on the commissioner's initial findings by January 1, 2026.

(c) By January 1, 2024, the commissioner must submit to the chairs and ranking minority members of the house and senate committees with jurisdiction over the regulation of hospitals a report on the available data, potential sources of additional useful data, and any additional statutory authority the commissioner requires to collect additional useful information from hospitals.

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

Sec. 189. **DIRECTION TO COMMISSIONER OF HEALTH; NURSING WORKFORCE REPORT.**

(a) The commissioner of health must publish a public report on the current status of the state's nursing workforce employed by hospitals. In preparing the report, the commissioner shall utilize information collected in collaboration with the Board of Nursing as directed under Minnesota Statutes, sections 144.051 and 144.052, on Minnesota's supply of active licensed nurses and reasons licensed nurses are leaving direct care positions at hospitals; information collected and shared by the Minnesota Hospital Association on retention by hospitals of licensed nurses; information collected through an independent study on reasons licensed nurses are choosing not to renew their licenses and leaving the profession; and other publicly available data the commissioner deems useful.

(b) The commissioner must publish the report by January 1, 2026.

Sec. 190. **EMMETT LOUIS TILL VICTIMS RECOVERY PROGRAM.**

Subdivision 1. **Short title.** This section shall be known as the Emmett Louis Till Victims Recovery Program.

Subd. 2. **Program established; grants.** (a) The commissioner of health shall establish the Emmett Louis Till Victims Recovery Program to address the health and wellness needs of:

(1) victims who experienced trauma, including historical trauma, resulting from events such as assault or another violent physical act, intimidation, false accusations, wrongful

conviction, a hate crime, the violent death of a family member, or experiences of discrimination or oppression based on the victim's race, ethnicity, or national origin; and

(2) the families and heirs of victims described in clause (1), who experienced trauma, including historical trauma, because of their proximity or connection to the victim.

(b) The commissioner, in consultation with victims, families, and heirs described in paragraph (a), shall award competitive grants to applicants for projects to provide the following services to victims, families, and heirs described in paragraph (a):

(1) health and wellness services, which may include services and support to address physical health, mental health, and cultural needs;

(2) remembrance and legacy preservation activities;

(3) cultural awareness services; and

(4) community resources and services to promote healing for victims, families, and heirs described in paragraph (a).

(c) In awarding grants under this section, the commissioner must prioritize grant awards to community-based organizations experienced in providing support and services to victims, families, and heirs described in paragraph (a).

Subd. 3. **Evaluation.** Grant recipients must provide the commissioner with information required by the commissioner to evaluate the grant program, in a time and manner specified by the commissioner.

Subd. 4. **Reports.** The commissioner must submit a status report by January 15, 2024, and an additional report by January 15, 2025, on the operation and results of the grant program, to the extent available. These reports must be submitted to the chairs and ranking minority members of the legislative committees with jurisdiction over health care. The report due January 15, 2024, must include information on grant program activities to date and an assessment of the need to continue to offer services provided by grant recipients to victims, families, and heirs who experienced trauma resulting from government-sponsored activities. The report due January 15, 2025, must include a summary of the services offered by grant recipients; an assessment of the need to continue to offer services provided by grant recipients to victims, families, and heirs described in subdivision 2, paragraph (a); and an evaluation of the grant program's goals and outcomes.

Sec. 191. **HEALTHY BEGINNINGS, HEALTHY FAMILIES ACT.**

Subdivision 1. **Purpose.** The purpose of the Healthy Beginnings, Healthy Families Act is to build equitable, inclusive, and culturally and linguistically responsive systems that ensure the health and well-being of young children and their families by supporting the Minnesota perinatal quality collaborative, establishing the Minnesota partnership to prevent infant mortality, increasing access to culturally relevant developmental and social-emotional screening with follow-up, and sustaining and expanding the model jail practices for children of incarcerated parents in Minnesota jails.

Subd. 2. **Minnesota perinatal quality collaborative.** The Minnesota perinatal quality collaborative is established to improve pregnancy outcomes for pregnant people and newborns through efforts to:

(1) advance evidence-based and evidence-informed clinics and other health service practices and processes through quality care review, chart audits, and continuous quality improvement initiatives that enable equitable outcomes;

(2) review current data, trends, and research on best practices to inform and prioritize quality improvement initiatives;

(3) identify methods that incorporate antiracism into individual practice and organizational guidelines in the delivery of perinatal health services;

(4) support quality improvement initiatives to address substance use disorders in pregnant people and infants with neonatal abstinence syndrome or other effects of substance use;

(5) provide a forum to discuss state-specific system and policy issues to guide quality improvement efforts that improve population-level perinatal outcomes;

(6) reach providers and institutions in a multidisciplinary, collaborative, and coordinated effort across system organizations to reinforce a continuum of care model; and

(7) support health care facilities in monitoring interventions through rapid data collection and applying system changes to provide improved care in perinatal health.

Subd. 3. **Eligible organizations.** The commissioner of health shall make a grant to a nonprofit organization to create or sustain a multidisciplinary network of representatives of health care systems, health care providers, academic institutions, local and state agencies, and community partners that will collaboratively improve pregnancy and infant outcomes through evidence-based, population-level quality improvement initiatives.

Subd. 4. **Grants authorized.** The commissioner shall award one grant to a nonprofit organization to support efforts that improve maternal and infant health outcomes aligned with the purpose outlined in subdivision 2. The commissioner shall give preference to a nonprofit organization that has the ability to provide these services throughout the state. The commissioner shall provide content expertise to the grant recipient to further the accomplishment of the purpose.

Subd. 5. **Minnesota partnership to prevent infant mortality program.** (a) The commissioner of health shall establish the Minnesota partnership to prevent infant mortality program that is a statewide partnership program to engage communities, exchange best practices, share summary data on infant health, and promote policies to improve birth outcomes and eliminate preventable infant mortality.

(b) The goals of the Minnesota partnership to prevent infant mortality program are to:

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

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

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

Subd. 5a. **Grants authorized.** (a) The commissioner of health shall award grants to eligible applicants to convene, coordinate, and implement data-driven strategies and culturally relevant activities to improve infant health by reducing preterm births, sleep-related infant deaths, and congenital malformations and address social and environmental determinants of health. Grants shall be awarded to support community nonprofit organizations, Tribal governments, and community health boards. In accordance with available funding, grants shall be noncompetitively awarded to the eleven sovereign Tribal governments if their respective proposals demonstrate the ability to implement programs designed to achieve the purposes in subdivision 5 and meet other requirements of this section. An eligible applicant must submit a complete application to the commissioner of health by the deadline established by the commissioner. The commissioner shall award all other grants competitively

to eligible applicants in metropolitan and rural areas of the state and may consider geographic representation in grant awards.

(b) Grantee activities shall:

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

(2) be based on community input;

(3) focus on policy, systems, and environmental changes that support infant health; and

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

(c) The commissioner shall review each application to determine whether the application is complete and whether the applicant and the project are eligible for a grant. In evaluating applications according to subdivision 5, the commissioner shall establish criteria including but not limited to: the eligibility of the applicant's project under this section; the applicant's thoroughness and clarity in describing the infant health issues grant funds are intended to address; a description of the applicant's proposed project; the project's likelihood to achieve the grant's purposes as described in this section; a description of the population demographics and service area of the proposed project; and evidence of efficiencies and effectiveness gained through collaborative efforts.

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

Subd. 5b. **Technical assistance.** (a) The commissioner shall provide content expertise, technical expertise, training to grant recipients, and advice on data-driven strategies.

(b) For the purposes of carrying out the grant program under subdivision 5, including for administrative purposes, the commissioner shall award contracts to appropriate entities to assist in training and provide technical assistance to grantees.

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

(1) partnership development and capacity building;

(2) Tribal support;

(3) implementation support for specific infant health strategies;

(4) communications by convening and sharing lessons learned; and

(5) health equity.

Subd. 6. **Developmental and social-emotional screening with follow-up.** The goal of the developmental and social-emotional screening is to identify young children at risk for developmental and behavioral concerns and provide follow-up services to connect families and young children to appropriate community-based resources and programs. The commissioner of health shall work with the commissioners of human services and education to implement this section and promote interagency coordination with other early childhood programs including those that provide screening and assessment.

Subd. 6a. **Duties.** The commissioner shall:

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

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

(3) provide screening for developmental and social-emotional delays based on current recommended best practices;

(4) review and share the results of the screening with the parent or guardian. Support families in their role as caregivers by providing anticipatory guidance around typical growth and development;

(5) ensure children and families are referred to and linked with appropriate community-based services and resources when any developmental or social-emotional concerns are identified through screening; and

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

Subd. 6b. **Grants authorized.** The commissioner shall award grants to community-based organizations, community health boards, and Tribal nations to support follow-up services for children with developmental or social-emotional concerns identified through screening in order to link children and their families to appropriate community-based services and resources. Grants shall also be awarded to community-based organizations to train and utilize cultural liaisons to help families navigate the screening and follow-up process in a culturally and linguistically responsive manner. The commissioner shall provide technical assistance, content expertise, and training to grant recipients to ensure that follow-up services are effectively provided.

Subd. 7. **Model jail practices for incarcerated parents.** (a) The commissioner of health may make special grants to counties and groups of counties to implement model jail practices and to county governments, Tribal governments, or nonprofit organizations in corresponding geographic areas to build partnerships with county jails to support children of incarcerated parents and their caregivers.

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

Subd. 7a. **Grants authorized; model jail practices.** (a) The commissioner of health shall award grants to eligible county jails to implement model jail practices and separate grants to county governments, Tribal governments, or nonprofit organizations in corresponding geographic areas to build partnerships with county jails to support children of incarcerated parents and their caregivers.

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

(1) parenting classes or groups;

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

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

(4) correctional staff training;

(5) policies and practices for family visits; and

(6) family-focused reentry planning.

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

Subd. 7b. **Technical assistance and oversight; model jail practices.** (a) The commissioner shall provide content expertise, training to grant recipients, and advice on evidence-based strategies, including evidence-based training to support incarcerated parents.

(b) For the purposes of carrying out the grant program under subdivision 7a, including for administrative purposes, the commissioner shall award contracts to appropriate entities to assist in training and provide technical assistance to grantees.

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

(1) evidence-based training for incarcerated parents;

(2) partnership building and community engagement;

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

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

Sec. 192. **INITIAL IMPLEMENTATION OF THE KEEPING NURSES AT THE BEDSIDE ACT.**

(a) By October 1, 2024, each hospital must establish and convene a hospital nurse staffing committee as described under Minnesota Statutes, section 144.7053, and a hospital nurse workload committee as described under Minnesota Statutes, section 144.7054.

(b) By October 1, 2025, each hospital must implement core staffing plans developed by its hospital nurse staffing committee and satisfy the plan posting requirements under Minnesota Statutes, section 144.7056.

(c) By October 1, 2025, each hospital must submit to the commissioner of health core staffing plans meeting the requirements of Minnesota Statutes, section 144.7055.

(d) By October 1, 2025, the commissioner of health must develop a standard concern for safe staffing form and provide an electronic means of submitting the form to the relevant hospital nurse staffing committee. The commissioner must base the form on the existing concern for safe staffing form maintained by the Minnesota Nurses' Association.

(e) By January 1, 2026, the commissioner of health must provide electronic access to the uniform format or standard form for nurse staffing reporting described under Minnesota Statutes, section 144.7057, subdivision 4.

Sec. 193. **LONG COVID.**

Subdivision 1. **Definition.** For the purpose of this section, "long COVID" means health problems that people experience four or more weeks after being infected with SARS-CoV-2, the virus that causes COVID-19. Long COVID is also called post COVID conditions, long-haul COVID, chronic COVID, post-acute COVID, or post-acute sequelae of COVID-19 (PASC).

Subd. 2. **Establishment.** The commissioner of health shall establish a program to conduct community assessments and epidemiologic investigations to monitor and address impacts of long COVID. The purposes of these activities are to:

(1) monitor trends in: incidence, prevalence, mortality, and health outcomes; care management and costs; changes in disability status, employment, and quality of life; and service needs of individuals with long COVID and to detect potential public health problems, predict risks, and assist in investigating long COVID health inequities;

(2) more accurately target information and resources for communities and patients and their families;

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

(4) promote evidence-based practices around long COVID prevention and management and to address public concerns and questions about long COVID.

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

Subd. 4. **Grants and contracts.** The commissioner of health shall coordinate and collaborate with community and organizational partners to implement evidence-informed priority actions through community-based grants and contracts. The commissioner of health shall award contracts and grants to organizations that serve communities disproportionately impacted by COVID-19 and long COVID, including but not limited to rural and low-income areas, Black and African Americans, African immigrants, American Indians, Asian American-Pacific Islanders, Latino(a) communities, LGBTQ+ communities, and persons with disabilities. Organizations may also address intersectionality within the groups. The commissioner shall award grants and contracts to eligible organizations to plan, construct, and disseminate resources and information to support survivors of long COVID, including caregivers, health care providers, ancillary health care workers, workplaces, schools, communities, and local and Tribal public health.

Sec. 194. **MEMBERSHIP TERMS; PALLIATIVE CARE ADVISORY COUNCIL.**

Notwithstanding the terms of office specified to the members upon their appointment, the terms for members appointed to the Palliative Care Advisory Council under Minnesota Statutes, section 144.059, on or after February 1, 2022, shall be three years, as provided in Minnesota Statutes, section 144.059, subdivision 3.

Sec. 195. **REPORT ON TRANSPARENCY OF HEALTH CARE PAYMENTS.**

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

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

(c) "Nonclaims-based payments" means payments to health care providers designed to support and reward value of health care services over volume of health care services and includes alternative payment models or incentives, payments for infrastructure expenditures or investments, and payments for workforce expenditures or investments.

(d) "Nonpublic data" has the meaning given in Minnesota Statutes, section 13.02, subdivision 9.

(e) "Primary care services" means integrated, accessible health care services provided by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community. Primary care services include but are not limited to preventive services, office visits, administration of vaccines, annual physicals, pre-operative physicals, assessments, care coordination, development of treatment plans, management of chronic conditions, and diagnostic tests.

Subd. 2. **Report.** (a) To provide the legislature with information needed to meet the evolving health care needs of Minnesotans, the commissioner shall report to the legislature by February 15, 2024, on the volume and distribution of health care spending across payment models used by health plan companies and third-party administrators, with a particular focus on value-based care models and primary care spending.

(b) The report must include specific health plan and third-party administrator estimates of health care spending for claims-based payments and nonclaims-based payments for the most recent available year, reported separately for Minnesotans enrolled in state health care programs, Medicare Advantage, and commercial health insurance. The report must also include recommendations on changes needed to gather better data from health plan companies and third-party administrators on the use of value-based payments that pay for value of health care services provided over volume of services provided, promote the health of all Minnesotans, reduce health disparities, and support the provision of primary care services and preventive services.

(c) In preparing the report, the commissioner shall:

(1) describe the form, manner, and timeline for submission of data by health plan companies and third-party administrators to produce estimates as specified in paragraph (b);

(2) collect summary data that permits the computation of:

(i) the percentage of total payments that are nonclaims-based payments; and

(ii) the percentage of payments in item (i) that are for primary care services;

(3) where data was not directly derived, specify the methods used to estimate data elements;

(4) notwithstanding Minnesota Statutes, section 62U.04, subdivision 11, conduct analyses of the magnitude of primary care payments using data collected by the commissioner under Minnesota Statutes, section 62U.04; and

(5) conduct interviews with health plan companies and third-party administrators to better understand the types of nonclaims-based payments and models in use, the purposes or goals of each, the criteria for health care providers to qualify for these payments, and the timing and structure of health plan companies or third-party administrators making these payments to health care provider organizations.

(d) Health plan companies and third-party administrators must comply with data requests from the commissioner under this section within 60 days after receiving the request.

(e) Data collected under this section is nonpublic data. Notwithstanding the definition of summary data in Minnesota Statutes, section 13.02, subdivision 19, summary data prepared under this section may be derived from nonpublic data. The commissioner shall establish procedures and safeguards to protect the integrity and confidentiality of any data maintained by the commissioner.

Sec. 196. **RETURN OF CHARITABLE ASSETS.**

If a health system that is organized as a charitable organization, and that includes M Health Fairview University of Minnesota Medical Center, sells or transfers control to an out-of-state nonprofit entity or to any for-profit entity, the health system must return to the general fund any charitable assets the health system received from the state.

EFFECTIVE DATE. This section is effective the day following final enactment and applies to transactions completed on or after that date.

Sec. 197. **STUDY AND RECOMMENDATIONS; NONPROFIT HEALTH MAINTENANCE ORGANIZATION CONVERSIONS AND OTHER TRANSACTIONS.**

(a) The commissioner of health shall study and develop recommendations on the regulation of conversions, mergers, transfers of assets, and other transactions affecting Minnesota-domiciled nonprofit health maintenance organizations and for-profit health maintenance organizations. The recommendations must at least address:

(1) monitoring and regulation of Minnesota-domiciled for-profit health maintenance organizations;

(2) issues related to public benefit assets held by a nonprofit health maintenance organization, including identifying the portion of the organization's assets that are considered public benefit assets to be protected, establishing a fair and independent process to value to the assets, and how public benefit assets should be stewarded for the public good;

(3) designating a state agency or executive branch office with authority to review and approve or deny a nonprofit health maintenance organization's plan to convert to a for-profit organization; and

(4) establishing a process for the public to learn about and provide input on a nonprofit health maintenance organization's proposed conversion to a for-profit organization.

(b) To fulfill the requirements under this section, the commissioner:

(1) may consult with the commissioners of human services and commerce;

(2) may enter into one or more contracts for professional or technical services;

(3) notwithstanding any law to the contrary, may use data submitted under Minnesota Statutes, sections 62U.04 and 144.695 to 144.705, and other data held by the commissioner for purposes of regulating health maintenance organizations or already submitted to the commissioner by health carriers; and

(4) may collect from health maintenance organizations and their parent or affiliated companies, financial data and other information, including nonpublic data and trade secret data, that are deemed necessary by the commissioner to conduct the study and develop the recommendations under this section. Health maintenance organizations must provide the commissioner with any information requested by the commissioner under this clause, in the form and manner specified by the commissioner. Any data collected by the commissioner under this clause is classified as confidential data as defined in Minnesota Statutes, section

13.02, subdivision 3 or protected nonpublic data as defined in Minnesota Statutes, section 13.02, subdivision 13.

(c) No later than October 1, 2023, the commissioner must seek public comments on the regulation of conversion transactions involving nonprofit health maintenance organizations.

(d) The commissioner may use the enforcement authority in Minnesota Statutes, section 62D.17, if a health maintenance organization fails to comply with a request for information under paragraph (b), clause (4).

(e) The commissioner shall submit preliminary findings from this study to the chairs of the legislative committees with jurisdiction over health and human services by January 15, 2024, and shall submit a final report and recommendations to the legislature by June 30, 2024.

Sec. 198. **STUDY OF THE DEVELOPMENT OF A STATEWIDE REGISTRY FOR PROVIDER ORDERS FOR LIFE-SUSTAINING TREATMENT.**

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

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

(c) "Life-sustaining treatment" means any medical procedure, pharmaceutical drug, medical device, or medical intervention that maintains life by sustaining, restoring, or supplanting a vital function. Life-sustaining treatment does not include routine care necessary to sustain patient cleanliness and comfort.

(d) "POLST" means a provider order for life-sustaining treatment, signed by a physician, advanced practice registered nurse, or physician assistant, to ensure that the medical treatment preferences of a patient with an advanced serious illness who is nearing the end of the their life are honored.

(e) "POLST form" means a portable medical form used to communicate a physician's order to help ensure that a patient's medical treatment preferences are conveyed to emergency medical service personnel and other health care providers.

Subd. 2. **Establishment.** (a) The commissioner, in consultation with the advisory committee established in paragraph (c), shall develop recommendations for a statewide registry of POLST forms to ensure that a patient's medical treatment preferences are followed by all health care providers. The registry must allow for the submission of completed POLST

forms and for the forms to be accessed by health care providers and emergency medical service personnel in a timely manner for the provision of care or services.

(b) The commissioner shall develop recommendations on the following:

(1) electronic capture, storage, and security of information in the registry;

(2) procedures to protect the accuracy and confidentiality of information submitted to the registry;

(3) limits as to who can access the registry;

(4) where the registry should be housed;

(5) ongoing funding models for the registry; and

(6) any other action needed to ensure that patients' rights are protected and that their health care decisions are followed.

(c) The commissioner shall create an advisory committee with members representing physicians, physician assistants, advanced practice registered nurses, nursing homes, emergency medical system providers, hospice and palliative care providers, the disability community, attorneys, medical ethicists, and the religious community.

Subd. 3. **Report.** The commissioner shall submit recommendations on establishing a statewide registry of POLST forms to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services policy and finance by February 1, 2024, and implement the registry no later than December 1, 2024.

Sec. 199. **VACCINES FOR UNINSURED AND UNDERINSURED ADULTS.**

The commissioner of health shall administer a program to provide vaccines to uninsured and underinsured adults. The commissioner shall determine adult eligibility for free or low-cost vaccines under this program and shall enroll clinics to participate in the program and administer vaccines recommended by the Centers for Disease Control and Prevention. In administering the program, the commissioner shall address racial and ethnic disparities in vaccine coverage rates. State money appropriated for purposes of this section shall be used to supplement, but not supplant, available federal funding for purposes of this section.

Sec. 200. **WORKPLACE SAFETY GRANTS; HEALTH CARE ENTITIES AND HUMAN SERVICES PROVIDERS.**

Subdivision 1. **Grant program established.** The commissioner of health shall administer a program to award workplace safety grants to health care entities and human services

providers to increase safety measures at health care settings and at human services workplaces providing behavioral health care; services for children, families, and vulnerable adults; services for older adults and people with disabilities; and other social services or related care.

Subd. 2. **Eligible applicants; application.** (a) Entities eligible for a grant under this section shall include health systems, hospitals, medical clinics, dental clinics, ambulance services, community health clinics, county human services agencies, Tribal human services agencies, and other human services provider organizations.

(b) An entity seeking a grant under this section must submit an application to the commissioner in a form and manner prescribed by the commissioner. An application must include information about:

(1) the type of entity or organization seeking grant funding;

(2) the specific safety measures or activities for which the applicant will use the grant funding;

(3) the specific policies that will be implemented or upheld to ensure that individuals' rights to privacy and data protection are protected during the use of safety equipment obtained or operated through grant funding;

(4) a proposed budget for each of the specific activities for which the applicant will use the grant funding;

(5) an outline of efforts to enhance or improve existing safety measures or proposed new measures to improve the safety of staff at the entity, agency, or organization;

(6) sample consent forms for any safety equipment that has capacity to record, store, or share audio or video that will be collected from patients or clients prior to implementation of grant-funded safety measures, excluding equipment located in public spaces in provider-controlled, licensed settings;

(7) how the grant-funded measures will lead to long-term improvements in safety and stability for staff and for patients and clients accessing health care or services from the applicant; and

(8) methods the applicant will use to evaluate effectiveness of the safety measures and changes that will be made if the measures are deemed ineffective.

Subd. 3. **Grant awards.** Grants must be awarded to eligible applicants that meet application requirements on a first-come, first-served basis. Forty percent of grant funds

must be awarded to eligible applicants located outside of the seven-county metropolitan area. Each grant award must be for at least $5,000, but no more than $100,000.

Subd. 4. **Allowable uses of grant funds.** (a) Grant funds may be used for one or more of the following:

(1) the procurement and installation of safety equipment, including but not limited to cellular telephones; personal radios; wearable tracking devices for staff to share their location with supervisors, subject to the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) data privacy requirements outlined in Code of Federal Regulations, title 45, parts 160 and 164, subparts A and E; security systems and cameras in public spaces of provider-controlled, licensed settings or of health care settings; and panic buttons;

(2) training for staff, which may include:

(i) sessions and exercises for crisis management, strategies for de-escalating conflict situations, safety planning, and self-defense in accordance with positive support strategies under Minnesota Rules, chapter 9544, and person-centered planning and service delivery according to Minnesota Statutes, section 245D.07, subdivision 1a;

(ii) training in culturally informed and culturally affirming practices, including linguistic training;

(iii) training in trauma-informed social, emotional, and behavioral support; and

(iv) other training topics, sessions, and exercises the commissioner determines to be appropriate;

(3) facility safety improvements, including but not limited to a threat and vulnerability review and barrier protection;

(4) support services, counseling, and additional resources for staff who have experienced safety concerns or trauma-related incidents in the workplace;

(5) installation and implementation of an internal data incident tracking system to track and prevent workplace safety incidents; and

(6) other prevention and mitigation measures and safety training, resources, and support services the commissioner determines to be appropriate.

(b) The following restrictions apply to the eligible uses of grant funds under paragraph (a):

(1) safety equipment must not include:

(i) tools or devices that facilitate physical or chemical restraint;

(ii) barriers, environmental modifications, or other tools or devices that facilitate individual seclusion, except plexiglass barriers in office settings are allowed;

(iii) wearable body cameras; or

(iv) wearable tracking devices that have the capacity to store location data;

(2) security cameras must only be used in staff spaces and entry points of buildings and may not be used in common areas, bedrooms, and bathrooms;

(3) in settings that are required to comply with the positive supports rule, all safety equipment or measures must comply with Minnesota Rules, chapter 9544;

(4) settings licensed under Minnesota Statutes, section 245D, must follow person-centered practices according to Minnesota Statutes, section 245D.07;

(5) any safety equipment purchased with grant funding that has electronic monitoring capacity must be used according to Minnesota Statutes, section 144.6502, or the brain injury, community alternative care, community access for disability inclusion, and developmental disabilities federal waiver plan language that outlines monitoring technology use;

(6) prior to the use of safety equipment that has capacity to record, store, and share audio, video, or a combination thereof, the grant recipient must:

(i) provide patients or clients with information about electronic monitoring in a way that is most accessible to the patients or clients, including the definition of electronic monitoring, the type of device that will be in use, how the footage captured will be used, with whom the footage captured will be shared, and a statement that a patient or client has the right to decline use of safety equipment that has capacity to record, store, and share audio, video, or a combination thereof;

(ii) provide notice every time electronic monitoring devices are in use; and

(iii) obtain written consent from anyone whose audio or video may be recorded during the time the device is in use and, if applicable, from guardians of individuals whose audio or video may be recorded during the time the device is in use; and

(7) in settings that provide home and community-based services, if at any point a client or their guardian declines the use of safety equipment that has capacity to record, store, or share audio, video, or a combination thereof or revokes prior consent to such use, the provider must cease using the safety equipment immediately and indefinitely. A provider may not deny or delay the provision of services as a result of an individual's decision to decline the

use of safety equipment that has capacity to record, store, or share audio, video, or a combination thereof.

(c) All video, audio, or other personally identifiable information collected through safety equipment paid for by grant funds under this section must:

(1) be treated consistently with the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) requirements outlined in Code of Federal Regulations, title 45, parts 160 and 164, subparts A and E;

(2) be subject to applicable rules of evidence and procedure if admitted into evidence in a civil, criminal, or administrative proceeding; and

(3) not result in the denial or delay of services provided to an individual.

Subd. 5. **Report.** Within two years after receiving grant funds under this section, each grant recipient must submit a report to the commissioner. The commissioner must submit a compilation of the reports to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services, the Office of Ombudsman for Long-Term Care, and Office of Ombudsman for Mental Health and Developmental Disabilities. Grant recipient reports to the commissioner must include:

(1) the number of workplace safety incidents that occurred over the course of the grant period;

(2) the number and type of safety measures funded by the grants, and how those safety measures helped alleviate or de-escalate workplace safety incidents;

(3) the number of staff benefiting from safety measures implemented through grant funding;

(4) the number of patients or clients benefiting from safety measures implemented through grant funding;

(5) practices implemented concurrently with the use of safety equipment that ensured that the rights of patients or clients served were upheld;

(6) the number of patients or clients who declined to consent to the use of any safety equipment that had capacity to record, store, or share audio, video, or a combination thereof;

(7) an evaluation of the effectiveness of the safety measures, including assessment of whether and how the grant funding has led or will lead to improved safety and service provisions for staff, patients, and clients; and

(8) changes to policy or practice that were made if safety measures implemented using grant funds were deemed ineffective.

Subd. 6. **Technical assistance.** The commissioner must provide technical assistance to grant applicants throughout the application process and to applicants and grant recipients regarding grant distribution and required grant recipient reporting

Sec. 201. **TASK FORCE ON PREGNANCY HEALTH AND SUBSTANCE USE DISORDERS.**

Subdivision 1. **Establishment.** The Task Force on Pregnancy Health and Substance Use Disorders is established to recommend protocols for when physicians, advanced practice registered nurses, and physician assistants should administer a toxicology test and requirements for reporting for prenatal exposure to a controlled substance.

Subd. 2. **Membership.** (a) The task force shall consist of the following members:

(1) a physician licensed in Minnesota to practice obstetrics and gynecology who provides care primarily to medical assistance enrollees during pregnancy appointed by the American College of Obstetricians and Gynecologists;

(2) a physician licensed in Minnesota to practice pediatrics or family medicine who provides care primarily to medical assistance enrollees with substance use disorders or who provides addiction medicine care during pregnancy appointed by the Minnesota Medical Association;

(3) a certified nurse-midwife licensed as an advanced practice registered nurse in Minnesota who provides care primarily to medical assistance enrollees with substance use disorders or provides addiction medicine care during pregnancy appointed by the Minnesota Advanced Practice Registered Nurses Coalition;

(4) two representatives of county social services agencies, one from a county outside the seven-county metropolitan area and one from a county within the seven-county metropolitan area, appointed by the Minnesota Association of County Social Service Administrators;

(5) one representative from the Board of Social Work;

(6) two Tribal representatives appointed by the Minnesota Indian Affairs Council;

(7) two members who identify as Black or African American and who have lived experience with the child welfare system and substance use disorders appointed by the Cultural and Ethnic Communities Leadership Council;

(8) two members who are licensed substance use disorder treatment providers appointed by the Minnesota Association of Resources for Recovery and Chemical Health;

(9) one member representing hospitals appointed by the Minnesota Hospital Association;

(10) one designee of the commissioner of health with expertise in substance use disorders and treatment;

(11) two members who identify as Native American or American Indian and who have lived experience with the child welfare system and substance use disorders appointed by the Minnesota Indian Affairs Council;

(12) two members from the Council for Minnesotans of African Heritage; and

(13) one member of the Minnesota Perinatal Quality Collaborative.

(b) Appointments to the task force must be made by October 1, 2023.

Subd. 3. **Chairs; meetings.** (a) The task force shall elect a chair and cochair at the first meeting, which shall be convened no later than October 15, 2023.

(b) Task force meetings are subject to the Minnesota Open Meeting Law under Minnesota Statutes, chapter 13D.

Subd. 4. **Administrative support.** The Department of Health must provide administrative support and meeting space for the task force.

Subd. 5. **Duties; reports.** (a) The task force shall develop recommended protocols for when a toxicology test for prenatal exposure to a controlled substance should be administered to a birthing parent and a newborn infant. The task force must also recommend protocols for providing notice or reporting of prenatal exposure to a controlled substance to local welfare agencies under Minnesota Statutes, chapter 260E.

(b) No later than December 1, 2024, the task force must submit a written report to the chairs and ranking minority members of the legislative committees and divisions with jurisdiction over health and human services on the task force's activities and recommendations on the protocols developed under paragraph (a).

Subd. 6. **Expiration.** The task force shall expire upon submission of the report required under subdivision 5, paragraph (b), or December 1, 2024, whichever is later.

Sec. 202. **REVISOR INSTRUCTION.**

(a) The revisor of statutes shall change the term "cancer surveillance system" to "cancer reporting system" wherever it appears in the next edition of Minnesota Statutes and Minnesota Rules and in the online publication.

(b) The revisor of statutes shall amend the headnote for Minnesota Statutes, section 145.423, to read "RECOGNITION OF INFANT WHO IS BORN ALIVE."

(c) In Minnesota Statutes, section 144.7055, the revisor shall renumber paragraphs (b) to (e) alphabetically as individual subdivisions under Minnesota Statutes, section 144.7051. The revisor shall make any necessary changes to sentence structure for this renumbering while preserving the meaning of the text. The revisor shall also make necessary cross-reference changes in Minnesota Statutes and Minnesota Rules consistent with the renumbering.

Sec. 203. **REPEALER.**

(a) Minnesota Rules, parts 4640.1500; 4640.1600; 4640.1700; 4640.1800; 4640.1900; 4640.2000; 4640.2100; 4640.2200; 4640.2300; 4640.2400; 4640.2500; 4640.2600; 4640.2700; 4640.2800; 4640.2900; 4640.3000; 4640.3100; 4640.3200; 4640.3300; 4640.3400; 4640.3500; 4640.3600; 4640.3700; 4640.3800; 4640.3900; 4640.4000; 4640.4100; 4640.4200; 4640.4300; 4640.6100; 4640.6200; 4640.6300; 4640.6400; 4645.0300; 4645.0400; 4645.0500; 4645.0600; 4645.0700; 4645.0800; 4645.0900; 4645.1000; 4645.1100; 4645.1200; 4645.1300; 4645.1400; 4645.1500; 4645.1600; 4645.1700; 4645.1800; 4645.1900; 4645.2000; 4645.2100; 4645.2200; 4645.2300; 4645.2400; 4645.2500; 4645.2600; 4645.2700; 4645.2800; 4645.2900; 4645.3000; 4645.3100; 4645.3200; 4645.3300; 4645.3400; 4645.3500; 4645.3600; 4645.3700; 4645.3800; 4645.3805; 4645.3900; 4645.4000; 4645.4100; 4645.4200; 4645.4300; 4645.4400; 4645.4500; 4645.4600; 4645.4700; 4645.4800; 4645.4900; 4645.5100; and 4645.5200, are repealed effective January 1, 2024.

(b) Minnesota Statutes 2022, sections 62J.84, subdivision 5; 62U.10, subdivisions 6, 7, and 8; 144.059, subdivision 10; 144.9505, subdivision 3; 145.4235; and 153A.14, subdivision 5, are repealed.

(c) Minnesota Rules, part 4615.3600, is repealed effective the day following final enactment.

(d) Minnesota Rules, parts 4700.1900; 4700.2000; 4700.2100; 4700.2210; 4700.2300, subparts 1, 3, 4, 4a, and 5; 4700.2410; 4700.2420; and 4700.2500, are repealed.

(e) Minnesota Statutes 2022, sections 62Q.145; 145.1621; 145.411, subdivisions 2 and 4; 145.412; 145.413, subdivisions 2 and 3; 145.4131; 145.4132; 145.4133; 145.4134; 145.4135; 145.4136; 145.415; 145.416; 145.423, subdivisions 2, 3, 4, 5, 6, 7, 8, and 9; 145.4241; 145.4242; 145.4243; 145.4244; 145.4245; 145.4246; 145.4247; 145.4248; 145.4249; 256B.011; 256B.40; 261.28; and 393.07, subdivision 11, are repealed effective the day following final enactment.

ARTICLE 4
MEDICAL EDUCATION AND RESEARCH COSTS

Section 1. Minnesota Statutes 2022, section 62J.692, subdivision 1, is amended to read:

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

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

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

(d) "Clinical medical education program" means the accredited clinical training of physicians (medical students and residents), doctor of pharmacy practitioners (pharmacy students and residents), doctors of chiropractic, dentists (dental students and residents), advanced practice registered nurses (clinical nurse specialists, certified registered nurse anesthetists, nurse practitioners, and certified nurse midwives), physician assistants, dental therapists and advanced dental therapists, psychologists, clinical social workers, community paramedics, and community health workers.

(e) "Sponsoring institution" means a hospital, school, or consortium located in Minnesota that sponsors and maintains primary organizational and financial responsibility for a clinical medical education program in Minnesota and which is accountable to the accrediting body.

(f) "Teaching institution" means a hospital, medical center, clinic, or other organization that conducts a clinical medical education program in Minnesota.

(g) "Trainee" means a student or resident involved in a clinical medical education program.

(h) "Eligible trainee FTE's" means the number of trainees, as measured by full-time equivalent counts, that are at training sites located in Minnesota with currently active medical assistance enrollment status and a National Provider Identification (NPI) number where training occurs in either an inpatient or ambulatory patient care setting and where the training is funded, in part, by patient care revenues. Training that occurs in nursing facility settings is not eligible for funding under this section.

Sec. 2. Minnesota Statutes 2022, section 62J.692, subdivision 3, is amended to read:

Subd. 3. **Application process.** (a) A clinical medical education program conducted in Minnesota by a teaching institution to train physicians, doctor of pharmacy practitioners, dentists, chiropractors, physician assistants, dental therapists and advanced dental therapists, psychologists, clinical social workers, community paramedics, or community health workers is eligible for funds under subdivision 4 if the program:

(1) is funded, in part, by patient care revenues;

(2) occurs in patient care settings that face increased financial pressure as a result of competition with nonteaching patient care entities; and

(3) emphasizes primary care or specialties that are in undersupply in Minnesota.

(b) A clinical medical education program for advanced practice nursing is eligible for funds under subdivision 4 if the program meets the eligibility requirements in paragraph (a), clauses (1) to (3), and is sponsored by the University of Minnesota Academic Health Center, the Mayo Foundation, or institutions that are part of the Minnesota State Colleges and Universities system or members of the Minnesota Private College Council.

(c) Applications must be submitted to the commissioner by a sponsoring institution on behalf of an eligible clinical medical education program ~~and must be received by October 31 of each year for distribution in the following year~~ on a timeline determined by the commissioner. An application for funds must contain ~~the following information:~~ information the commissioner deems necessary to determine program eligibility based on the criteria in paragraphs (a) and (b) and to ensure the equitable distribution of funds.

~~(1) the official name and address of the sponsoring institution and the official name and site address of the clinical medical education programs on whose behalf the sponsoring institution is applying;~~

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

~~(3) for each clinical medical education program for which funds are being sought; the type and specialty orientation of trainees in the program; the name, site address, and medical assistance provider number and national provider identification number of each training site used in the program; the federal tax identification number of each training site used in the program, where available; the total number of trainees at each training site; and the total number of eligible trainee FTEs at each site; and~~

~~(4) other supporting information the commissioner deems necessary to determine program eligibility based on the criteria in paragraphs (a) and (b) and to ensure the equitable distribution of funds.~~

~~(d) An application must include the information specified in clauses (1) to (3) for each clinical medical education program on an annual basis for three consecutive years. After that time, an application must include the information specified in clauses (1) to (3) when requested, at the discretion of the commissioner:~~

~~(1) audited clinical training costs per trainee for each clinical medical education program when available or estimates of clinical training costs based on audited financial data;~~

~~(2) a description of current sources of funding for clinical medical education costs, including a description and dollar amount of all state and federal financial support, including Medicare direct and indirect payments; and~~

~~(3) other revenue received for the purposes of clinical training.~~

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

Sec. 3. Minnesota Statutes 2022, section 62J.692, subdivision 4, is amended to read:

Subd. 4. **Distribution of funds.** (a) The commissioner shall annually distribute ~~the available medical education funds~~ revenue credited or money transferred to the medical education and research costs account under subdivision 8 and section 297F.10, subdivision 1, clause (2), to all qualifying applicants based on a public program volume factor, which is determined by the total volume of public program revenue received by each training site as a percentage of all public program revenue received by all training sites in the fund pool.

Public program revenue for the distribution formula includes revenue from medical assistance and prepaid medical assistance. Training sites that receive no public program revenue are ineligible for funds available under this subdivision. ~~For purposes of determining training-site level grants to be distributed under this paragraph, total statewide average costs per trainee for medical residents is based on audited clinical training costs per trainee in~~

~~primary care clinical medical education programs for medical residents. Total statewide average costs per trainee for dental residents is based on audited clinical training costs per trainee in clinical medical education programs for dental students. Total statewide average costs per trainee for pharmacy residents is based on audited clinical training costs per trainee in clinical medical education programs for pharmacy students.~~

Training sites whose training site level grant is less than $5,000, based on the ~~formula~~ formulas described in this ~~paragraph~~ subdivision, or that train fewer than 0.1 FTE eligible trainees, are ineligible for funds available under this subdivision. No training sites shall receive a grant per FTE trainee that is in excess of the 95th percentile grant per FTE across all eligible training sites; grants in excess of this amount will be redistributed to other eligible sites based on the ~~formula~~ formulas described in this ~~paragraph~~ subdivision.

(b) ~~For funds distributed in fiscal years 2014 and 2015, the distribution formula shall include a supplemental public program volume factor, which is determined by providing a supplemental payment to training sites whose public program revenue accounted for at least 0.98 percent of the total public program revenue received by all eligible training sites. The supplemental public program volume factor shall be equal to ten percent of each training site's grant for funds distributed in fiscal year 2014 and for funds distributed in fiscal year 2015. Grants to training sites whose public program revenue accounted for less than 0.98 percent of the total public program revenue received by all eligible training sites shall be reduced by an amount equal to the total value of the supplemental payment. For fiscal year 2016 and beyond, the distribution of funds shall be based solely on the public program volume factor as described in paragraph (a).~~ Money appropriated through the state general fund, the health care access fund, and any additional fund for the purpose of funding medical education and research costs and that does not require federal approval must be awarded only to eligible training sites that do not qualify for a medical education and research cost rate factor under sections 256.969, subdivision 2b, paragraph (k), or 256B.75, paragraph (b). The commissioner shall distribute the available medical education money appropriated to eligible training sites that do not qualify for a medical education and research cost rate factor based on a distribution formula determined by the commissioner. The distribution formula under this paragraph must consider clinical training costs, public program revenues, and other factors identified by the commissioner that address the objective of supporting clinical training.

(c) Funds distributed shall not be used to displace current funding appropriations from federal or state sources.

(d) Funds shall be distributed to the sponsoring institutions indicating the amount to be distributed to each of the sponsor's clinical medical education programs based on the criteria in this subdivision and in accordance with the commissioner's approval letter. Each clinical medical education program must distribute funds allocated under paragraphs (a) and (b) to the training sites as specified in the commissioner's approval letter. Sponsoring institutions, which are accredited through an organization recognized by the Department of Education or the Centers for Medicare and Medicaid Services, may contract directly with training sites to provide clinical training. To ensure the quality of clinical training, those accredited sponsoring institutions must:

(1) develop contracts specifying the terms, expectations, and outcomes of the clinical training conducted at sites; and

(2) take necessary action if the contract requirements are not met. Action may include ~~the withholding of payments~~ disqualifying the training site under this section or the removal of students from the site.

(e) Use of funds is limited to expenses related to eligible clinical training ~~program~~ costs ~~for eligible programs~~. The commissioner shall develop a methodology for determining eligible costs.

(f) Any funds ~~not~~ that cannot be distributed in accordance with the commissioner's approval letter must be returned to the medical education and research fund within 30 days of receiving notice from the commissioner. ~~The commissioner shall distribute returned funds to the appropriate training sites in accordance with the commissioner's approval letter.~~ When appropriate, the commissioner shall include the undistributed money in the subsequent distribution cycle using the applicable methodology described in this subdivision.

~~(g) A maximum of $150,000 of the funds dedicated to the commissioner under section 297F.10, subdivision 1, clause (2), may be used by the commissioner for administrative expenses associated with implementing this section.~~

Sec. 4. Minnesota Statutes 2022, section 62J.692, subdivision 5, is amended to read:

Subd. 5. **Report.** (a) Sponsoring institutions receiving funds under this section must ~~sign and~~ submit a medical education grant verification report (GVR) to verify that the correct grant amount was forwarded to each eligible training site. ~~If the sponsoring institution fails to submit the GVR by the stated deadline, or to request and meet the deadline for an extension, the sponsoring institution is required to return the full amount of funds received to the commissioner within 30 days of receiving notice from the commissioner. The~~

~~commissioner shall distribute returned funds to the appropriate training sites in accordance with the commissioner's approval letter.~~

(b) The reports must provide verification of the distribution of the funds and must include:

~~(1) the total number of eligible trainee FTEs in each clinical medical education program;~~

~~(2) the name of each funded program and, for each program, the dollar amount distributed to each training site and a training site expenditure report;~~

~~(3)~~ (1) documentation of any discrepancies between the ~~initial~~ grant distribution notice included in the commissioner's approval letter and the actual distribution;

~~(4)~~ (2) a statement by the sponsoring institution stating that the completed grant verification report is valid and accurate; and

~~(5)~~ (3) other information the commissioner deems appropriate to evaluate the effectiveness of the use of funds for medical education.

~~(c) Each year, the commissioner shall provide an annual summary report to the legislature on the implementation of this section. This report is exempt from section 144.05, subdivision 7.~~

Sec. 5. Minnesota Statutes 2022, section 62J.692, subdivision 8, is amended to read:

Subd. 8. **Federal financial participation.** The commissioner of human services shall seek ~~to maximize~~ federal financial participation ~~in payments~~ for the dedicated revenue for medical education and research costs provided under section 297F.10, subdivision 1, clause (2).

~~The commissioner shall use physician clinic rates where possible to maximize federal financial participation. Any additional funds that become available must be distributed under subdivision 4, paragraph (a).~~

Sec. 6. **[144.1913] CLINICAL DENTAL EDUCATION INNOVATION GRANTS.**

(a) The commissioner shall award clinical dental education innovation grants to teaching institutions and clinical training sites for projects that increase dental access for underserved populations and promote innovative clinical training of dental professionals. In awarding the grants, the commissioner shall consider the following:

(1) potential to successfully increase access to dental services for an underserved population;

(2) the long-term viability of the project to improve access to dental services beyond the period of initial funding;

(3) evidence of collaboration between the applicant and local communities;

(4) efficiency in the use of grant funding; and

(5) the priority level of the project in relation to state education, access, and workforce goals.

(b) The commissioner shall periodically evaluate the priorities in awarding innovations grants under this section to ensure that the priorities meet the changing workforce needs of the state.

Sec. 7. Minnesota Statutes 2022, section 256.969, subdivision 2b, is amended to read:

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

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

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

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

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

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

(c) Effective for discharges occurring on and after November 1, 2014, payment rates for hospital inpatient services provided by hospitals located in Minnesota or the local trade area, except for the hospitals paid under the methodologies described in paragraph (a), clauses (2) and (3), shall be rebased, incorporating cost and payment methodologies in a

manner similar to Medicare. The base year or years for the rates effective November 1, 2014, shall be calendar year 2012. The rebasing under this paragraph shall be budget neutral, ensuring that the total aggregate payments under the rebased system are equal to the total aggregate payments that were made for the same number and types of services in the base year. Separate budget neutrality calculations shall be determined for payments made to critical access hospitals and payments made to hospitals paid under the DRG system. Only the rate increases or decreases under subdivision 3a or 3c that applied to the hospitals being rebased during the entire base period shall be incorporated into the budget neutrality calculation.

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

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

(1) pediatric services;

(2) behavioral health services;

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

(4) transplant services;

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

(6) outlier admissions;

(7) low-volume providers; and

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

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

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

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

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

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

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

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

(i) Effective for discharges occurring on or after July 1, 2015, inpatient payment rates for critical access hospitals located in Minnesota or the local trade area shall be determined using a new cost-based methodology. The commissioner shall establish within the methodology tiers of payment designed to promote efficiency and cost-effectiveness. Payment rates for hospitals under this paragraph shall be set at a level that does not exceed the total cost for critical access hospitals as reflected in base year cost reports. Until the next rebasing that occurs, the new methodology shall result in no greater than a five percent decrease from the base year payments for any hospital, except a hospital that had payments that were greater than 100 percent of the hospital's costs in the base year shall have their rate set equal to 100 percent of costs in the base year. The rates paid for discharges on and after July 1, 2016, covered under this paragraph shall be increased by the inflation factor in subdivision 1, paragraph (a). The new cost-based rate shall be the final rate and shall not be settled to actual incurred costs. Hospitals shall be assigned a payment tier based on the following criteria:

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

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

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

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

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

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

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

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

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

(6) geographic location.

(k) Effective for discharges occurring on or after January 1, 2024, the rates paid to hospitals described in paragraph (a), clauses (2) to (4), must include a rate factor specific to each hospital that qualifies for a medical education and research cost distribution under section 62J.692 subdivision 4, paragraph (a).

Sec. 8. Minnesota Statutes 2022, section 256B.75, is amended to read:

256B.75 HOSPITAL OUTPATIENT REIMBURSEMENT.

(a) For outpatient hospital facility fee payments for services rendered on or after October 1, 1992, the commissioner of human services shall pay the lower of (1) submitted charge, or (2) 32 percent above the rate in effect on June 30, 1992, except for those services for which there is a federal maximum allowable payment. Effective for services rendered on or after January 1, 2000, payment rates for nonsurgical outpatient hospital facility fees and emergency room facility fees shall be increased by eight percent over the rates in effect on December 31, 1999, except for those services for which there is a federal maximum allowable payment. Services for which there is a federal maximum allowable payment shall be paid at the lower of (1) submitted charge, or (2) the federal maximum allowable payment. Total aggregate payment for outpatient hospital facility fee services shall not exceed the Medicare upper limit. If it is determined that a provision of this section conflicts with existing or future requirements of the United States government with respect to federal financial participation in medical assistance, the federal requirements prevail. The commissioner may, in the aggregate, prospectively reduce payment rates to avoid reduced federal financial participation resulting from rates that are in excess of the Medicare upper limitations.

(b) Notwithstanding paragraph (a), payment for outpatient, emergency, and ambulatory surgery hospital facility fee services for critical access hospitals designated under section 144.1483, clause (9), shall be paid on a cost-based payment system that is based on the cost-finding methods and allowable costs of the Medicare program. Effective for services provided on or after July 1, 2015, rates established for critical access hospitals under this paragraph for the applicable payment year shall be the final payment and shall not be settled to actual costs. Effective for services delivered on or after the first day of the hospital's fiscal year ending in 2017, the rate for outpatient hospital services shall be computed using information from each hospital's Medicare cost report as filed with Medicare for the year that is two years before the year that the rate is being computed. Rates shall be computed

using information from Worksheet C series until the department finalizes the medical assistance cost reporting process for critical access hospitals. After the cost reporting process is finalized, rates shall be computed using information from Title XIX Worksheet D series. The outpatient rate shall be equal to ancillary cost plus outpatient cost, excluding costs related to rural health clinics and federally qualified health clinics, divided by ancillary charges plus outpatient charges, excluding charges related to rural health clinics and federally qualified health clinics. Effective for services delivered on or after January 1, 2024, the rates paid to critical access hospitals under this section must be adjusted to include the amount of any distributions under section 62J.692, subdivision 4, paragraph (a), that were not included in the rate adjustment described under section 256.969, subdivision 2b, paragraph (k).

(c) Effective for services provided on or after July 1, 2003, rates that are based on the Medicare outpatient prospective payment system shall be replaced by a budget neutral prospective payment system that is derived using medical assistance data. The commissioner shall provide a proposal to the 2003 legislature to define and implement this provision. When implementing prospective payment methodologies, the commissioner shall use general methods and rate calculation parameters similar to the applicable Medicare prospective payment systems for services delivered in outpatient hospital and ambulatory surgical center settings unless other payment methodologies for these services are specified in this chapter.

(d) For fee-for-service services provided on or after July 1, 2002, the total payment, before third-party liability and spenddown, made to hospitals for outpatient hospital facility services is reduced by .5 percent from the current statutory rate.

(e) In addition to the reduction in paragraph (d), the total payment for fee-for-service services provided on or after July 1, 2003, made to hospitals for outpatient hospital facility services before third-party liability and spenddown, is reduced five percent from the current statutory rates. Facilities defined under section 256.969, subdivision 16, are excluded from this paragraph.

(f) In addition to the reductions in paragraphs (d) and (e), the total payment for fee-for-service services provided on or after July 1, 2008, made to hospitals for outpatient hospital facility services before third-party liability and spenddown, is reduced three percent from the current statutory rates. Mental health services and facilities defined under section 256.969, subdivision 16, are excluded from this paragraph.

Sec. 9. Minnesota Statutes 2022, section 297F.10, subdivision 1, is amended to read:

Subdivision 1. **Tax and use tax on cigarettes.** Revenue received from cigarette taxes, as well as related penalties, interest, license fees, and miscellaneous sources of revenue shall be deposited by the commissioner in the state treasury and credited as follows:

(1) $22,250,000 each year must be credited to the Academic Health Center special revenue fund hereby created and is annually appropriated to the Board of Regents at the University of Minnesota for Academic Health Center funding at the University of Minnesota; and

(2) ~~$3,937,000~~ $3,788,000 each year must be credited to the medical education and research costs account hereby created in the special revenue fund and is annually appropriated to the commissioner of health for distribution under section 62J.692, subdivision 4, paragraph (a); and

(3) the balance of the revenues derived from taxes, penalties, and interest (under this chapter) and from license fees and miscellaneous sources of revenue shall be credited to the general fund.

Sec. 10. **REPEALER.**

Minnesota Statutes 2022, sections 62J.692, subdivisions 4a, 7, and 7a; 137.38, subdivision 1; and 256B.69, subdivision 5c, are repealed.

ARTICLE 5
HEALTH-RELATED LICENSING BOARDS

Section 1. Minnesota Statutes 2022, section 144E.001, subdivision 1, is amended to read:

Subdivision 1. **Scope.** For the purposes of ~~sections 144E.001 to 144E.52~~ this chapter, the terms defined in this section have the meanings given them.

Sec. 2. Minnesota Statutes 2022, section 144E.001, is amended by adding a subdivision to read:

Subd. 8b. **Medical resource communication center.** "Medical resource communication center" means an entity that:

(1) facilitates hospital-to-ambulance communications for ambulance services, the regional emergency medical services systems, and the board by coordinating patient care and transportation for ground and air operations;

(2) is integrated with the state's Allied Radio Matrix for Emergency Response (ARMER) radio system; and

(3) is the point of contact and a communication resource for statewide public safety entities, hospitals, and communities.

Sec. 3. Minnesota Statutes 2022, section 144E.101, subdivision 6, is amended to read:

Subd. 6. **Basic life support.** (a) Except as provided in paragraph (e), a basic life-support ambulance shall be staffed by at least two EMTs, one of whom must accompany the patient and provide a level of care so as to ensure that:

(1) life-threatening situations and potentially serious injuries are recognized;

(2) patients are protected from additional hazards;

(3) basic treatment to reduce the seriousness of emergency situations is administered; and

(4) patients are transported to an appropriate medical facility for treatment.

(b) A basic life-support service shall provide basic airway management.

(c) A basic life-support service shall provide automatic defibrillation.

(d) A basic life-support service licensee's medical director may authorize ambulance service personnel to perform intravenous infusion and use equipment that is within the licensure level of the ambulance service~~, including~~. A basic life-support licensee's medical director must authorize ambulance service personnel to perform administration of an opiate antagonist. Ambulance service personnel must be properly trained. Documentation of authorization for use, guidelines for use, continuing education, and skill verification must be maintained in the licensee's files.

(e) For emergency ambulance calls and interfacility transfers, an ambulance service may staff its basic life-support ambulances with one EMT, who must accompany the patient, and one registered emergency medical responder driver. For purposes of this paragraph, "ambulance service" means either an ambulance service whose primary service area is mainly located outside the metropolitan counties listed in section 473.121, subdivision 4, and outside the cities of Duluth, Mankato, Moorhead, Rochester, and St. Cloud; or an ambulance service based in a community with a population of less than 2,500.

Sec. 4. Minnesota Statutes 2022, section 144E.101, subdivision 7, is amended to read:

Subd. 7. **Advanced life support.** (a) Except as provided in paragraphs (f) and (g), an advanced life-support ambulance shall be staffed by at least:

(1) one EMT or one AEMT and one paramedic;

(2) one EMT or one AEMT and one registered nurse who is an EMT or an AEMT, is currently practicing nursing, and has passed a paramedic practical skills test approved by the board and administered by an education program; or

(3) one EMT or one AEMT and one physician assistant who is an EMT or an AEMT, is currently practicing as a physician assistant, and has passed a paramedic practical skills test approved by the board and administered by an education program.

(b) An advanced life-support service shall provide basic life support, as specified under subdivision 6, paragraph (a), advanced airway management, manual defibrillation, ~~and~~ administration of intravenous fluids and pharmaceuticals, and administration of opiate antagonists.

(c) In addition to providing advanced life support, an advanced life-support service may staff additional ambulances to provide basic life support according to subdivision 6 and section 144E.103, subdivision 1.

(d) An ambulance service providing advanced life support shall have a written agreement with its medical director to ensure medical control for patient care 24 hours a day, seven days a week. The terms of the agreement shall include a written policy on the administration of medical control for the service. The policy shall address the following issues:

(1) two-way communication for physician direction of ambulance service personnel;

(2) patient triage, treatment, and transport;

(3) use of standing orders; and

(4) the means by which medical control will be provided 24 hours a day.

The agreement shall be signed by the licensee's medical director and the licensee or the licensee's designee and maintained in the files of the licensee.

(e) When an ambulance service provides advanced life support, the authority of a paramedic, Minnesota registered nurse-EMT, or Minnesota registered physician assistant-EMT to determine the delivery of patient care prevails over the authority of an EMT.

(f) Upon application from an ambulance service that includes evidence demonstrating hardship, the board may grant a variance from the staff requirements in paragraph (a), clause (1), and may authorize an advanced life-support ambulance to be staffed by a registered emergency medical responder driver with a paramedic for all emergency calls and interfacility transfers. The variance shall apply to advanced life-support ambulance services until the ambulance service renews its license. When the variance expires, an ambulance service may apply for a new variance under this paragraph. This paragraph applies only to an ambulance service whose primary service area is mainly located outside the metropolitan counties listed in section 473.121, subdivision 4, and outside the cities of Duluth, Mankato, Moorhead, Rochester, and St. Cloud, or an ambulance based in a community with a population of less than 1,000 persons.

(g) After an initial emergency ambulance call, each subsequent emergency ambulance response, until the initial ambulance is again available, and interfacility transfers, may be staffed by one registered emergency medical responder driver and an EMT or paramedic. This paragraph applies only to an ambulance service whose primary service area is mainly located outside the metropolitan counties listed in section 473.121, subdivision 4, and outside the cities of Duluth, Mankato, Moorhead, Rochester, and St. Cloud, or an ambulance based in a community with a population of less than 1,000 persons.

Sec. 5. Minnesota Statutes 2022, section 144E.103, subdivision 1, is amended to read:

Subdivision 1. **General requirements.** Every ambulance in service for patient care shall carry, at a minimum:

(1) oxygen;

(2) airway maintenance equipment in various sizes to accommodate all age groups;

(3) splinting equipment in various sizes to accommodate all age groups;

(4) dressings, bandages, commercially manufactured tourniquets, and bandaging equipment;

(5) an emergency obstetric kit;

(6) equipment to determine vital signs in various sizes to accommodate all age groups;

(7) a stretcher;

(8) a defibrillator; ~~and~~

(9) a fire extinguisher; and

(10) opiate antagonists.

Sec. 6. Minnesota Statutes 2022, section 144E.35, is amended to read:

144E.35 REIMBURSEMENT TO ~~NONPROFIT~~ AMBULANCE SERVICES FOR VOLUNTEER EDUCATION COSTS.

Subdivision 1. **Repayment for volunteer education.** A licensed ambulance service shall be reimbursed by the board for the necessary expense of the initial education of a volunteer ambulance attendant upon successful completion by the attendant of an EMT education course, or a continuing education course for EMT care, or both, which has been approved by the board, pursuant to section 144E.285. Reimbursement may include tuition, transportation, food, lodging, hourly payment for the time spent in the education course, and other necessary expenditures, except that in no instance shall a volunteer ambulance attendant be reimbursed more than ~~$600~~ $900 for successful completion of an initial education course, and ~~$275~~ $375 for successful completion of a continuing education course.

Subd. 2. **Reimbursement provisions.** Reimbursement ~~will~~ must be paid under provisions of this section when documentation is provided to the board that the individual has served for one year from the date of the final certification exam as an active member of a Minnesota licensed ambulance service.

Sec. 7. **[144E.53] MEDICAL RESOURCE COMMUNICATION CENTER GRANTS.**

The board shall distribute medical resource communication center grants annually to the two medical resource communication centers that were in operation in the state prior to January 1, 2000.

Sec. 8. Minnesota Statutes 2022, section 147.02, subdivision 1, is amended to read:

Subdivision 1. **United States or Canadian medical school graduates.** The board shall issue a license to practice medicine to a person not currently licensed in another state or Canada and who meets the requirements in paragraphs (a) to (i).

(a) An applicant for a license shall file a written application on forms provided by the board, showing to the board's satisfaction that the applicant is of good moral character and satisfies the requirements of this section.

(b) The applicant shall present evidence satisfactory to the board of being a graduate of a medical or osteopathic medical school located in the United States, its territories or Canada, and approved by the board based upon its faculty, curriculum, facilities, accreditation by a

recognized national accrediting organization approved by the board, and other relevant data, or is currently enrolled in the final year of study at the school.

(c) The applicant must have passed an examination as described in clause (1) or (2).

(1) The applicant must have passed a comprehensive examination for initial licensure prepared and graded by the National Board of Medical Examiners, the Federation of State Medical Boards, the Medical Council of Canada, the National Board of Osteopathic Examiners, or the appropriate state board that the board determines acceptable. The board shall by rule determine what constitutes a passing score in the examination.

(2) The applicant taking the United States Medical Licensing Examination (USMLE) or Comprehensive Osteopathic Medical Licensing Examination (COMLEX-USA) must have passed steps or levels one, two, and three. Step or level three must be passed within five years of passing step or level two, or before the end of residency training. The applicant must pass each of steps or levels one, two, and three with passing scores as recommended by the USMLE program or National Board of Osteopathic Medical Examiners within three attempts. The applicant taking combinations of Federation of State Medical Boards, National Board of Medical Examiners, and USMLE may be accepted only if the combination is approved by the board as comparable to existing comparable examination sequences and all examinations are completed prior to the year 2000.

(d) The applicant shall present evidence satisfactory to the board of the completion of one year of graduate, clinical medical training in a program accredited by a national accrediting organization approved by the board ~~or other graduate training approved in advance by the board as meeting standards similar to those of a national accrediting organization~~.

(e) The applicant may make arrangements with the executive director to appear in person before the board or its designated representative to show that the applicant satisfies the requirements of this section. The board may establish as internal operating procedures the procedures or requirements for the applicant's personal presentation.

(f) The applicant shall pay a nonrefundable fee established by the board. Upon application or notice of license renewal, the board must provide notice to the applicant and to the person whose license is scheduled to be issued or renewed of any additional fees, surcharges, or other costs which the person is obligated to pay as a condition of licensure. The notice must:

(1) state the dollar amount of the additional costs; and

(2) clearly identify to the applicant the payment schedule of additional costs.

(g) The applicant must not be under license suspension or revocation by the licensing board of the state or jurisdiction in which the conduct that caused the suspension or revocation occurred.

(h) The applicant must not have engaged in conduct warranting disciplinary action against a licensee, or have been subject to disciplinary action other than as specified in paragraph (g). If the applicant does not satisfy the requirements stated in this paragraph, the board may issue a license only on the applicant's showing that the public will be protected through issuance of a license with conditions and limitations the board considers appropriate.

(i) If the examination in paragraph (c) was passed more than ten years ago, the applicant must either:

(1) pass the special purpose examination of the Federation of State Medical Boards with a score of 75 or better within three attempts; or

(2) have a current certification by a specialty board of the American Board of Medical Specialties, of the American Osteopathic Association, the Royal College of Physicians and Surgeons of Canada, or of the College of Family Physicians of Canada.

Sec. 9. Minnesota Statutes 2022, section 147.03, subdivision 1, is amended to read:

Subdivision 1. **Endorsement; reciprocity.** (a) The board may issue a license to practice medicine to any person who satisfies the requirements in paragraphs (b) to (e).

(b) The applicant shall satisfy all the requirements established in section 147.02, subdivision 1, paragraphs (a), (b), (d), (e), and (f), or section 147.037, subdivision 1, paragraphs (a) to (e).

(c) The applicant shall:

(1) have passed an examination prepared and graded by the Federation of State Medical Boards, the National Board of Medical Examiners, or the United States Medical Licensing Examination (USMLE) program in accordance with section 147.02, subdivision 1, paragraph (c), clause (2); the National Board of Osteopathic Medical Examiners; or the Medical Council of Canada; and

(2) have a current license from the equivalent licensing agency in another state or Canada and, if the examination in clause (1) was passed more than ten years ago, either:

(i) pass the Special Purpose Examination of the Federation of State Medical Boards ~~with a score of 75 or better~~ (SPEX) within three attempts; or

(ii) have a current certification by a specialty board of the American Board of Medical Specialties, of the American Osteopathic Association, the Royal College of Physicians and Surgeons of Canada, or of the College of Family Physicians of Canada; or

(3) if the applicant fails to meet the requirement established in section 147.02, subdivision 1, paragraph (c), clause (2), because the applicant failed to pass within the permitted three attempts each of steps or levels one, two, and three of the USMLE ~~within the required three attempts~~ or the Comprehensive Osteopathic Medical Licensing Examination (COMLEX-USA), the applicant may be granted a license provided the applicant:

(i) has passed each of steps or levels one, two, and three within no more than four attempts for any of the three steps or levels with passing scores as recommended by the USMLE or COMLEX-USA program ~~within no more than four attempts for any of the three steps~~;

(ii) is currently licensed in another state; and

(iii) has current certification by a specialty board of the American Board of Medical Specialties, the American Osteopathic Association ~~Bureau of Professional Education~~, the Royal College of Physicians and Surgeons of Canada, or the College of Family Physicians of Canada.

(d) The applicant must not be under license suspension or revocation by the licensing board of the state or jurisdiction in which the conduct that caused the suspension or revocation occurred.

(e) The applicant must not have engaged in conduct warranting disciplinary action against a licensee, or have been subject to disciplinary action other than as specified in paragraph (d). If an applicant does not satisfy the requirements stated in this paragraph, the board may issue a license only on the applicant's showing that the public will be protected through issuance of a license with conditions or limitations the board considers appropriate.

(f) Upon the request of an applicant, the board may conduct the final interview of the applicant by teleconference.

Sec. 10. Minnesota Statutes 2022, section 147.037, subdivision 1, is amended to read:

Subdivision 1. **Requirements.** The board shall issue a license to practice medicine to any person who satisfies the requirements in paragraphs (a) to (g).

(a) The applicant shall satisfy all the requirements established in section 147.02, subdivision 1, paragraphs (a), (e), (f), (g), and (h).

(b) The applicant shall present evidence satisfactory to the board that the applicant is a graduate of a medical or osteopathic school approved by the board as equivalent to accredited United States or Canadian schools based upon its faculty, curriculum, facilities, accreditation, or other relevant data. If the applicant is a graduate of a medical or osteopathic program that is not accredited by the Liaison Committee for Medical Education or the American Osteopathic Association, the applicant may use the Federation of State Medical Boards' Federation Credentials Verification Service (FCVS) or its successor. If the applicant uses this service as allowed under this paragraph, the physician application fee may be less than $200 but must not exceed the cost of administering this paragraph.

(c) The applicant shall present evidence satisfactory to the board that the applicant has been awarded a certificate by the Educational Council for Foreign Medical Graduates, and the applicant has a working ability in the English language sufficient to communicate with patients and physicians and to engage in the practice of medicine.

(d) The applicant shall present evidence satisfactory to the board of the completion of one year of graduate, clinical medical training in a program accredited by a national accrediting organization approved by the board ~~or other graduate training approved in advance by the board as meeting standards similar to those of a national accrediting organization~~. This requirement does not apply to an applicant who is admitted pursuant to the rules of the United States Department of Labor and:

(1) ~~to an applicant~~ who ~~is~~ was admitted as a permanent immigrant to the United States on or before October 1, 1991, as a person of exceptional ability in the sciences according to Code of Federal Regulations, title 20, section 656.22(d); or

(2) ~~to an applicant holding~~ who holds a valid license to practice medicine in another country and was issued a permanent immigrant visa after October 1, 1991, as a person of extraordinary ability in the field of science or as an outstanding professor or researcher according to Code of Federal Regulations, title 8, section 204.5(h) and (i), or a temporary nonimmigrant visa as a person of extraordinary ability in the field of science according to Code of Federal Regulations, title 8, section 214.2(o)~~,~~.

~~provided that a person under clause (1) or (2) is admitted pursuant to rules of the United States Department of Labor.~~

(e) The applicant must:

(1) have passed an examination prepared and graded by the Federation of State Medical Boards, the United States Medical Licensing Examination (USMLE) program in accordance

with section 147.02, subdivision 1, paragraph (c), clause (2), or the Medical Council of Canada; and

(2) if the examination in clause (1) was passed more than ten years ago, either:

(i) pass the Special Purpose Examination of the Federation of State Medical Boards ~~with a score of 75 or better within three attempts~~ (SPEX) or the Comprehensive Osteopathic Medical Variable-Purpose Examination of the National Board of Osteopathic Medical Examiners (COMVEX). The applicant must pass the SPEX or COMVEX within no more than three attempts of taking the SPEX, COMVEX, or a combination of the SPEX and COMVEX; or

(ii) have a current certification by a specialty board of the American Board of Medical Specialties, ~~of~~ the American Osteopathic Association, ~~of~~ the Royal College of Physicians and Surgeons of Canada, or ~~of~~ the College of Family Physicians of Canada; or

(3) if the applicant fails to meet the requirement established in section 147.02, subdivision 1, paragraph (c), clause (2), because the applicant failed to pass within the permitted three attempts each of steps or levels one, two, and three of the USMLE ~~within the required three attempts~~ or the Comprehensive Osteopathic Medical Licensing Examination (COMLEX-USA), the applicant may be granted a license provided the applicant:

(i) has passed each of steps or levels one, two, and three within no more than four attempts for any of the three steps or levels with passing scores as recommended by the USMLE or COMLEX-USA program ~~within no more than four attempts for any of the three steps~~;

(ii) is currently licensed in another state; and

(iii) has current certification by a specialty board of the American Board of Medical Specialties, the American Osteopathic Association, the Royal College of Physicians and Surgeons of Canada, or the College of Family Physicians of Canada.

(f) The applicant must not be under license suspension or revocation by the licensing board of the state or jurisdiction in which the conduct that caused the suspension or revocation occurred.

(g) The applicant must not have engaged in conduct warranting disciplinary action against a licensee~~,~~ or have been subject to disciplinary action other than as specified in paragraph (f). If an applicant does not satisfy the requirements stated in this paragraph, the board may issue a license only on the applicant's showing that the public will be protected through issuance of a license with conditions or limitations the board considers appropriate.

Sec. 11. Minnesota Statutes 2022, section 147.141, is amended to read:

147.141 FORMS OF DISCIPLINARY ACTION.

When the board finds that a licensed physician or a physician registered under section 147.032 has violated a provision or provisions of sections 147.01 to 147.22, it may do one or more of the following:

(1) revoke the license;

(2) suspend the license;

(3) revoke or suspend registration to perform interstate telehealth;

(4) impose limitations or conditions on the physician's practice of medicine, including limiting the ~~limitation of~~ scope of practice to designated field specialties; ~~the imposition of~~ imposing retraining or rehabilitation requirements; ~~the requirement of~~ requiring practice under supervision; or ~~the~~ conditioning ~~of~~ continued practice on demonstration of knowledge or skills by appropriate examination or other review of skill and competence;

(5) impose a civil penalty not exceeding $10,000 for each separate violation, the amount of the civil penalty to be fixed ~~so as~~ to deprive the physician of any economic advantage gained by reason of the violation charged or to reimburse the board for the cost of the investigation and proceeding;

(6) order the physician to provide unremunerated professional service under supervision at a designated public hospital, clinic, or other health care institution; or

(7) censure or reprimand the licensed physician.

Sec. 12. Minnesota Statutes 2022, section 147A.16, is amended to read:

147A.16 FORMS OF DISCIPLINARY ACTION.

(a) When the board finds that a licensed physician assistant has violated a provision of this chapter, it may do one or more of the following:

(1) revoke the license;

(2) suspend the license;

(3) impose limitations or conditions on the physician assistant's practice, including limiting the scope of practice to designated field specialties; imposing retraining or rehabilitation requirements; or limiting practice until demonstration of knowledge or skills by appropriate examination or other review of skill and competence;

(4) impose a civil penalty not exceeding $10,000 for each separate violation, the amount of the civil penalty to be fixed ~~so as~~ to deprive the physician assistant of any economic advantage gained by reason of the violation charged or to reimburse the board for the cost of the investigation and proceeding; or

(5) censure or reprimand the licensed physician assistant.

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

Sec. 13. Minnesota Statutes 2022, section 147B.02, subdivision 4, is amended to read:

Subd. 4. **Exceptions.** (a) The following persons may practice acupuncture within the scope of their practice without an acupuncture license:

(1) a physician licensed under chapter 147;

(2) an osteopathic physician licensed under chapter 147;

(3) a chiropractor licensed under chapter 148;

~~(4) a person who is studying in a formal course of study or tutorial intern program approved by the acupuncture advisory council established in section 147B.05 so long as the person's acupuncture practice is supervised by a licensed acupuncturist or a person who is exempt under clause (5);~~

~~(5)~~ (4) a visiting acupuncturist practicing acupuncture within an instructional setting for the sole purpose of teaching at a school registered with the Minnesota Office of Higher Education, who may practice without a license for a period of one year, with two one-year extensions permitted; and

~~(6)~~ (5) a visiting acupuncturist who is in the state for the sole purpose of providing a tutorial or workshop not to exceed 30 days in one calendar year.

(b) This chapter does not prohibit a person who does not have an acupuncturist license from practicing specific noninvasive techniques, such as acupressure, that are within the scope of practice as set forth in section 147B.06, subdivision 4.

Sec. 14. Minnesota Statutes 2022, section 147B.02, subdivision 7, is amended to read:

Subd. 7. **Licensure requirements.** (a) ~~After June 30, 1997,~~ An applicant for licensure must:

(1) submit a completed application for licensure on forms provided by the board, which must include the applicant's name and address of record, which shall be public;

(2) unless licensed under subdivision 5 or 6, submit ~~a notarized copy of a~~ evidence satisfactory to the board of current NCCAOM certification;

(3) sign a statement that the information in the application is true and correct to the best of the applicant's knowledge and belief;

(4) submit with the application all fees required; and

(5) sign a waiver authorizing the board to obtain access to the applicant's records in this state or any state in which the applicant has engaged in the practice of acupuncture.

(b) The board may ask the applicant to provide any additional information necessary to ensure that the applicant is able to practice with reasonable skill and safety to the public.

(c) The board may investigate information provided by an applicant to determine whether the information is accurate and complete. The board shall notify an applicant of action taken on the application and the reasons for denying licensure if licensure is denied.

Sec. 15. **[148.635] FEE.**

Subdivision 1. **Nonrefundable fee.** The fee in this section is nonrefundable.

Subd. 2. **Licensure verification fee.** The fee for verification of licensure is $20.

Sec. 16. Minnesota Statutes 2022, section 148B.392, subdivision 2, is amended to read:

Subd. 2. **Licensure and application fees.** Licensure and application fees established by the board shall not exceed the following amounts:

(1) application fee for national examination is ~~$110~~ $150;

(2) application fee for Licensed Marriage and Family Therapist (LMFT) state examination is ~~$110~~ $150;

(3) initial LMFT license fee is prorated, but cannot exceed $125;

(4) annual renewal fee for LMFT license is ~~$125~~ $225;

(5) late fee for LMFT license renewal is ~~$50~~ $100;

(6) application fee for LMFT licensure by reciprocity is ~~$220~~ $300;

(7) fee for initial Licensed Associate Marriage and Family Therapist (LAMFT) license is ~~$75~~ $100;

(8) annual renewal fee for LAMFT license is ~~$75~~ $100;

(9) late fee for LAMFT renewal is ~~$25~~ $50;

(10) fee for reinstatement of license is $150;

(11) fee for emeritus status is ~~$125~~ $225; and

(12) fee for temporary license for members of the military is $100.

Sec. 17. Minnesota Statutes 2022, section 148F.11, is amended by adding a subdivision to read:

Subd. 2a. **Former students.** (a) A former student may practice alcohol and drug counseling for 90 days from the former student's degree conferral date from an accredited school or educational program or from the last date the former student received credit for an alcohol and drug counseling course from an accredited school or educational program. The former student's practice must be supervised by an alcohol and drug counselor or an alcohol and drug counselor supervisor, as defined in section 245G.11. The former student's practice is limited to the site where the student completed their internship or practicum. A former student must be paid for work performed during the 90-day period.

(b) The former student's right to practice automatically expires after 90 days from the former student's degree conferral date or date of last course credit for an alcohol and drug counseling course, whichever occurs last.

Sec. 18. Minnesota Statutes 2022, section 150A.08, subdivision 1, is amended to read:

Subdivision 1. **Grounds.** The board may refuse or by order suspend or revoke, limit or modify by imposing conditions it deems necessary, the license of a dentist, dental therapist, dental hygienist, or dental ~~assisting~~ assistant upon any of the following grounds:

(1) fraud or deception in connection with the practice of dentistry or the securing of a license certificate;

(2) conviction, including a finding or verdict of guilt, an admission of guilt, or a no contest plea, in any court of a felony or gross misdemeanor reasonably related to the practice of dentistry as evidenced by a certified copy of the conviction;

(3) conviction, including a finding or verdict of guilt, an admission of guilt, or a no contest plea, in any court of an offense involving moral turpitude as evidenced by a certified copy of the conviction;

(4) habitual overindulgence in the use of intoxicating liquors;

(5) improper or unauthorized prescription, dispensing, administering, or personal or other use of any legend drug as defined in chapter 151, of any chemical as defined in chapter 151, or of any controlled substance as defined in chapter 152;

(6) conduct unbecoming a person licensed to practice dentistry, dental therapy, dental hygiene, or dental assisting, or conduct contrary to the best interest of the public, as such conduct is defined by the rules of the board;

(7) gross immorality;

(8) any physical, mental, emotional, or other disability which adversely affects a dentist's, dental therapist's, dental hygienist's, or dental assistant's ability to perform the service for which the person is licensed;

(9) revocation or suspension of a license or equivalent authority to practice, or other disciplinary action or denial of a license application taken by a licensing or credentialing authority of another state, territory, or country as evidenced by a certified copy of the licensing authority's order, if the disciplinary action or application denial was based on facts that would provide a basis for disciplinary action under this chapter and if the action was taken only after affording the credentialed person or applicant notice and opportunity to refute the allegations or pursuant to stipulation or other agreement;

(10) failure to maintain adequate safety and sanitary conditions for a dental office in accordance with the standards established by the rules of the board;

(11) employing, assisting, or enabling in any manner an unlicensed person to practice dentistry;

(12) failure or refusal to attend, testify, and produce records as directed by the board under subdivision 7;

(13) violation of, or failure to comply with, any other provisions of sections 150A.01 to 150A.12, the rules of the Board of Dentistry, or any disciplinary order issued by the board, sections 144.291 to 144.298 or 595.02, subdivision 1, paragraph (d), or for any other just cause related to the practice of dentistry. Suspension, revocation, modification or limitation of any license shall not be based upon any judgment as to therapeutic or monetary value of any individual drug prescribed or any individual treatment rendered, but only upon a repeated pattern of conduct;

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

(15) aiding suicide or aiding attempted suicide in violation of section 609.215 as established by any of the following:

(i) a copy of the record of criminal conviction or plea of guilty for a felony in violation of section 609.215, subdivision 1 or 2;

(ii) a copy of the record of a judgment of contempt of court for violating an injunction issued under section 609.215, subdivision 4;

(iii) a copy of the record of a judgment assessing damages under section 609.215, subdivision 5; or

(iv) a finding by the board that the person violated section 609.215, subdivision 1 or 2. The board shall investigate any complaint of a violation of section 609.215, subdivision 1 or 2.

Sec. 19. Minnesota Statutes 2022, section 150A.08, subdivision 5, is amended to read:

Subd. 5. **Medical examinations.** If the board has probable cause to believe that a dentist, dental therapist, dental hygienist, dental assistant, or applicant engages in acts described in subdivision 1, clause (4) or (5), or has a condition described in subdivision 1, clause (8), it shall direct the dentist, dental therapist, dental hygienist, dental assistant, or applicant to submit to a mental or physical examination or a substance use disorder assessment. For the purpose of this subdivision, every dentist, dental therapist, dental hygienist, or dental assistant licensed under this chapter or person submitting an application for a license is deemed to have given consent to submit to a mental or physical examination when directed in writing by the board and to have waived all objections in any proceeding under this section to the admissibility of the examining physician's testimony or examination reports on the ground that they constitute a privileged communication. Failure to submit to an examination without just cause may result in an application being denied or a default and final order being entered without the taking of testimony or presentation of evidence, other than evidence which may be submitted by affidavit, that the licensee or applicant did not submit to the examination. A dentist, dental therapist, dental hygienist, dental assistant, or applicant affected under this section shall at reasonable intervals be afforded an opportunity to demonstrate ability to start or resume the competent practice of dentistry or perform the duties of a dental therapist, dental hygienist, or dental assistant with reasonable skill and safety to patients. In any proceeding under this subdivision, neither the record of proceedings nor the orders entered by the board is admissible, is subject to subpoena, or may be used against the dentist, dental therapist, dental hygienist, dental assistant, or applicant in any proceeding not commenced

by the board. Information obtained under this subdivision shall be classified as private pursuant to the Minnesota Government Data Practices Act.

Sec. 20. Minnesota Statutes 2022, section 150A.091, is amended by adding a subdivision to read:

Subd. 23. **Mailing list services.** Each licensee must submit a nonrefundable $5 fee to request a mailing address list.

Sec. 21. Minnesota Statutes 2022, section 150A.13, subdivision 10, is amended to read:

Subd. 10. **Failure to report.** ~~On or after August 1, 2012,~~ Any person, institution, insurer, or organization that fails to report as required under subdivisions 2 to 6 shall be subject to civil penalties for failing to report as required by law.

Sec. 22. Minnesota Statutes 2022, section 151.01, subdivision 27, is amended to read:

Subd. 27. **Practice of pharmacy.** (a) "Practice of pharmacy" means:

(1) interpretation and evaluation of prescription drug orders;

(2) compounding, labeling, and dispensing drugs and devices (except labeling by a manufacturer or packager of nonprescription drugs or commercially packaged legend drugs and devices);

(3) participation in clinical interpretations and monitoring of drug therapy for assurance of safe and effective use of drugs, including the performance of laboratory tests that are waived under the federal Clinical Laboratory Improvement Act of 1988, United States Code, title 42, section 263a et seq., provided that a pharmacist may interpret the results of laboratory tests but may modify drug therapy only pursuant to a protocol or collaborative practice agreement;

(4) participation in drug and therapeutic device selection; drug administration for first dosage and medical emergencies; intramuscular and subcutaneous drug administration under a prescription drug order; drug regimen reviews; and drug or drug-related research;

(5) drug administration, through intramuscular and subcutaneous administration used to treat mental illnesses as permitted under the following conditions:

(i) upon the order of a prescriber and the prescriber is notified after administration is complete; or

(ii) pursuant to a protocol or collaborative practice agreement as defined by section 151.01, subdivisions 27b and 27c, and participation in the initiation, management, modification, administration, and discontinuation of drug therapy is according to the protocol or collaborative practice agreement between the pharmacist and a dentist, optometrist, physician, physician assistant, podiatrist, or veterinarian, or an advanced practice registered nurse authorized to prescribe, dispense, and administer under section 148.235. Any changes in drug therapy or medication administration made pursuant to a protocol or collaborative practice agreement must be documented by the pharmacist in the patient's medical record or reported by the pharmacist to a practitioner responsible for the patient's care;

(6) participation in administration of influenza vaccines and vaccines authorized or approved by the United States Food and Drug Administration related to COVID-19 or SARS-CoV-2 to all eligible individuals six years of age and older and all other vaccines to patients 13 years of age and older by written protocol with a physician licensed under chapter 147, a physician assistant authorized to prescribe drugs under chapter 147A, or an advanced practice registered nurse authorized to prescribe drugs under section 148.235, provided that:

(i) the protocol includes, at a minimum:

(A) the name, dose, and route of each vaccine that may be given;

(B) the patient population for whom the vaccine may be given;

(C) contraindications and precautions to the vaccine;

(D) the procedure for handling an adverse reaction;

(E) the name, signature, and address of the physician, physician assistant, or advanced practice registered nurse;

(F) a telephone number at which the physician, physician assistant, or advanced practice registered nurse can be contacted; and

(G) the date and time period for which the protocol is valid;

(ii) the pharmacist has successfully completed a program approved by the Accreditation Council for Pharmacy Education (ACPE) specifically for the administration of immunizations or a program approved by the board;

(iii) the pharmacist utilizes the Minnesota Immunization Information Connection to assess the immunization status of individuals prior to the administration of vaccines, except when administering influenza vaccines to individuals age nine and older;

(iv) the pharmacist reports the administration of the immunization to the Minnesota Immunization Information Connection; ~~and~~

(v) the pharmacist complies with guidelines for vaccines and immunizations established by the federal Advisory Committee on Immunization Practices, except that a pharmacist does not need to comply with those portions of the guidelines that establish immunization schedules when administering a vaccine pursuant to a valid, patient-specific order issued by a physician licensed under chapter 147, a physician assistant authorized to prescribe drugs under chapter 147A, or an advanced practice registered nurse authorized to prescribe drugs under section 148.235, provided that the order is consistent with the United States Food and Drug Administration approved labeling of the vaccine; and

(vi) the pharmacist has a current certificate in cardiopulmonary resuscitation;

(7) participation in the initiation, management, modification, and discontinuation of drug therapy according to a written protocol or collaborative practice agreement between: (i) one or more pharmacists and one or more dentists, optometrists, physicians, physician assistants, podiatrists, or veterinarians; or (ii) one or more pharmacists and one or more physician assistants authorized to prescribe, dispense, and administer under chapter 147A, or advanced practice registered nurses authorized to prescribe, dispense, and administer under section 148.235. Any changes in drug therapy made pursuant to a protocol or collaborative practice agreement must be documented by the pharmacist in the patient's medical record or reported by the pharmacist to a practitioner responsible for the patient's care;

(8) participation in the storage of drugs and the maintenance of records;

(9) patient counseling on therapeutic values, content, hazards, and uses of drugs and devices;

(10) offering or performing those acts, services, operations, or transactions necessary in the conduct, operation, management, and control of a pharmacy;

(11) participation in the initiation, management, modification, and discontinuation of therapy with opiate antagonists, as defined in section 604A.04, subdivision 1, pursuant to:

(i) a written protocol as allowed under clause (7); or

(ii) a written protocol with a community health board medical consultant or a practitioner designated by the commissioner of health, as allowed under section 151.37, subdivision 13;

(12) prescribing self-administered hormonal contraceptives; nicotine replacement medications; and opiate antagonists for the treatment of an acute opiate overdose pursuant to section 151.37, subdivision 14, 15, or 16; and

(13) participation in the placement of drug monitoring devices according to a prescription, protocol, or collaborative practice agreement.

(b) A pharmacist may delegate the authority to administer vaccines under paragraph (a), clause 6, to a pharmacy technician or pharmacist intern who has completed training in vaccine administration if:

(1) the pharmacy technician or pharmacist intern has successfully completed a program approved by the ACPE specifically for the administration of immunizations or a program approved by the board;

(2) the pharmacy technician or pharmacist intern has a current certificate in cardiopulmonary resuscitation;

(3) the pharmacist intern has the ability, under the direct supervision of a pharmacist, to utilize the Minnesota Immunization Information Connection to assess the immunization status of individuals prior to the administration of vaccines, except when administering influenza vaccines to individuals age nine and older;

(4) the pharmacy technician has completed a minimum of two hours of ACPE-approved, immunization-related continuing pharmacy education as part of the pharmacy technician's two-year continuing education schedule;

(5) the pharmacy technician has completed one of the training programs listed under Minnesota Rules, part 6800.3850, subpart 1h, item B; and

(6) the pharmacy technician or pharmacist intern administering vaccinations is supervised by a licensed pharmacist according to the following requirements:

(i) the supervising pharmacist is readily and immediately available to the immunizing pharmacy technician or pharmacist intern; and

(ii) direct supervision under this clause is provided in person and not through telehealth, as defined under section 62A.673, subdivision 2.

Sec. 23. Minnesota Statutes 2022, section 151.065, subdivision 1, is amended to read:

Subdivision 1. **Application fees.** Application fees for licensure and registration are as follows:

(1) pharmacist licensed by examination, ~~$175~~ $210;

(2) pharmacist licensed by reciprocity, ~~$275~~ $300;

(3) pharmacy intern, ~~$50~~ $75;

(4) pharmacy technician, ~~$50~~ $60;

(5) pharmacy, ~~$260~~ $300;

(6) drug wholesaler, legend drugs only, ~~$5,260~~ $5,300;

(7) drug wholesaler, legend and nonlegend drugs, ~~$5,260~~ $5,300;

(8) drug wholesaler, nonlegend drugs, veterinary legend drugs, or both, ~~$5,260~~ $5,300;

(9) drug wholesaler, medical gases, ~~$5,260~~ $5,300 for the first facility and ~~$260~~ $300 for each additional facility;

(10) third-party logistics provider, ~~$260~~ $300;

(11) drug manufacturer, nonopiate legend drugs only, ~~$5,260~~ $5,300;

(12) drug manufacturer, nonopiate legend and nonlegend drugs, ~~$5,260~~ $5,300;

(13) drug manufacturer, nonlegend or veterinary legend drugs, ~~$5,260~~ $5,300;

(14) drug manufacturer, medical gases, ~~$5,260~~ $5,300 for the first facility and ~~$260~~ $300 for each additional facility;

(15) drug manufacturer, also licensed as a pharmacy in Minnesota, ~~$5,260~~ $5,300;

(16) drug manufacturer of opiate-containing controlled substances listed in section 152.02, subdivisions 3 to 5, ~~$55,260~~ $55,300;

(17) medical gas dispenser, $260;

(18) controlled substance researcher, ~~$75~~ $150; and

(19) pharmacy professional corporation, $150.

Sec. 24. Minnesota Statutes 2022, section 151.065, subdivision 2, is amended to read:

Subd. 2. **Original license fee.** The pharmacist original licensure fee, ~~$175~~ $210.

Sec. 25. Minnesota Statutes 2022, section 151.065, subdivision 3, is amended to read:

Subd. 3. **Annual renewal fees.** Annual licensure and registration renewal fees are as follows:

(1) pharmacist, ~~$175~~ $210;

(2) pharmacy technician, ~~$50~~ $60;

(3) pharmacy, ~~$260~~ $300;

(4) drug wholesaler, legend drugs only, ~~$5,260~~ $5,300;

(5) drug wholesaler, legend and nonlegend drugs, ~~$5,260~~ $5,300;

(6) drug wholesaler, nonlegend drugs, veterinary legend drugs, or both, ~~$5,260~~ $5,300;

(7) drug wholesaler, medical gases, ~~$5,260~~ $5,300 for the first facility and ~~$260~~ $300 for each additional facility;

(8) third-party logistics provider, ~~$260~~ $300;

(9) drug manufacturer, nonopiate legend drugs only, ~~$5,260~~ $5,300;

(10) drug manufacturer, nonopiate legend and nonlegend drugs, ~~$5,260~~ $5,300;

(11) drug manufacturer, nonlegend, veterinary legend drugs, or both, ~~$5,260~~ $5,300;

(12) drug manufacturer, medical gases, ~~$5,260~~ $5,300 for the first facility and ~~$260~~ $300 for each additional facility;

(13) drug manufacturer, also licensed as a pharmacy in Minnesota, ~~$5,260~~ $5,300;

(14) drug manufacturer of opiate-containing controlled substances listed in section 152.02, subdivisions 3 to 5, ~~$55,260~~ $55,300;

(15) medical gas dispenser, $260;

(16) controlled substance researcher, ~~$75~~ $150; and

(17) pharmacy professional corporation, ~~$100~~ $150.

Sec. 26. Minnesota Statutes 2022, section 151.065, subdivision 4, is amended to read:

Subd. 4. **Miscellaneous fees.** Fees for issuance of affidavits and duplicate licenses and certificates are as follows:

(1) intern affidavit, ~~$20~~ $30;

(2) duplicate small license, ~~$20~~ $30; and

(3) duplicate large certificate, $30.

Sec. 27. Minnesota Statutes 2022, section 151.065, subdivision 6, is amended to read:

Subd. 6. **Reinstatement fees.** (a) A pharmacist who has allowed the pharmacist's license to lapse may reinstate the license with board approval and upon payment of any fees and late fees in arrears, up to a maximum of $1,000.

(b) A pharmacy technician who has allowed the technician's registration to lapse may reinstate the registration with board approval and upon payment of any fees and late fees in arrears, up to a maximum of ~~$90~~ $250.

(c) An owner of a pharmacy, a drug wholesaler, a drug manufacturer, third-party logistics provider, or a medical gas dispenser who has allowed the license of the establishment to lapse may reinstate the license with board approval and upon payment of any fees and late fees in arrears.

(d) A controlled substance researcher who has allowed the researcher's registration to lapse may reinstate the registration with board approval and upon payment of any fees and late fees in arrears.

(e) A pharmacist owner of a professional corporation who has allowed the corporation's registration to lapse may reinstate the registration with board approval and upon payment of any fees and late fees in arrears.

Sec. 28. Minnesota Statutes 2022, section 151.555, is amended to read:

151.555 ~~PRESCRIPTION DRUG~~ MEDICATION REPOSITORY PROGRAM.

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

(b) "Central repository" means a wholesale distributor that meets the requirements under subdivision 3 and enters into a contract with the Board of Pharmacy in accordance with this section.

(c) "Distribute" means to deliver, other than by administering or dispensing.

(d) "Donor" means:

(1) a health care facility as defined in this subdivision;

(2) a skilled nursing facility licensed under chapter 144A;

(3) an assisted living facility licensed under chapter 144G;

(4) a pharmacy licensed under section 151.19, and located either in the state or outside the state;

(5) a drug wholesaler licensed under section 151.47;

(6) a drug manufacturer licensed under section 151.252; or

(7) an individual at least 18 years of age, provided that the drug or medical supply that is donated was obtained legally and meets the requirements of this section for donation.

(e) "Drug" means any prescription drug that has been approved for medical use in the United States, is listed in the United States Pharmacopoeia or National Formulary, and meets the criteria established under this section for donation; or any over-the-counter medication that meets the criteria established under this section for donation. This definition includes cancer drugs and antirejection drugs, but does not include controlled substances, as defined in section 152.01, subdivision 4, or a prescription drug that can only be dispensed to a patient registered with the drug's manufacturer in accordance with federal Food and Drug Administration requirements.

(f) "Health care facility" means:

(1) a physician's office or health care clinic where licensed practitioners provide health care to patients;

(2) a hospital licensed under section 144.50;

(3) a pharmacy licensed under section 151.19 and located in Minnesota; or

(4) a nonprofit community clinic, including a federally qualified health center; a rural health clinic; public health clinic; or other community clinic that provides health care utilizing a sliding fee scale to patients who are low-income, uninsured, or underinsured.

(g) "Local repository" means a health care facility that elects to accept donated drugs and medical supplies and meets the requirements of subdivision 4.

(h) "Medical supplies" or "supplies" means any prescription ~~and~~ or nonprescription medical supplies needed to administer a ~~preseription~~ drug.

(i) "Original, sealed, unopened, tamper-evident packaging" means packaging that is sealed, unopened, and tamper-evident, including a manufacturer's original unit dose or unit-of-use container, a repackager's original unit dose or unit-of-use container, or unit-dose packaging prepared by a licensed pharmacy according to the standards of Minnesota Rules, part 6800.3750.

(j) "Practitioner" has the meaning given in section 151.01, subdivision 23, except that it does not include a veterinarian.

Subd. 2. **Establishment; contract and oversight.** ~~By January 1, 2020,~~ (a) The Board of Pharmacy shall establish a ~~drug~~ medication repository program, through which donors may donate a drug or medical supply for use by an individual who meets the eligibility criteria specified under subdivision 5.

(b) The board shall contract with a central repository that meets the requirements of subdivision 3 to implement and administer the ~~prescription drug~~ medication repository program. The contract must:

(1) require the board to transfer to the central repository any money appropriated by the legislature for the purpose of operating the medication repository program and require the central repository to spend any money transferred only for purposes specified in the contract;

(2) require the central repository to report the following performance measures to the board:

(i) the number of individuals served and the types of medications these individuals received;

(ii) the number of clinics, pharmacies, and long-term care facilities with which the central repository partnered;

(iii) the number and cost of medications accepted for inventory, disposed of, and dispensed to individuals in need; and

(iv) locations within the state to which medications were shipped or delivered; and

(3) require the board to annually audit the expenditure by the central repository of any money appropriated by the legislature and transferred by the board to ensure that this money is used only for purposes specified in the contract.

Subd. 3. **Central repository requirements.** (a) The board may publish a request for proposal for participants who meet the requirements of this subdivision and are interested in acting as the central repository for the ~~drug~~ medication repository program. If the board publishes a request for proposal, it shall follow all applicable state procurement procedures in the selection process. The board may also work directly with the University of Minnesota to establish a central repository.

(b) To be eligible to act as the central repository, the participant must be a wholesale drug distributor located in Minnesota, licensed pursuant to section 151.47, and in compliance with all applicable federal and state statutes, rules, and regulations.

(c) The central repository shall be subject to inspection by the board pursuant to section 151.06, subdivision 1.

(d) The central repository shall comply with all applicable federal and state laws, rules, and regulations pertaining to the ~~drug~~ medication repository program, drug storage, and dispensing. The facility must maintain in good standing any state license or registration that applies to the facility.

Subd. 4. **Local repository requirements.** (a) To be eligible for participation in the ~~drug~~ medication repository program, a health care facility must agree to comply with all applicable federal and state laws, rules, and regulations pertaining to the ~~drug~~ medication repository program, drug storage, and dispensing. The facility must also agree to maintain in good standing any required state license or registration that may apply to the facility.

(b) A local repository may elect to participate in the program by submitting the following information to the central repository on a form developed by the board and made available on the board's website:

(1) the name, street address, and telephone number of the health care facility and any state-issued license or registration number issued to the facility, including the issuing state agency;

(2) the name and telephone number of a responsible pharmacist or practitioner who is employed by or under contract with the health care facility; and

(3) a statement signed and dated by the responsible pharmacist or practitioner indicating that the health care facility meets the eligibility requirements under this section and agrees to comply with this section.

(c) Participation in the ~~drug~~ medication repository program is voluntary. A local repository may withdraw from participation in the ~~drug~~ medication repository program at any time by providing written notice to the central repository on a form developed by the board and made available on the board's website. The central repository shall provide the board with a copy of the withdrawal notice within ten business days from the date of receipt of the withdrawal notice.

Subd. 5. **Individual eligibility and application requirements.** (a) To be eligible for the ~~drug~~ medication repository program, an individual must submit to a local repository an intake application form that is signed by the individual and attests that the individual:

(1) is a resident of Minnesota;

(2) is uninsured and is not enrolled in the medical assistance program under chapter 256B or the MinnesotaCare program under chapter 256L, has no prescription drug coverage, or is underinsured;

(3) acknowledges that the drugs or medical supplies to be received through the program may have been donated; and

(4) consents to a waiver of the child-resistant packaging requirements of the federal Poison Prevention Packaging Act.

(b) Upon determining that an individual is eligible for the program, the local repository shall furnish the individual with an identification card. The card shall be valid for one year from the date of issuance and may be used at any local repository. A new identification card may be issued upon expiration once the individual submits a new application form.

(c) The local repository shall send a copy of the intake application form to the central repository by regular mail, facsimile, or secured email within ten days from the date the application is approved by the local repository.

(d) The board shall develop and make available on the board's website an application form and the format for the identification card.

Subd. 6. **Standards and procedures for accepting donations of drugs and supplies.** (a) A donor may donate ~~prescription~~ drugs or medical supplies to the central repository or a local repository if the drug or supply meets the requirements of this section as determined by a pharmacist or practitioner who is employed by or under contract with the central repository or a local repository.

(b) A ~~prescription~~ drug is eligible for donation under the ~~drug~~ medication repository program if the following requirements are met:

(1) the donation is accompanied by a ~~drug~~ medication repository donor form described under paragraph (d) that is signed by an individual who is authorized by the donor to attest to the donor's knowledge in accordance with paragraph (d);

(2) the drug's expiration date is at least six months after the date the drug was donated. If a donated drug bears an expiration date that is less than six months from the donation date, the drug may be accepted and distributed if the drug is in high demand and can be dispensed for use by a patient before the drug's expiration date;

(3) the drug is in its original, sealed, unopened, tamper-evident packaging that includes the expiration date. Single-unit-dose drugs may be accepted if the single-unit-dose packaging is unopened;

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

(5) the drug does not require storage temperatures other than normal room temperature as specified by the manufacturer or United States Pharmacopoeia, unless the drug is being donated directly by its manufacturer, a wholesale drug distributor, or a pharmacy located in Minnesota; and

(6) the ~~prescription~~ drug is not a controlled substance.

(c) A medical supply is eligible for donation under the ~~drug~~ medication repository program if the following requirements are met:

(1) the supply has no physical signs of tampering, misbranding, or alteration and there is no reason to believe it has been adulterated, tampered with, or misbranded;

(2) the supply is in its original, unopened, sealed packaging;

(3) the donation is accompanied by a ~~drug~~ medication repository donor form described under paragraph (d) that is signed by an individual who is authorized by the donor to attest to the donor's knowledge in accordance with paragraph (d); and

(4) if the supply bears an expiration date, the date is at least six months later than the date the supply was donated. If the donated supply bears an expiration date that is less than six months from the date the supply was donated, the supply may be accepted and distributed if the supply is in high demand and can be dispensed for use by a patient before the supply's expiration date.

(d) The board shall develop the ~~drug~~ medication repository donor form and make it available on the board's website. The form must state that to the best of the donor's knowledge the donated drug or supply has been properly stored under appropriate temperature and humidity conditions and that the drug or supply has never been opened, used, tampered with, adulterated, or misbranded.

(e) Donated drugs and supplies may be shipped or delivered to the premises of the central repository or a local repository, and shall be inspected by a pharmacist or an authorized practitioner who is employed by or under contract with the repository and who has been designated by the repository to accept donations. A drop box must not be used to deliver or accept donations.

(f) The central repository and local repository shall inventory all drugs and supplies donated to the repository. For each drug, the inventory must include the drug's name, strength, quantity, manufacturer, expiration date, and the date the drug was donated. For each medical

supply, the inventory must include a description of the supply, its manufacturer, the date the supply was donated, and, if applicable, the supply's brand name and expiration date.

Subd. 7. **Standards and procedures for inspecting and storing donated ~~prescription~~ drugs and supplies.** (a) A pharmacist or authorized practitioner who is employed by or under contract with the central repository or a local repository shall inspect all donated ~~prescription~~ drugs and supplies before the drug or supply is dispensed to determine, to the extent reasonably possible in the professional judgment of the pharmacist or practitioner, that the drug or supply is not adulterated or misbranded, has not been tampered with, is safe and suitable for dispensing, has not been subject to a recall, and meets the requirements for donation. The pharmacist or practitioner who inspects the drugs or supplies shall sign an inspection record stating that the requirements for donation have been met. If a local repository receives drugs and supplies from the central repository, the local repository does not need to reinspect the drugs and supplies.

(b) The central repository and local repositories shall store donated drugs and supplies in a secure storage area under environmental conditions appropriate for the drug or supply being stored. Donated drugs and supplies may not be stored with nondonated inventory.

(c) The central repository and local repositories shall dispose of all ~~prescription~~ drugs and medical supplies that are not suitable for donation in compliance with applicable federal and state statutes, regulations, and rules concerning hazardous waste.

(d) In the event that controlled substances or ~~prescription~~ drugs that can only be dispensed to a patient registered with the drug's manufacturer are shipped or delivered to a central or local repository for donation, the shipment delivery must be documented by the repository and returned immediately to the donor or the donor's representative that provided the drugs.

(e) Each repository must develop drug and medical supply recall policies and procedures. If a repository receives a recall notification, the repository shall destroy all of the drug or medical supply in its inventory that is the subject of the recall and complete a record of destruction form in accordance with paragraph (f). If a drug or medical supply that is the subject of a Class I or Class II recall has been dispensed, the repository shall immediately notify the recipient of the recalled drug or medical supply. A drug that potentially is subject to a recall need not be destroyed if its packaging bears a lot number and that lot of the drug is not subject to the recall. If no lot number is on the drug's packaging, it must be destroyed.

(f) A record of destruction of donated drugs and supplies that are not dispensed under subdivision 8, are subject to a recall under paragraph (e), or are not suitable for donation

shall be maintained by the repository for at least two years. For each drug or supply destroyed, the record shall include the following information:

(1) the date of destruction;

(2) the name, strength, and quantity of the drug destroyed; and

(3) the name of the person or firm that destroyed the drug.

Subd. 8. **Dispensing requirements.** (a) Donated drugs and supplies may be dispensed if the drugs or supplies are prescribed by a practitioner for use by an eligible individual and are dispensed by a pharmacist or practitioner. A repository shall dispense drugs and supplies to eligible individuals in the following priority order: (1) individuals who are uninsured; (2) individuals with no prescription drug coverage; and (3) individuals who are underinsured. A repository shall dispense donated ~~prescription~~ drugs in compliance with applicable federal and state laws and regulations for dispensing ~~prescription~~ drugs, including all requirements relating to packaging, labeling, record keeping, drug utilization review, and patient counseling.

(b) Before dispensing or administering a drug or supply, the pharmacist or practitioner shall visually inspect the drug or supply for adulteration, misbranding, tampering, and date of expiration. Drugs or supplies that have expired or appear upon visual inspection to be adulterated, misbranded, or tampered with in any way must not be dispensed or administered.

(c) Before a drug or supply is dispensed or administered to an individual, the individual must sign a drug repository recipient form acknowledging that the individual understands the information stated on the form. The board shall develop the form and make it available on the board's website. The form must include the following information:

(1) that the drug or supply being dispensed or administered has been donated and may have been previously dispensed;

(2) that a visual inspection has been conducted by the pharmacist or practitioner to ensure that the drug or supply has not expired, has not been adulterated or misbranded, and is in its original, unopened packaging; and

(3) that the dispensing pharmacist, the dispensing or administering practitioner, the central repository or local repository, the Board of Pharmacy, and any other participant of the ~~drug~~ medication repository program cannot guarantee the safety of the drug or medical supply being dispensed or administered and that the pharmacist or practitioner has determined that the drug or supply is safe to dispense or administer based on the accuracy of the donor's

form submitted with the donated drug or medical supply and the visual inspection required to be performed by the pharmacist or practitioner before dispensing or administering.

Subd. 9. **Handling fees.** (a) The central or local repository may charge the individual receiving a drug or supply a handling fee of no more than 250 percent of the medical assistance program dispensing fee for each drug or medical supply dispensed or administered by that repository.

(b) A repository that dispenses or administers a drug or medical supply through the ~~drug~~ medication repository program shall not receive reimbursement under the medical assistance program or the MinnesotaCare program for that dispensed or administered drug or supply.

Subd. 10. **Distribution of donated drugs and supplies.** (a) The central repository and local repositories may distribute drugs and supplies donated under the ~~drug~~ medication repository program to other participating repositories for use pursuant to this program.

(b) A local repository that elects not to dispense donated drugs or supplies must transfer all donated drugs and supplies to the central repository. A copy of the donor form that was completed by the original donor under subdivision 6 must be provided to the central repository at the time of transfer.

Subd. 11. **Forms and record-keeping requirements.** (a) The following forms developed for the administration of this program shall be utilized by the participants of the program and shall be available on the board's website:

(1) intake application form described under subdivision 5;

(2) local repository participation form described under subdivision 4;

(3) local repository withdrawal form described under subdivision 4;

(4) ~~drug~~ medication repository donor form described under subdivision 6;

(5) record of destruction form described under subdivision 7; and

(6) ~~drug~~ medication repository recipient form described under subdivision 8.

(b) All records, including drug inventory, inspection, and disposal of donated ~~prescription~~ drugs and medical supplies, must be maintained by a repository for a minimum of two years. Records required as part of this program must be maintained pursuant to all applicable practice acts.

(c) Data collected by the ~~drug~~ medication repository program from all local repositories shall be submitted quarterly or upon request to the central repository. Data collected may consist of the information, records, and forms required to be collected under this section.

(d) The central repository shall submit reports to the board as required by the contract or upon request of the board.

Subd. 12. **Liability.** (a) The manufacturer of a drug or supply is not subject to criminal or civil liability for injury, death, or loss to a person or to property for causes of action described in clauses (1) and (2). A manufacturer is not liable for:

(1) the intentional or unintentional alteration of the drug or supply by a party not under the control of the manufacturer; or

(2) the failure of a party not under the control of the manufacturer to transfer or communicate product or consumer information or the expiration date of the donated drug or supply.

(b) A health care facility participating in the program, a pharmacist dispensing a drug or supply pursuant to the program, a practitioner dispensing or administering a drug or supply pursuant to the program, or a donor of a drug or medical supply is immune from civil liability for an act or omission that causes injury to or the death of an individual to whom the drug or supply is dispensed and no disciplinary action by a health-related licensing board shall be taken against a pharmacist or practitioner so long as the drug or supply is donated, accepted, distributed, and dispensed according to the requirements of this section. This immunity does not apply if the act or omission involves reckless, wanton, or intentional misconduct, or malpractice unrelated to the quality of the drug or medical supply.

Subd. 13. **Drug returned for credit.** Nothing in this section allows a long-term care facility to donate a drug to a central or local repository when federal or state law requires the drug to be returned to the pharmacy that initially dispensed it, so that the pharmacy can credit the payer for the amount of the drug returned.

Subd. 14. **Cooperation.** The central repository, as approved by the Board of Pharmacy, may enter into an agreement with another state that has an established drug repository or drug donation program if the other state's program includes regulations to ensure the purity, integrity, and safety of the drugs and supplies donated, to permit the central repository to offer to another state program inventory that is not needed by a Minnesota resident and to accept inventory from another state program to be distributed to local repositories and dispensed to Minnesota residents in accordance with this program.

Subd. 15. **Funding.** The central repository may seek grants and other funds from nonprofit charitable organizations, the federal government, and other sources to fund the ongoing operations of the medication repository program.

Sec. 29. **REPEALER.**

Minnesota Rules, parts 5610.0100; 5610.0200; and 5610.0300, are repealed.

ARTICLE 6
BACKGROUND STUDIES

Section 1. Minnesota Statutes 2022, section 13.46, subdivision 4, is amended to read:

Subd. 4. **Licensing data.** (a) As used in this subdivision:

(1) "licensing data" are all data collected, maintained, used, or disseminated by the welfare system pertaining to persons licensed or registered or who apply for licensure or registration or who formerly were licensed or registered under the authority of the commissioner of human services;

(2) "client" means a person who is receiving services from a licensee or from an applicant for licensure; and

(3) "personal and personal financial data" are Social Security numbers, identity of and letters of reference, insurance information, reports from the Bureau of Criminal Apprehension, health examination reports, and social/home studies.

(b)(1)(i) Except as provided in paragraph (c), the following data on applicants, license holders, and former licensees are public: name, address, telephone number of licensees, date of receipt of a completed application, dates of licensure, licensed capacity, type of client preferred, variances granted, record of training and education in child care and child development, type of dwelling, name and relationship of other family members, previous license history, class of license, the existence and status of complaints, and the number of serious injuries to or deaths of individuals in the licensed program as reported to the commissioner of human services, the local social services agency, or any other county welfare agency. For purposes of this clause, a serious injury is one that is treated by a physician.

(ii) Except as provided in item (v), when a correction order, an order to forfeit a fine, an order of license suspension, an order of temporary immediate suspension, an order of license revocation, an order of license denial, or an order of conditional license has been issued, or a complaint is resolved, the following data on current and former licensees and applicants are public: the general nature of the complaint or allegations leading to the temporary immediate suspension; the substance and investigative findings of the licensing or maltreatment complaint, licensing violation, or substantiated maltreatment; the existence

of settlement negotiations; the record of informal resolution of a licensing violation; orders of hearing; findings of fact; conclusions of law; specifications of the final correction order, fine, suspension, temporary immediate suspension, revocation, denial, or conditional license contained in the record of licensing action; whether a fine has been paid; and the status of any appeal of these actions.

(iii) When a license denial under section 245A.05 or a sanction under section 245A.07 is based on a determination that a license holder, applicant, or controlling individual is responsible for maltreatment under section 626.557 or chapter 260E, the identity of the applicant, license holder, or controlling individual as the individual responsible for maltreatment is public data at the time of the issuance of the license denial or sanction.

(iv) When a license denial under section 245A.05 or a sanction under section 245A.07 is based on a determination that a license holder, applicant, or controlling individual is disqualified under chapter 245C, the identity of the license holder, applicant, or controlling individual as the disqualified individual ~~and the reason for the disqualification are~~ is public data at the time of the issuance of the licensing sanction or denial. If the applicant, license holder, or controlling individual requests reconsideration of the disqualification and the disqualification is affirmed, the reason for the disqualification and the reason to not set aside the disqualification are ~~public~~ private data.

(v) A correction order or fine issued to a child care provider for a licensing violation is private data on individuals under section 13.02, subdivision 12, or nonpublic data under section 13.02, subdivision 9, if the correction order or fine is seven years old or older.

(2) For applicants who withdraw their application prior to licensure or denial of a license, the following data are public: the name of the applicant, the city and county in which the applicant was seeking licensure, the dates of the commissioner's receipt of the initial application and completed application, the type of license sought, and the date of withdrawal of the application.

(3) For applicants who are denied a license, the following data are public: the name and address of the applicant, the city and county in which the applicant was seeking licensure, the dates of the commissioner's receipt of the initial application and completed application, the type of license sought, the date of denial of the application, the nature of the basis for the denial, the existence of settlement negotiations, the record of informal resolution of a denial, orders of hearings, findings of fact, conclusions of law, specifications of the final order of denial, and the status of any appeal of the denial.

(4) When maltreatment is substantiated under section 626.557 or chapter 260E and the victim and the substantiated perpetrator are affiliated with a program licensed under chapter 245A, the commissioner of human services, local social services agency, or county welfare agency may inform the license holder where the maltreatment occurred of the identity of the substantiated perpetrator and the victim.

(5) Notwithstanding clause (1), for child foster care, only the name of the license holder and the status of the license are public if the county attorney has requested that data otherwise classified as public data under clause (1) be considered private data based on the best interests of a child in placement in a licensed program.

(c) The following are private data on individuals under section 13.02, subdivision 12, or nonpublic data under section 13.02, subdivision 9: personal and personal financial data on family day care program and family foster care program applicants and licensees and their family members who provide services under the license.

(d) The following are private data on individuals: the identity of persons who have made reports concerning licensees or applicants that appear in inactive investigative data, and the records of clients or employees of the licensee or applicant for licensure whose records are received by the licensing agency for purposes of review or in anticipation of a contested matter. The names of reporters of complaints or alleged violations of licensing standards under chapters 245A, 245B, 245C, and 245D, and applicable rules and alleged maltreatment under section 626.557 and chapter 260E, are confidential data and may be disclosed only as provided in section 260E.21, subdivision 4; 260E.35; or 626.557, subdivision 12b.

(e) Data classified as private, confidential, nonpublic, or protected nonpublic under this subdivision become public data if submitted to a court or administrative law judge as part of a disciplinary proceeding in which there is a public hearing concerning a license which has been suspended, immediately suspended, revoked, or denied.

(f) Data generated in the course of licensing investigations that relate to an alleged violation of law are investigative data under subdivision 3.

(g) Data that are not public data collected, maintained, used, or disseminated under this subdivision that relate to or are derived from a report as defined in section 260E.03, or 626.5572, subdivision 18, are subject to the destruction provisions of sections 260E.35, subdivision 6, and 626.557, subdivision 12b.

(h) Upon request, not public data collected, maintained, used, or disseminated under this subdivision that relate to or are derived from a report of substantiated maltreatment as defined in section 626.557 or chapter 260E may be exchanged with the Department of

Health for purposes of completing background studies pursuant to section 144.057 and with the Department of Corrections for purposes of completing background studies pursuant to section 241.021.

(i) Data on individuals collected according to licensing activities under chapters 245A and 245C, data on individuals collected by the commissioner of human services according to investigations under section 626.557 and chapters 245A, 245B, 245C, 245D, and 260E may be shared with the Department of Human Rights, the Department of Health, the Department of Corrections, the ombudsman for mental health and developmental disabilities, and the individual's professional regulatory board when there is reason to believe that laws or standards under the jurisdiction of those agencies may have been violated or the information may otherwise be relevant to the board's regulatory jurisdiction. Background study data on an individual who is the subject of a background study under chapter 245C for a licensed service for which the commissioner of human services is the license holder may be shared with the commissioner and the commissioner's delegate by the licensing division. Unless otherwise specified in this chapter, the identity of a reporter of alleged maltreatment or licensing violations may not be disclosed.

(j) In addition to the notice of determinations required under sections 260E.24, subdivisions 5 and 7, and 260E.30, subdivision 6, paragraphs (b), (c), (d), (e), and (f), if the commissioner or the local social services agency has determined that an individual is a substantiated perpetrator of maltreatment of a child based on sexual abuse, as defined in section 260E.03, and the commissioner or local social services agency knows that the individual is a person responsible for a child's care in another facility, the commissioner or local social services agency shall notify the head of that facility of this determination. The notification must include an explanation of the individual's available appeal rights and the status of any appeal. If a notice is given under this paragraph, the government entity making the notification shall provide a copy of the notice to the individual who is the subject of the notice.

(k) All not public data collected, maintained, used, or disseminated under this subdivision and subdivision 3 may be exchanged between the Department of Human Services, Licensing Division, and the Department of Corrections for purposes of regulating services for which the Department of Human Services and the Department of Corrections have regulatory authority.

Sec. 2. Minnesota Statutes 2022, section 245C.02, is amended by adding a subdivision to read:

Subd. 7a. **Conservator.** "Conservator" has the meaning given under section 524.1-201, clause (10), and includes proposed and current conservators.

Sec. 3. Minnesota Statutes 2022, section 245C.02, is amended by adding a subdivision to read:

Subd. 11f. **Guardian.** "Guardian" has the meaning given under section 524.1-201, clause (27), and includes proposed and current guardians.

Sec. 4. Minnesota Statutes 2022, section 245C.02, subdivision 13e, is amended to read:

Subd. 13e. **NETStudy 2.0.** "NETStudy 2.0" means the commissioner's system that replaces both NETStudy and the department's internal background study processing system. NETStudy 2.0 is designed to enhance protection of children and vulnerable adults by improving the accuracy of background studies through fingerprint-based criminal record checks and expanding the background studies to include a review of information from the Minnesota Court Information System and the national crime information database. NETStudy 2.0 is also designed to increase efficiencies in and the speed of the hiring process by:

(1) providing access to and updates from public web-based data related to employment eligibility;

(2) decreasing the need for repeat studies through electronic updates of background study subjects' criminal records;

(3) supporting identity verification using subjects' Social Security numbers and photographs;

(4) using electronic employer notifications; ~~and~~

(5) issuing immediate verification of subjects' eligibility to provide services as more studies are completed under the NETStudy 2.0 system~~.~~; and

(6) providing electronic access to certain notices for entities and background study subjects.

Sec. 5. Minnesota Statutes 2022, section 245C.03, subdivision 1, is amended to read:

Subdivision 1. **Licensed programs.** (a) The commissioner shall conduct a background study on:

(1) the person or persons applying for a license;

(2) an individual age 13 and over living in the household where the licensed program will be provided who is not receiving licensed services from the program;

(3) current or prospective employees or contractors of the applicant who will have direct contact with persons served by the facility, agency, or program;

(4) volunteers or student volunteers who will have direct contact with persons served by the program to provide program services if the contact is not under the continuous, direct supervision by an individual listed in clause (1) or (3);

(5) an individual age ten to 12 living in the household where the licensed services will be provided when the commissioner has reasonable cause as defined in section 245C.02, subdivision 15;

(6) an individual who, without providing direct contact services at a licensed program, may have unsupervised access to children or vulnerable adults receiving services from a program, when the commissioner has reasonable cause as defined in section 245C.02, subdivision 15;

(7) all controlling individuals as defined in section 245A.02, subdivision 5a;

(8) notwithstanding the other requirements in this subdivision, child care background study subjects as defined in section 245C.02, subdivision 6a; and

(9) notwithstanding clause (3), for children's residential facilities and foster residence settings, any adult working in the facility, whether or not the individual will have direct contact with persons served by the facility.

(b) For child foster care when the license holder resides in the home where foster care services are provided, a short-term substitute caregiver providing direct contact services for a child for less than 72 hours of continuous care is not required to receive a background study under this chapter.

(c) This subdivision applies to the following programs that must be licensed under chapter 245A:

(1) adult foster care;

(2) child foster care;

(3) children's residential facilities;

(4) family child care;

(5) licensed child care centers;

(6) licensed home and community-based services under chapter 245D;

(7) residential mental health programs for adults;

(8) substance use disorder treatment programs under chapter 245G;

(9) withdrawal management programs under chapter 245F;

(10) adult day care centers;

(11) family adult day services;

(12) independent living assistance for youth;

(13) detoxification programs;

(14) community residential settings; ~~and~~

(15) intensive residential treatment services and residential crisis stabilization under chapter 245I~~.~~; and

(16) treatment programs for persons with sexual psychopathic personality or sexually dangerous persons, licensed under chapter 245A and according to Minnesota Rules, parts 9515.3000 to 9515.3110.

Sec. 6. Minnesota Statutes 2022, section 245C.03, subdivision 1a, is amended to read:

Subd. 1a. **Procedure.** (a) Individuals and organizations that are required under this section to have or initiate background studies shall comply with the requirements of this chapter.

(b) All studies conducted under this section shall be conducted according to sections 299C.60 to 299C.64. This requirement does not apply to subdivisions 1, paragraph (c), clauses (2) to (5), and 6a.

(c) All data obtained by the commissioner for a background study completed under this section shall be classified as private data.

Sec. 7. Minnesota Statutes 2022, section 245C.031, subdivision 1, is amended to read:

Subdivision 1. **Alternative background studies.** (a) The commissioner shall conduct an alternative background study of individuals listed in this section.

(b) Notwithstanding other sections of this chapter, all alternative background studies except subdivision 12 shall be conducted according to this section and with sections 299C.60 to 299C.64.

(c) All terms in this section shall have the definitions provided in section 245C.02.

(d) The entity that submits an alternative background study request under this section shall submit the request to the commissioner according to section 245C.05.

(e) The commissioner shall comply with the destruction requirements in section 245C.051.

(f) Background studies conducted under this section are subject to the provisions of section 245C.32.

(g) The commissioner shall forward all information that the commissioner receives under section 245C.08 to the entity that submitted the alternative background study request under subdivision 2. The commissioner shall not make any eligibility determinations regarding background studies conducted under this section.

(h) All data obtained by the commissioner for a background study completed under this section shall be classified as private data.

Sec. 8. **[245C.033] GUARDIANS AND CONSERVATORS; MALTREATMENT AND STATE LICENSING AGENCY CHECKS.**

Subdivision 1. **Maltreatment data.** Requests for maltreatment data and records checks submitted pursuant to section 524.5-118 shall include information regarding whether the guardian or conservator has been a perpetrator of substantiated maltreatment of a vulnerable adult under section 626.557 or a minor under chapter 260E. If the guardian or conservator has been the perpetrator of substantiated maltreatment of a vulnerable adult or a minor, the commissioner must include a copy of any available public portion of the investigation memorandum under section 626.557, subdivision 12b, or any available public portion of the investigation memorandum under section 260E.30.

Subd. 2. **State licensing agency data.** (a) Requests for state licensing agency data and records checks submitted pursuant to section 524.5-118 shall include information from a check of state licensing agency records.

(b) The commissioner shall provide the court with licensing agency data for licenses directly related to the responsibilities of a guardian or conservator if the guardian or conservator has a current or prior affiliation with the:

(1) Lawyers Responsibility Board;

(2) State Board of Accountancy;

(3) Board of Social Work;

(4) Board of Psychology;

(5) Board of Nursing;

(6) Board of Medical Practice;

(7) Department of Education;

(8) Department of Commerce;

(9) Board of Chiropractic Examiners;

(10) Board of Dentistry;

(11) Board of Marriage and Family Therapy;

(12) Department of Human Services;

(13) Peace Officer Standards and Training (POST) Board; and

(14) Professional Educator Licensing and Standards Board.

(c) The commissioner shall provide to the court the electronically available data maintained in the agency's database, including whether the guardian or conservator is or has been licensed by the agency and whether a disciplinary action or a sanction against the individual's license, including a condition, suspension, revocation, or cancellation, is in the licensing agency's database.

Subd. 3. **Procedure; maltreatment and state licensing agency data.** Requests for maltreatment and state licensing agency data checks shall be submitted by the guardian or conservator to the commissioner on the form or in the manner prescribed by the commissioner. Upon receipt of a signed informed consent, and payment under 245C.10, the commissioner shall complete the maltreatment and state licensing agency checks. Upon completion of the checks, the commissioner shall provide the requested information to the courts on the form or in the manner prescribed by the commissioner.

Subd. 4. **Classification of maltreatment and state licensing agency data; access to information.** All data obtained by the commissioner for maltreatment and state licensing agency checks completed under this section shall be classified as private data.

Sec. 9. Minnesota Statutes 2022, section 245C.05, subdivision 1, is amended to read:

Subdivision 1. **Individual studied.** (a) The individual who is the subject of the background study must provide the applicant, license holder, or other entity under section 245C.04 with sufficient information to ensure an accurate study, including:

(1) the individual's first, middle, and last name and all other names by which the individual has been known;

(2) current home address, city, and state of residence;

(3) current zip code;

(4) sex;

(5) date of birth;

(6) driver's license number or state identification number; and

(7) upon implementation of NETStudy 2.0, the home address, city, county, and state of residence for the past five years.

(b) Every subject of a background study conducted or initiated by counties or private agencies under this chapter must also provide the home address, city, county, and state of residence for the past five years.

(c) Every subject of a background study related to private agency adoptions or related to child foster care licensed through a private agency, who is 18 years of age or older, shall also provide the commissioner a signed consent for the release of any information received from national crime information databases to the private agency that initiated the background study.

(d) The subject of a background study shall provide fingerprints and a photograph as required in subdivision 5.

(e) The subject of a background study shall submit a completed criminal and maltreatment history records check consent form for applicable national and state level record checks.

(f) A background study subject who has access to the NETStudy 2.0 applicant portal must provide updated contact information to the commissioner via NETStudy 2.0 any time their personal information changes for as long as they remain affiliated on any roster.

(g) An entity must update contact information in NETStudy 2.0 for a background study subject on the entity's roster any time the entity receives new contact information from the study subject.

Sec. 10. Minnesota Statutes 2022, section 245C.05, subdivision 2c, is amended to read:

Subd. 2c. **Privacy notice to background study subject.** (a) Prior to initiating each background study, the entity initiating the study must provide the commissioner's privacy notice to the background study subject required under section 13.04, subdivision 2. The notice must be available through the commissioner's electronic NETStudy and NETStudy 2.0 systems and shall include the information in paragraphs (b) and (c).

(b) The background study subject shall be informed that any previous background studies that received a set-aside will be reviewed, and without further contact with the background study subject, the commissioner may notify the agency that initiated the subsequent background study~~:~~

~~(1)~~ that the individual has a disqualification that has been set aside for the program or agency that initiated the study~~;~~.

~~(2) the reason for the disqualification; and~~

~~(3) that information about the decision to set aside the disqualification will be available to the license holder upon request without the consent of the background study subject.~~

(c) The background study subject must also be informed that:

(1) the subject's fingerprints collected for purposes of completing the background study under this chapter must not be retained by the Department of Public Safety, Bureau of Criminal Apprehension, or by the commissioner. The Federal Bureau of Investigation will not retain background study subjects' fingerprints;

(2) effective upon implementation of NETStudy 2.0, the subject's photographic image will be retained by the commissioner, and if the subject has provided the subject's Social Security number for purposes of the background study, the photographic image will be available to prospective employers and agencies initiating background studies under this chapter to verify the identity of the subject of the background study;

(3) the authorized fingerprint collection vendor or vendors shall, for purposes of verifying the identity of the background study subject, be able to view the identifying information entered into NETStudy 2.0 by the entity that initiated the background study, but shall not retain the subject's fingerprints, photograph, or information from NETStudy 2.0. The authorized fingerprint collection vendor or vendors shall retain no more than the subject's name and the date and time the subject's fingerprints were recorded and sent, only as necessary for auditing and billing activities;

(4) the commissioner shall provide the subject notice, as required in section 245C.17, subdivision 1, paragraph (a), when an entity initiates a background study on the individual;

(5) the subject may request in writing a report listing the entities that initiated a background study on the individual as provided in section 245C.17, subdivision 1, paragraph (b);

(6) the subject may request in writing that information used to complete the individual's background study in NETStudy 2.0 be destroyed if the requirements of section 245C.051, paragraph (a), are met; and

(7) notwithstanding clause (6), the commissioner shall destroy:

(i) the subject's photograph after a period of two years when the requirements of section 245C.051, paragraph (c), are met; and

(ii) any data collected on a subject under this chapter after a period of two years following the individual's death as provided in section 245C.051, paragraph (d).

Sec. 11. Minnesota Statutes 2022, section 245C.05, subdivision 4, is amended to read:

Subd. 4. **Electronic transmission.** (a) For background studies conducted by the Department of Human Services, the commissioner shall implement a secure system for the electronic transmission of:

(1) background study information to the commissioner;

(2) background study results to the license holder;

(3) background study information obtained under this section and section 245C.08 to counties and private agencies for background studies conducted by the commissioner for child foster care, including a summary of nondisqualifying results, except as prohibited by law; and

(4) background study results to county agencies for background studies conducted by the commissioner for adult foster care and family adult day services and, upon implementation of NETStudy 2.0, family child care and legal nonlicensed child care authorized under chapter 119B.

(b) Unless the commissioner has granted a hardship variance under paragraph (c), a license holder or an applicant must use the electronic transmission system known as NETStudy or NETStudy 2.0 to submit all requests for background studies to the commissioner as required by this chapter.

(c) A license holder or applicant whose program is located in an area in which high-speed Internet is inaccessible may request the commissioner to grant a variance to the electronic transmission requirement.

(d) Section 245C.08, subdivision 3, paragraph (c), applies to results transmitted under this subdivision.

(e) The background study subject shall access background study-related documents electronically in the applicant portal. A background study subject may request the commissioner to grant a variance to the requirement to access documents electronically in the NETStudy 2.0 applicant portal, and maintains the ability to request paper documentation of their background studies.

Sec. 12. Minnesota Statutes 2022, section 245C.08, subdivision 1, is amended to read:

Subdivision 1. **Background studies conducted by Department of Human Services.** (a) For a background study conducted by the Department of Human Services, the commissioner shall review:

(1) information related to names of substantiated perpetrators of maltreatment of vulnerable adults that has been received by the commissioner as required under section 626.557, subdivision 9c, paragraph (j);

(2) the commissioner's records relating to the maltreatment of minors in licensed programs, and from findings of maltreatment of minors as indicated through the social service information system;

(3) information from juvenile courts as required in subdivision 4 for individuals listed in section 245C.03, subdivision 1, paragraph (a), when there is reasonable cause;

(4) information from the Bureau of Criminal Apprehension, including information regarding a background study subject's registration in Minnesota as a predatory offender under section 243.166;

(5) except as provided in clause (6), information received as a result of submission of fingerprints for a national criminal history record check, as defined in section 245C.02, subdivision 13c, when the commissioner has reasonable cause for a national criminal history record check as defined under section 245C.02, subdivision 15a, or as required under section 144.057, subdivision 1, clause (2);

(6) for a background study related to a child foster family setting application for licensure, foster residence settings, children's residential facilities, a transfer of permanent legal and

physical custody of a child under sections 260C.503 to 260C.515, or adoptions, and for a background study required for family child care, certified license-exempt child care, child care centers, and legal nonlicensed child care authorized under chapter 119B, the commissioner shall also review:

(i) information from the child abuse and neglect registry for any state in which the background study subject has resided for the past five years;

(ii) when the background study subject is 18 years of age or older, or a minor under section 245C.05, subdivision 5a, paragraph (c), information received following submission of fingerprints for a national criminal history record check; and

(iii) when the background study subject is 18 years of age or older or a minor under section 245C.05, subdivision 5a, paragraph (d), for licensed family child care, certified license-exempt child care, licensed child care centers, and legal nonlicensed child care authorized under chapter 119B, information obtained using non-fingerprint-based data including information from the criminal and sex offender registries for any state in which the background study subject resided for the past five years and information from the national crime information database and the national sex offender registry; ~~and~~

(7) for a background study required for family child care, certified license-exempt child care centers, licensed child care centers, and legal nonlicensed child care authorized under chapter 119B, the background study shall also include, to the extent practicable, a name and date-of-birth search of the National Sex Offender Public website~~.~~; and

(8) for a background study required for treatment programs for sexual psychopathic personality or sexually dangerous persons, the background study shall only include a review of the information required under paragraph (a), clauses (1), (2), (3), and (4).

(b) Notwithstanding expungement by a court, the commissioner may consider information obtained under paragraph (a), clauses (3) and (4), unless the commissioner received notice of the petition for expungement and the court order for expungement is directed specifically to the commissioner.

(c) The commissioner shall also review criminal case information received according to section 245C.04, subdivision 4a, from the Minnesota court information system that relates to individuals who have already been studied under this chapter and who remain affiliated with the agency that initiated the background study.

(d) When the commissioner has reasonable cause to believe that the identity of a background study subject is uncertain, the commissioner may require the subject to provide

a set of classifiable fingerprints for purposes of completing a fingerprint-based record check with the Bureau of Criminal Apprehension. Fingerprints collected under this paragraph shall not be saved by the commissioner after they have been used to verify the identity of the background study subject against the particular criminal record in question.

(e) The commissioner may inform the entity that initiated a background study under NETStudy 2.0 of the status of processing of the subject's fingerprints.

Sec. 13. Minnesota Statutes 2022, section 245C.10, subdivision 1d, is amended to read:

Subd. 1d. **State; national criminal history record check fees.** The commissioner may increase background study fees as necessary, commensurate with an increase in state Bureau of Criminal Apprehension or the national criminal history record check ~~fee~~ fees. The commissioner shall report any fee increase under this subdivision to the legislature during the legislative session following the fee increase, so that the legislature may consider adoption of the fee increase into statute. By July 1 of every year, background study fees shall be set at the amount adopted by the legislature under this section.

Sec. 14. Minnesota Statutes 2022, section 245C.10, subdivision 2, is amended to read:

Subd. 2. **Supplemental nursing services agencies.** The commissioner shall recover the cost of the background studies initiated by supplemental nursing services agencies registered under section 144A.71, subdivision 1, through a fee of no more than ~~$42~~ $44 per study charged to the agency. The fees collected under this subdivision are appropriated to the commissioner for the purpose of conducting background studies.

Sec. 15. Minnesota Statutes 2022, section 245C.10, subdivision 3, is amended to read:

Subd. 3. **Personal care provider organizations.** The commissioner shall recover the cost of background studies initiated by a personal care provider organization under sections 256B.0651 to 256B.0654 and 256B.0659 through a fee of no more than ~~$42~~ $44 per study charged to the organization responsible for submitting the background study form. The fees collected under this subdivision are appropriated to the commissioner for the purpose of conducting background studies.

Sec. 16. Minnesota Statutes 2022, section 245C.10, subdivision 4, is amended to read:

Subd. 4. **Temporary personnel agencies, educational programs, and professional services agencies.** The commissioner shall recover the cost of the background studies initiated by temporary personnel agencies, educational programs, and professional services

agencies that initiate background studies under section 245C.03, subdivision 4, through a fee of no more than ~~$42~~ $44 per study charged to the agency. The fees collected under this subdivision are appropriated to the commissioner for the purpose of conducting background studies.

Sec. 17. Minnesota Statutes 2022, section 245C.10, subdivision 5, is amended to read:

Subd. 5. **Adult foster care and family adult day services.** The commissioner shall recover the cost of background studies required under section 245C.03, subdivision 1, for the purposes of adult foster care and family adult day services licensing, through a fee of no more than ~~$42~~ $44 per study charged to the license holder. The fees collected under this subdivision are appropriated to the commissioner for the purpose of conducting background studies.

Sec. 18. Minnesota Statutes 2022, section 245C.10, subdivision 6, is amended to read:

Subd. 6. **Unlicensed home and community-based waiver providers of service to seniors and individuals with disabilities.** The commissioner shall recover the cost of background studies initiated by unlicensed home and community-based waiver providers of service to seniors and individuals with disabilities under section 256B.4912 through a fee of no more than ~~$42~~ $44 per study.

Sec. 19. Minnesota Statutes 2022, section 245C.10, subdivision 8, is amended to read:

Subd. 8. **Children's therapeutic services and supports providers.** The commissioner shall recover the cost of background studies required under section 245C.03, subdivision 7, for the purposes of children's therapeutic services and supports under section 256B.0943, through a fee of no more than ~~$42~~ $44 per study charged to the license holder. The fees collected under this subdivision are appropriated to the commissioner for the purpose of conducting background studies.

Sec. 20. Minnesota Statutes 2022, section 245C.10, subdivision 9, is amended to read:

Subd. 9. **Human services licensed programs.** The commissioner shall recover the cost of background studies required under section 245C.03, subdivision 1, for all programs that are licensed by the commissioner, except child foster care when the applicant or license holder resides in the home where child foster care services are provided, family child care, child care centers, certified license-exempt child care centers, and legal nonlicensed child care authorized under chapter 119B, through a fee of no more than ~~$42~~ $44 per study charged

to the license holder. The fees collected under this subdivision are appropriated to the commissioner for the purpose of conducting background studies.

Sec. 21. Minnesota Statutes 2022, section 245C.10, subdivision 9a, is amended to read:

Subd. 9a. **Child care programs.** The commissioner shall recover the cost of a background study required for family child care, certified license-exempt child care centers, licensed child care centers, and legal nonlicensed child care providers authorized under chapter 119B through a fee of no more than ~~$40~~ $44 per study charged to the license holder. A fee of no more than ~~$42~~ $44 per study shall be charged for studies conducted under section 245C.05, subdivision 5a, paragraph (a). The fees collected under this subdivision are appropriated to the commissioner to conduct background studies.

Sec. 22. Minnesota Statutes 2022, section 245C.10, subdivision 10, is amended to read:

Subd. 10. **Community first services and supports organizations.** The commissioner shall recover the cost of background studies initiated by an agency-provider delivering services under section 256B.85, subdivision 11, or a financial management services provider providing service functions under section 256B.85, subdivision 13, through a fee of no more than ~~$42~~ $44 per study, charged to the organization responsible for submitting the background study form. The fees collected under this subdivision are appropriated to the commissioner for the purpose of conducting background studies.

Sec. 23. Minnesota Statutes 2022, section 245C.10, subdivision 11, is amended to read:

Subd. 11. **Providers of housing support.** The commissioner shall recover the cost of background studies initiated by providers of housing support under section 256I.04 through a fee of no more than ~~$42~~ $44 per study. The fees collected under this subdivision are appropriated to the commissioner for the purpose of conducting background studies.

Sec. 24. Minnesota Statutes 2022, section 245C.10, subdivision 12, is amended to read:

Subd. 12. **Child protection workers or social services staff having responsibility for child protective duties.** The commissioner shall recover the cost of background studies initiated by county social services agencies and local welfare agencies for individuals who are required to have a background study under section 260E.36, subdivision 3, through a fee of no more than ~~$42~~ $44 per study. The fees collected under this subdivision are appropriated to the commissioner for the purpose of conducting background studies.

Sec. 25. Minnesota Statutes 2022, section 245C.10, subdivision 13, is amended to read:

Subd. 13. **Providers of special transportation service.** The commissioner shall recover the cost of background studies initiated by providers of special transportation service under section 174.30 through a fee of no more than ~~$42~~ $44 per study. The fees collected under this subdivision are appropriated to the commissioner for the purpose of conducting background studies.

Sec. 26. Minnesota Statutes 2022, section 245C.10, subdivision 14, is amended to read:

Subd. 14. **Children's residential facilities.** The commissioner shall recover the cost of background studies initiated by a licensed children's residential facility through a fee of no more than ~~$51~~ $53 per study. Fees collected under this subdivision are appropriated to the commissioner for purposes of conducting background studies.

Sec. 27. Minnesota Statutes 2022, section 245C.10, subdivision 15, is amended to read:

Subd. 15. **Guardians and conservators.** The commissioner shall recover the cost of conducting ~~background studies~~ maltreatment and state licensing agency checks for guardians and conservators under section ~~524.5-118~~ 245C.033 through a fee of no more than ~~$110~~ $50 per study. The fees collected under this subdivision are appropriated to the commissioner for the purpose of conducting ~~background studies~~ maltreatment and state licensing agency checks. The fee ~~for conducting an alternative background study for appointment of a professional guardian or conservator must be paid by the guardian or conservator. In other cases, the fee must be paid as follows:~~ must be paid directly to and in the manner prescribed by the commissioner before any maltreatment and state licensing agency checks under section 245C.033 may be conducted.

~~(1) if the matter is proceeding in forma pauperis, the fee must be paid as an expense for purposes of section 524.5-502, paragraph (a);~~

~~(2) if there is an estate of the ward or protected person, the fee must be paid from the estate; or~~

~~(3) in the case of a guardianship or conservatorship of a person that is not proceeding in forma pauperis, the fee must be paid by the guardian, conservator, or the court.~~

Sec. 28. Minnesota Statutes 2022, section 245C.10, subdivision 16, is amended to read:

Subd. 16. **Providers of housing support services.** The commissioner shall recover the cost of background studies initiated by providers of housing support services under section

256B.051 through a fee of no more than ~~$42~~ $44 per study. The fees collected under this subdivision are appropriated to the commissioner for the purpose of conducting background studies.

Sec. 29. Minnesota Statutes 2022, section 245C.10, subdivision 17, is amended to read:

Subd. 17. **Early intensive developmental and behavioral intervention providers.** The commissioner shall recover the cost of background studies required under section 245C.03, subdivision 15, for the purposes of early intensive developmental and behavioral intervention under section 256B.0949, through a fee of no more than ~~$42~~ $44 per study charged to the enrolled agency. The fees collected under this subdivision are appropriated to the commissioner for the purpose of conducting background studies.

Sec. 30. Minnesota Statutes 2022, section 245C.10, subdivision 20, is amended to read:

Subd. 20. **Professional Educators Licensing Standards Board.** The commissioner shall recover the cost of background studies initiated by the Professional Educators Licensing Standards Board through a fee of no more than ~~$51~~ $53 per study. Fees collected under this subdivision are appropriated to the commissioner for purposes of conducting background studies.

Sec. 31. Minnesota Statutes 2022, section 245C.10, subdivision 21, is amended to read:

Subd. 21. **Board of School Administrators.** The commissioner shall recover the cost of background studies initiated by the Board of School Administrators through a fee of no more than ~~$51~~ $53 per study. Fees collected under this subdivision are appropriated to the commissioner for purposes of conducting background studies.

Sec. 32. Minnesota Statutes 2022, section 245C.10, is amended by adding a subdivision to read:

Subd. 22. **Tribal organizations.** The commissioner shall recover the cost of background studies initiated by Tribal organizations under section 245C.34 for adoption and child foster care. The fee amount shall be established through interagency agreements between the commissioner and Tribal organizations or their designees. The fees collected under this subdivision shall be deposited in the special revenue fund and are appropriated to the commissioner for the purpose of conducting background studies and criminal background checks. This change shall go into effect July 1, 2024.

Sec. 33. Minnesota Statutes 2022, section 245C.17, subdivision 2, is amended to read:

Subd. 2. **Disqualification notice sent to subject.** (a) If the information in the study indicates the individual is disqualified from direct contact with, or from access to, persons served by the program, the commissioner shall disclose to the individual studied:

(1) the information causing disqualification;

(2) instructions on how to request a reconsideration of the disqualification;

(3) an explanation of any restrictions on the commissioner's discretion to set aside the disqualification under section 245C.24, when applicable to the individual;

~~(4) a statement that, if the individual's disqualification is set aside under section 245C.22, the applicant, license holder, or other entity that initiated the background study will be provided with the reason for the individual's disqualification and an explanation that the factors under section 245C.22, subdivision 4, which were the basis of the decision to set aside the disqualification shall be made available to the license holder upon request without the consent of the subject of the background study;~~

~~(5) a statement indicating that if the individual's disqualification is set aside or the facility is granted a variance under section 245C.30, the individual's identity and the reason for the individual's disqualification will become public data under section 245C.22, subdivision 7, when applicable to the individual;~~

~~(6)~~ (4) a statement that when a subsequent background study is initiated on the individual following a set-aside of the individual's disqualification, and the commissioner makes a determination under section 245C.22, subdivision 5, paragraph (b), that the previous set-aside applies to the subsequent background study, the applicant, license holder, or other entity that initiated the background study will be informed in the notice under section 245C.22, subdivision 5, paragraph (c)~~:~~

~~(i)~~ of the reason for the individual's disqualification; and

~~(ii) that the individual's disqualification is set aside for that program or agency; and~~

~~(iii) that information about the factors under section 245C.22, subdivision 4, that were the basis of the decision to set aside the disqualification are available to the license holder upon request without the consent of the background study subject; and~~

~~(7)~~ (5) the commissioner's determination of the individual's immediate risk of harm under section 245C.16.

(b) If the commissioner determines under section 245C.16 that an individual poses an imminent risk of harm to persons served by the program where the individual will have direct contact with, or access to, people receiving services, the commissioner's notice must include an explanation of the basis of this determination.

(c) If the commissioner determines under section 245C.16 that an individual studied does not pose a risk of harm that requires immediate removal, the individual shall be informed of the conditions under which the agency that initiated the background study may allow the individual to have direct contact with, or access to, people receiving services, as provided under subdivision 3.

Sec. 34. Minnesota Statutes 2022, section 245C.17, subdivision 3, is amended to read:

Subd. 3. **Disqualification notification.** (a) The commissioner shall notify an applicant, license holder, or other entity as provided in this chapter who is not the subject of the study:

(1) that the commissioner has found information that disqualifies the individual studied from being in a position allowing direct contact with, or access to, people served by the program; and

(2) the commissioner's determination of the individual's risk of harm under section 245C.16.

(b) If the commissioner determines under section 245C.16 that an individual studied poses an imminent risk of harm to persons served by the program where the individual studied will have direct contact with, or access to, people served by the program, the commissioner shall order the license holder to immediately remove the individual studied from any position allowing direct contact with, or access to, people served by the program.

(c) If the commissioner determines under section 245C.16 that an individual studied poses a risk of harm that requires continuous, direct supervision, the commissioner shall order the applicant, license holder, or other entities as provided in this chapter to:

(1) immediately remove the individual studied from any position allowing direct contact with, or access to, people receiving services; or

(2) before allowing the disqualified individual to be in a position allowing direct contact with, or access to, people receiving services, the applicant, license holder, or other entity, as provided in this chapter, must:

~~(i) obtain from the disqualified individual a copy of the individual's notice of disqualification from the commissioner that explains the reason for disqualification;~~

~~(ii)~~ (i) ensure that the individual studied is under continuous, direct supervision when in a position allowing direct contact with, or access to, people receiving services during the period in which the individual may request a reconsideration of the disqualification under section 245C.21; and

~~(iii)~~ (ii) ensure that the disqualified individual requests reconsideration within 30 days of receipt of the notice of disqualification.

(d) If the commissioner determines under section 245C.16 that an individual studied does not pose a risk of harm that requires continuous, direct supervision, the commissioner shall order the applicant, license holder, or other entities as provided in this chapter to:

(1) immediately remove the individual studied from any position allowing direct contact with, or access to, people receiving services; or

(2) before allowing the disqualified individual to be in any position allowing direct contact with, or access to, people receiving services, the applicant, license holder, or other entity as provided in this chapter must~~:~~

~~(i) obtain from the disqualified individual a copy of the individual's notice of disqualification from the commissioner that explains the reason for disqualification; and~~

~~(ii)~~ ensure that the disqualified individual requests reconsideration within 15 days of receipt of the notice of disqualification.

(e) The commissioner shall not notify the applicant, license holder, or other entity as provided in this chapter of the information contained in the subject's background study unless:

(1) the basis for the disqualification is failure to cooperate with the background study ~~or substantiated maltreatment under section 626.557 or chapter 260E~~;

(2) the Data Practices Act under chapter 13 provides for release of the information; or

(3) the individual studied authorizes the release of the information.

Sec. 35. Minnesota Statutes 2022, section 245C.22, subdivision 7, is amended to read:

Subd. 7. **Classification of certain data.** (a) Notwithstanding section 13.46, except as provided in paragraph ~~(f)~~ (e), upon setting aside a disqualification under this section, the identity of the disqualified individual who received the set-aside and the individual's disqualifying characteristics are ~~public~~ private data ~~if the set-aside was:~~.

~~(1) for any disqualifying characteristic under section 245C.15, except a felony-level conviction for a drug-related offense within the past five years, when the set-aside relates to a child care center or a family child care provider licensed under chapter 245A, certified license-exempt child care center, or legal nonlicensed family child care; or~~

~~(2) for a disqualifying characteristic under section 245C.15, subdivision 2.~~

(b) Notwithstanding section 13.46, upon granting a variance to a license holder under section 245C.30, the identity of the disqualified individual who is the subject of the variance, the individual's disqualifying characteristics under section 245C.15, and the terms of the variance are ~~public data, except as provided in paragraph (c), clause (6), when the variance:~~ private.

~~(1) is issued to a child care center or a family child care provider licensed under chapter 245A; or~~

~~(2) relates to an individual with a disqualifying characteristic under section 245C.15, subdivision 2.~~

(c) The identity of a disqualified individual and the reason for disqualification remain private data when:

(1) a disqualification is not set aside and no variance is granted, except as provided under section 13.46, subdivision 4;

(2) the data are not public under paragraph (a) or (b);

(3) the disqualification is rescinded because the information relied upon to disqualify the individual is incorrect;

(4) the disqualification relates to a license to provide relative child foster care. As used in this clause, "relative" has the meaning given it under section 260C.007, subdivision 26b or 27;

(5) the disqualified individual is a household member of a licensed foster care provider and:

(i) the disqualified individual previously received foster care services from this licensed foster care provider;

(ii) the disqualified individual was subsequently adopted by this licensed foster care provider; and

(iii) the disqualifying act occurred before the adoption; or

(6) a variance is granted to a child care center or family child care license holder for an individual's disqualification that is based on a felony-level conviction for a drug-related offense that occurred within the past five years.

~~(d) Licensed family child care providers and child care centers must provide notices as required under section 245C.301.~~

~~(e)~~ (d) Notwithstanding paragraphs (a) and (b), the identity of household members who are the subject of a disqualification related set-aside or variance is not public data if:

(1) the household member resides in the residence where the family child care is provided;

(2) the subject of the set-aside or variance is under the age of 18 years; and

(3) the set-aside or variance only relates to a disqualification under section 245C.15, subdivision 4, for a misdemeanor-level theft crime as defined in section 609.52.

~~(f)~~ (e) When the commissioner has reason to know that a disqualified individual has received an order for expungement for the disqualifying record that does not limit the commissioner's access to the record, and the record was opened or exchanged with the commissioner for purposes of a background study under this chapter, the data that would otherwise become public under paragraph (a) or (b) remain private data.

Sec. 36. Minnesota Statutes 2022, section 245C.23, subdivision 1, is amended to read:

Subdivision 1. **Disqualification that is rescinded or set aside.** (a) If the commissioner rescinds or sets aside a disqualification, the commissioner shall notify the applicant, license holder, or other entity in writing or by electronic transmission of the decision.

(b) In the notice from the commissioner that a disqualification has been rescinded, the commissioner must inform the applicant, license holder, or other entity that the information relied upon to disqualify the individual was incorrect.

~~(c) Except as provided in paragraphs (d) and (e), in the notice from the commissioner that a disqualification has been set aside, the commissioner must inform the applicant, license holder, or other entity of the reason for the individual's disqualification and that information about which factors under section 245C.22, subdivision 4, were the basis of the decision to set aside the disqualification are available to the license holder upon request without the consent of the background study subject.~~

~~(d) When the commissioner has reason to know that a disqualified individual has received an order for expungement for the disqualifying record that does not limit the commissioner's access to the record, and the record was opened or exchanged with the commissioner for~~

~~purposes of a background study under this chapter, the information provided under paragraph (c) must only inform the applicant, license holder, or other entity that the disqualifying criminal record is sealed under a court order.~~

~~(e) The notification requirements in paragraph (c) do not apply when the set aside is granted to an individual related to a background study for a licensed child care center, certified license-exempt child care center, or family child care license holder, or for a legal nonlicensed child care provider authorized under chapter 119B, and the individual is disqualified for a felony-level conviction for a drug-related offense that occurred within the past five years. The notice that the individual's disqualification is set aside must inform the applicant, license holder, or legal nonlicensed child care provider that the disqualifying criminal record is not public.~~

Sec. 37. Minnesota Statutes 2022, section 245C.32, subdivision 2, is amended to read:

Subd. 2. **Use.** (a) The commissioner may also use these systems and records to obtain and provide criminal history data from the Bureau of Criminal Apprehension, criminal history data held by the commissioner, and data about substantiated maltreatment under section 626.557 or chapter 260E, for other purposes, provided that:

(1) the background study is specifically authorized in statute; or

(2) the request is made with the informed consent of the subject of the study as provided in section 13.05, subdivision 4.

(b) An individual making a request under paragraph (a), clause (2), must agree in writing not to disclose the data to any other individual without the consent of the subject of the data.

(c) The commissioner may use these systems to share background study documentation electronically with entities and individuals who are the subject of a background study.

~~(c)~~ (d) The commissioner may recover the cost of obtaining and providing background study data by charging the individual or entity requesting the study a fee ~~of no more than $42 per study~~ as described in section 245C.10. The fees collected under this paragraph are appropriated to the commissioner for the purpose of conducting background studies.

Sec. 38. Minnesota Statutes 2022, section 524.5-118, is amended to read:

524.5-118 ~~BACKGROUND STUDY~~ MALTREATMENT AND STATE LICENSING AGENCY CHECKS; CRIMINAL HISTORY CHECK.

Subdivision 1. **When required; exception.** (a) The court shall require ~~a background study~~ maltreatment and state licensing agency checks and a criminal history check under this section:

(1) before the appointment of a guardian or conservator, unless ~~a background study has~~ maltreatment and state licensing agency checks and a criminal history check have been done on the person under this section within the previous five years; and

(2) once every five years after the appointment, if the person continues to serve as a guardian or conservator.

(b) The ~~background study~~ maltreatment and state licensing agency checks and criminal history check under this section must include:

(1) criminal history data from the Bureau of Criminal Apprehension~~, other criminal history data held by the commissioner of human services, and data regarding whether the person has been a perpetrator of substantiated maltreatment of a vulnerable adult or minor~~;

(2) criminal history data from a national criminal history record check ~~as defined in section 245C.02, subdivision 13c~~; ~~and~~

(3) state licensing agency data if a search of the database or databases of the agencies listed in subdivision 2a shows that the proposed guardian or conservator has ever held a professional license directly related to the responsibilities of a professional fiduciary from an agency listed in subdivision 2a that was conditioned, suspended, revoked, or canceled~~.~~; and

(4) data regarding whether the person has been a perpetrator of substantiated maltreatment of a vulnerable adult or minor.

(c) If the guardian or conservator is not an individual, the ~~background study~~ maltreatment and state licensing agency checks and criminal history check must be done on all individuals currently employed by the proposed guardian or conservator who will be responsible for exercising powers and duties under the guardianship or conservatorship.

(d) Notwithstanding paragraph (a), if the court determines that it would be in the best interests of the person subject to guardianship or conservatorship to appoint a guardian or conservator before the ~~background study~~ maltreatment and state licensing agency checks

and criminal history check can be completed, the court may make the appointment pending the results of the ~~study~~ checks, however, the ~~background study~~ maltreatment and state licensing agency checks and criminal history check must then be completed as soon as reasonably possible after appointment~~, no later than 30 days after appointment~~.

(e) The ~~fee~~ fees for ~~background studies~~ the maltreatment and state licensing agency checks and the criminal history check conducted under this section ~~is~~ are specified in ~~section~~ sections 245C.10, subdivision ~~14~~ 15, and 299C.10, subdivisions 4 and 5. The ~~fee~~ fees for conducting ~~a background study~~ these checks for appointment of a professional guardian or conservator must be paid by the guardian or conservator. In other cases, the fee must be paid as follows:

(1) if the matter is proceeding in forma pauperis, the fee is an expense for purposes of section 524.5-502, paragraph (a);

(2) if there is an estate of the person subject to guardianship or conservatorship, the fee must be paid from the estate; or

(3) in the case of a guardianship or conservatorship of the person that is not proceeding in forma pauperis, the court may order that the fee be paid by the guardian or conservator or by the court.

(f) The requirements of this subdivision do not apply if the guardian or conservator is:

(1) a state agency or county;

(2) a parent or guardian of a person proposed to be subject to guardianship or conservatorship who has a developmental disability, if the parent or guardian has raised the person proposed to be subject to guardianship or conservatorship in the family home until the time the petition is filed, unless counsel appointed for the person proposed to be subject to guardianship or conservatorship under section 524.5-205, paragraph (e); 524.5-304, paragraph (b); 524.5-405, paragraph (a); or 524.5-406, paragraph (b), recommends a background study; or

(3) a bank with trust powers, bank and trust company, or trust company, organized under the laws of any state or of the United States and which is regulated by the commissioner of commerce or a federal regulator.

Subd. 2. **Procedure; maltreatment and state licensing agency checks and criminal history ~~and maltreatment records background~~ check.** (a) The ~~court~~ guardian or conservator shall request the ~~commissioner of human services~~ Bureau of Criminal Apprehension to complete a ~~background study under section 245C.32~~ criminal history

check. The request must be accompanied by the applicable fee and acknowledgment that the ~~study subject~~ guardian or conservator received a privacy notice ~~required under subdivision 3~~. The ~~commissioner of human services~~ Bureau of Criminal Apprehension shall conduct a national criminal history record check. The ~~study subject~~ guardian or conservator shall submit a set of classifiable fingerprints. The fingerprints must be recorded on a fingerprint card provided by the ~~commissioner of human services~~ Bureau of Criminal Apprehension.

(b) The ~~commissioner of human services~~ Bureau of Criminal Apprehension shall provide the court with criminal history data as defined in section 13.87 from the Bureau of Criminal Apprehension in the Department of Public Safety~~, other criminal history data held by the commissioner of human services, data regarding substantiated maltreatment of vulnerable adults under section 626.557, and substantiated maltreatment of minors under chapter 260E,~~ and criminal history information from other states or jurisdictions as indicated from a national criminal history record check within 20 working days of receipt of a request. In accordance with section 245C.033, the commissioner of human services shall provide the court with data regarding substantiated maltreatment of vulnerable adults under section 626.557, and substantiated maltreatment of minors under chapter 260E within 25 working days of receipt of a request. If the ~~subject of the study~~ guardian or conservator has been the perpetrator of substantiated maltreatment of a vulnerable adult or minor, the response must include a copy of ~~the~~ any available public portion of the investigation memorandum under section 626.557, subdivision 12b, or ~~the~~ any available public portion of the investigation memorandum under section 260E.30. ~~The commissioner shall provide the court with information from a review of information according to subdivision 2a if the study subject provided information indicating current or prior affiliation with a state licensing agency.~~

(c) Notwithstanding section 260E.30 or 626.557, subdivision 12b, if the commissioner of human services or a county lead agency or lead investigative agency has information that a person ~~on whom a background study was previously done~~ under this section has been determined to be a perpetrator of maltreatment of a vulnerable adult or minor, the commissioner or the county may provide this information to the court that ~~requested the background study~~ is determining eligibility for the guardian or conservator. ~~The commissioner may also provide the court with additional criminal history or substantiated maltreatment information that becomes available after the background study is done.~~

Subd. 2a. **Procedure; state licensing agency data.** (a) In response to a request submitted under section 245C.033, the ~~court shall request the~~ commissioner of human services ~~to~~ shall provide ~~the court within 25 working days of receipt of the request with~~ licensing agency data for licenses directly related to the responsibilities of a professional fiduciary if the ~~study~~

~~subject indicates~~ guardian or conservator has a current or prior affiliation from the following agencies in Minnesota:

(1) Lawyers Responsibility Board;

(2) State Board of Accountancy;

(3) Board of Social Work;

(4) Board of Psychology;

(5) Board of Nursing;

(6) Board of Medical Practice;

(7) Department of Education;

(8) Department of Commerce;

(9) Board of Chiropractic Examiners;

(10) Board of Dentistry;

(11) Board of Marriage and Family Therapy;

(12) Department of Human Services;

(13) Peace Officer Standards and Training (POST) Board; and

(14) Professional Educator Licensing and Standards Board.

~~(b) The commissioner shall enter into agreements with these agencies to provide the commissioner with electronic access to the relevant licensing data, and to provide the commissioner with a quarterly list of new sanctions issued by the agency.~~

~~(c)~~ (b) The commissioner shall provide information to the court ~~the electronically available data maintained in the agency's database, including whether the proposed guardian or conservator is or has been licensed by the agency, and if the licensing agency database indicates a disciplinary action or a sanction against the individual's license, including a condition, suspension, revocation, or cancellation~~ in accordance with section 245C.033.

~~(d) If the proposed guardian or conservator has resided in a state other than Minnesota in the previous ten years, licensing agency data under this section shall also include the licensing agency data from any other state where the proposed guardian or conservator reported to have resided during the previous ten years if the study subject indicates current or prior affiliation. If the proposed guardian or conservator has or has had a professional license in another state that is directly related to the responsibilities of a professional fiduciary~~

~~from one of the agencies listed under paragraph (a), state licensing agency data shall also include data from the relevant licensing agency of that state.~~

~~(e) The commissioner is not required to repeat a search for Minnesota or out-of-state licensing data on an individual if the commissioner has provided this information to the court within the prior five years.~~

~~(f) The commissioner shall review the information in paragraph (c) at least once every four months to determine if an individual who has been studied within the previous five years:~~

~~(1) has new disciplinary action or sanction against the individual's license; or~~

~~(2) did not disclose a prior or current affiliation with a Minnesota licensing agency.~~

~~(g) If the commissioner's review in paragraph (f) identifies new information, the commissioner shall provide any new information to the court.~~

Subd. 3. **Forms and systems.** ~~The court~~ In accordance with section 245C.033, subdivision 3, the commissioner must provide the ~~study subject~~ guardian or conservator with a privacy notice for the maltreatment and state licensing agency checks that complies with section ~~245C.05, subdivision 2e~~ 13.04, subdivision 2. ~~The commissioner of human services shall use the NETStudy 2.0 system to conduct a background study under this section.~~ The Bureau of Criminal Apprehension must provide the guardian or conservator with a privacy notice for the criminal history check.

Subd. 4. **Rights.** The court shall notify the ~~subject of a background study~~ guardian or conservator that ~~the subject has~~ they have the following rights:

(1) the right to be informed that the court will request ~~a background study on the subject~~ maltreatment and state licensing agency checks and a criminal history check on the guardian or conservator for the purpose of determining whether the person's appointment or continued appointment is in the best interests of the person subject to guardianship or conservatorship;

(2) the right to be informed of the results of the study and to obtain from the court a copy of the results; and

(3) the right to challenge the accuracy and completeness of information contained in the results under section 13.04, subdivision 4, except to the extent precluded by section 256.045, subdivision 3.

Sec. 39. **REPEALER.**

Minnesota Statutes 2022, sections 245C.02, subdivision 14b; 245C.031, subdivisions 5, 6, and 7; 245C.032; and 245C.30, subdivision 1a, are repealed.

ARTICLE 7
BEHAVIORAL HEALTH

Section 1. Minnesota Statutes 2022, section 245I.04, subdivision 14, is amended to read:

Subd. 14. **Mental health rehabilitation worker qualifications.** (a) A mental health rehabilitation worker must:

(1) have a high school diploma or equivalent; ~~and~~

(2) have the training required under section 245I.05, subdivision 3, paragraph (c); and

~~(2)~~ (3) meet one of the following qualification requirements:

(i) be fluent in the non-English language or competent in the culture of the ethnic group to which at least 20 percent of the mental health rehabilitation worker's clients belong;

(ii) have an associate of arts degree;

(iii) have two years of full-time postsecondary education or a total of 15 semester hours or 23 quarter hours in behavioral sciences or related fields;

(iv) be a registered nurse;

(v) have, within the previous ten years, three years of personal life experience with mental illness;

(vi) have, within the previous ten years, three years of life experience as a primary caregiver to an adult with a mental illness, traumatic brain injury, substance use disorder, or developmental disability; or

(vii) have, within the previous ten years, 2,000 hours of work experience providing health and human services to individuals.

(b) A mental health rehabilitation worker who is exclusively scheduled as an overnight staff person ~~and works alone~~ is exempt from the additional qualification requirements in paragraph (a), clause ~~(2)~~ (3).

Sec. 2. Minnesota Statutes 2022, section 245I.04, subdivision 16, is amended to read:

Subd. 16. **Mental health behavioral aide qualifications.** (a) A level 1 mental health behavioral aide must have the training required under section 245I.05, subdivision 3, paragraph (c), and: (1) a high school diploma or equivalent; or (2) two years of experience as a primary caregiver to a child with mental illness within the previous ten years.

(b) A level 2 mental health behavioral aide must~~: (1)~~ have the training required under section 245I.05, subdivision 3, paragraph (c), and an associate or bachelor's degree~~; or (2) be certified by a program under section 256B.0943, subdivision 8a~~.

Sec. 3. Minnesota Statutes 2022, section 245I.08, subdivision 2, is amended to read:

Subd. 2. **Documentation standards.** A license holder must ensure that all documentation required by this chapter:

(1) is legible;

(2) identifies the applicable client name on each page of the client file and staff person name on each page of the personnel file; and

(3) is signed and dated by the staff persons who provided services to the client or completed the documentation, including the staff persons' credentials.

Sec. 4. Minnesota Statutes 2022, section 245I.08, subdivision 4, is amended to read:

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

(1) the type of service;

(2) the date of service;

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

(4) the location of the service;

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

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

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

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

Sec. 5. Minnesota Statutes 2022, section 245I.10, subdivision 2, is amended to read:

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

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

(1) an explanation of findings;

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

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

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

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

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

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

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

(d) Based on the client's needs in the client's brief diagnostic assessment, a license holder may provide a client with any combination of psychotherapy sessions, group psychotherapy

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

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

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

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

(f) A license holder must complete a new standard diagnostic assessment of a client or an update to an assessment as permitted under paragraph (g):

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

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

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

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

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

Sec. 6. Minnesota Statutes 2022, section 245I.10, subdivision 3, is amended to read:

Subd. 3. **Continuity of services.** (a) For any client with a diagnostic assessment completed under Minnesota Rules, parts 9505.0370 to 9505.0372, before July 1, 2022, or upon federal approval, whichever is later, the diagnostic assessment is valid for authorizing the client's treatment and billing for one calendar year after the date that the assessment was completed.

(b) For any client with an individual treatment plan completed under section 256B.0622, 256B.0623, 256B.0943, 256B.0946, or 256B.0947 or Minnesota Rules, parts 9505.0370 to 9505.0372, the client's treatment plan is valid for authorizing treatment and billing until the treatment plan's expiration date.

(c) This subdivision expires ~~July 1~~ October 17, 2023.

Sec. 7. Minnesota Statutes 2022, section 245I.10, subdivision 6, is amended to read:

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

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

(1) the client's age;

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

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

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

(5) the client's current medications;

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

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

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

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

(10) cultural influences on the client.

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

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

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

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

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

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

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

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

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

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

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

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

(5) When completing a standard diagnostic assessment of a client who is 18 years of age or older, an assessor must use either (i) the CAGE-AID Questionnaire or (ii) the criteria

in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association to screen and assess the client for a substance use disorder.

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

(1) the client's mental status examination;

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

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

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

(g) Information from other providers and prior assessments may be used to complete the diagnostic assessment if the source of the information is documented in the diagnostic assessment.

Sec. 8. Minnesota Statutes 2022, section 245I.10, subdivision 7, is amended to read:

Subd. 7. **Individual treatment plan.** A license holder must follow each client's written individual treatment plan when providing services to the client with the following exceptions:

(1) services that do not require that a license holder completes a standard diagnostic assessment of a client before providing services to the client;

(2) when developing a treatment or service plan; and

(3) when a client re-engages in services under subdivision 8, paragraph (b).

Sec. 9. Minnesota Statutes 2022, section 245I.10, subdivision 8, is amended to read:

Subd. 8. **Individual treatment plan; required elements.** (a) After completing a client's diagnostic assessment or reviewing a client's diagnostic assessment received from a different

provider, and before providing services to the client beyond those permitted under subdivision 7, the license holder must complete the client's individual treatment plan. The license holder must:

(1) base the client's individual treatment plan on the client's diagnostic assessment and baseline measurements;

(2) for a child client, use a child-centered, family-driven, and culturally appropriate planning process that allows the child's parents and guardians to observe and participate in the child's individual and family treatment services, assessments, and treatment planning;

(3) for an adult client, use a person-centered, culturally appropriate planning process that allows the client's family and other natural supports to observe and participate in the client's treatment services, assessments, and treatment planning;

(4) identify the client's treatment goals, measureable treatment objectives, a schedule for accomplishing the client's treatment goals and objectives, a treatment strategy, and the individuals responsible for providing treatment services and supports to the client. The license holder must have a treatment strategy to engage the client in treatment if the client:

(i) has a history of not engaging in treatment; and

(ii) is ordered by a court to participate in treatment services or to take neuroleptic medications;

(5) identify the participants involved in the client's treatment planning. The client must be a participant in the client's treatment planning. If applicable, the license holder must document the reasons that the license holder did not involve the client's family or other natural supports in the client's treatment planning;

(6) review the client's individual treatment plan every 180 days and update the client's individual treatment plan with the client's treatment progress, new treatment objectives and goals or, if the client has not made treatment progress, changes in the license holder's approach to treatment; and

(7) ensure that the client approves of the client's individual treatment plan unless a court orders the client's treatment plan under chapter 253B.

(b) If the client disagrees with the client's treatment plan, the license holder must document in the client file the reasons why the client does not agree with the treatment plan. If the license holder cannot obtain the client's approval of the treatment plan, a mental health professional must make efforts to obtain approval from a person who is authorized to consent on the client's behalf within 30 days after the client's previous individual treatment plan

expired. A license holder may not deny a client service during this time period solely because the license holder could not obtain the client's approval of the client's individual treatment plan. A license holder may continue to bill for the client's otherwise eligible services when the client re-engages in services.

Sec. 10. Minnesota Statutes 2022, section 245I.11, subdivision 3, is amended to read:

Subd. 3. **Storing and accounting for medications.** (a) If a license holder stores client medications, the license holder must:

(1) store client medications in original containers in a locked location;

(2) store refrigerated client medications in special trays or containers that are separate from food;

(3) store client medications marked "for external use only" in a compartment that is separate from other client medications;

(4) store Schedule II ~~to IV~~ drugs listed in section 152.02, ~~subdivisions~~ subdivision 3 ~~to 5~~, in a compartment that is locked separately from other medications;

(5) ensure that only authorized staff persons have access to stored client medications;

(6) follow a documentation procedure ~~on each shift~~ to account for all ~~scheduled~~ Schedule II to V drugs listed in section 152.02, subdivisions 3 to 6; and

(7) record each incident when a staff person accepts a supply of client medications and destroy discontinued, outdated, or deteriorated client medications.

(b) If a license holder is licensed as a residential program, the license holder must allow clients who self-administer medications to keep a private medication supply. The license holder must ensure that the client stores all private medication in a locked container in the client's private living area, unless the private medication supply poses a health and safety risk to any clients. A client must not maintain a private medication supply of a prescription medication without a written medication order from a licensed prescriber and a prescription label that includes the client's name.

Sec. 11. Minnesota Statutes 2022, section 245I.11, subdivision 4, is amended to read:

Subd. 4. **Medication orders.** (a) If a license holder stores, prescribes, or administers medications or observes a client self-administer medications, the license holder must:

(1) ensure that a licensed prescriber writes all orders to accept, administer, or discontinue client medications;

(2) accept nonwritten orders to administer client medications in emergency circumstances only;

(3) establish a timeline and process for obtaining a written order with the licensed prescriber's signature when the license holder accepts a nonwritten order to administer client medications; and

~~(4) obtain prescription medication renewals from a licensed prescriber for each client every 90 days for psychotropic medications and annually for all other medications; and~~

~~(5)~~ (4) maintain the client's right to privacy and dignity.

(b) If a license holder employs a licensed prescriber, the license holder must inform the client about potential medication effects and side effects and obtain and document the client's informed consent before the licensed prescriber prescribes a medication.

Sec. 12. Minnesota Statutes 2022, section 245I.20, subdivision 6, is amended to read:

Subd. 6. **Additional policy and procedure requirements.** (a) In addition to the policies and procedures required by section 245I.03, the certification holder must establish, enforce, and maintain the policies and procedures required by this subdivision.

(b) The certification holder must have a clinical evaluation procedure to identify and document each treatment team member's areas of competence.

(c) The certification holder must have policies and procedures for client intake and case assignment that:

(1) outline the client intake process;

(2) describe how the mental health clinic determines the appropriateness of accepting a client into treatment by reviewing the client's condition and need for treatment, the clinical services that the mental health clinic offers to clients, and other available resources; and

(3) contain a process for assigning a client's case to a mental health professional who is responsible for the client's case and other treatment team members.

(d) Notwithstanding the requirements under section 245I.10, subdivisions 5 to 10, for the required elements of a diagnostic assessment and a treatment plan, psychiatry billed as evaluation and management services must be documented in accordance with the most recent current procedural terminology as published by the American Medical Association.

Sec. 13. Minnesota Statutes 2022, section 254B.02, subdivision 5, is amended to read:

Subd. 5. ~~**Administrative adjustment**~~ **Local agency allocation.** The commissioner may make payments to local agencies from money allocated under this section to support ~~administrative activities under sections 254B.03 and 254B.04~~ individuals with substance use disorders. The ~~administrative~~ payment must not ~~exceed the lesser of: (1) five percent of the first $50,000, four percent of the next $50,000, and three percent of the remaining payments for services from the special revenue account according to subdivision 1; or (2)~~ be less than 133 percent of the local agency ~~administrative~~ payment for the fiscal year ending June 30, 2009, adjusted in proportion to the statewide change in the appropriation for this chapter.

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

Sec. 14. Minnesota Statutes 2022, section 254B.05, subdivision 1, is amended to read:

Subdivision 1. **Licensure required.** (a) Programs licensed by the commissioner are eligible vendors. Hospitals may apply for and receive licenses to be eligible vendors, notwithstanding the provisions of section 245A.03. American Indian programs that provide substance use disorder treatment, extended care, transitional residence, or outpatient treatment services, and are licensed by tribal government are eligible vendors.

(b) A licensed professional in private practice as defined in section 245G.01, subdivision 17, who meets the requirements of section 245G.11, subdivisions 1 and 4, is an eligible vendor of a comprehensive assessment and assessment summary provided according to section 245G.05, and treatment services provided according to sections 245G.06 and 245G.07, subdivision 1, paragraphs (a), clauses (1) to (5), and (b); and subdivision 2, clauses (1) to (6).

(c) A county is an eligible vendor for a comprehensive assessment and assessment summary when provided by an individual who meets the staffing credentials of section 245G.11, subdivisions 1 and 5, and completed according to the requirements of section 245G.05. A county is an eligible vendor of care coordination services when provided by an individual who meets the staffing credentials of section 245G.11, subdivisions 1 and 7, and provided according to the requirements of section 245G.07, subdivision 1, paragraph (a), clause (5).

(d) A recovery community organization that meets certification requirements identified by the commissioner is an eligible vendor of peer support services.

(e) Detoxification programs licensed under Minnesota Rules, parts 9530.6510 to 9530.6590, are not eligible vendors. Programs that are not licensed as a residential or nonresidential substance use disorder treatment or withdrawal management program by the commissioner or by tribal government or do not meet the requirements of subdivisions 1a and 1b are not eligible vendors.

(f) Hospitals, federally qualified health centers, and rural health clinics are eligible vendors of a comprehensive assessment when the comprehensive assessment is completed according to section 245G.05 and by an individual who meets the criteria of an alcohol and drug counselor according to section 245G.11, subdivision 5. The alcohol and drug counselor must be individually enrolled with the commissioner and reported on the claim as the individual who provided the service.

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

Sec. 15. Minnesota Statutes 2022, section 254B.05, subdivision 1a, is amended to read:

Subd. 1a. **Room and board provider requirements.** (a) ~~Effective January 1, 2000,~~ Vendors of room and board are eligible for behavioral health fund payment if the vendor:

(1) has rules prohibiting residents bringing chemicals into the facility or using chemicals while residing in the facility and provide consequences for infractions of those rules;

(2) is determined to meet applicable health and safety requirements;

(3) is not a jail or prison;

(4) is not concurrently receiving funds under chapter 256I for the recipient;

(5) admits individuals who are 18 years of age or older;

(6) is registered as a board and lodging or lodging establishment according to section 157.17;

(7) has awake staff on site 24 hours per day;

(8) has staff who are at least 18 years of age and meet the requirements of section 245G.11, subdivision 1, paragraph (b);

(9) has emergency behavioral procedures that meet the requirements of section 245G.16;

(10) meets the requirements of section 245G.08, subdivision 5, if administering medications to clients;

(11) meets the abuse prevention requirements of section 245A.65, including a policy on fraternization and the mandatory reporting requirements of section 626.557;

(12) documents coordination with the treatment provider to ensure compliance with section 254B.03, subdivision 2;

(13) protects client funds and ensures freedom from exploitation by meeting the provisions of section 245A.04, subdivision 13;

(14) has a grievance procedure that meets the requirements of section 245G.15, subdivision 2; and

(15) has sleeping and bathroom facilities for men and women separated by a door that is locked, has an alarm, or is supervised by awake staff.

(b) Programs licensed according to Minnesota Rules, chapter 2960, are exempt from paragraph (a), clauses (5) to (15).

(c) Programs providing children's mental health crisis admissions and stabilization under section 245.4882, subdivision 6, are eligible vendors of room and board.

(d) Programs providing children's residential services under section 245.4882, except services for individuals who have a placement under chapter 260C or 260D, are eligible vendors of room and board.

~~(d)~~ (e) Licensed programs providing intensive residential treatment services or residential crisis stabilization services pursuant to section 256B.0622 or 256B.0624 are eligible vendors of room and board and are exempt from paragraph (a), clauses (6) to (15).

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

Sec. 16. Minnesota Statutes 2022, section 256.478, subdivision 2, is amended to read:

Subd. 2. **Eligibility.** An individual is eligible for the transition to community initiative if the individual does not meet eligibility criteria for the medical assistance program under section 256B.056 or 256B.057, but who meets at least one of the following criteria:

(1) the person otherwise meets the criteria under section 256B.092, subdivision 13, or 256B.49, subdivision 24;

(2) the person has met treatment objectives and no longer requires a hospital-level care or a secure treatment setting, but the person's discharge from the Anoka Metro Regional Treatment Center, the Minnesota ~~Security Hospital~~ Forensic Mental Health Program, the Child and Adolescent Behavioral Health Hospital program, a psychiatric residential treatment

facility under section 256B.0941, intensive residential treatment services under section 256B.0622, children's residential services under section 245.4882, or a ~~community behavioral health~~ hospital would be substantially delayed without additional resources available through the transitions to community initiative; or

~~(3) the person is in a community hospital, but alternative community living options would be appropriate for the person, and the person has received approval from the commissioner; or~~

~~(4)(i)~~ (3) the person (i) is receiving customized living services reimbursed under section 256B.4914, 24-hour customized living services reimbursed under section 256B.4914, or community residential services reimbursed under section 256B.4914; (ii) ~~the person~~ expresses a desire to move; and (iii) ~~the person~~ has received approval from the commissioner.

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

Sec. 17. Minnesota Statutes 2022, section 256B.0622, subdivision 2a, is amended to read:

Subd. 2a. **Eligibility for assertive community treatment.** An eligible client for assertive community treatment is an individual who meets the following criteria as assessed by an ACT team:

(1) is age 18 or older. Individuals ages 16 and 17 may be eligible upon approval by the commissioner;

(2) has a primary diagnosis of schizophrenia, schizoaffective disorder, major depressive disorder with psychotic features, other psychotic disorders, or bipolar disorder. Individuals with other psychiatric illnesses may qualify for assertive community treatment if they have a serious mental illness and meet the criteria outlined in clauses (3) and (4), but no more than ten percent of an ACT team's clients may be eligible based on this criteria. Individuals with a primary diagnosis of a substance use disorder, intellectual developmental disabilities, borderline personality disorder, antisocial personality disorder, traumatic brain injury, or an autism spectrum disorder are not eligible for assertive community treatment;

(3) has significant functional impairment as demonstrated by at least one of the following conditions:

(i) significant difficulty consistently performing the range of routine tasks required for basic adult functioning in the community or persistent difficulty performing daily living tasks without significant support or assistance;

(ii) significant difficulty maintaining employment at a self-sustaining level or significant difficulty consistently carrying out the head-of-household responsibilities; or

(iii) significant difficulty maintaining a safe living situation;

(4) has a need for continuous high-intensity services as evidenced by at least two of the following:

(i) two or more psychiatric hospitalizations or residential crisis stabilization services in the previous 12 months;

(ii) frequent utilization of mental health crisis services in the previous six months;

(iii) 30 or more consecutive days of psychiatric hospitalization in the previous 24 months;

(iv) intractable, persistent, or prolonged severe psychiatric symptoms;

(v) coexisting mental health and substance use disorders lasting at least six months;

(vi) recent history of involvement with the criminal justice system or demonstrated risk of future involvement;

(vii) significant difficulty meeting basic survival needs;

(viii) residing in substandard housing, experiencing homelessness, or facing imminent risk of homelessness;

(ix) significant impairment with social and interpersonal functioning such that basic needs are in jeopardy;

(x) coexisting mental health and physical health disorders lasting at least six months;

(xi) residing in an inpatient or supervised community residence but clinically assessed to be able to live in a more independent living situation if intensive services are provided;

(xii) requiring a residential placement if more intensive services are not available; ~~or~~

(xiii) difficulty effectively using traditional office-based outpatient services; or

(xiv) receiving services under section 256B.0946 and continuing to meet the criteria but for turning age 21;

(5) there are no indications that other available community-based services would be equally or more effective as evidenced by consistent and extensive efforts to treat the individual; and

(6) in the written opinion of a licensed mental health professional, has the need for mental health services that cannot be met with other available community-based services, or is

likely to experience a mental health crisis or require a more restrictive setting if assertive community treatment is not provided.

Sec. 18. Minnesota Statutes 2022, section 256B.0622, subdivision 8, is amended to read:

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

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

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

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

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

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

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

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

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

(vi) for assertive community treatment, intensive residential treatment services, and residential crisis services, providers may include in their prospective cost-based rate-setting methodology a line item reflecting estimated additional staffing compensation costs. Estimated additional staffing compensation costs are subject to review by the commissioner; and

(vii) for intensive residential treatment services and residential crisis services, providers may include in their prospective cost-based rate-setting methodology a line item reflecting estimated new capital costs. Estimated new capital costs are subject to review by the commissioner;

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

(3) the number of service units;

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

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

(d) The rate for intensive residential treatment services and assertive community treatment must exclude room and board, as defined in section 256I.03, subdivision 6, and services not covered under this section, such as partial hospitalization, home care, and inpatient services.

(e) Physician services that are not separately billed may be included in the rate to the extent that a psychiatrist, or other health care professional providing physician services within their scope of practice, is a member of the intensive residential treatment services treatment team. Physician services, whether billed separately or included in the rate, may be delivered by telehealth. For purposes of this paragraph, "telehealth" has the meaning given to "mental health telehealth" in section 256B.0625, subdivision 46, when telehealth is used to provide intensive residential treatment services.

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

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

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

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

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

Sec. 19. Minnesota Statutes 2022, section 256B.0624, subdivision 5, is amended to read:

Subd. 5. **Crisis assessment and intervention staff qualifications.** (a) Qualified individual staff of a qualified provider entity must provide crisis assessment and intervention services to a recipient. A staff member providing crisis assessment and intervention services to a recipient must be qualified as a:

(1) mental health professional;

(2) clinical trainee;

(3) mental health practitioner;

(4) mental health certified family peer specialist; or

(5) mental health certified peer specialist.

(b) When crisis assessment and intervention services are provided to a recipient in the community, a mental health professional, clinical trainee, or mental health practitioner must lead the response.

(c) The 30 hours of ongoing training required by section 245I.05, subdivision 4, paragraph (b), must be specific to providing crisis services to children and adults and include training about evidence-based practices identified by the commissioner of health to reduce the recipient's risk of suicide and self-injurious behavior.

(d) At least six hours of the ongoing training under paragraph (c) must be specific to working with families and providing crisis stabilization services to children and include the following topics:

(1) developmental tasks of childhood and adolescence;

(2) family relationships;

(3) child and youth engagement and motivation, including motivational interviewing;

(4) culturally responsive care, including care for lesbian, gay, bisexual, transgender, and queer youth;

(5) positive behavior support;

(6) crisis intervention for youth with developmental disabilities;

(7) child traumatic stress, trauma-informed care, and trauma-focused cognitive behavioral therapy; and

(8) youth substance use.

~~(d)~~ (e) Team members must be experienced in crisis assessment, crisis intervention techniques, treatment engagement strategies, working with families, and clinical decision-making under emergency conditions and have knowledge of local services and resources.

Sec. 20. Minnesota Statutes 2022, section 256B.0624, subdivision 8, is amended to read:

Subd. 8. **Crisis stabilization staff qualifications.** (a) Mental health crisis stabilization services must be provided by qualified individual staff of a qualified provider entity. A staff member providing crisis stabilization services to a recipient must be qualified as a:

(1) mental health professional;

(2) certified rehabilitation specialist;

(3) clinical trainee;

(4) mental health practitioner;

(5) mental health certified family peer specialist;

(6) mental health certified peer specialist; or

(7) mental health rehabilitation worker.

(b) The 30 hours of ongoing training required in section 245I.05, subdivision 4, paragraph (b), must be specific to providing crisis services to children and adults and include training about evidence-based practices identified by the commissioner of health to reduce a recipient's risk of suicide and self-injurious behavior.

(c) For providers who deliver care to children 21 years of age and younger, at least six hours of the ongoing training under this subdivision must be specific to working with families and providing crisis stabilization services to children and include the following topics:

(1) developmental tasks of childhood and adolescence;

(2) family relationships;

(3) child and youth engagement and motivation, including motivational interviewing;

(4) culturally responsive care, including care for lesbian, gay, bisexual, transgender, and queer youth;

(5) positive behavior support;

(6) crisis intervention for youth with developmental disabilities;

(7) child traumatic stress, trauma-informed care, and trauma-focused cognitive behavioral therapy; and

(8) youth substance use.

Sec. 21. Minnesota Statutes 2022, section 256B.0941, is amended by adding a subdivision to read:

Subd. 2b. **Shared site.** Related services that have a bright line separation from psychiatric residential treatment facility service operations may be delivered in the same facility, including under the same structural roof. In shared site settings, staff must provide services only to programs they are affiliated to through NETStudy 2.0.

Sec. 22. Minnesota Statutes 2022, section 256B.0941, is amended by adding a subdivision to read:

Subd. 5. **Start-up and capacity-building grants.** (a) The commissioner shall establish start-up and capacity-building grants for psychiatric residential treatment facility sites.

Start-up grants to prospective psychiatric residential treatment facility sites may be used for:

(1) administrative expenses;

(2) consulting services;

(3) Health Insurance Portability and Accountability Act of 1996 compliance;

(4) therapeutic resources, including evidence-based, culturally appropriate curriculums and training programs for staff and clients;

(5) allowable physical renovations to the property; and

(6) emergency workforce shortage uses, as determined by the commissioner.

(b) Start-up and capacity-building grants to prospective and current psychiatric residential treatment facilities may be used to support providers who treat and accept individuals with complex support needs, including but not limited to:

(1) neurocognitive disorders;

(2) co-occurring intellectual developmental disabilities;

(3) schizophrenia spectrum disorders;

(4) manifested or labeled aggressive behaviors; and

(5) manifested sexually inappropriate behaviors.

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

Sec. 23. Minnesota Statutes 2022, section 256B.0947, is amended by adding a subdivision to read:

Subd. 10. **Young adult continuity of care.** A client who received services under this section or section 256B.0946 and aged out of eligibility may continue to receive services from the same providers under this section until the client is 27 years old.

Sec. 24. Minnesota Statutes 2022, section 256B.761, is amended to read:

256B.761 REIMBURSEMENT FOR MENTAL HEALTH SERVICES.

(a) Effective for services rendered on or after July 1, 2001, payment for medication management provided to psychiatric patients, outpatient mental health services, day treatment services, home-based mental health services, and family community support services shall

be paid at the lower of (1) submitted charges, or (2) 75.6 percent of the 50th percentile of 1999 charges.

(b) Effective July 1, 2001, the medical assistance rates for outpatient mental health services provided by an entity that operates: (1) a Medicare-certified comprehensive outpatient rehabilitation facility; and (2) a facility that was certified prior to January 1, 1993, with at least 33 percent of the clients receiving rehabilitation services in the most recent calendar year who are medical assistance recipients, will be increased by 38 percent, when those services are provided within the comprehensive outpatient rehabilitation facility and provided to residents of nursing facilities owned by the entity.

(c) In addition to rate increases otherwise provided, the commissioner may restructure coverage policy and rates to improve access to adult rehabilitative mental health services under section 256B.0623 and related mental health support services under section 256B.021, subdivision 4, paragraph (f), clause (2). For state fiscal years 2015 and 2016, the projected state share of increased costs due to this paragraph is transferred from adult mental health grants under sections 245.4661 and 256E.12. The transfer for fiscal year 2016 is a permanent base adjustment for subsequent fiscal years. Payments made to managed care plans and county-based purchasing plans under sections 256B.69, 256B.692, and 256L.12 shall reflect the rate changes described in this paragraph.

(d) Any ratables effective before July 1, 2015, do not apply to early intensive developmental and behavioral intervention (EIDBI) benefits described in section 256B.0949.

(e) Effective for services rendered on or after January 1, 2024, payment rates for behavioral health services included in the rate analysis required by Laws 2021, First Special Session chapter 7, article 17, section 18, must be increased by four percent from the rates in effect on December 31, 2023. This paragraph does not apply to federally qualified health centers, rural health centers, Indian health services, certified community behavioral health clinics, cost-based rates, and rates that are negotiated with the county. This paragraph expires upon legislative implementation of the new rate methodology resulting from the rate analysis required by Laws 2021, First Special Session chapter 7, article 17, section 18.

(f) Effective January 1, 2024, the commissioner shall increase capitation payments made to managed care plans and county-based purchasing plans to reflect the behavioral health service rate increase provided in paragraph (e). Managed care and county-based purchasing plans must use the capitation rate increase provided under this paragraph to increase payment rates to behavioral health services providers. The commissioner must monitor the effect of this rate increase on enrollee access to behavioral health services. If, for any contract year,

federal approval is not received for this paragraph, the commissioner must adjust the capitation rates paid to managed care plans and county-based purchasing plans for that contract year to reflect the removal of this provision. Contracts between managed care plans and county-based purchasing plans and providers to whom this paragraph applies must allow recovery of payments from those providers if capitation rates are adjusted in accordance with this paragraph. Payment recoveries must not exceed the amount equal to any increase in rates that results from this provision.

Sec. 25. **LOCAL AGENCY SUBSTANCE USE DISORDER ALLOCATION.**

The commissioner of human services shall evaluate the ongoing need for local agency substance use disorder allocations under section 254B.02. The evaluation must include recommendations on whether local agency allocations should continue, and if so, must recommend what the purpose of the allocations should be and propose an updated allocation methodology that aligns with the purpose and person-centered outcomes for people experiencing substance use disorders and behavioral health conditions. The commissioner may contract with a vendor to support this evaluation through research and actuarial analysis.

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

Sec. 26. **RATE INCREASE FOR MENTAL HEALTH ADULT DAY TREATMENT.**

The commissioner of human services must increase the reimbursement rate for adult day treatment under Minnesota Statutes, section 256B.0671, subdivision 3, by 50 percent over the reimbursement rate in effect as of June 30, 2023.

EFFECTIVE DATE. This section is effective January 1, 2024, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 27. **ROOM AND BOARD COSTS IN CHILDREN'S RESIDENTIAL FACILITIES.**

The commissioner of human services must update the behavioral health fund room and board rate schedule to include services provided under Minnesota Statutes, section 245.4882, for individuals who do not have a placement under Minnesota Statutes, chapter 260C or 260D. The commissioner must establish room and board rates commensurate with current room and board rates for adolescent programs licensed under Minnesota Statutes, section 245G.18.

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

ARTICLE 8

DEPARTMENT OF HUMAN SERVICES POLICY

Section 1. Minnesota Statutes 2022, section 245.4661, subdivision 9, is amended to read:

Subd. 9. **Services and programs.** (a) The following three distinct grant programs are funded under this section:

(1) mental health crisis services;

(2) housing with supports for adults with serious mental illness; and

(3) projects for assistance in transitioning from homelessness (PATH program).

(b) In addition, the following are eligible for grant funds:

(1) community education and prevention;

(2) client outreach;

(3) early identification and intervention;

(4) adult outpatient diagnostic assessment and psychological testing;

(5) peer support services;

(6) community support program services (CSP);

(7) adult residential crisis stabilization;

(8) supported employment;

(9) assertive community treatment (ACT);

(10) housing subsidies;

(11) basic living, social skills, and community intervention;

(12) emergency response services;

(13) adult outpatient psychotherapy;

(14) adult outpatient medication management;

(15) adult mobile crisis services;

(16) adult day treatment;

(17) partial hospitalization;

(18) adult residential treatment;

(19) adult mental health targeted case management; and

~~(20) intensive community rehabilitative services (ICRS); and~~

~~(21)~~ (20) transportation.

Sec. 2. Minnesota Statutes 2022, section 245.469, subdivision 3, is amended to read:

Subd. 3. **Mental health crisis services.** The commissioner of human services shall increase access to mental health crisis services for children and adults. In order to increase access, the commissioner must:

(1) develop a central phone number where calls can be routed to the appropriate crisis services;

(2) provide telephone consultation 24 hours a day to mobile crisis teams who are serving people with traumatic brain injury or intellectual disabilities who are experiencing a mental health crisis;

(3) expand crisis services across the state, including rural areas of the state and examining access per population;

(4) establish and implement state standards and requirements for crisis services as outlined in section 256B.0624; and

(5) provide grants to adult mental health initiatives, counties, tribes, or community mental health providers to establish new mental health crisis residential service capacity.

Priority will be given to regions that do not have a mental health crisis residential services program, do not have an inpatient psychiatric unit within the region, do not have an inpatient psychiatric unit within 90 miles, or have a demonstrated need based on the number of crisis residential or intensive residential treatment beds available to meet the needs of the residents in the region. At least 50 percent of the funds must be distributed to programs in rural Minnesota. Grant funds may be used for start-up costs, including but not limited to renovations, furnishings, and staff training. Grant applications shall provide details on how the intended service will address identified needs and shall demonstrate collaboration with crisis teams, other mental health providers, hospitals, and police.

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

Sec. 3. **[245.4903] CULTURAL AND ETHNIC MINORITY INFRASTRUCTURE GRANT PROGRAM.**

Subdivision 1. **Establishment.** The commissioner of human services shall establish a cultural and ethnic minority infrastructure grant program to ensure that mental health and

substance use disorder treatment supports and services are culturally specific and culturally responsive to meet the cultural needs of the communities served.

Subd. 2. **Eligible applicants.** An eligible applicant is a licensed entity or provider from a cultural or ethnic minority population who:

(1) provides mental health or substance use disorder treatment services and supports to individuals from cultural and ethnic minority populations, including individuals who are lesbian, gay, bisexual, transgender, or queer and from cultural and ethnic minority populations;

(2) provides or is qualified and has the capacity to provide clinical supervision and support to members of culturally diverse and ethnic minority communities to qualify as mental health and substance use disorder treatment providers; or

(3) has the capacity and experience to provide training for mental health and substance use disorder treatment providers on cultural competency and cultural humility.

Subd. 2. **Allowable grant activities.** (a) The cultural and ethnic minority infrastructure grant program grantees must engage in activities and provide supportive services to ensure and increase equitable access to culturally specific and responsive care and to build organizational and professional capacity for licensure and certification for the communities served. Allowable grant activities include but are not limited to:

(1) workforce development activities focused on recruiting, supporting, training, and supervision activities for mental health and substance use disorder practitioners and professionals from diverse racial, cultural, and ethnic communities;

(2) supporting members of culturally diverse and ethnic minority communities to qualify as mental health and substance use disorder professionals, practitioners, clinical supervisors, recovery peer specialists, mental health certified peer specialists, and mental health certified family peer specialists;

(3) culturally specific outreach, early intervention, trauma-informed services, and recovery support in mental health and substance use disorder services;

(4) provision of trauma-informed, culturally responsive mental health and substance use disorder supports and services for children and families, youth, or adults who are from cultural and ethnic minority backgrounds and are uninsured or underinsured;

(5) mental health and substance use disorder service expansion and infrastructure improvement activities, particularly in greater Minnesota;

(6) training for mental health and substance use disorder treatment providers on cultural competency and cultural humility;

(7) activities to increase the availability of culturally responsive mental health and substance use disorder services for children and families, youth, or adults or to increase the availability of substance use disorder services for individuals from cultural and ethnic minorities in the state; and

(8) providing interpreter services at intensive residential treatment facilities, children's residential treatment centers, or psychiatric residential treatment facilities in order for children or adults with limited English proficiency or for children or adults who are fluent in another language to be able to access treatment.

(b) The commissioner must assist grantees with meeting third-party credentialing requirements, and grantees must obtain all available third-party reimbursement sources as a condition of receiving grant funds. Grantees must serve individuals from cultural and ethnic minority communities regardless of health coverage status or ability to pay.

Subd. 3. **Data collection and outcomes.** Grantees must provide regular data summaries to the commissioner for purposes of evaluating the effectiveness of the cultural and ethnic minority infrastructure grant program. The commissioner must use identified culturally appropriate outcome measures instruments to evaluate outcomes and must evaluate program activities by analyzing whether the program:

(1) increased access to culturally specific services for individuals from cultural and ethnic minority communities across the state;

(2) increased the number of individuals from cultural and ethnic minority communities served by grantees;

(3) increased cultural responsiveness and cultural competency of mental health and substance use disorder treatment providers;

(4) increased the number of mental health and substance use disorder treatment providers and clinical supervisors from cultural and ethnic minority communities;

(5) increased the number of mental health and substance use disorder treatment organizations owned, managed, or led by individuals who are Black, Indigenous, or people of color;

(6) reduced health disparities through improved clinical and functional outcomes for those accessing services; and

(7) led to an overall increase in culturally specific mental health and substance use disorder service availability.

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

Sec. 4. **[245.4906] MENTAL HEALTH CERTIFIED PEER SPECIALIST GRANT PROGRAM.**

Subdivision 1. **Establishment.** The mental health certified peer specialist grant program is established in the Department of Human Services to provide funding for training for mental health certified peer specialists who provide services to support individuals with lived experience of mental illness under section 256B.0615. Certified peer specialists provide services to individuals who are receiving assertive community treatment or intensive residential treatment services under section 256B.0622, adult rehabilitative mental health services under section 256B.0623, or crisis response services under section 256B.0624. Mental health certified peer specialist qualifications are defined in section 245I.04, subdivision 10, and mental health certified peer specialists' scope of practice is defined in section 245I.04, subdivision 11.

Subd. 2. **Activities.** Grant funding may be used to provide training for mental health certified peer specialists as specified in section 256B.0615, subdivision 5.

Subd. 3. **Outcomes.** Evaluation includes the extent to which individuals receiving peer services:

(1) experience progress on achieving treatment goals; and

(2) experience a reduction in hospital admissions.

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

Sec. 5. **[245.4907] MENTAL HEALTH CERTIFIED FAMILY PEER SPECIALIST GRANT PROGRAM.**

Subdivision 1. **Establishment.** The mental health certified peer family specialist grant program is established in the Department of Human Services to provide funding for training for mental health certified peer family specialists who provide services to support individuals with lived experience of mental illness under section 256B.0616. Certified family peer specialists provide services to families who have a child with an emotional disturbance or severe emotional disturbance under chapter 245. Certified family peer specialists provide services to families whose children are receiving inpatient hospitalization under section 256B.0625, subdivision 1; partial hospitalization under Minnesota Rules, parts 9505.0370,

subpart 24, and 9505.0372, subpart 9; residential treatment under section 245.4882; children's intensive behavioral health services under section 256B.0946; and day treatment, children's therapeutic services and supports, or crisis response services under section 256B.0624. Mental health certified family peer specialist qualifications are defined in section 245I.04, subdivision 12, and mental health certified family peer specialists' scope of practice is defined in section 245I.04, subdivision 13.

Subd. 2. **Activities.** Grant funding may be used to provide training for mental health certified family peer specialists as specified in section 256B.0616, subdivision 5.

Subd. 3. **Outcomes.** Evaluation includes the extent to which individuals receiving family peer services:

(1) progress on achieving treatment goals; and

(2) experience a reduction in hospital admissions.

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

Sec. 6. **[245.991] PROJECTS FOR ASSISTANCE IN TRANSITION FROM HOMELESSNESS PROGRAM.**

Subdivision 1. **Establishment.** The projects for assistance in transition from homelessness program is established in the Department of Human Services to prevent or end homelessness for people with serious mental illness or co-occurring substance use disorder and ensure the commissioner may achieve the goals of the housing mission statement in section 245.461, subdivision 4.

Subd. 2. **Activities.** All projects for assistance in transition from homelessness must provide homeless outreach and case management services. Projects may provide clinical assessment, habilitation and rehabilitation services, community mental health services, substance use disorder treatment, housing transition and sustaining services, direct assistance funding, and other activities as determined by the commissioner.

Subd. 3. **Eligibility.** Program activities must be provided to people with serious mental illness, or with co-occurring substance use disorder, who meet homeless criteria determined by the commissioner. People receiving homeless outreach may be presumed eligible until serious mental illness can be verified.

Subd. 4. **Outcomes.** Evaluation of each project includes the extent to which:

(1) grantees contact individuals through homeless outreach services;

(2) grantees enroll individuals in case management services;

(3) individuals access behavioral health services; and

(4) individuals transition from homelessness to housing.

Subd. 5. **Federal aid or grants.** The commissioner of human services must comply with all conditions and requirements necessary to receive federal aid or grants with respect to homeless services or programs as specified in section 245.70.

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

Sec. 7. **[245.992] HOUSING WITH SUPPORT FOR ADULTS WITH SERIOUS MENTAL ILLNESS PROGRAM.**

Subdivision 1. **Creation.** The housing with support for adults with serious mental illness program is established in the Department of Human Services to prevent or end homelessness for people with serious mental illness, increase the availability of housing with support, and ensure the commissioner may achieve the goals of the housing mission statement in section 245.461, subdivision 4.

Subd. 2. **Activities.** The housing with support for adults with serious mental illness program may provide a range of activities and supportive services to assure that people obtain and retain permanent supportive housing. Program activities may include case management, site-based housing services, housing transition and sustaining services, outreach services, community support services, direct assistance funding, and other activities as determined by the commissioner.

Subd. 3. **Eligibility.** Program activities must be provided to people with serious mental illness, or with co-occurring substance use disorder, who meet homeless criteria determined by the commissioner.

Subd. 4. **Outcomes.** Evaluation of program activities must utilize evidence-based practices and must include the extent to which:

(1) grantees' housing and activities utilize evidence-based practices;

(2) individuals transition from homelessness to housing;

(3) individuals retain housing; and

(4) individuals are satisfied with their housing.

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

Sec. 8. Minnesota Statutes 2022, section 256.478, is amended by adding a subdivision to read:

Subd. 3. **Authorized uses of grant funds.** Grant funds may be used for but are not limited to the following:

(1) increasing access to home and community-based services for an individual;

(2) improving caregiver-child relationships and aiding progress toward treatment goals; and

(3) reducing emergency department visits.

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

Sec. 9. Minnesota Statutes 2022, section 256.478, is amended by adding a subdivision to read:

Subd. 4. **Outcomes.** Program evaluation is based on but not limited to the following criteria:

(1) expediting discharges for individuals who no longer need hospital level of care;

(2) individuals obtaining and retaining housing;

(3) individuals maintaining community living by diverting admission to Anoka Metro Regional Treatment Center and Forensic Mental Health Program;

(4) reducing recidivism rates of individuals returning to state institutions; and

(5) individuals' ability to live in the least restrictive community setting.

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

Sec. 10. Minnesota Statutes 2022, section 256B.056, is amended by adding a subdivision to read:

Subd. 5d. **Medical assistance room and board rate.** "Medical assistance room and board rate" means an amount equal to 81 percent of the federal poverty guideline for a single individual living alone in the community less the medical assistance personal needs allowance under section 256B.35. The amount of the room and board rate, as defined in section 256I.03, subdivision 2, that exceeds the medical assistance room and board rate is considered a remedial care cost. A remedial care cost may be used to meet a spenddown obligation under this section. The medical assistance room and board rate is to be adjusted on January 1 of each year.

Sec. 11. Minnesota Statutes 2022, section 256B.0622, subdivision 8, is amended to read:

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

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

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

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

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

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

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

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

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

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

(3) the number of service units;

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

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

(d) The rate for intensive residential treatment services and assertive community treatment must exclude the medical assistance room and board rate, as defined in section ~~256I.03, subdivision 6~~ 256B.056, subdivision 5d, and services not covered under this section, such as partial hospitalization, home care, and inpatient services.

(e) Physician services that are not separately billed may be included in the rate to the extent that a psychiatrist, or other health care professional providing physician services within their scope of practice, is a member of the intensive residential treatment services treatment team. Physician services, whether billed separately or included in the rate, may be delivered by telehealth. For purposes of this paragraph, "telehealth" has the meaning given to "mental health telehealth" in section 256B.0625, subdivision 46, when telehealth is used to provide intensive residential treatment services.

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

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

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

(i) Entities who discontinue providing services must be subject to a settle-up process whereby actual costs and reimbursement for the previous 12 months are compared. In the event that the entity was paid more than the entity's actual costs plus any applicable

performance-related funding due the provider, the excess payment must be reimbursed to the department. If a provider's revenue is less than actual allowed costs due to lower utilization than projected, the commissioner may reimburse the provider to recover its actual allowable costs. The resulting adjustments by the commissioner must be proportional to the percent of total units of service reimbursed by the commissioner and must reflect a difference of greater than five percent.

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

Sec. 12. Minnesota Statutes 2022, section 256B.0946, subdivision 6, is amended to read:

Subd. 6. **Excluded services.** (a) Services in clauses (1) to (7) are not covered under this section and are not eligible for medical assistance payment as components of children's intensive behavioral health services, but may be billed separately:

(1) inpatient psychiatric hospital treatment;

(2) mental health targeted case management;

(3) partial hospitalization;

(4) medication management;

(5) children's mental health day treatment services;

(6) crisis response services under section 256B.0624;

(7) transportation; and

(8) mental health certified family peer specialist services under section 256B.0616.

(b) Children receiving intensive behavioral health services are not eligible for medical assistance reimbursement for the following services while receiving children's intensive behavioral health services:

(1) psychotherapy and skills training components of children's therapeutic services and supports under section 256B.0943;

(2) mental health behavioral aide services as defined in section 256B.0943, subdivision 1, paragraph (l);

(3) home and community-based waiver services;

(4) mental health residential treatment; and

(5) medical assistance room and board ~~costs~~ rate, as defined in section ~~256I.03, subdivision 6~~ 256B.056, subdivision 5d.

Sec. 13. Minnesota Statutes 2022, section 256B.0947, subdivision 7a, is amended to read:

Subd. 7a. **Noncovered services.** (a) The rate for intensive rehabilitative mental health services does not include medical assistance payment for services in clauses (1) to (7). Services not covered under this paragraph may be billed separately:

(1) inpatient psychiatric hospital treatment;

(2) partial hospitalization;

(3) children's mental health day treatment services;

(4) physician services outside of care provided by a psychiatrist serving as a member of the treatment team;

(5) medical assistance room and board ~~costs~~ rate, as defined in section ~~256I.03, subdivision 6~~ 256B.056, subdivision 5d;

(6) home and community-based waiver services; and

(7) other mental health services identified in the child's individualized education program.

(b) The following services are not covered under this section and are not eligible for medical assistance payment while youth are receiving intensive rehabilitative mental health services:

(1) mental health residential treatment; and

(2) mental health behavioral aide services, as defined in section 256B.0943, subdivision 1, paragraph (l).

Sec. 14. Minnesota Statutes 2022, section 256D.02, is amended by adding a subdivision to read:

Subd. 20. **Date of application.** "Date of application" has the meaning given in section 256P.01, subdivision 2b.

Sec. 15. Minnesota Statutes 2022, section 256D.07, is amended to read:

256D.07 TIME OF PAYMENT OF ASSISTANCE.

An applicant for general assistance shall be deemed eligible if the application and the verification of the statement on that application demonstrate that the applicant is within the

eligibility criteria established by sections 256D.01 to 256D.21 and any applicable rules of the commissioner. Any person requesting general assistance shall be permitted by the county agency to make an application for assistance as soon as administratively possible and in no event later than the fourth day following the date on which assistance is first requested, and no county agency shall require that a person requesting assistance appear at the offices of the county agency more than once prior to the date on which the person is permitted to make the application. ~~The application shall be in writing in the manner and upon the form prescribed by the commissioner and attested to by the oath of the applicant or in lieu thereof shall contain the following declaration which shall be signed by the applicant: "I declare that this application has been examined by me and to the best of my knowledge and belief is a true and correct statement of every material point."~~ Applications must be submitted according to section 256P.04, subdivision 1a. On the date that general assistance is first requested, the county agency shall inquire and determine whether the person requesting assistance is in immediate need of food, shelter, clothing, assistance for necessary transportation, or other emergency assistance pursuant to section 256D.06, subdivision 2. A person in need of emergency assistance shall be granted emergency assistance immediately, and necessary emergency assistance shall continue for up to 30 days following the date of application. A determination of an applicant's eligibility for general assistance shall be made by the county agency as soon as the required verifications are received by the county agency and in no event later than 30 days following the date that the application is made. Any verifications required of the applicant shall be reasonable, and the commissioner shall by rule establish reasonable verifications. General assistance shall be granted to an eligible applicant without the necessity of first securing action by the board of the county agency. The first month's grant must be computed to cover the time period starting with the date ~~a signed application form is received by the county agency~~ of application, as defined by section 256P.01, subdivision 2b, or from the date that the applicant meets all eligibility factors, whichever occurs later.

If upon verification and due investigation it appears that the applicant provided false information and the false information materially affected the applicant's eligibility for general assistance or the amount of the applicant's general assistance grant, the county agency may refer the matter to the county attorney. The county attorney may commence a criminal prosecution or a civil action for the recovery of any general assistance wrongfully received, or both.

Sec. 16. Minnesota Statutes 2022, section 256I.03, subdivision 15, is amended to read:

Subd. 15. **Supportive housing.** "Supportive housing" means housing that is not time-limited ~~and~~, provides or coordinates services necessary for a resident to maintain housing stability, and is not licensed as an assisted living facility under chapter 144G.

Sec. 17. Minnesota Statutes 2022, section 256I.03, is amended by adding a subdivision to read:

Subd. 16. **Date of application.** "Date of application" has the meaning given in section 256P.01, subdivision 2b.

Sec. 18. Minnesota Statutes 2022, section 256I.04, subdivision 2, is amended to read:

Subd. 2. **Date of eligibility.** An individual who has met the eligibility requirements of subdivision 1, shall have a housing support payment made on the individual's behalf from the first day of the month ~~in which a signed~~ of the date of application ~~form is received by a county agency~~, as defined by section 256P.01, subdivision 2b, or the first day of the month in which all eligibility factors have been met, whichever is later.

Sec. 19. Minnesota Statutes 2022, section 256I.06, subdivision 3, is amended to read:

Subd. 3. **Filing of application.** ~~The county agency must immediately provide an application form to any person requesting housing support. Application for housing support must be in writing on a form prescribed by the commissioner.~~ Applications must be submitted according to section 256P.04, subdivision 1a. The county agency must determine an applicant's eligibility for housing support as soon as the required verifications are received by the county agency and within 30 days after a signed application is received by the county agency for the aged or blind or within 60 days for people with a disability.

Sec. 20. Minnesota Statutes 2022, section 256I.09, is amended to read:

256I.09 COMMUNITY LIVING INFRASTRUCTURE.

The commissioner shall award grants to agencies and multi-Tribal collaboratives through an annual competitive process. Grants awarded under this section may be used for: (1) outreach to locate and engage people who are homeless or residing in segregated settings to screen for basic needs and assist with referral to community living resources; (2) building capacity to provide technical assistance and consultation on housing and related support service resources for persons with both disabilities and low income; or (3) streamlining the

administration and monitoring activities related to housing support funds. Agencies may collaborate and submit a joint application for funding under this section.

Sec. 21. Minnesota Statutes 2022, section 256J.08, subdivision 21, is amended to read:

Subd. 21. **Date of application.** "Date of application" ~~means the date on which the county agency receives an applicant's application as a signed written application, an application submitted by telephone, or an application submitted through Internet telepresence~~ has the meaning given in section 256P.01, subdivision 2b.

Sec. 22. Minnesota Statutes 2022, section 256J.09, subdivision 3, is amended to read:

Subd. 3. **Submitting application form.** (a) A county agency must offer, in person or by mail, the application forms prescribed by the commissioner as soon as a person makes a written or oral inquiry. At that time, the county agency must:

(1) inform the person that assistance begins on the date ~~that the~~ of application ~~is received by the county agency either as a signed written application; an application submitted by telephone; or an application submitted through Internet telepresence;~~, as defined in section 256P.01, subdivision 2b, or on the date that all eligibility criteria are met, whichever is later;

(2) inform a person that the person may submit the application by telephone or through Internet telepresence;

(3) inform a person ~~that when the person submits the application by telephone or through Internet telepresence, the county agency must receive a signed written application within 30 days of the date that the person submitted the application by telephone or through Internet telepresence~~ of the application submission requirements in section 256P.04, subdivision 1a;

(4) inform the person that any delay in submitting the application will reduce the amount of assistance paid for the month of application;

(5) inform a person that the person may submit the application before an interview;

(6) explain the information that will be verified during the application process by the county agency as provided in section 256J.32;

(7) inform a person about the county agency's average application processing time and explain how the application will be processed under subdivision 5;

(8) explain how to contact the county agency if a person's application information changes and how to withdraw the application;

(9) inform a person that the next step in the application process is an interview and what a person must do if the application is approved including, but not limited to, attending orientation under section 256J.45 and complying with employment and training services requirements in sections 256J.515 to 256J.57;

(10) inform the person that an interview must be conducted. The interview may be conducted face-to-face in the county office or at a location mutually agreed upon, through Internet telepresence, or by telephone;

(11) explain the child care and transportation services that are available under paragraph (c) to enable caregivers to attend the interview, screening, and orientation; and

(12) identify any language barriers and arrange for translation assistance during appointments, including, but not limited to, screening under subdivision 3a, orientation under section 256J.45, and assessment under section 256J.521.

(b) Upon receipt of a signed application, the county agency must stamp the date of receipt on the face of the application. The county agency must process the application within the time period required under subdivision 5. An applicant may withdraw the application at any time by giving written or oral notice to the county agency. The county agency must issue a written notice confirming the withdrawal. The notice must inform the applicant of the county agency's understanding that the applicant has withdrawn the application and no longer wants to pursue it. When, within ten days of the date of the agency's notice, an applicant informs a county agency, in writing, that the applicant does not wish to withdraw the application, the county agency must reinstate the application and finish processing the application.

(c) Upon a participant's request, the county agency must arrange for transportation and child care or reimburse the participant for transportation and child care expenses necessary to enable participants to attend the screening under subdivision 3a and orientation under section 256J.45.

Sec. 23. Minnesota Statutes 2022, section 256J.95, subdivision 5, is amended to read:

Subd. 5. **Submitting application form.** The eligibility date for the diversionary work program begins on the date ~~that the combined~~ of application ~~form (CAF) is received by the county agency either as a signed written application; an application submitted by telephone; or an application submitted through Internet telepresence;~~, as defined in section 256P.01, subdivision 2b, or on the date that diversionary work program eligibility criteria are met, whichever is later. The county agency must inform an applicant ~~that when the applicant~~

~~submits the application by telephone or through Internet telepresence, the county agency must receive a signed written application within 30 days of the date that the applicant submitted the application by telephone or through Internet telepresence~~ of the application submission requirements in section 256P.04, subdivision 1a. The county agency must inform the applicant that any delay in submitting the application will reduce the benefits paid for the month of application. The county agency must inform a person that an application may be submitted before the person has an interview appointment. Upon receipt of a signed application, the county agency must stamp the date of receipt on the face of the application. The applicant may withdraw the application at any time prior to approval by giving written or oral notice to the county agency. The county agency must follow the notice requirements in section 256J.09, subdivision 3, when issuing a notice confirming the withdrawal.

Sec. 24. Minnesota Statutes 2022, section 256P.01, is amended by adding a subdivision to read:

Subd. 2b. **Date of application.** "Date of application" means the date on which the agency receives an applicant's application as a signed written application, an application submitted by telephone, or an application submitted through Internet telepresence. The child care assistance program under chapter 119B is exempt from this definition.

Sec. 25. Minnesota Statutes 2022, section 256P.04, is amended by adding a subdivision to read:

Subd. 1a. **Application submission.** An agency must offer, in person or by mail, the application forms prescribed by the commissioner as soon as a person makes a written or oral inquiry about assistance. Applications must be received by the agency as a signed written application, an application submitted by telephone, or an application submitted through Internet telepresence. When a person submits an application by telephone or through Internet telepresence, the agency must receive a signed written application within 30 days of the date that the person submitted the application by telephone or through Internet telepresence.

Sec. 26. **REVISOR INSTRUCTION.**

The revisor of statutes shall renumber the subdivisions in Minnesota Statutes, sections 256D.02 and 256I.03, in alphabetical order, excluding the first subdivision in each section, and correct any cross-reference changes that result.

Sec. 27. **REPEALER.**

Minnesota Statutes 2022, section 256I.03, subdivision 6, is repealed.

ARTICLE 9
DEPARTMENT OF HUMAN SERVICES OPERATIONS POLICY

Section 1. Minnesota Statutes 2022, section 13.46, subdivision 4, is amended to read:

Subd. 4. **Licensing data.** (a) As used in this subdivision:

(1) "licensing data" are all data collected, maintained, used, or disseminated by the welfare system pertaining to persons licensed or registered or who apply for licensure or registration or who formerly were licensed or registered under the authority of the commissioner of human services. "Licensing data" includes data pertaining to persons or government entities certified under chapter 245H or section 245I.20. "License holder" includes "certification holder" under section 245H.01, subdivision 4, and a person or government entity issued a certification under section 245I.20;

(2) "client" means a person who is receiving services from a licensee or from an applicant for licensure; and

(3) "personal and personal financial data" are Social Security numbers, identity of and letters of reference, insurance information, reports from the Bureau of Criminal Apprehension, health examination reports, and social/home studies.

(b)(1)(i) Except as provided in paragraph (c), the following data on applicants, license holders, and former licensees are public: name, address, telephone number of licensees, the public email address provided by nonfamily foster care license holder, date of receipt of a completed application, dates of licensure, licensed capacity, type of client preferred, variances granted, record of training and education in child care and child development, type of dwelling, name and relationship of other family members, previous license history, class of license, the existence and status of complaints, and the number of serious injuries to or deaths of individuals in the licensed program as reported to the commissioner of human services, the local social services agency, or any other county welfare agency. For purposes of this clause, a serious injury is one that is treated by a physician.

(ii) Except as provided in item (v), when a correction order, an order to forfeit a fine, an order of license suspension, an order of temporary immediate suspension, an order of license revocation, an order of license denial, or an order of conditional license has been issued, or a complaint is resolved, the following data on current and former licensees and

applicants are public: the general nature of the complaint or allegations leading to the temporary immediate suspension; the substance and investigative findings of the licensing or maltreatment complaint, licensing violation, or substantiated maltreatment; the existence of settlement negotiations; the record of informal resolution of a licensing violation; orders of hearing; findings of fact; conclusions of law; specifications of the final correction order, fine, suspension, temporary immediate suspension, revocation, denial, or conditional license contained in the record of licensing action; whether a fine has been paid; and the status of any appeal of these actions.

(iii) When a license denial under section 245A.05 or a sanction under section 245A.07 is based on a determination that a license holder, applicant, or controlling individual is responsible for maltreatment under section 626.557 or chapter 260E, the identity of the applicant, license holder, or controlling individual as the individual responsible for maltreatment is public data at the time of the issuance of the license denial or sanction.

(iv) When a license denial under section 245A.05 or a sanction under section 245A.07 is based on a determination that a license holder, applicant, or controlling individual is disqualified under chapter 245C, the identity of the license holder, applicant, or controlling individual as the disqualified individual and the reason for the disqualification are public data at the time of the issuance of the licensing sanction or denial. If the applicant, license holder, or controlling individual requests reconsideration of the disqualification and the disqualification is affirmed, the reason for the disqualification and the reason to not set aside the disqualification are public data.

(v) A correction order or fine issued to a child care provider for a licensing violation is private data on individuals under section 13.02, subdivision 12, or nonpublic data under section 13.02, subdivision 9, if the correction order or fine is seven years old or older.

(2) For applicants who withdraw their application prior to licensure or denial of a license, the following data are public: the name of the applicant, the city and county in which the applicant was seeking licensure, the dates of the commissioner's receipt of the initial application and completed application, the type of license sought, and the date of withdrawal of the application.

(3) For applicants who are denied a license, the following data are public: the name and address of the applicant, the city and county in which the applicant was seeking licensure, the dates of the commissioner's receipt of the initial application and completed application, the type of license sought, the date of denial of the application, the nature of the basis for the denial, the existence of settlement negotiations, the record of informal resolution of a

denial, orders of hearings, findings of fact, conclusions of law, specifications of the final order of denial, and the status of any appeal of the denial.

(4) When maltreatment is substantiated under section 626.557 or chapter 260E and the victim and the substantiated perpetrator are affiliated with a program licensed under chapter 245A, the commissioner of human services, local social services agency, or county welfare agency may inform the license holder where the maltreatment occurred of the identity of the substantiated perpetrator and the victim.

(5) Notwithstanding clause (1), for child foster care, only the name of the license holder and the status of the license are public if the county attorney has requested that data otherwise classified as public data under clause (1) be considered private data based on the best interests of a child in placement in a licensed program.

(c) The following are private data on individuals under section 13.02, subdivision 12, or nonpublic data under section 13.02, subdivision 9: personal and personal financial data on family day care program and family foster care program applicants and licensees and their family members who provide services under the license.

(d) The following are private data on individuals: the identity of persons who have made reports concerning licensees or applicants that appear in inactive investigative data, and the records of clients or employees of the licensee or applicant for licensure whose records are received by the licensing agency for purposes of review or in anticipation of a contested matter. The names of reporters of complaints or alleged violations of licensing standards under chapters 245A, 245B, 245C, and 245D, and applicable rules and alleged maltreatment under section 626.557 and chapter 260E, are confidential data and may be disclosed only as provided in section 260E.21, subdivision 4; 260E.35; or 626.557, subdivision 12b.

(e) Data classified as private, confidential, nonpublic, or protected nonpublic under this subdivision become public data if submitted to a court or administrative law judge as part of a disciplinary proceeding in which there is a public hearing concerning a license which has been suspended, immediately suspended, revoked, or denied.

(f) Data generated in the course of licensing investigations that relate to an alleged violation of law are investigative data under subdivision 3.

(g) Data that are not public data collected, maintained, used, or disseminated under this subdivision that relate to or are derived from a report as defined in section 260E.03, or 626.5572, subdivision 18, are subject to the destruction provisions of sections 260E.35, subdivision 6, and 626.557, subdivision 12b.

(h) Upon request, not public data collected, maintained, used, or disseminated under this subdivision that relate to or are derived from a report of substantiated maltreatment as defined in section 626.557 or chapter 260E may be exchanged with the Department of Health for purposes of completing background studies pursuant to section 144.057 and with the Department of Corrections for purposes of completing background studies pursuant to section 241.021.

(i) Data on individuals collected according to licensing activities under chapters 245A and 245C, data on individuals collected by the commissioner of human services according to investigations under section 626.557 and chapters 245A, 245B, 245C, 245D, and 260E may be shared with the Department of Human Rights, the Department of Health, the Department of Corrections, the ombudsman for mental health and developmental disabilities, and the individual's professional regulatory board when there is reason to believe that laws or standards under the jurisdiction of those agencies may have been violated or the information may otherwise be relevant to the board's regulatory jurisdiction. Background study data on an individual who is the subject of a background study under chapter 245C for a licensed service for which the commissioner of human services is the license holder may be shared with the commissioner and the commissioner's delegate by the licensing division. Unless otherwise specified in this chapter, the identity of a reporter of alleged maltreatment or licensing violations may not be disclosed.

(j) In addition to the notice of determinations required under sections 260E.24, subdivisions 5 and 7, and 260E.30, subdivision 6, paragraphs (b), (c), (d), (e), and (f), if the commissioner or the local social services agency has determined that an individual is a substantiated perpetrator of maltreatment of a child based on sexual abuse, as defined in section 260E.03, and the commissioner or local social services agency knows that the individual is a person responsible for a child's care in another facility, the commissioner or local social services agency shall notify the head of that facility of this determination. The notification must include an explanation of the individual's available appeal rights and the status of any appeal. If a notice is given under this paragraph, the government entity making the notification shall provide a copy of the notice to the individual who is the subject of the notice.

(k) All not public data collected, maintained, used, or disseminated under this subdivision and subdivision 3 may be exchanged between the Department of Human Services, Licensing Division, and the Department of Corrections for purposes of regulating services for which the Department of Human Services and the Department of Corrections have regulatory authority.

Sec. 2. Minnesota Statutes 2022, section 62V.05, subdivision 4a, is amended to read:

Subd. 4a. **Background study required.** (a) The board must initiate background studies under section 245C.031 of:

(1) each navigator;

(2) each in-person assister; and

(3) each certified application counselor.

(b) The board may initiate the background studies required by paragraph (a) using the online NETStudy 2.0 system operated by the commissioner of human services.

(c) The board shall not permit any individual to provide any service or function listed in paragraph (a) until ~~the board has received notification from the commissioner of human services indicating that the individual~~:

(1) the board has evaluated any notification received from the commissioner of human services indicating the individual's potential disqualifications and has determined that the individual is not disqualified under chapter 245C; or

(2) the board has determined that the individual is disqualified~~,~~ but has ~~received~~ granted a set aside ~~from the board~~ of that disqualification according to sections 245C.22 and 245C.23.

(d) The board or its delegate shall review a reconsideration request of an individual in paragraph (a), including granting a set aside, according to the procedures and criteria in chapter 245C. The board shall notify the individual and the Department of Human Services of the board's decision.

Sec. 3. Minnesota Statutes 2022, section 122A.18, subdivision 8, is amended to read:

Subd. 8. **Background studies.** (a) The Professional Educator Licensing and Standards Board and the Board of School Administrators must initiate criminal history background studies of all first-time applicants for educator and administrator licenses under their jurisdiction. Applicants must include with their licensure applications:

(1) an executed criminal history consent form, including fingerprints; and

(2) payment to conduct the background study. The Professional Educator Licensing and Standards Board must deposit payments received under this subdivision in an account in the special revenue fund. Amounts in the account are annually appropriated to the Professional Educator Licensing and Standards Board to pay for the costs of background studies on applicants for licensure.

(b) The background study for all first-time ~~teaching~~ applicants for educator licenses must include a review of information from the Bureau of Criminal Apprehension, including criminal history data as defined in section 13.87, and must also include a review of the national criminal records repository. The superintendent of the Bureau of Criminal Apprehension is authorized to exchange fingerprints with the Federal Bureau of Investigation for purposes of the criminal history check.

(c) The Professional Educator Licensing and Standards Board may initiate criminal history background studies through the commissioner of human services according to section 245C.031 to obtain background study data required under this chapter.

Sec. 4. Minnesota Statutes 2022, section 245A.02, subdivision 5a, is amended to read:

Subd. 5a. **Controlling individual.** (a) "Controlling individual" means an owner of a program or service provider licensed under this chapter and the following individuals, if applicable:

(1) each officer of the organization, including the chief executive officer and chief financial officer;

(2) the individual designated as the authorized agent under section 245A.04, subdivision 1, paragraph (b);

(3) the individual designated as the compliance officer under section 256B.04, subdivision 21, paragraph (g);

(4) each managerial official whose responsibilities include the direction of the management or policies of a program; ~~and~~

(5) the individual designated as the primary provider of care for a special family child care program under section 245A.14, subdivision 4, paragraph (i)~~.~~; and

(6) the president and treasurer of the board of directors of a nonprofit corporation.

(b) Controlling individual does not include:

(1) a bank, savings bank, trust company, savings association, credit union, industrial loan and thrift company, investment banking firm, or insurance company unless the entity operates a program directly or through a subsidiary;

(2) an individual who is a state or federal official, or state or federal employee, or a member or employee of the governing body of a political subdivision of the state or federal government that operates one or more programs, unless the individual is also an officer,

owner, or managerial official of the program, receives remuneration from the program, or owns any of the beneficial interests not excluded in this subdivision;

(3) an individual who owns less than five percent of the outstanding common shares of a corporation:

(i) whose securities are exempt under section 80A.45, clause (6); or

(ii) whose transactions are exempt under section 80A.46, clause (2);

(4) an individual who is a member of an organization exempt from taxation under section 290.05, unless the individual is also an officer, owner, or managerial official of the program or owns any of the beneficial interests not excluded in this subdivision. This clause does not exclude from the definition of controlling individual an organization that is exempt from taxation; or

(5) an employee stock ownership plan trust, or a participant or board member of an employee stock ownership plan, unless the participant or board member is a controlling individual according to paragraph (a).

(c) For purposes of this subdivision, "managerial official" means an individual who has the decision-making authority related to the operation of the program, and the responsibility for the ongoing management of or direction of the policies, services, or employees of the program. A site director who has no ownership interest in the program is not considered to be a managerial official for purposes of this definition.

Sec. 5. Minnesota Statutes 2022, section 245A.02, subdivision 10b, is amended to read:

Subd. 10b. **Owner.** "Owner" means an individual or organization that has a direct or indirect ownership interest of five percent or more in a program licensed under this chapter. For purposes of this subdivision, "direct ownership interest" means the possession of equity in capital, stock, or profits of an organization, and "indirect ownership interest" means a direct ownership interest in an entity that has a direct or indirect ownership interest in a licensed program. For purposes of this chapter, "owner of ~~a nonprofit corporation" means the president and treasurer of the board of directors or, for an entity owned by~~ an employee stock ownership plan~~,~~" means the president and treasurer of the entity. A government entity or nonprofit corporation that is issued a license under this chapter shall be designated the owner.

Sec. 6. Minnesota Statutes 2022, section 245A.04, subdivision 1, is amended to read:

Subdivision 1. **Application for licensure.** (a) An individual, organization, or government entity that is subject to licensure under section 245A.03 must apply for a license. The application must be made on the forms and in the manner prescribed by the commissioner. The commissioner shall provide the applicant with instruction in completing the application and provide information about the rules and requirements of other state agencies that affect the applicant. An applicant seeking licensure in Minnesota with headquarters outside of Minnesota must have a program office located within 30 miles of the Minnesota border. An applicant who intends to buy or otherwise acquire a program or services licensed under this chapter that is owned by another license holder must apply for a license under this chapter and comply with the application procedures in this section and section ~~245A.03~~ 245A.043.

The commissioner shall act on the application within 90 working days after a complete application and any required reports have been received from other state agencies or departments, counties, municipalities, or other political subdivisions. The commissioner shall not consider an application to be complete until the commissioner receives all of the required information.

When the commissioner receives an application for initial licensure that is incomplete because the applicant failed to submit required documents or that is substantially deficient because the documents submitted do not meet licensing requirements, the commissioner shall provide the applicant written notice that the application is incomplete or substantially deficient. In the written notice to the applicant the commissioner shall identify documents that are missing or deficient and give the applicant 45 days to resubmit a second application that is substantially complete. An applicant's failure to submit a substantially complete application after receiving notice from the commissioner is a basis for license denial under section 245A.05.

(b) An application for licensure must identify all controlling individuals as defined in section 245A.02, subdivision 5a, and must designate one individual to be the authorized agent. The application must be signed by the authorized agent and must include the authorized agent's first, middle, and last name; mailing address; and email address. By submitting an application for licensure, the authorized agent consents to electronic communication with the commissioner throughout the application process. The authorized agent must be authorized to accept service on behalf of all of the controlling individuals. A government entity that holds multiple licenses under this chapter may designate one authorized agent for all licenses issued under this chapter or may designate a different authorized agent for

each license. Service on the authorized agent is service on all of the controlling individuals. It is not a defense to any action arising under this chapter that service was not made on each controlling individual. The designation of a controlling individual as the authorized agent under this paragraph does not affect the legal responsibility of any other controlling individual under this chapter.

(c) An applicant or license holder must have a policy that prohibits license holders, employees, subcontractors, and volunteers, when directly responsible for persons served by the program, from abusing prescription medication or being in any manner under the influence of a chemical that impairs the individual's ability to provide services or care. The license holder must train employees, subcontractors, and volunteers about the program's drug and alcohol policy.

(d) An applicant and license holder must have a program grievance procedure that permits persons served by the program and their authorized representatives to bring a grievance to the highest level of authority in the program.

(e) The commissioner may limit communication during the application process to the authorized agent or the controlling individuals identified on the license application and for whom a background study was initiated under chapter 245C. The commissioner may require the applicant, except for child foster care, to demonstrate competence in the applicable licensing requirements by successfully completing a written examination. The commissioner may develop a prescribed written examination format.

(f) When an applicant is an individual, the applicant must provide:

(1) the applicant's taxpayer identification numbers including the Social Security number or Minnesota tax identification number, and federal employer identification number if the applicant has employees;

(2) at the request of the commissioner, a copy of the most recent filing with the secretary of state that includes the complete business name, if any;

(3) if doing business under a different name, the doing business as (DBA) name, as registered with the secretary of state;

(4) if applicable, the applicant's National Provider Identifier (NPI) number and Unique Minnesota Provider Identifier (UMPI) number; and

(5) at the request of the commissioner, the notarized signature of the applicant or authorized agent~~.~~; and

(6) except for family foster care providers, an email address that will be made public subject to the requirements under section 13.46, subdivision 4, paragraph (b), clause (1), item (i).

(g) When an applicant is an organization, the applicant must provide:

(1) the applicant's taxpayer identification numbers including the Minnesota tax identification number and federal employer identification number;

(2) at the request of the commissioner, a copy of the most recent filing with the secretary of state that includes the complete business name, and if doing business under a different name, the doing business as (DBA) name, as registered with the secretary of state;

(3) the first, middle, and last name, and address for all individuals who will be controlling individuals, including all officers, owners, and managerial officials as defined in section 245A.02, subdivision 5a, and the date that the background study was initiated by the applicant for each controlling individual;

(4) if applicable, the applicant's NPI number and UMPI number;

(5) the documents that created the organization and that determine the organization's internal governance and the relations among the persons that own the organization, have an interest in the organization, or are members of the organization, in each case as provided or authorized by the organization's governing statute, which may include a partnership agreement, bylaws, articles of organization, organizational chart, and operating agreement, or comparable documents as provided in the organization's governing statute; ~~and~~

(6) the notarized signature of the applicant or authorized agent~~.~~; and

(7) an email address that will be made public subject to the requirements under section 13.46, subdivision 4, paragraph (b), clause (1), item (i).

(h) When the applicant is a government entity, the applicant must provide:

(1) the name of the government agency, political subdivision, or other unit of government seeking the license and the name of the program or services that will be licensed;

(2) the applicant's taxpayer identification numbers including the Minnesota tax identification number and federal employer identification number;

(3) a letter signed by the manager, administrator, or other executive of the government entity authorizing the submission of the license application; and

(4) if applicable, the applicant's NPI number and UMPI number~~.~~; and

(5) an email address that will be made public subject to the requirements under section 13.46, subdivision 4, paragraph (b), clause (1), item (i).

(i) At the time of application for licensure or renewal of a license under this chapter, the applicant or license holder must acknowledge on the form provided by the commissioner if the applicant or license holder elects to receive any public funding reimbursement from the commissioner for services provided under the license that:

(1) the applicant's or license holder's compliance with the provider enrollment agreement or registration requirements for receipt of public funding may be monitored by the commissioner as part of a licensing investigation or licensing inspection; and

(2) noncompliance with the provider enrollment agreement or registration requirements for receipt of public funding that is identified through a licensing investigation or licensing inspection, or noncompliance with a licensing requirement that is a basis of enrollment for reimbursement for a service, may result in:

(i) a correction order or a conditional license under section 245A.06, or sanctions under section 245A.07;

(ii) nonpayment of claims submitted by the license holder for public program reimbursement;

(iii) recovery of payments made for the service;

(iv) disenrollment in the public payment program; or

(v) other administrative, civil, or criminal penalties as provided by law.

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

Sec. 7. Minnesota Statutes 2022, section 245A.04, subdivision 7, is amended to read:

Subd. 7. **Grant of license; license extension.** (a) If the commissioner determines that the program complies with all applicable rules and laws, the commissioner shall issue a license consistent with this section or, if applicable, a temporary change of ownership license under section 245A.043. At minimum, the license shall state:

(1) the name of the license holder;

(2) the address of the program;

(3) the effective date and expiration date of the license;

(4) the type of license;

(5) the maximum number and ages of persons that may receive services from the program; ~~and~~

(6) any special conditions of licensure~~.~~; and

(7) the public email address of the program.

(b) The commissioner may issue a license for a period not to exceed two years if:

(1) the commissioner is unable to conduct the ~~evaluation or~~ observation required by subdivision 4, paragraph (a), clause ~~(4)~~ (3), because the program is not yet operational;

(2) certain records and documents are not available because persons are not yet receiving services from the program; and

(3) the applicant complies with applicable laws and rules in all other respects.

(c) A decision by the commissioner to issue a license does not guarantee that any person or persons will be placed or cared for in the licensed program.

(d) Except as provided in paragraphs (f) and (g), the commissioner shall not issue or reissue a license if the applicant, license holder, or controlling individual has:

(1) been disqualified and the disqualification was not set aside and no variance has been granted;

(2) been denied a license under this chapter, within the past two years;

(3) had a license issued under this chapter revoked within the past five years;

(4) an outstanding debt related to a license fee, licensing fine, or settlement agreement for which payment is delinquent; or

(5) failed to submit the information required of an applicant under subdivision 1, paragraph (f) ~~or~~, (g), or (h), after being requested by the commissioner.

When a license issued under this chapter is revoked under clause (1) or (3), the license holder and controlling individual may not hold any license under chapter 245A for five years following the revocation, and other licenses held by the applicant, license holder, or controlling individual shall also be revoked.

(e) The commissioner shall not issue or reissue a license under this chapter if an individual living in the household where the services will be provided as specified under section 245C.03, subdivision 1, has been disqualified and the disqualification has not been set aside and no variance has been granted.

(f) Pursuant to section 245A.07, subdivision 1, paragraph (b), when a license issued under this chapter has been suspended or revoked and the suspension or revocation is under appeal, the program may continue to operate pending a final order from the commissioner. If the license under suspension or revocation will expire before a final order is issued, a temporary provisional license may be issued provided any applicable license fee is paid before the temporary provisional license is issued.

(g) Notwithstanding paragraph (f), when a revocation is based on the disqualification of a controlling individual or license holder, and the controlling individual or license holder is ordered under section 245C.17 to be immediately removed from direct contact with persons receiving services or is ordered to be under continuous, direct supervision when providing direct contact services, the program may continue to operate only if the program complies with the order and submits documentation demonstrating compliance with the order. If the disqualified individual fails to submit a timely request for reconsideration, or if the disqualification is not set aside and no variance is granted, the order to immediately remove the individual from direct contact or to be under continuous, direct supervision remains in effect pending the outcome of a hearing and final order from the commissioner.

(h) For purposes of reimbursement for meals only, under the Child and Adult Care Food Program, Code of Federal Regulations, title 7, subtitle B, chapter II, subchapter A, part 226, relocation within the same county by a licensed family day care provider, shall be considered an extension of the license for a period of no more than 30 calendar days or until the new license is issued, whichever occurs first, provided the county agency has determined the family day care provider meets licensure requirements at the new location.

(i) Unless otherwise specified by statute, all licenses issued under this chapter expire at 12:01 a.m. on the day after the expiration date stated on the license. A license holder must apply for and be granted a new license to operate the program or the program must not be operated after the expiration date.

(j) The commissioner shall not issue or reissue a license under this chapter if it has been determined that a tribal licensing authority has established jurisdiction to license the program or service.

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

Sec. 8. Minnesota Statutes 2022, section 245A.041, is amended by adding a subdivision to read:

Subd. 6. **First date of direct contact; documentation requirements.** Except for family child care, family foster care for children, and family adult day services that the license holder provides in the license holder's residence, license holders must document the first date that a background study subject has direct contact, as defined in section 245C.02, subdivision 11, with a person served by the license holder's program. Unless this chapter otherwise requires, if the license holder does not maintain the documentation required by this subdivision in the license holder's personnel files, the license holder must provide the documentation to the commissioner upon the commissioner's request.

EFFECTIVE DATE. This section is effective January 1, 2024.

Sec. 9. Minnesota Statutes 2022, section 245A.07, subdivision 2a, is amended to read:

Subd. 2a. **Immediate suspension expedited hearing.** (a) Within five working days of receipt of the license holder's timely appeal, the commissioner shall request assignment of an administrative law judge. The request must include a proposed date, time, and place of a hearing. A hearing must be conducted by an administrative law judge within 30 calendar days of the request for assignment, unless an extension is requested by either party and granted by the administrative law judge for good cause. The commissioner shall issue a notice of hearing by certified mail or personal service at least ten working days before the hearing. The scope of the hearing shall be limited solely to the issue of whether the temporary immediate suspension should remain in effect pending the commissioner's final order under section 245A.08, regarding a licensing sanction issued under subdivision 3 following the immediate suspension. For suspensions under subdivision 2, paragraph (a), clause (1), the burden of proof in expedited hearings under this subdivision shall be limited to the commissioner's demonstration that reasonable cause exists to believe that the license holder's actions or failure to comply with applicable law or rule poses, or the actions of other individuals or conditions in the program poses an imminent risk of harm to the health, safety, or rights of persons served by the program. "Reasonable cause" means there exist specific articulable facts or circumstances which provide the commissioner with a reasonable suspicion that there is an imminent risk of harm to the health, safety, or rights of persons served by the program. When the commissioner has determined there is reasonable cause to order the temporary immediate suspension of a license based on a violation of safe sleep requirements, as defined in section 245A.1435, the commissioner is not required to demonstrate that an infant died or was injured as a result of the safe sleep violations. For

suspensions under subdivision 2, paragraph (a), clause (2), the burden of proof in expedited hearings under this subdivision shall be limited to the commissioner's demonstration by a preponderance of the evidence that, since the license was revoked, the license holder committed additional violations of law or rule which may adversely affect the health or safety of persons served by the program.

(b) The administrative law judge shall issue findings of fact, conclusions, and a recommendation within ten working days from the date of hearing. The parties shall have ten calendar days to submit exceptions to the administrative law judge's report. The record shall close at the end of the ten-day period for submission of exceptions. The commissioner's final order shall be issued within ten working days from the close of the record. When an appeal of a temporary immediate suspension is withdrawn or dismissed, the commissioner shall issue a final order affirming the temporary immediate suspension within ten calendar days of the commissioner's receipt of the withdrawal or dismissal. Within 90 calendar days after an immediate suspension has been issued and the license holder has not submitted a timely appeal under subdivision 2, paragraph (b), or within 90 calendar days after a final order affirming an immediate suspension, the commissioner shall ~~make a determination regarding~~ determine:

(1) whether a final licensing sanction shall be issued under subdivision 3, paragraph (a), clauses (1) to (5). The license holder shall continue to be prohibited from operation of the program during this 90-day period~~.~~; or

(2) whether the outcome of related, ongoing investigations or judicial proceedings are necessary to determine if a final licensing sanction under subdivision 3, paragraph (a), clauses (1) to (5), will be issued, and persons served by the program remain at an imminent risk of harm during the investigation period or proceedings. If so, the commissioner shall issue a suspension order under subdivision 3, paragraph (a), clause (6).

(c) When the final order under paragraph (b) affirms an immediate suspension or the license holder does not submit a timely appeal of the immediate suspension, and a final licensing sanction is issued under subdivision 3 and the license holder appeals that sanction, the license holder continues to be prohibited from operation of the program pending a final commissioner's order under section 245A.08, subdivision 5, regarding the final licensing sanction.

(d) The license holder shall continue to be prohibited from operation of the program while a suspension order issued under paragraph (b), clause (2), remains in effect.

~~(d)~~ (e) For suspensions under subdivision 2, paragraph (a), clause (3), the burden of proof in expedited hearings under this subdivision shall be limited to the commissioner's demonstration by a preponderance of the evidence that a criminal complaint and warrant or summons was issued for the license holder that was not dismissed, and that the criminal charge is an offense that involves fraud or theft against a program administered by the commissioner.

Sec. 10. Minnesota Statutes 2022, section 245A.07, subdivision 3, is amended to read:

Subd. 3. **License suspension, revocation, or fine.** (a) The commissioner may suspend or revoke a license, or impose a fine if:

(1) a license holder fails to comply fully with applicable laws or rules including but not limited to the requirements of this chapter and chapter 245C;

(2) a license holder, a controlling individual, or an individual living in the household where the licensed services are provided or is otherwise subject to a background study has been disqualified and the disqualification was not set aside and no variance has been granted;

(3) a license holder knowingly withholds relevant information from or gives false or misleading information to the commissioner in connection with an application for a license, in connection with the background study status of an individual, during an investigation, or regarding compliance with applicable laws or rules;

(4) a license holder is excluded from any program administered by the commissioner under section 245.095; ~~or~~

(5) revocation is required under section 245A.04, subdivision 7, paragraph (d)~~.~~; or

(6) suspension is necessary under subdivision 2a, paragraph (b), clause (2).

A license holder who has had a license issued under this chapter suspended, revoked, or has been ordered to pay a fine must be given notice of the action by certified mail or personal service. If mailed, the notice must be mailed to the address shown on the application or the last known address of the license holder. The notice must state in plain language the reasons the license was suspended or revoked, or a fine was ordered.

(b) If the license was suspended or revoked, the notice must inform the license holder of the right to a contested case hearing under chapter 14 and Minnesota Rules, parts 1400.8505 to 1400.8612. The license holder may appeal an order suspending or revoking a license. The appeal of an order suspending or revoking a license must be made in writing by certified mail or personal service. If mailed, the appeal must be postmarked and sent to

the commissioner within ten calendar days after the license holder receives notice that the license has been suspended or revoked. If a request is made by personal service, it must be received by the commissioner within ten calendar days after the license holder received the order. Except as provided in subdivision 2a, paragraph (c), if a license holder submits a timely appeal of an order suspending or revoking a license, the license holder may continue to operate the program as provided in section 245A.04, subdivision 7, paragraphs (f) and (g), until the commissioner issues a final order on the suspension or revocation.

(c)(1) If the license holder was ordered to pay a fine, the notice must inform the license holder of the responsibility for payment of fines and the right to a contested case hearing under chapter 14 and Minnesota Rules, parts 1400.8505 to 1400.8612. The appeal of an order to pay a fine must be made in writing by certified mail or personal service. If mailed, the appeal must be postmarked and sent to the commissioner within ten calendar days after the license holder receives notice that the fine has been ordered. If a request is made by personal service, it must be received by the commissioner within ten calendar days after the license holder received the order.

(2) The license holder shall pay the fines assessed on or before the payment date specified. If the license holder fails to fully comply with the order, the commissioner may issue a second fine or suspend the license until the license holder complies. If the license holder receives state funds, the state, county, or municipal agencies or departments responsible for administering the funds shall withhold payments and recover any payments made while the license is suspended for failure to pay a fine. A timely appeal shall stay payment of the fine until the commissioner issues a final order.

(3) A license holder shall promptly notify the commissioner of human services, in writing, when a violation specified in the order to forfeit a fine is corrected. If upon reinspection the commissioner determines that a violation has not been corrected as indicated by the order to forfeit a fine, the commissioner may issue a second fine. The commissioner shall notify the license holder by certified mail or personal service that a second fine has been assessed. The license holder may appeal the second fine as provided under this subdivision.

(4) Fines shall be assessed as follows:

(i) the license holder shall forfeit $1,000 for each determination of maltreatment of a child under chapter 260E or the maltreatment of a vulnerable adult under section 626.557 for which the license holder is determined responsible for the maltreatment under section 260E.30, subdivision 4, paragraphs (a) and (b), or 626.557, subdivision 9c, paragraph (c);

(ii) if the commissioner determines that a determination of maltreatment for which the license holder is responsible is the result of maltreatment that meets the definition of serious maltreatment as defined in section 245C.02, subdivision 18, the license holder shall forfeit $5,000;

(iii) for a program that operates out of the license holder's home and a program licensed under Minnesota Rules, parts 9502.0300 to 9502.0445, the fine assessed against the license holder shall not exceed $1,000 for each determination of maltreatment;

(iv) the license holder shall forfeit $200 for each occurrence of a violation of law or rule governing matters of health, safety, or supervision, including but not limited to the provision of adequate staff-to-child or adult ratios, and failure to comply with background study requirements under chapter 245C; and

(v) the license holder shall forfeit $100 for each occurrence of a violation of law or rule other than those subject to a $5,000, $1,000, or $200 fine in items (i) to (iv).

For purposes of this section, "occurrence" means each violation identified in the commissioner's fine order. Fines assessed against a license holder that holds a license to provide home and community-based services, as identified in section 245D.03, subdivision 1, and a community residential setting or day services facility license under chapter 245D where the services are provided, may be assessed against both licenses for the same occurrence, but the combined amount of the fines shall not exceed the amount specified in this clause for that occurrence.

(5) When a fine has been assessed, the license holder may not avoid payment by closing, selling, or otherwise transferring the licensed program to a third party. In such an event, the license holder will be personally liable for payment. In the case of a corporation, each controlling individual is personally and jointly liable for payment.

(d) Except for background study violations involving the failure to comply with an order to immediately remove an individual or an order to provide continuous, direct supervision, the commissioner shall not issue a fine under paragraph (c) relating to a background study violation to a license holder who self-corrects a background study violation before the commissioner discovers the violation. A license holder who has previously exercised the provisions of this paragraph to avoid a fine for a background study violation may not avoid a fine for a subsequent background study violation unless at least 365 days have passed since the license holder self-corrected the earlier background study violation.

Sec. 11. Minnesota Statutes 2022, section 245A.10, subdivision 3, is amended to read:

Subd. 3. **Application fee for initial license or certification.** (a) For fees required under subdivision 1, an applicant for an initial license or certification issued by the commissioner shall submit a $500 application fee with each new application required under this subdivision. An applicant for an initial day services facility license under chapter 245D shall submit a $250 application fee with each new application. The application fee shall not be prorated, is nonrefundable, and is in lieu of the annual license or certification fee that expires on December 31. The commissioner shall not process an application until the application fee is paid.

(b) Except as provided in clauses (1) ~~to (3)~~ and (2), an applicant shall apply for a license to provide services at a specific location.

(1) For a license to provide home and community-based services to persons with disabilities or age 65 and older under chapter 245D, an applicant shall submit an application to provide services statewide. Notwithstanding paragraph (a), applications received by the commissioner between July 1, 2013, and December 31, 2013, for licensure of services provided under chapter 245D must include an application fee that is equal to the annual license renewal fee under subdivision 4, paragraph (b), or $500, whichever is less. Applications received by the commissioner after January 1, 2014, must include the application fee required under paragraph (a). Applicants who meet the modified application criteria identified in section 245A.042, subdivision 2, are exempt from paying an application fee.

~~(2) For a license to provide independent living assistance for youth under section 245A.22, an applicant shall submit a single application to provide services statewide.~~

~~(3)~~ (2) For a license for a private agency to provide foster care or adoption services under Minnesota Rules, parts 9545.0755 to 9545.0845, an applicant shall submit a single application to provide services statewide.

(c) The initial application fee charged under this subdivision does not include the temporary license surcharge under section 16E.22.

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

Sec. 12. Minnesota Statutes 2022, section 245A.10, subdivision 4, is amended to read:

Subd. 4. **License or certification fee for certain programs.** (a) Child care centers shall pay an annual nonrefundable license fee based on the following schedule:

Licensed Capacity	Child Care Center License Fee
1 to 24 persons	$200
25 to 49 persons	$300
50 to 74 persons	$400
75 to 99 persons	$500
100 to 124 persons	$600
125 to 149 persons	$700
150 to 174 persons	$800
175 to 199 persons	$900
200 to 224 persons	$1,000
225 or more persons	$1,100

(b)(1) A program licensed to provide one or more of the home and community-based services and supports identified under chapter 245D to persons with disabilities or age 65 and older, shall pay an annual nonrefundable license fee based on revenues derived from the provision of services that would require licensure under chapter 245D during the calendar year immediately preceding the year in which the license fee is paid, according to the following schedule:

License Holder Annual Revenue	License Fee
less than or equal to $10,000	$200
greater than $10,000 but less than or equal to $25,000	$300
greater than $25,000 but less than or equal to $50,000	$400
greater than $50,000 but less than or equal to $100,000	$500
greater than $100,000 but less than or equal to $150,000	$600
greater than $150,000 but less than or equal to $200,000	$800
greater than $200,000 but less than or equal to $250,000	$1,000
greater than $250,000 but less than or equal to $300,000	$1,200
greater than $300,000 but less than or equal to $350,000	$1,400
greater than $350,000 but less than or equal to $400,000	$1,600
greater than $400,000 but less than or equal to $450,000	$1,800

greater than $450,000 but less than or equal to $500,000	$2,000
greater than $500,000 but less than or equal to $600,000	$2,250
greater than $600,000 but less than or equal to $700,000	$2,500
greater than $700,000 but less than or equal to $800,000	$2,750
greater than $800,000 but less than or equal to $900,000	$3,000
greater than $900,000 but less than or equal to $1,000,000	$3,250
greater than $1,000,000 but less than or equal to $1,250,000	$3,500
greater than $1,250,000 but less than or equal to $1,500,000	$3,750
greater than $1,500,000 but less than or equal to $1,750,000	$4,000
greater than $1,750,000 but less than or equal to $2,000,000	$4,250
greater than $2,000,000 but less than or equal to $2,500,000	$4,500
greater than $2,500,000 but less than or equal to $3,000,000	$4,750
greater than $3,000,000 but less than or equal to $3,500,000	$5,000
greater than $3,500,000 but less than or equal to $4,000,000	$5,500
greater than $4,000,000 but less than or equal to $4,500,000	$6,000
greater than $4,500,000 but less than or equal to $5,000,000	$6,500
greater than $5,000,000 but less than or equal to $7,500,000	$7,000
greater than $7,500,000 but less than or equal to $10,000,000	$8,500
greater than $10,000,000 but less than or equal to $12,500,000	$10,000
greater than $12,500,000 but less than or equal to $15,000,000	$14,000
greater than $15,000,000	$18,000

(2) If requested, the license holder shall provide the commissioner information to verify the license holder's annual revenues or other information as needed, including copies of documents submitted to the Department of Revenue.

(3) At each annual renewal, a license holder may elect to pay the highest renewal fee, and not provide annual revenue information to the commissioner.

(4) A license holder that knowingly provides the commissioner incorrect revenue amounts for the purpose of paying a lower license fee shall be subject to a civil penalty in the amount of double the fee the provider should have paid.

(5) Notwithstanding clause (1), a license holder providing services under one or more licenses under chapter 245B that are in effect on May 15, 2013, shall pay an annual license fee for calendar years 2014, 2015, and 2016, equal to the total license fees paid by the license holder for all licenses held under chapter 245B for calendar year 2013. For calendar year 2017 and thereafter, the license holder shall pay an annual license fee according to clause (1).

(c) A substance use disorder treatment program licensed under chapter 245G, to provide substance use disorder treatment shall pay an annual nonrefundable license fee based on the following schedule:

Licensed Capacity	License Fee
1 to 24 persons	$600
25 to 49 persons	$800
50 to 74 persons	$1,000
75 to 99 persons	$1,200
100 or more persons	$1,400

(d) A detoxification program licensed under Minnesota Rules, parts 9530.6510 to 9530.6590, or a withdrawal management program licensed under chapter 245F shall pay an annual nonrefundable license fee based on the following schedule:

Licensed Capacity	License Fee
1 to 24 persons	$760
25 to 49 persons	$960
50 or more persons	$1,160

A detoxification program that also operates a withdrawal management program at the same location shall only pay one fee based upon the licensed capacity of the program with the higher overall capacity.

(e) Except for child foster care, a residential facility licensed under Minnesota Rules, chapter 2960, to serve children shall pay an annual nonrefundable license fee based on the following schedule:

Licensed Capacity	License Fee
1 to 24 persons	$1,000
25 to 49 persons	$1,100
50 to 74 persons	$1,200
75 to 99 persons	$1,300
100 or more persons	$1,400

(f) A residential facility licensed under section 245I.23 or Minnesota Rules, parts 9520.0500 to 9520.0670, to serve persons with mental illness shall pay an annual nonrefundable license fee based on the following schedule:

Licensed Capacity	License Fee
1 to 24 persons	$2,525
25 or more persons	$2,725

(g) A residential facility licensed under Minnesota Rules, parts 9570.2000 to 9570.3400, to serve persons with physical disabilities shall pay an annual nonrefundable license fee based on the following schedule:

Licensed Capacity	License Fee
1 to 24 persons	$450
25 to 49 persons	$650
50 to 74 persons	$850
75 to 99 persons	$1,050
100 or more persons	$1,250

~~(h) A program licensed to provide independent living assistance for youth under section 245A.22 shall pay an annual nonrefundable license fee of $1,500.~~

~~(i)~~ (h) A private agency licensed to provide foster care and adoption services under Minnesota Rules, parts 9545.0755 to 9545.0845, shall pay an annual nonrefundable license fee of $875.

~~(j)~~ (i) A program licensed as an adult day care center licensed under Minnesota Rules, parts 9555.9600 to 9555.9730, shall pay an annual nonrefundable license fee based on the following schedule:

Licensed Capacity	License Fee
1 to 24 persons	$500
25 to 49 persons	$700
50 to 74 persons	$900

75 to 99 persons	$1,100
100 or more persons	$1,300

~~(k)~~ (j) A program licensed to provide treatment services to persons with sexual psychopathic personalities or sexually dangerous persons under Minnesota Rules, parts 9515.3000 to 9515.3110, shall pay an annual nonrefundable license fee of $20,000.

~~(l)~~ (k) A mental health clinic certified under section 245I.20 shall pay an annual nonrefundable certification fee of $1,550. If the mental health clinic provides services at a primary location with satellite facilities, the satellite facilities shall be certified with the primary location without an additional charge.

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

Sec. 13. Minnesota Statutes 2022, section 245A.16, subdivision 1, is amended to read:

Subdivision 1. **Delegation of authority to agencies.** (a) County agencies and private agencies that have been designated or licensed by the commissioner to perform licensing functions and activities under section 245A.04 ~~and background studies for family child care under chapter 245C~~; to recommend denial of applicants under section 245A.05; to issue correction orders, to issue variances, and recommend a conditional license under section 245A.06; or to recommend suspending or revoking a license or issuing a fine under section 245A.07, shall comply with rules and directives of the commissioner governing those functions and with this section. The following variances are excluded from the delegation of variance authority and may be issued only by the commissioner:

(1) dual licensure of family child care and child foster care, dual licensure of child and adult foster care, and adult foster care and family child care;

(2) adult foster care maximum capacity;

(3) adult foster care minimum age requirement;

(4) child foster care maximum age requirement;

(5) variances regarding disqualified individuals ~~except that, before the implementation of NETStudy 2.0, county agencies may issue variances under section 245C.30 regarding disqualified individuals when the county is responsible for conducting a consolidated reconsideration according to sections 245C.25 and 245C.27, subdivision 2, clauses (a) and (b), of a county maltreatment determination and a disqualification based on serious or recurring maltreatment~~;

(6) the required presence of a caregiver in the adult foster care residence during normal sleeping hours;

(7) variances to requirements relating to chemical use problems of a license holder or a household member of a license holder; and

(8) variances to section 245A.53 for a time-limited period. If the commissioner grants a variance under this clause, the license holder must provide notice of the variance to all parents and guardians of the children in care.

Except as provided in section 245A.14, subdivision 4, paragraph (e), a county agency must not grant a license holder a variance to exceed the maximum allowable family child care license capacity of 14 children.

(b) A county agency that has been designated by the commissioner to issue family child care variances must:

(1) publish the county agency's policies and criteria for issuing variances on the county's public website and update the policies as necessary; and

(2) annually distribute the county agency's policies and criteria for issuing variances to all family child care license holders in the county.

~~(c) Before the implementation of NETStudy 2.0, county agencies must report information about disqualification reconsiderations under sections 245C.25 and 245C.27, subdivision 2, paragraphs (a) and (b), and variances granted under paragraph (a), clause (5), to the commissioner at least monthly in a format prescribed by the commissioner.~~

~~(d)~~ (c) For family child care programs, the commissioner shall require a county agency to conduct one unannounced licensing review at least annually.

~~(e)~~ (d) For family adult day services programs, the commissioner may authorize licensing reviews every two years after a licensee has had at least one annual review.

~~(f)~~ (e) A license issued under this section may be issued for up to two years.

~~(g)~~ (f) During implementation of chapter 245D, the commissioner shall consider:

(1) the role of counties in quality assurance;

(2) the duties of county licensing staff; and

(3) the possible use of joint powers agreements, according to section 471.59, with counties through which some licensing duties under chapter 245D may be delegated by the commissioner to the counties.

Any consideration related to this paragraph must meet all of the requirements of the corrective action plan ordered by the federal Centers for Medicare and Medicaid Services.

~~(h)~~ (g) Licensing authority specific to section 245D.06, subdivisions 5, 6, 7, and 8, or successor provisions; and section 245D.061 or successor provisions, for family child foster care programs providing out-of-home respite, as identified in section 245D.03, subdivision 1, paragraph (b), clause (1), is excluded from the delegation of authority to county and private agencies.

~~(i)~~ (h) A county agency shall report to the commissioner, in a manner prescribed by the commissioner, the following information for a licensed family child care program:

(1) the results of each licensing review completed, including the date of the review, and any licensing correction order issued;

(2) any death, serious injury, or determination of substantiated maltreatment; and

(3) any fires that require the service of a fire department within 48 hours of the fire. The information under this clause must also be reported to the state fire marshal within two business days of receiving notice from a licensed family child care provider.

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

Sec. 14. **[245A.211] PRONE RESTRAINT PROHIBITION.**

Subdivision 1. **Applicability.** This section applies to all programs licensed or certified under this chapter, chapters 245D, 245F, 245G, 245H, and sections 245I.20 and 245I.23. The requirements in this section are in addition to any applicable requirements for the use of holds or restraints for each license or certification type.

Subd. 2. **Definitions.** (a) "Mechanical restraint" means a restraint device that limits the voluntary movement of a person or the person's limbs.

(b) "Prone restraint" means a restraint that places a person in a face-down position with the person's chest in contact with the floor or other surface.

(c) "Restraint" means a physical hold, physical restraint, manual restraint, restraint equipment, or mechanical restraint that holds a person immobile or limits the voluntary movement of a person or the person's limbs.

Subd. 3. **Prone restraint prohibition.** (a) A license or certification holder must not use a prone restraint on any person receiving services in a program, except in the instances allowed by paragraphs (b) to (d).

(b) If a person rolls into a prone position during the use of a restraint, the person must be restored to a nonprone position as quickly as possible.

(c) If the applicable licensing requirements allow a program to use mechanical restraints, a person may be briefly held in a prone restraint for the purpose of applying mechanical restraints if the person is restored to a nonprone position as quickly as possible.

(d) If the applicable licensing requirements allow a program to use seclusion, a person may be briefly held in a prone restraint to allow staff to safely exit a seclusion room.

Subd. 4. **Contraindicated physical restraints.** A license or certification holder must not implement a restraint on a person receiving services in a program in a way that is contraindicated for any of the person's known medical or psychological conditions. Prior to using restraints on a person, the license or certification holder must assess and document a determination of any medical or psychological conditions that restraints are contraindicated for and the type of restraints that will not be used on the person based on this determination.

Sec. 15. Minnesota Statutes 2022, section 245C.02, subdivision 6a, is amended to read:

Subd. 6a. **Child care background study subject.** (a) "Child care background study subject" means an individual who is affiliated with a licensed child care center, certified license-exempt child care center, licensed family child care program, or legal nonlicensed child care provider authorized under chapter 119B, and who is:

(1) employed by a child care provider for compensation;

(2) assisting in the care of a child for a child care provider;

(3) a person applying for licensure, certification, or enrollment;

(4) a controlling individual as defined in section 245A.02, subdivision 5a;

(5) an individual 13 years of age or older who lives in the household where the licensed program will be provided and who is not receiving licensed services from the program;

(6) an individual ten to 12 years of age who lives in the household where the licensed services will be provided when the commissioner has reasonable cause as defined in section 245C.02, subdivision 15;

(7) an individual who, without providing direct contact services at a licensed program, certified program, or program authorized under chapter 119B, may have unsupervised access to a child receiving services from a program when the commissioner has reasonable cause as defined in section 245C.02, subdivision 15; or

(8) a volunteer, contractor providing services for hire in the program, prospective employee, or other individual who has unsupervised physical access to a child served by a program and who is not under supervision by an individual listed in clause (1) or (5), regardless of whether the individual provides program services.

(b) Notwithstanding paragraph (a), an individual who is providing services that are not part of the child care program is not required to have a background study if:

(1) the child receiving services is signed out of the child care program for the duration that the services are provided;

(2) the licensed child care center, certified license-exempt child care center, licensed family child care program, or legal nonlicensed child care provider authorized under chapter 119B has obtained advanced written permission from the parent authorizing the child to receive the services, which is maintained in the child's record;

(3) the licensed child care center, certified license-exempt child care center, licensed family child care program, or legal nonlicensed child care provider authorized under chapter 119B maintains documentation on site that identifies the individual service provider and the services being provided; and

(4) the licensed child care center, certified license-exempt child care center, licensed family child care program, or legal nonlicensed child care provider authorized under chapter 119B ensures that the service provider does not have unsupervised access to a child not receiving the provider's services.

Sec. 16. Minnesota Statutes 2022, section 245C.02, subdivision 11c, is amended to read:

Subd. 11c. **Entity.** "Entity" means any program, organization, license holder, government agency, or agency ~~initiating~~ required to initiate a background study.

Sec. 17. Minnesota Statutes 2022, section 245C.02, is amended by adding a subdivision to read:

Subd. 11f. **Employee.** "Employee" means an individual who provides services or seeks to provide services for the entity with which they are required to be affiliated in NETStudy 2.0 and who is subject to oversight by the entity, which includes but is not limited to continuous, direct supervision by the entity and being subject to immediate removal from providing direct care services by the entity when required.

Sec. 18. Minnesota Statutes 2022, section 245C.02, is amended by adding a subdivision to read:

Subd. 22. **Volunteer.** "Volunteer" means an individual who provides or seeks to provide services for an entity without direct compensation for services provided, is required to be affiliated in NETStudy 2.0 and is subject to oversight by the entity, including but not limited to continuous, direct supervision and immediate removal from providing direct care services when required.

Sec. 19. Minnesota Statutes 2022, section 245C.03, subdivision 1, is amended to read:

Subdivision 1. **Licensed programs.** (a) The commissioner shall conduct a background study on:

(1) the person or persons applying for a license;

(2) an individual age 13 and over living in the household where the licensed program will be provided who is not receiving licensed services from the program;

(3) current or prospective employees ~~or contractors~~ of the applicant who will have direct contact with persons served by the facility, agency, or program;

(4) volunteers or student volunteers who will have direct contact with persons served by the program to provide program services if the contact is not under the continuous, direct supervision by an individual listed in clause (1) or (3);

(5) an individual age ten to 12 living in the household where the licensed services will be provided when the commissioner has reasonable cause as defined in section 245C.02, subdivision 15;

(6) an individual who, without providing direct contact services at a licensed program, may have unsupervised access to children or vulnerable adults receiving services from a program, when the commissioner has reasonable cause as defined in section 245C.02, subdivision 15;

(7) all controlling individuals as defined in section 245A.02, subdivision 5a;

(8) notwithstanding the other requirements in this subdivision, child care background study subjects as defined in section 245C.02, subdivision 6a; and

(9) notwithstanding clause (3), for children's residential facilities and foster residence settings, any adult working in the facility, whether or not the individual will have direct contact with persons served by the facility.

(b) For child foster care when the license holder resides in the home where foster care services are provided, a short-term substitute caregiver providing direct contact services for a child for less than 72 hours of continuous care is not required to receive a background study under this chapter.

(c) This subdivision applies to the following programs that must be licensed under chapter 245A:

(1) adult foster care;

(2) child foster care;

(3) children's residential facilities;

(4) family child care;

(5) licensed child care centers;

(6) licensed home and community-based services under chapter 245D;

(7) residential mental health programs for adults;

(8) substance use disorder treatment programs under chapter 245G;

(9) withdrawal management programs under chapter 245F;

(10) adult day care centers;

(11) family adult day services;

~~(12) independent living assistance for youth;~~

~~(13)~~ (12) detoxification programs;

~~(14)~~ (13) community residential settings; and

~~(15)~~ (14) intensive residential treatment services and residential crisis stabilization under chapter 245I.

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

Sec. 20. Minnesota Statutes 2022, section 245C.03, subdivision 1a, is amended to read:

Subd. 1a. **Procedure.** (a) Individuals and organizations that are required under this section to have or initiate background studies shall comply with the requirements of this chapter.

(b) All studies conducted under this section shall be conducted according to sections 299C.60 to 299C.64, including the consent and self-disclosure required in section 299C.62,

subdivision 2. This requirement does not apply to subdivisions 1, paragraph (c), clauses (2) to (5), and 6a.

Sec. 21. Minnesota Statutes 2022, section 245C.03, subdivision 4, is amended to read:

Subd. 4. **Personnel pool agencies; temporary personnel agencies; educational programs; professional services agencies.** (a) The commissioner also may conduct studies on individuals specified in subdivision 1, paragraph (a), clauses (3) and (4), when the studies are initiated by:

(1) personnel pool agencies;

(2) temporary personnel agencies;

(3) educational programs that train individuals by providing direct contact services in licensed programs; and

(4) professional services agencies that are not licensed and ~~which contract~~ that work with licensed programs to provide direct contact services or individuals who provide direct contact services.

(b) Personnel pool agencies, temporary personnel agencies, and professional services agencies must employ the individuals providing direct care services for children, people with disabilities, or the elderly. Individuals must be affiliated in NETStudy 2.0 and subject to oversight by the entity, which includes but is not limited to continuous, direct supervision by the entity and being subject to immediate removal from providing direct care services by the entity when required.

Sec. 22. Minnesota Statutes 2022, section 245C.03, subdivision 5, is amended to read:

Subd. 5. **Other state agencies.** The commissioner shall conduct background studies on applicants and license holders under the jurisdiction of other state agencies who are required in other statutory sections to initiate background studies under this chapter, including the applicant's or license holder's employees~~, contractors,~~ and volunteers when required under other statutory sections.

Sec. 23. Minnesota Statutes 2022, section 245C.03, subdivision 5a, is amended to read:

Subd. 5a. **Facilities serving children or adults licensed or regulated by the Department of Health.** (a) Except as specified in paragraph (b), the commissioner shall conduct background studies of:

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

(2) individuals specified in subdivision 2 who provide direct contact services in a nursing home or a home care agency licensed under chapter 144A; an assisted living facility or assisted living facility with dementia care licensed under chapter 144G; or a boarding care home licensed under sections 144.50 to 144.58. If the individual undergoing a study resides outside of Minnesota, the study must include a check for substantiated findings of maltreatment of adults and children in the individual's state of residence when the state makes the information available;

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

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

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

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

(b) ~~The commissioner of human services shall not conduct~~ An entity shall not initiate a background study on any individual identified in paragraph (a), clauses (1) to (5), if the individual has a valid license issued by a health-related licensing board as defined in section 214.01, subdivision 2, and has completed the criminal background check as required in

section 214.075. An entity that is affiliated with individuals who meet the requirements of this paragraph must separate those individuals from the entity's roster for NETStudy 2.0. The Department of Human Services is not liable for conducting background studies that have been submitted or not removed from the roster in violation of this provision.

(c) If a facility or program is licensed by the Department of Human Services and the Department of Health and is subject to the background study provisions of this chapter, the Department of Human Services is solely responsible for the background studies of individuals in the jointly licensed program.

(d) The commissioner of health shall review and make decisions regarding reconsideration requests, including whether to grant variances, according to the procedures and criteria in this chapter. The commissioner of health shall inform the requesting individual and the Department of Human Services of the commissioner of health's decision regarding the reconsideration. The commissioner of health's decision to grant or deny a reconsideration of a disqualification is a final administrative agency action.

Sec. 24. Minnesota Statutes 2022, section 245C.031, subdivision 1, is amended to read:

Subdivision 1. **Alternative background studies.** (a) The commissioner shall conduct an alternative background study of individuals listed in this section.

(b) Notwithstanding other sections of this chapter, all alternative background studies except subdivision 12 shall be conducted according to this section and with sections 299C.60 to 299C.64, including the consent and self-disclosure required in section 299C.62, subdivision 2.

(c) All terms in this section shall have the definitions provided in section 245C.02.

(d) The entity that submits an alternative background study request under this section shall submit the request to the commissioner according to section 245C.05.

(e) The commissioner shall comply with the destruction requirements in section 245C.051.

(f) Background studies conducted under this section are subject to the provisions of section 245C.32.

(g) The commissioner shall forward all information that the commissioner receives under section 245C.08 to the entity that submitted the alternative background study request under subdivision 2. The commissioner shall not make any eligibility determinations regarding background studies conducted under this section.

Sec. 25. Minnesota Statutes 2022, section 245C.031, subdivision 4, is amended to read:

Subd. 4. **Applicants, licensees, and other occupations regulated by the commissioner of health.** The commissioner shall conduct an alternative background study, including a check of state data, and a national criminal history records check of the following individuals. For studies under this section, the following persons shall complete a consent form and criminal history disclosure form:

(1) An applicant for initial licensure, temporary licensure, or relicensure after a lapse in licensure as an audiologist or speech-language pathologist or an applicant for initial certification as a hearing instrument dispenser who must submit to a background study under section 144.0572.

(2) An applicant for a renewal license or certificate as an audiologist, speech-language pathologist, or hearing instrument dispenser who was licensed or obtained a certificate before January 1, 2018.

Sec. 26. Minnesota Statutes 2022, section 245C.05, subdivision 1, is amended to read:

Subdivision 1. **Individual studied.** (a) The individual who is the subject of the background study must provide the applicant, license holder, or other entity under section 245C.04 with sufficient information to ensure an accurate study, including:

(1) the individual's first, middle, and last name and all other names by which the individual has been known;

(2) current home address, city, and state of residence;

(3) current zip code;

(4) sex;

(5) date of birth;

(6) driver's license number or state identification number or, for those without a driver's license or state identification card, an acceptable form of identification as determined by the commissioner; and

(7) upon implementation of NETStudy 2.0, the home address, city, county, and state of residence for the past five years.

(b) Every subject of a background study conducted or initiated by counties or private agencies under this chapter must also provide the home address, city, county, and state of residence for the past five years.

(c) Every subject of a background study related to private agency adoptions or related to child foster care licensed through a private agency, who is 18 years of age or older, shall also provide the commissioner a signed consent for the release of any information received from national crime information databases to the private agency that initiated the background study.

(d) The subject of a background study who is 18 years of age or older shall provide fingerprints and a photograph as required in subdivision 5. The subject of a background study who is 17 years of age or younger shall provide fingerprints and a photograph only as required in subdivision 5a.

(e) The subject of a background study shall submit a completed criminal and maltreatment history records check consent form and criminal history disclosure form for applicable national and state level record checks.

Sec. 27. Minnesota Statutes 2022, section 245C.05, subdivision 5a, is amended to read:

Subd. 5a. **Background study requirements for minors.** (a) A background study completed under this chapter on a subject who is required to be studied under section 245C.03, subdivision 1, and is 17 years of age or younger shall be completed by the commissioner for:

(1) a legal nonlicensed child care provider authorized under chapter 119B;

(2) a licensed family child care program; or

(3) a licensed foster care home.

(b) The subject shall submit to the commissioner only the information under subdivision 1, paragraph (a).

(c) Notwithstanding paragraph (b), a subject who is 17 years of age or younger ~~is required to submit fingerprints and a photograph, and the commissioner shall conduct a national criminal history record check~~ must provide the commissioner with a set of the background study subject's classifiable fingerprints and photograph, if:

(1) the commissioner has reasonable cause to require a national criminal history record check defined in section 245C.02, subdivision 15a; or

(2) under paragraph (a), clauses (1) and (2), the subject is employed by the provider or supervises children served by the program.

~~(d) A subject who is 17 years of age or younger is required to submit non-fingerprint-based data according to section 245C.08, subdivision 1, paragraph (a), clause (6), item (iii), and the commissioner shall conduct the check if:~~

~~(1) the commissioner has reasonable cause to require a national criminal history record check defined in section 245C.02, subdivision 15a; or~~

~~(2) the subject is employed by the provider or supervises children served by the program under paragraph (a), clauses (1) and (2).~~

Sec. 28. Minnesota Statutes 2022, section 245C.05, is amended by adding a subdivision to read:

Subd. 8. **Study submitted.** The entity with which the background study subject is seeking affiliation shall initiate the background study in the NETStudy 2.0 system.

Sec. 29. Minnesota Statutes 2022, section 245C.07, is amended to read:

245C.07 STUDY SUBJECT AFFILIATED WITH MULTIPLE FACILITIES.

(a) Subject to the conditions in paragraph (d), when a license holder, applicant, or other entity owns multiple programs or services that are licensed by the Department of Human Services, Department of Health, or Department of Corrections, only one background study is required for an individual who provides direct contact services in one or more of the licensed programs or services if:

(1) the license holder designates one individual with one address and telephone number as the person to receive sensitive background study information for the multiple licensed programs or services that depend on the same background study; and

(2) the individual designated to receive the sensitive background study information is capable of determining, upon request of the department, whether a background study subject is providing direct contact services in one or more of the license holder's programs or services and, if so, at which location or locations.

(b) When a license holder maintains background study compliance for multiple licensed programs according to paragraph (a), and one or more of the licensed programs closes, the license holder shall immediately notify the commissioner which staff must be transferred to an active license so that the background studies can be electronically paired with the license holder's active program.

(c) When a background study is being initiated by a licensed program or service or a foster care provider that is also licensed under chapter 144G, a study subject affiliated with multiple licensed programs or services may attach to the background study form a cover letter indicating the additional names of the programs or services, addresses, and background study identification numbers.

When the commissioner receives a notice, the commissioner shall notify each program or service identified by the background study subject of the study results.

The background study notice the commissioner sends to the subsequent agencies shall satisfy those programs' or services' responsibilities for initiating a background study on that individual.

(d) If a background study was conducted on an individual related to child foster care and the requirements under paragraph (a) are met, the background study is transferable across all licensed programs. If a background study was conducted on an individual under a license other than child foster care and the requirements under paragraph (a) are met, the background study is transferable to all licensed programs except child foster care.

(e) The provisions of this section that allow a single background study in one or more licensed programs or services do not apply to background studies submitted by adoption agencies, supplemental nursing services agencies, personnel pool agencies, educational programs, professional services agencies, temporary personnel agencies, and unlicensed personal care provider organizations.

(f) For an entity operating under NETStudy 2.0, the entity's active roster must be the system used to document when a background study subject is affiliated with multiple entities. For a background study to be transferable:

(1) the background study subject must be on and moving to a roster for which the person designated to receive sensitive background study information is the same; and

(2) the same entity must own or legally control both the roster from which the transfer is occurring and the roster to which the transfer is occurring. For an entity that holds or controls multiple licenses, or unlicensed personal care provider organizations, there must be a common highest level entity that has a legally identifiable structure that can be verified through records available from the secretary of state.

Sec. 30. Minnesota Statutes 2022, section 245C.08, subdivision 1, is amended to read:

Subdivision 1. **Background studies conducted by Department of Human Services.** (a) For a background study conducted by the Department of Human Services, the commissioner shall review:

(1) information related to names of substantiated perpetrators of maltreatment of vulnerable adults that has been received by the commissioner as required under section 626.557, subdivision 9c, paragraph (j);

(2) the commissioner's records relating to the maltreatment of minors in licensed programs, and from findings of maltreatment of minors as indicated through the social service information system;

(3) information from juvenile courts as required in subdivision 4 for individuals listed in section 245C.03, subdivision 1, paragraph (a), when there is reasonable cause;

(4) information from the Bureau of Criminal Apprehension, including information regarding a background study subject's registration in Minnesota as a predatory offender under section 243.166;

(5) except as provided in clause (6), information received as a result of submission of fingerprints for a national criminal history record check, as defined in section 245C.02, subdivision 13c, when the commissioner has reasonable cause for a national criminal history record check as defined under section 245C.02, subdivision 15a, or as required under section 144.057, subdivision 1, clause (2);

(6) for a background study related to a child foster family setting application for licensure, foster residence settings, children's residential facilities, a transfer of permanent legal and physical custody of a child under sections 260C.503 to 260C.515, or adoptions, and for a background study required for family child care, certified license-exempt child care, child care centers, and legal nonlicensed child care authorized under chapter 119B, the commissioner shall also review:

(i) information from the child abuse and neglect registry for any state in which the background study subject has resided for the past five years;

(ii) when the background study subject is 18 years of age or older, or a minor under section 245C.05, subdivision 5a, paragraph (c), information received following submission of fingerprints for a national criminal history record check; and

(iii) when the background study subject is 18 years of age or older or a minor under section 245C.05, subdivision 5a, ~~paragraph (d),~~ for licensed family child care, certified

license-exempt child care, licensed child care centers, and legal nonlicensed child care authorized under chapter 119B, information obtained using non-fingerprint-based data including information from the criminal and sex offender registries for any state in which the background study subject resided for the past five years and information from the national crime information database and the national sex offender registry; and

(7) for a background study required for family child care, certified license-exempt child care centers, licensed child care centers, and legal nonlicensed child care authorized under chapter 119B, the background study shall also include, to the extent practicable, a name and date-of-birth search of the National Sex Offender Public website.

(b) Notwithstanding expungement by a court, the commissioner may consider information obtained under paragraph (a), clauses (3) and (4), unless the commissioner received notice of the petition for expungement and the court order for expungement is directed specifically to the commissioner.

(c) The commissioner shall also review criminal case information received according to section 245C.04, subdivision 4a, from the Minnesota court information system that relates to individuals who have already been studied under this chapter and who remain affiliated with the agency that initiated the background study.

(d) When the commissioner has reasonable cause to believe that the identity of a background study subject is uncertain, the commissioner may require the subject to provide a set of classifiable fingerprints for purposes of completing a fingerprint-based record check with the Bureau of Criminal Apprehension. Fingerprints collected under this paragraph shall not be saved by the commissioner after they have been used to verify the identity of the background study subject against the particular criminal record in question.

(e) The commissioner may inform the entity that initiated a background study under NETStudy 2.0 of the status of processing of the subject's fingerprints.

Sec. 31. Minnesota Statutes 2022, section 245C.10, subdivision 4, is amended to read:

Subd. 4. **Temporary personnel agencies, <u>personnel pool agencies,</u> educational programs, and professional services agencies.** The commissioner shall recover the cost of the background studies initiated by temporary personnel agencies, <u>personnel pool agencies,</u> educational programs, and professional services agencies that initiate background studies under section 245C.03, subdivision 4, through a fee of no more than $42 per study charged to the agency. The fees collected under this subdivision are appropriated to the commissioner for the purpose of conducting background studies.

Sec. 32. Minnesota Statutes 2022, section 245C.30, subdivision 2, is amended to read:

Subd. 2. **Disclosure of reason for disqualification.** (a) The commissioner may not grant a variance for a disqualified individual unless the applicant, license-exempt child care center certification holder, or license holder requests the variance and the disqualified individual provides written consent for the commissioner to disclose to the applicant, license-exempt child care center certification holder, or license holder the reason for the disqualification.

(b) This subdivision does not apply to programs licensed to provide family child care for children, foster care for children in the provider's own home, or foster care or day care services for adults in the provider's own home. ~~When the commissioner grants a variance for a disqualified individual in connection with a license to provide the services specified in this paragraph, the disqualified individual's consent is not required to disclose the reason for the disqualification to the license holder in the variance issued under subdivision 1, provided that the commissioner may not disclose the reason for the disqualification if the disqualification is based on a felony-level conviction for a drug-related offense within the past five years.~~

Sec. 33. Minnesota Statutes 2022, section 245C.31, subdivision 1, is amended to read:

Subdivision 1. **Board determines disciplinary or corrective action.** ~~(a)~~ The commissioner shall notify a health-related licensing board as defined in section 214.01, subdivision 2, if the commissioner determines that an individual who is licensed by the health-related licensing board and who is included on the board's roster list provided in accordance with subdivision 3a is responsible for substantiated maltreatment under section 626.557 or chapter 260E, in accordance with subdivision 2. Upon receiving notification, the health-related licensing board shall make a determination as to whether to impose disciplinary or corrective action under chapter 214.

~~(b) This section does not apply to a background study of an individual regulated by a health-related licensing board if the individual's study is related to child foster care, adult foster care, or family child care licensure.~~

Sec. 34. Minnesota Statutes 2022, section 245C.33, subdivision 4, is amended to read:

Subd. 4. **Information commissioner reviews.** (a) The commissioner shall review the following information regarding the background study subject:

(1) the information under section 245C.08, subdivisions 1, 3, and 4;

(2) information from the child abuse and neglect registry for any state in which the subject has resided for the past five years; and

(3) information from national crime information databases, when required under section 245C.08.

(b) The commissioner shall provide any information collected under this subdivision to the county or private agency that initiated the background study. The commissioner shall also provide the agency~~:~~

~~(1)~~ with a notice whether the information collected shows that the subject of the background study has a conviction listed in United States Code, title 42, section 671(a)(20)(A)~~; and~~.

~~(2) for background studies conducted under subdivision 1, paragraph (a), the date of all adoption-related background studies completed on the subject by the commissioner after June 30, 2007, and the name of the county or private agency that initiated the adoption-related background study.~~

Sec. 35. Minnesota Statutes 2022, section 245H.13, subdivision 9, is amended to read:

Subd. 9. **Behavior guidance.** The certified center must ensure that staff and volunteers use positive behavior guidance and do not subject children to:

(1) corporal punishment, including but not limited to rough handling, shoving, hair pulling, ear pulling, shaking, slapping, kicking, biting, pinching, hitting, and spanking;

(2) humiliation;

(3) abusive language;

(4) the use of mechanical restraints, including tying;

(5) the use of physical restraints other than to physically hold a child when containment is necessary to protect a child or others from harm; ~~or~~

(6) prone restraints, as prohibited by section 245A.211; or

~~(6)~~ (7) the withholding or forcing of food and other basic needs.

Sec. 36. Minnesota Statutes 2022, section 245I.20, subdivision 10, is amended to read:

Subd. 10. **Application procedures.** (a) The applicant for certification must submit any documents that the commissioner requires on forms approved by the commissioner.

(b) Upon submitting an application for certification, an applicant must pay the application fee required by section 245A.10, subdivision 3.

(c) The commissioner must act on an application within 90 working days of receiving a completed application.

(d) When the commissioner receives an application for initial certification that is incomplete because the applicant failed to submit required documents or is deficient because the submitted documents do not meet certification requirements, the commissioner must provide the applicant with written notice that the application is incomplete or deficient. In the notice, the commissioner must identify the particular documents that are missing or deficient and give the applicant 45 days to submit a second application that is complete. An applicant's failure to submit a complete application within 45 days after receiving notice from the commissioner is a basis for certification denial.

(e) The commissioner must give notice of a denial to an applicant when the commissioner has made the decision to deny the certification application. In the notice of denial, the commissioner must state the reasons for the denial in plain language. The commissioner must send or deliver the notice of denial to an applicant by certified mail or personal service. In the notice of denial, the commissioner must state the reasons that the commissioner denied the application and must inform the applicant of the applicant's right to request a contested case hearing under chapter 14 and Minnesota Rules, parts 1400.8505 to 1400.8612. The applicant may appeal the denial by notifying the commissioner in writing by certified mail or personal service. If mailed, the appeal must be postmarked and sent to the commissioner within 20 calendar days after the applicant received the notice of denial. If an applicant delivers an appeal by personal service, the commissioner must receive the appeal within 20 calendar days after the applicant received the notice of denial.

(f) The commissioner may require the applicant or certification holder to provide an email address for the certification holder that will be made public subject to the requirements under section 13.46, subdivision 4, paragraph (b), clause (1), item (i).

Sec. 37. Minnesota Statutes 2022, section 256.9685, subdivision 1a, is amended to read:

Subd. 1a. **Administrative reconsideration.** Notwithstanding section 256B.04, subdivision 15, the commissioner shall establish an administrative reconsideration process for appeals of inpatient hospital services determined to be medically unnecessary. A physician, advanced practice registered nurse, physician assistant, or hospital may request a reconsideration of the decision that inpatient hospital services are not medically necessary by submitting a written request for review to the commissioner within 30 calendar days

after ~~receiving~~ the date of the notice of the decision was mailed. The request for reconsideration ~~process~~ shall ~~take place prior to the procedures of subdivision 1b and shall be conducted~~ be reviewed by ~~the~~ at least one medical review agent that is independent of the case under reconsideration. The medical review agent shall make a recommendation to the commissioner. The commissioner's decision on reconsideration is final and not subject to appeal under chapter 14.

Sec. 38. Minnesota Statutes 2022, section 256.9685, subdivision 1b, is amended to read:

Subd. 1b. **Appeal of reconsideration.** ~~Notwithstanding section 256B.72, the commissioner may recover inpatient hospital payments for services that have been determined to be medically unnecessary after the reconsideration and determinations. A physician, advanced practice registered nurse, physician assistant, or hospital may appeal the result of the reconsideration process by submitting a written request for review to the commissioner within 30 days after receiving notice of the action. The commissioner shall review the medical record and information submitted during the reconsideration process and the medical review agent's basis for the determination that the services were not medically necessary for inpatient hospital services. The commissioner shall issue an order upholding or reversing the decision of the reconsideration process based on the review.~~ The commissioner's decision under subdivision 1a is appealable by petition for writ of certiorari under chapter 606.

Sec. 39. Minnesota Statutes 2022, section 256.9686, is amended by adding a subdivision to read:

Subd. 7a. **Medical review agent.** "Medical review agent" means the representative of the commissioner who is authorized by the commissioner to administer medical record reviews; conduct administrative reconsiderations as defined by section 256.9685, subdivision 1a; and perform other functions as stipulated in the terms of the agent's contract with the department. Medical records reviews and administrative reconsiderations will be performed by medical professionals within their scope of expertise, including but not limited to physicians, physician assistants, advanced practice registered nurses, and registered nurses. The medical professional performing the review or reconsideration must be on staff with the medical review agent, in good standing, and licensed to practice in the state where the medical professional resides.

Sec. 40. Minnesota Statutes 2022, section 256B.04, subdivision 15, is amended to read:

Subd. 15. **Utilization review.** (a) Establish on a statewide basis a new program to safeguard against unnecessary or inappropriate use of medical assistance services, against

excess payments, against unnecessary or inappropriate hospital admissions or lengths of stay, and against underutilization of services in prepaid health plans, long-term care facilities or any health care delivery system subject to fixed rate reimbursement. In implementing the program, the state agency shall utilize both prepayment and postpayment review systems to determine if utilization is reasonable and necessary. The determination of whether services are reasonable and necessary shall be made by the commissioner in consultation with a professional services advisory group or health care consultant appointed by the commissioner.

(b) Contracts entered into for purposes of meeting the requirements of this subdivision shall not be subject to the set-aside provisions of chapter 16C.

(c) A recipient aggrieved by the commissioner's termination of services or denial of future services may appeal pursuant to section 256.045. Unless otherwise provided by law, a vendor aggrieved by the commissioner's determination that services provided were not reasonable or necessary may appeal pursuant to the contested case procedures of chapter 14. To appeal, the vendor shall notify the commissioner in writing within 30 days of receiving the commissioner's notice. The appeal request shall specify each disputed item, the reason for the dispute, an estimate of the dollar amount involved for each disputed item, the computation that the vendor believes is correct, the authority in statute or rule upon which the vendor relies for each disputed item, the name and address of the person or firm with whom contacts may be made regarding the appeal, and other information required by the commissioner.

(d) The commissioner may select providers to provide case management services to recipients who use health care services inappropriately or to recipients who are eligible for other managed care projects. The providers shall be selected based upon criteria that may include a comparison with a peer group of providers related to the quality, quantity, or cost of health care services delivered or a review of sanctions previously imposed by health care services programs or the provider's professional licensing board.

Sec. 41. Minnesota Statutes 2022, section 256B.064, is amended to read:

256B.064 SANCTIONS; MONETARY RECOVERY.

Subdivision 1. **Terminating payments to ineligible ~~vendors~~ individuals or entities.** The commissioner may terminate payments under this chapter to any person or facility that, under applicable federal law or regulation, has been determined to be ineligible for payments under title XIX of the Social Security Act.

Subd. 1a. **Grounds for sanctions ~~against vendors.~~** (a) The commissioner may impose sanctions against ~~a vendor of medical care~~ any individual or entity that receives payments from medical assistance or provides goods or services for which payment is made from medical assistance for any of the following: (1) fraud, theft, or abuse in connection with the provision of ~~medical care~~ goods and services to recipients of public assistance for which payment is made from medical assistance; (2) a pattern of presentment of false or duplicate claims or claims for services not medically necessary; (3) a pattern of making false statements of material facts for the purpose of obtaining greater compensation than that to which the ~~vendor~~ individual or entity is legally entitled; (4) suspension or termination as a Medicare vendor; (5) refusal to grant the state agency access during regular business hours to examine all records necessary to disclose the extent of services provided to program recipients and appropriateness of claims for payment; (6) failure to repay an overpayment or a fine finally established under this section; (7) failure to correct errors in the maintenance of health service or financial records for which a fine was imposed or after issuance of a warning by the commissioner; and (8) any reason for which ~~a vendor~~ an individual or entity could be excluded from participation in the Medicare program under section 1128, 1128A, or 1866(b)(2) of the Social Security Act. For the purposes of this section, goods or services for which payment is made from medical assistance includes but is not limited to care and services identified in section 256B.0625 or provided pursuant to any federally approved waiver.

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

Subd. 1b. **Sanctions available.** The commissioner may impose the following sanctions for the conduct described in subdivision 1a: suspension or withholding of payments to ~~a vendor~~ an individual or entity and suspending or terminating participation in the program, or imposition of a fine under subdivision 2, paragraph (f). When imposing sanctions under this section, the commissioner shall consider the nature, chronicity, or severity of the conduct and the effect of the conduct on the health and safety of persons served by the ~~vendor~~ individual or entity. The commissioner shall suspend ~~a vendor's~~ an individual's or entity's participation in the program for a minimum of five years if the ~~vendor~~ individual or entity is convicted of a crime, received a stay of adjudication, or entered a court-ordered diversion program for an offense related to a provision of a health service under medical assistance, including a federally approved waiver, or health care fraud. Regardless of imposition of sanctions, the commissioner may make a referral to the appropriate state licensing board.

Subd. 1c. **Grounds for and methods of monetary recovery.** (a) The commissioner may obtain monetary recovery from ~~a vendor who~~ an individual or entity that has been improperly paid by the department either as a result of conduct described in subdivision 1a or as a result of ~~a vendor or department~~ an error by the individual or entity submitting the claim or by the department, regardless of whether the error was intentional. Patterns need not be proven as a precondition to monetary recovery of erroneous or false claims, duplicate claims, claims for services not medically necessary, or claims based on false statements.

(b) The commissioner may obtain monetary recovery using methods including but not limited to the following: assessing and recovering money improperly paid and debiting from future payments any money improperly paid. The commissioner shall charge interest on money to be recovered if the recovery is to be made by installment payments or debits, except when the monetary recovery is of an overpayment that resulted from a department error. The interest charged shall be the rate established by the commissioner of revenue under section 270C.40.

Subd. 1d. **Investigative costs.** The commissioner may seek recovery of investigative costs from any ~~vendor of medical care or services who~~ individual or entity that willfully submits a claim for reimbursement for services that the ~~vendor~~ individual or entity knows, or reasonably should have known, is a false representation and that results in the payment of public funds for which the ~~vendor~~ individual or entity is ineligible. Billing errors that result in unintentional overcharges shall not be grounds for investigative cost recoupment.

Subd. 2. **Imposition of monetary recovery and sanctions.** (a) The commissioner shall determine any monetary amounts to be recovered and sanctions to be imposed upon ~~a vendor of medical care~~ an individual or entity under this section. Except as provided in paragraphs (b) and (d), neither a monetary recovery nor a sanction will be imposed by the commissioner without prior notice and an opportunity for a hearing, according to chapter 14, on the commissioner's proposed action, provided that the commissioner may suspend or reduce payment to ~~a vendor of medical care~~ an individual or entity, except a nursing home or convalescent care facility, after notice and prior to the hearing if in the commissioner's opinion that action is necessary to protect the public welfare and the interests of the program.

(b) Except when the commissioner finds good cause not to suspend payments under Code of Federal Regulations, title 42, section 455.23 (e) or (f), the commissioner shall withhold or reduce payments to ~~a vendor of medical care~~ an individual or entity without providing advance notice of such withholding or reduction if either of the following occurs:

(1) the ~~vendor~~ individual or entity is convicted of a crime involving the conduct described in subdivision 1a; or

(2) the commissioner determines there is a credible allegation of fraud for which an investigation is pending under the program. Allegations are considered credible when they have an indicium of reliability and the state agency has reviewed all allegations, facts, and evidence carefully and acts judiciously on a case-by-case basis. A credible allegation of fraud is an allegation which has been verified by the state, from any source, including but not limited to:

(i) fraud hotline complaints;

(ii) claims data mining; and

(iii) patterns identified through provider audits, civil false claims cases, and law enforcement investigations.

~~Allegations are considered to be credible when they have an indicia of reliability and the state agency has reviewed all allegations, facts, and evidence carefully and acts judiciously on a case-by-case basis.~~

(c) The commissioner must send notice of the withholding or reduction of payments under paragraph (b) within five days of taking such action unless requested in writing by a law enforcement agency to temporarily withhold the notice. The notice must:

(1) state that payments are being withheld according to paragraph (b);

(2) set forth the general allegations as to the nature of the withholding action, but need not disclose any specific information concerning an ongoing investigation;

(3) except in the case of a conviction for conduct described in subdivision 1a, state that the withholding is for a temporary period and cite the circumstances under which withholding will be terminated;

(4) identify the types of claims to which the withholding applies; and

(5) inform the ~~vendor~~ individual or entity of the right to submit written evidence for consideration by the commissioner.

(d) The withholding or reduction of payments will not continue after the commissioner determines there is insufficient evidence of fraud by the ~~vendor~~ individual or entity, or after legal proceedings relating to the alleged fraud are completed, unless the commissioner has sent notice of intention to impose monetary recovery or sanctions under paragraph (a). Upon conviction for a crime related to the provision, management, or administration of a health

service under medical assistance, a payment held pursuant to this section by the commissioner or a managed care organization that contracts with the commissioner under section 256B.035 is forfeited to the commissioner or managed care organization, regardless of the amount charged in the criminal complaint or the amount of criminal restitution ordered.

~~(d)~~ (e) The commissioner shall suspend or terminate ~~a vendor's~~ an individual's or entity's participation in the program without providing advance notice and an opportunity for a hearing when the suspension or termination is required because of the ~~vendor's~~ individual's or entity's exclusion from participation in Medicare. Within five days of taking such action, the commissioner must send notice of the suspension or termination. The notice must:

(1) state that suspension or termination is the result of the ~~vendor's~~ individual's or entity's exclusion from Medicare;

(2) identify the effective date of the suspension or termination; and

(3) inform the ~~vendor~~ individual or entity of the need to be reinstated to Medicare before reapplying for participation in the program.

~~(e)~~ (f) Upon receipt of a notice under paragraph (a) that a monetary recovery or sanction is to be imposed, ~~a vendor~~ an individual or entity may request a contested case, as defined in section 14.02, subdivision 3, by filing with the commissioner a written request of appeal. The appeal request must be received by the commissioner no later than 30 days after the date the notification of monetary recovery or sanction was mailed to the ~~vendor~~ individual or entity. The appeal request must specify:

(1) each disputed item, the reason for the dispute, and an estimate of the dollar amount involved for each disputed item;

(2) the computation that the ~~vendor~~ individual or entity believes is correct;

(3) the authority in statute or rule upon which the ~~vendor~~ individual or entity relies for each disputed item;

(4) the name and address of the person or entity with whom contacts may be made regarding the appeal; and

(5) other information required by the commissioner.

~~(f)~~ (g) The commissioner may order ~~a vendor~~ an individual or entity to forfeit a fine for failure to fully document services according to standards in this chapter and Minnesota Rules, chapter 9505. The commissioner may assess fines if specific required components of documentation are missing. The fine for incomplete documentation shall equal 20 percent

of the amount paid on the claims for reimbursement submitted by the ~~vendor~~ individual or entity, or up to $5,000, whichever is less. If the commissioner determines that ~~a vendor~~ an individual or entity repeatedly violated this chapter, chapter 254B or 245G, or Minnesota Rules, chapter 9505, related to the provision of services to program recipients and the submission of claims for payment, the commissioner may order ~~a vendor~~ an individual or entity to forfeit a fine based on the nature, severity, and chronicity of the violations, in an amount of up to $5,000 or 20 percent of the value of the claims, whichever is greater. The commissioner may issue fines under this paragraph in place of or in addition to full monetary recovery of the value of the claims submitted under subdivision 1c.

~~(g)~~ (h) The ~~vendor~~ individual or entity shall pay the fine assessed on or before the payment date specified. If the ~~vendor~~ individual or entity fails to pay the fine, the commissioner may withhold or reduce payments and recover the amount of the fine. A timely appeal shall stay payment of the fine until the commissioner issues a final order.

Subd. 3. **~~Vendor~~ Mandates on prohibited payments.** (a) The commissioner shall maintain and publish a list of each excluded individual and entity that was convicted of a crime related to the provision, management, or administration of a medical assistance health service, or suspended or terminated under subdivision 2. Medical assistance payments cannot be made by ~~a vendor~~ an individual or entity for items or services furnished either directly or indirectly by an excluded individual or entity, or at the direction of excluded individuals or entities.

(b) The ~~vendor~~ entity must check the exclusion list on a monthly basis and document the date and time the exclusion list was checked and the name and title of the person who checked the exclusion list. The ~~vendor~~ entity must immediately terminate payments to an individual or entity on the exclusion list.

(c) ~~A vendor's~~ An entity's requirement to check the exclusion list and to terminate payments to individuals or entities on the exclusion list applies to each individual or entity on the exclusion list, even if the named individual or entity is not responsible for direct patient care or direct submission of a claim to medical assistance.

(d) ~~A vendor~~ An entity that pays medical assistance program funds to an individual or entity on the exclusion list must refund any payment related to either items or services rendered by an individual or entity on the exclusion list from the date the individual or entity is first paid or the date the individual or entity is placed on the exclusion list, whichever is later, and ~~a vendor~~ an entity may be subject to:

(1) sanctions under subdivision 2;

(2) a civil monetary penalty of up to $25,000 for each determination by the department that the vendor employed or contracted with an individual or entity on the exclusion list; and

(3) other fines or penalties allowed by law.

Subd. 4. **Notice.** (a) The department shall serve the notice required under subdivision 2 ~~shall be served~~ by certified mail at the address submitted to the department by the ~~vendor~~ individual or entity. Service is complete upon mailing. ~~The commissioner shall place an affidavit of the certified mailing in the vendor's file as an indication of the address and the date of mailing.~~

(b) The department shall give notice in writing to a recipient placed in the Minnesota restricted recipient program under section 256B.0646 and Minnesota Rules, part 9505.2200. The department shall send the notice ~~shall be sent~~ by first class mail to the recipient's current address on file with the department. A recipient placed in the Minnesota restricted recipient program may contest the placement by submitting a written request for a hearing to the department within 90 days of the notice being mailed.

Subd. 5. **Immunity; good faith reporters.** (a) A person who makes a good faith report is immune from any civil or criminal liability that might otherwise arise from reporting or participating in the investigation. Nothing in this subdivision affects ~~a vendor's~~ an individual's or entity's responsibility for an overpayment established under this subdivision.

(b) A person employed by a lead investigative agency who is conducting or supervising an investigation or enforcing the law according to the applicable law or rule is immune from any civil or criminal liability that might otherwise arise from the person's actions, if the person is acting in good faith and exercising due care.

(c) For purposes of this subdivision, "person" includes a natural person or any form of a business or legal entity.

(d) After an investigation is complete, the reporter's name must be kept confidential. The subject of the report may compel disclosure of the reporter's name only with the consent of the reporter or upon a written finding by a district court that the report was false and there is evidence that the report was made in bad faith. This subdivision does not alter disclosure responsibilities or obligations under the Rules of Criminal Procedure, except that when the identity of the reporter is relevant to a criminal prosecution the district court shall conduct an in-camera review before determining whether to order disclosure of the reporter's identity.

Sec. 42. Minnesota Statutes 2022, section 256B.27, subdivision 3, is amended to read:

Subd. 3. **Access to medical records.** The commissioner of human services, with the written consent of the recipient, on file with the local welfare agency, shall be allowed access in the manner and within the time prescribed by the commissioner to all personal medical records of medical assistance recipients solely for the purposes of investigating whether or not: (a) a vendor of medical care has submitted a claim for reimbursement, a cost report or a rate application which is duplicative, erroneous, or false in whole or in part, or which results in the vendor obtaining greater compensation than the vendor is legally entitled to; or (b) the medical care was medically necessary. When the commissioner is investigating a possible overpayment of Medicaid funds, the commissioner must be given immediate access without prior notice to the vendor's office during regular business hours and to documentation and records related to services provided and submission of claims for services provided. The department shall document in writing the need for immediate access to records related to a specific investigation. Denying the commissioner access to records is cause for the vendor's immediate suspension of payment or termination according to section 256B.064. All providers receiving medical assistance payments must make those records available immediately to the commissioner upon request. Any records not provided to the commissioner at the date and time of the request are inadmissible if offered as evidence by the provider in any proceeding to contest sanctions against or monetary recovery from the provider. The determination of provision of services not medically necessary shall be made by the commissioner. Notwithstanding any other law to the contrary, a vendor of medical care shall not be subject to any civil or criminal liability for providing access to medical records to the commissioner of human services pursuant to this section.

Sec. 43. Minnesota Statutes 2022, section 524.5-118, subdivision 2a, is amended to read:

Subd. 2a. **Procedure; state licensing agency data.** (a) The court shall request the commissioner of human services to provide the court within 25 working days of receipt of the request with licensing agency data for licenses directly related to the responsibilities of a professional fiduciary if the study subject indicates current or prior affiliation from the following agencies in Minnesota:

(1) Lawyers Responsibility Board;

(2) State Board of Accountancy;

(3) Board of Social Work;

(4) Board of Psychology;

(5) Board of Nursing;

(6) Board of Medical Practice;

~~(7) Department of Education;~~

~~(8)~~ (7) Department of Commerce;

~~(9)~~ (8) Board of Chiropractic Examiners;

~~(10)~~ (9) Board of Dentistry;

~~(11)~~ (10) Board of Marriage and Family Therapy;

~~(12)~~ (11) Department of Human Services;

~~(13)~~ (12) Peace Officer Standards and Training (POST) Board; and

~~(14)~~ (13) Professional Educator Licensing and Standards Board.

(b) The commissioner shall enter into agreements with these agencies to provide the commissioner with electronic access to the relevant licensing data, and to provide the commissioner with a quarterly list of new sanctions issued by the agency.

(c) The commissioner shall provide to the court the electronically available data maintained in the agency's database, including whether the proposed guardian or conservator is or has been licensed by the agency, and if the licensing agency database indicates a disciplinary action or a sanction against the individual's license, including a condition, suspension, revocation, or cancellation.

(d) If the proposed guardian or conservator has resided in a state other than Minnesota in the previous ten years, licensing agency data under this section shall also include the licensing agency data from any other state where the proposed guardian or conservator reported to have resided during the previous ten years if the study subject indicates current or prior affiliation. If the proposed guardian or conservator has or has had a professional license in another state that is directly related to the responsibilities of a professional fiduciary from one of the agencies listed under paragraph (a), state licensing agency data shall also include data from the relevant licensing agency of that state.

(e) The commissioner is not required to repeat a search for Minnesota or out-of-state licensing data on an individual if the commissioner has provided this information to the court within the prior five years.

(f) The commissioner shall review the information in paragraph (c) at least once every four months to determine if an individual who has been studied within the previous five years:

(1) has new disciplinary action or sanction against the individual's license; or

(2) did not disclose a prior or current affiliation with a Minnesota licensing agency.

(g) If the commissioner's review in paragraph (f) identifies new information, the commissioner shall provide any new information to the court.

Sec. 44. **REVISOR INSTRUCTION.**

The revisor of statutes shall renumber the subdivisions in Minnesota Statutes, section 245C.02, in alphabetical order and correct any cross-reference changes that result.

Sec. 45. **REPEALER.**

(a) Minnesota Statutes 2022, sections 245A.22; 245C.02, subdivision 9; 245C.301; and 256.9685, subdivisions 1c and 1d, are repealed.

(b) Minnesota Rules, parts 9505.0505, subpart 18; and 9505.0520, subpart 9b, are repealed.

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

ARTICLE 10
ECONOMIC ASSISTANCE

Section 1. Minnesota Statutes 2022, section 256D.01, subdivision 1a, is amended to read:

Subd. 1a. **Standards.** (a) A principal objective in providing general assistance is to provide for single adults, childless couples, or children as defined in section 256D.02, subdivision 6, ineligible for federal programs who are unable to provide for themselves. The minimum standard of assistance determines the total amount of the general assistance grant without separate standards for shelter, utilities, or other needs.

(b) The ~~commissioner shall set the~~ standard of assistance for an assistance unit consisting of ~~an adult~~ a recipient who is childless and unmarried or living apart from children and spouse and who does not live with a parent or parents or a legal custodian is the cash portion of the MFIP transitional standard for a single adult under section 256J.24, subdivision 5. ~~When the other standards specified in this subdivision increase, this standard must also be increased by the same percentage.~~

(c) For an assistance unit consisting of a single adult who lives with a parent or parents, the general assistance standard of assistance ~~is the amount that the aid to families with dependent children standard of assistance, in effect on July 16, 1996, would increase if the recipient were added as an additional minor child to an assistance unit consisting of the recipient's parent and all of that parent's family members, except that the standard may not exceed the standard for a general assistance recipient living alone~~ is the cash portion of the MFIP transitional standard for a single adult under section 256J.24, subdivision 5. Benefits received by a responsible relative of the assistance unit under the Supplemental Security Income program, a workers' compensation program, the Minnesota supplemental aid program, or any other program based on the responsible relative's disability, and any benefits received by a responsible relative of the assistance unit under the Social Security retirement program, may not be counted in the determination of eligibility or benefit level for the assistance unit. Except as provided below, the assistance unit is ineligible for general assistance if the available resources or the countable income of the assistance unit and the parent or parents with whom the assistance unit lives are such that a family consisting of the assistance unit's parent or parents, the parent or parents' other family members and the assistance unit as the only or additional minor child would be financially ineligible for general assistance. For the purposes of calculating the countable income of the assistance unit's parent or parents, the calculation methods must follow the provisions under section 256P.06.

(d) For an assistance unit consisting of a childless couple, the standards of assistance are the same as the first and second adult standards of the aid to families with dependent children program in effect on July 16, 1996. If one member of the couple is not included in the general assistance grant, the standard of assistance for the other is the second adult standard of the aid to families with dependent children program as of July 16, 1996.

Sec. 2. Minnesota Statutes 2022, section 256D.024, subdivision 1, is amended to read:

Subdivision 1. **Person convicted of drug offenses.** (a) ~~If~~ An ~~applicant or recipient~~ individual who has been convicted of a felony-level drug offense ~~after July 1, 1997, the assistance unit is ineligible for benefits under this chapter until five years after the applicant has completed terms of the court-ordered sentence, unless the person is participating in a drug treatment program, has successfully completed a drug treatment program, or has been assessed by the county and determined not to be in need of a drug treatment program. Persons subject to the limitations of this subdivision who become eligible for assistance under this chapter shall~~ during the previous ten years from the date of application or recertification may be subject to random drug testing ~~as a condition of continued eligibility and shall lose eligibility for benefits for five years beginning the month following:~~. The county must

provide information about substance use disorder treatment programs to a person who tests positive for an illegal controlled substance.

~~(1) Any positive test result for an illegal controlled substance; or~~

~~(2) discharge of sentence after conviction for another drug felony.~~

(b) For the purposes of this subdivision, "drug offense" means a conviction that occurred ~~after July 1, 1997,~~ during the previous ten years from the date of application or recertification of sections 152.021 to 152.025, 152.0261, 152.0262, or 152.096. Drug offense also means a conviction in another jurisdiction of the possession, use, or distribution of a controlled substance, or conspiracy to commit any of these offenses, if the ~~offense~~ conviction occurred ~~after July 1, 1997,~~ during the previous ten years from the date of application or recertification and the conviction is a felony offense in that jurisdiction, or in the case of New Jersey, a high misdemeanor.

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

Sec. 3. Minnesota Statutes 2022, section 256D.06, subdivision 5, is amended to read:

Subd. 5. **Eligibility; requirements.** (a) Any applicant, otherwise eligible for general assistance and possibly eligible for maintenance benefits from any other source shall (1) make application for those benefits within ~~30~~ 90 days of the general assistance application; and (2) execute an interim assistance agreement on a form as directed by the commissioner.

(b) The commissioner shall review a denial of an application for other maintenance benefits and may require a recipient of general assistance to file an appeal of the denial if appropriate. If found eligible for benefits from other sources, and a payment received from another source relates to the period during which general assistance was also being received, the recipient shall be required to reimburse the county agency for the interim assistance paid. Reimbursement shall not exceed the amount of general assistance paid during the time period to which the other maintenance benefits apply and shall not exceed the state standard applicable to that time period.

(c) The commissioner may contract with the county agencies, qualified agencies, organizations, or persons to provide advocacy and support services to process claims for federal disability benefits for applicants or recipients of services or benefits supervised by the commissioner using money retained under this section.

(d) The commissioner may provide methods by which county agencies shall identify, refer, and assist recipients who may be eligible for benefits under federal programs for people with a disability.

(e) The total amount of interim assistance recoveries retained under this section for advocacy, support, and claim processing services shall not exceed 35 percent of the interim assistance recoveries in the prior fiscal year.

Sec. 4. Minnesota Statutes 2022, section 256J.26, subdivision 1, is amended to read:

Subdivision 1. **Person convicted of drug offenses.** (a) An individual who has been convicted of a felony level drug offense ~~committed~~ during the previous ten years from the date of application or recertification is subject to the following:

(1) Benefits for the entire assistance unit must be paid in vendor form for shelter and utilities during any time the applicant is part of the assistance unit.

(2) The convicted applicant or participant ~~shall~~ may be subject to random drug testing ~~as a condition of continued eligibility and~~. Following any positive test for an illegal controlled substance ~~is subject to the following sanctions:~~, the county must provide information about substance use disorder treatment programs to the applicant or participant.

~~(i) for failing a drug test the first time, the residual amount of the participant's grant after making vendor payments for shelter and utility costs, if any, must be reduced by an amount equal to 30 percent of the MFIP standard of need for an assistance unit of the same size. When a sanction under this subdivision is in effect, the job counselor must attempt to meet with the person face-to-face. During the face-to-face meeting, the job counselor must explain the consequences of a subsequent drug test failure and inform the participant of the right to appeal the sanction under section 256J.40. If a face-to-face meeting is not possible, the county agency must send the participant a notice of adverse action as provided in section 256J.31, subdivisions 4 and 5, and must include the information required in the face-to-face meeting; or~~

~~(ii) for failing a drug test two times, the participant is permanently disqualified from receiving MFIP assistance, both the cash and food portions. The assistance unit's MFIP grant must be reduced by the amount which would have otherwise been made available to the disqualified participant. Disqualification under this item does not make a participant ineligible for the Supplemental Nutrition Assistance Program (SNAP). Before a disqualification under this provision is imposed, the job counselor must attempt to meet with the participant face-to-face. During the face-to-face meeting, the job counselor must identify other resources that may be available to the participant to meet the needs of the family and inform the participant of the right to appeal the disqualification under section 256J.40. If a face-to-face meeting is not possible, the county agency must send the participant~~

~~a notice of adverse action as provided in section 256J.31, subdivisions 4 and 5, and must include the information required in the face-to-face meeting.~~

~~(3) A participant who fails a drug test the first time and is under a sanction due to other MFIP program requirements is considered to have more than one occurrence of noncompliance and is subject to the applicable level of sanction as specified under section 256J.46, subdivision 1, paragraph (d).~~

(b) Applicants requesting only SNAP benefits or participants receiving only SNAP benefits, who have been convicted of a felony-level drug offense ~~that occurred after July 1, 1997,~~ during the previous ten years from the date of application or recertification may, if otherwise eligible, receive SNAP benefits ~~if~~. The convicted applicant or participant ~~is~~ may be subject to random drug testing ~~as a condition of continued eligibility~~. Following a positive test for an illegal controlled substance, the ~~applicant is subject to the following sanctions:~~ county must provide information about substance use disorder treatment programs to the applicant or participant.

~~(1) for failing a drug test the first time, SNAP benefits shall be reduced by an amount equal to 30 percent of the applicable SNAP benefit allotment. When a sanction under this clause is in effect, a job counselor must attempt to meet with the person face-to-face. During the face-to-face meeting, a job counselor must explain the consequences of a subsequent drug test failure and inform the participant of the right to appeal the sanction under section 256J.40. If a face-to-face meeting is not possible, a county agency must send the participant a notice of adverse action as provided in section 256J.31, subdivisions 4 and 5, and must include the information required in the face-to-face meeting; and~~

~~(2) for failing a drug test two times, the participant is permanently disqualified from receiving SNAP benefits. Before a disqualification under this provision is imposed, a job counselor must attempt to meet with the participant face-to-face. During the face-to-face meeting, the job counselor must identify other resources that may be available to the participant to meet the needs of the family and inform the participant of the right to appeal the disqualification under section 256J.40. If a face-to-face meeting is not possible, a county agency must send the participant a notice of adverse action as provided in section 256J.31, subdivisions 4 and 5, and must include the information required in the face-to-face meeting.~~

(c) For the purposes of this subdivision, "drug offense" means ~~an offense~~ a conviction that occurred during the previous ten years from the date of application or recertification of sections 152.021 to 152.025, 152.0261, 152.0262, 152.096, or 152.137. Drug offense also means a conviction in another jurisdiction of the possession, use, or distribution of a

controlled substance, or conspiracy to commit any of these offenses, if the ~~offense~~ conviction occurred during the previous ten years from the date of application or recertification and the conviction is a felony offense in that jurisdiction, or in the case of New Jersey, a high misdemeanor.

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

Sec. 5. Minnesota Statutes 2022, section 256P.01, is amended by adding a subdivision to read:

Subd. 5a. **Lived-experience engagement.** "Lived-experience engagement" means an intentional engagement of people with lived experience by a federal, Tribal, state, county, municipal, or nonprofit human services agency funded in part or in whole by federal, state, local government, Tribal Nation, public, private, or philanthropic funds to gather and share feedback on the impact of human services programs.

Sec. 6. Minnesota Statutes 2022, section 256P.02, subdivision 2, is amended to read:

Subd. 2. **Personal property limitations.** The equity value of an assistance unit's personal property listed in clauses (1) to (5) must not exceed $10,000 for applicants and participants. For purposes of this subdivision, personal property is limited to:

(1) cash not excluded under subdivision 4;

(2) bank accounts;

(3) liquid stocks and bonds that can be readily accessed without a financial penalty;

(4) vehicles not excluded under subdivision 3; and

(5) the full value of business accounts used to pay expenses not related to the business.

Sec. 7. Minnesota Statutes 2022, section 256P.02, is amended by adding a subdivision to read:

Subd. 4. **Health and human services recipient engagement income.** Income received from lived-experience engagement, as defined in section 256P.01, subdivision 6, shall be excluded when determining the equity value of personal property.

Sec. 8. Minnesota Statutes 2022, section 256P.06, subdivision 3, is amended to read:

Subd. 3. **Income inclusions.** The following must be included in determining the income of an assistance unit:

(1) earned income; and

(2) unearned income, which includes:

(i) interest and dividends from investments and savings;

(ii) capital gains as defined by the Internal Revenue Service from any sale of real property;

(iii) proceeds from rent and contract for deed payments in excess of the principal and interest portion owed on property;

(iv) income from trusts, excluding special needs and supplemental needs trusts;

(v) interest income from loans made by the participant or household;

(vi) cash prizes and winnings;

(vii) unemployment insurance income that is received by an adult member of the assistance unit unless the individual receiving unemployment insurance income is:

(A) 18 years of age and enrolled in a secondary school; or

(B) 18 or 19 years of age, a caregiver, and is enrolled in school at least half-time;

(viii) retirement, survivors, and disability insurance payments;

(ix) nonrecurring income over $60 per quarter unless the nonrecurring income is: (A) from tax refunds, tax rebates, or tax credits; (B) a reimbursement, rebate, award, grant, or refund of personal or real property or costs or losses incurred when these payments are made by: a public agency; a court; solicitations through public appeal; a federal, state, or local unit of government; or a disaster assistance organization; (C) provided as an in-kind benefit; or (D) earmarked and used for the purpose for which it was intended, subject to verification requirements under section 256P.04;

(x) retirement benefits;

(xi) cash assistance benefits, as defined by each program in chapters 119B, 256D, 256I, and 256J;

~~(xii) Tribal per capita payments unless excluded by federal and state law;~~

~~(xiii)~~ (xii) income from members of the United States armed forces unless excluded from income taxes according to federal or state law;

~~(xiv)~~ (xiii) all child support payments for programs under chapters 119B, 256D, and 256I;

~~(xv)~~ (xiv) the amount of child support received that exceeds $100 for assistance units with one child and $200 for assistance units with two or more children for programs under chapter 256J;

~~(xvi)~~ (xv) spousal support; and

~~(xvii)~~ (xvi) workers' compensation.

Sec. 9. Minnesota Statutes 2022, section 256P.06, is amended by adding a subdivision to read:

Subd. 4. **Recipient engagement income.** Income received from lived-experience engagement, as defined in section 256P.01, subdivision 5a, must not be counted as income for purposes of determining or redetermining eligibility or benefits.

Sec. 10. Minnesota Statutes 2022, section 609B.425, subdivision 2, is amended to read:

Subd. 2. **Benefit eligibility.** (a) For general assistance benefits and Minnesota supplemental aid under chapter 256D, a person convicted of a felony-level drug offense ~~after July 1, 1997, is ineligible for general assistance benefits and Supplemental Security Income under chapter 256D until:~~ during the previous ten years from the date of application or recertification may be subject to random drug testing. The county must provide information about substance use disorder treatment programs to a person who tests positive for an illegal controlled substance.

~~(1) five years after completing the terms of a court-ordered sentence; or~~

~~(2) unless the person is participating in a drug treatment program, has successfully completed a program, or has been determined not to be in need of a drug treatment program.~~

~~(b) A person who becomes eligible for assistance under chapter 256D is subject to random drug testing and shall lose eligibility for benefits for five years beginning the month following:~~

~~(1) any positive test for an illegal controlled substance; or~~

~~(2) discharge of sentence for conviction of another drug felony.~~

~~(c)~~ (b) Parole violators and fleeing felons are ineligible for benefits and persons fraudulently misrepresenting eligibility are also ineligible to receive benefits for ten years.

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

Sec. 11. Minnesota Statutes 2022, section 609B.435, subdivision 2, is amended to read:

Subd. 2. **Drug offenders; random testing; sanctions.** A person who is an applicant for benefits from the Minnesota family investment program or MFIP, the vehicle for temporary assistance for needy families or TANF, and who has been convicted of a felony-level drug offense ~~shall~~ may be subject to ~~certain conditions, including~~ random drug testing~~, in order to receive MFIP benefits~~. Following any positive test for a controlled substance, the ~~convicted applicant or participant is subject to the following sanctions:~~ county must provide information about substance use disorder treatment programs to the applicant or participant.

~~(1) a first time drug test failure results in a reduction of benefits in an amount equal to 30 percent of the MFIP standard of need; and~~

~~(2) a second time drug test failure results in permanent disqualification from receiving MFIP assistance.~~

~~A similar disqualification sequence occurs if the applicant is receiving Supplemental Nutrition Assistance Program (SNAP) benefits.~~

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

ARTICLE 11
HOUSING SUPPORTS

Section 1. Minnesota Statutes 2022, section 256I.03, subdivision 7, is amended to read:

Subd. 7. **Countable income.** (a) "Countable income" means all income received by an applicant or recipient as described under section 256P.06, less any applicable exclusions or disregards. ~~For a recipient of any cash benefit from the SSI program, countable income means the SSI benefit limit in effect at the time the person is a recipient of housing support, less the medical assistance personal needs allowance under section 256B.35. If the SSI limit or benefit is reduced for a person due to events other than receipt of additional income, countable income means actual income less any applicable exclusions and disregards.~~

(b) For a recipient of any cash benefit from the SSI program who does not live in a setting described in section 256I.04, subdivision 2a, paragraph (b), clause (2), countable income equals the SSI benefit limit in effect at the time the person is a recipient of housing support, less the personal needs allowance under section 256B.35. If the SSI limit or benefit is reduced for a person due to events other than receipt of additional income, countable income equals actual income less any applicable exclusions and disregards.

(c) For a recipient of any cash benefit from the SSI program who lives in a setting as described in section 256I.04, subdivision 2a, paragraph (b), clause (2), countable income equals 30 percent of the SSI benefit limit in effect at the time a person is a recipient of housing support. If the SSI limit or benefit is reduced for a person due to events other than receipt of additional income, countable income equals 30 percent of the actual income less any applicable exclusions and disregards. For recipients under this paragraph, the personal needs allowance described in section 256B.35 does not apply.

(d) Notwithstanding the earned income disregard described in section 256P.03, for a recipient of unearned income as defined in section 256P.06, subdivision 3, clause (2), other than SSI and the general assistance personal needs allowance who lives in a setting described in section 256I.04, subdivision 2a, paragraph (b), clause (2), countable income equals 30 percent of the recipient's total income after applicable exclusions and disregards. Total income includes any unearned income as defined in section 256P.06 and any earned income in the month the person is a recipient of housing support. For recipients under this paragraph, the personal needs allowance described in section 256B.35 does not apply.

(e) For a recipient who lives in a setting as described in section 256I.04, subdivision 2a, paragraph (b), clause (2), and receives general assistance, the personal needs allowance described in section 256B.35 is not countable unearned income.

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

Sec. 2. Minnesota Statutes 2022, section 256I.04, subdivision 1, is amended to read:

Subdivision 1. **Individual eligibility requirements.** An individual is eligible for and entitled to a housing support payment to be made on the individual's behalf if the agency has approved the setting where the individual will receive housing support and the individual meets the requirements in paragraph (a), (b), ~~or~~ (c), or (d).

(a) The individual is aged, blind, or is over 18 years of age with a disability as determined under the criteria used by the title II program of the Social Security Act, and meets the resource restrictions and standards of section 256P.02, and the individual's countable income after deducting the (1) exclusions and disregards of the SSI program, (2) the medical assistance personal needs allowance under section 256B.35, and (3) an amount equal to the income actually made available to a community spouse by an elderly waiver participant under the provisions of sections 256B.0575, paragraph (a), clause (4), and 256B.058, subdivision 2, is less than the monthly rate specified in the agency's agreement with the provider of housing support in which the individual resides.

(b) The individual meets a category of eligibility under section 256D.05, subdivision 1, paragraph (a), clauses (1), (3), (4) to (8), and (13), and paragraph (b), if applicable, and the individual's resources are less than the standards specified by section 256P.02, and the individual's countable income as determined under section 256P.06, less the medical assistance personal needs allowance under section 256B.35 is less than the monthly rate specified in the agency's agreement with the provider of housing support in which the individual resides.

(c) The individual lacks a fixed, adequate, nighttime residence upon discharge from a residential behavioral health treatment program, as determined by treatment staff from the residential behavioral health treatment program. An individual is eligible under this paragraph for up to three months, including a full or partial month from the individual's move-in date at a setting approved for housing support following discharge from treatment, plus two full months.

(d) The individual meets the criteria related to establishing a certified disability or disabling condition in paragraph (a) or (b) and lacks a fixed, adequate, nighttime residence upon discharge from a correctional facility, as determined by an authorized representative from a Minnesota-based correctional facility. An individual is eligible under this paragraph for up to three months, including a full or partial month from the individual's move-in date at a setting approved for housing support following release, plus two full months. People who meet the disabling condition criteria established in paragraph (a) or (b) will not have any countable income for the duration of eligibility under this paragraph.

ARTICLE 12
MISCELLANEOUS

Section 1. Minnesota Statutes 2022, section 62A.30, is amended by adding a subdivision to read:

Subd. 5. **Mammogram; diagnostic services and testing.** If a health care provider determines an enrollee requires additional diagnostic services or testing after a mammogram, a health plan must provide coverage for the additional diagnostic services or testing with no cost sharing, including co-pay, deductible, or coinsurance.

EFFECTIVE DATE. This section is effective January 1, 2024, and applies to health plans offered, issued, or sold on or after that date.

Sec. 2. Minnesota Statutes 2022, section 62A.30, is amended by adding a subdivision to read:

Subd. 6. **Application.** If the application of subdivision 5 before an enrollee has met their health plan's deductible would result in: (1) health savings account ineligibility under United States Code, title 26, section 223; or (2) catastrophic health plan ineligibility under United States Code, title 42, section 18022(e), then subdivision 5 shall apply to diagnostic services or testing only after the enrollee has met their health plan's deductible.

EFFECTIVE DATE. This section is effective January 1, 2024, and applies to health plans offered, issued, or sold on or after that date.

Sec. 3. **[62Q.481] COST-SHARING FOR PRESCRIPTION DRUGS AND RELATED MEDICAL SUPPLIES TO TREAT CHRONIC DISEASE.**

Subdivision 1. **Cost-sharing limits.** (a) A health plan must limit the amount of any enrollee cost-sharing for prescription drugs prescribed to treat a chronic disease to no more than $25 per one-month supply for each prescription drug regardless of the amount or type of medication required to fill the prescription and to no more than $50 per month in total for all related medical supplies. The cost-sharing limit for related medical supplies does not increase with the number of chronic diseases for which an enrollee is treated. Coverage under this section shall not be subject to any deductible.

(b) If application of this section before an enrollee has met their plan's deductible would result in: (1) health savings account ineligibility under United States Code, title 26, section 223; or (2) catastrophic health plan ineligibility under United States Code, title 42, section 18022(e), then this section shall apply to that specific prescription drug or related medical supply only after the enrollee has met their plan's deductible.

Subd. 2. **Definitions.** (a) For purposes of this section, the following definitions apply.

(b) "Chronic disease" means diabetes, asthma, and allergies requiring the use of epinephrine auto-injectors.

(c) "Cost-sharing" means co-payments and coinsurance.

(d) "Related medical supplies" means syringes, insulin pens, insulin pumps, test strips, glucometers, continuous glucose monitors, epinephrine auto-injectors, asthma inhalers, and other medical supply items necessary to effectively and appropriately treat a chronic disease or administer a prescription drug prescribed to treat a chronic disease.

EFFECTIVE DATE. This section is effective January 1, 2024, and applies to health plans offered, issued, or renewed on or after that date.

Sec. 4. Minnesota Statutes 2022, section 121A.28, is amended to read:

121A.28 LAW ENFORCEMENT RECORDS.

A law enforcement agency shall provide notice of any drug incident occurring within the agency's jurisdiction, in which the agency has probable cause to believe a student violated section 152.021, 152.022, 152.023, 152.024, 152.025, 152.0262, 152.027, ~~152.092,~~ 152.097, or 340A.503, subdivision 1, 2, or 3. The notice shall be in writing and shall be provided, within two weeks after an incident occurs, to the chemical abuse preassessment team in the school where the student is enrolled.

Sec. 5. Minnesota Statutes 2022, section 151.01, is amended by adding a subdivision to read:

Subd. 43. **Syringe services provider.** "Syringe services provider" means a community-based public health program that offers cost-free comprehensive harm reduction services which may include: providing sterile needles, syringes, and other injection equipment; making safe disposal containers for needles and syringes available; educating participants and others about overdose prevention, safer injection practices, and infectious disease prevention; providing blood-borne pathogen testing or referrals to blood-borne pathogen testing; offering referrals to substance use disorder treatment, including substance use disorder treatment with medications for opioid use disorder; and providing referrals to medical treatment and services, mental health programs and services, and other social services.

Sec. 6. Minnesota Statutes 2022, section 151.40, subdivision 1, is amended to read:

Subdivision 1. **Generally.** It is unlawful for any person to ~~possess, control,~~ manufacture, sell, furnish, dispense, or otherwise dispose of hypodermic syringes or needles or any instrument or implement which can be adapted for subcutaneous injections, except for:

(1) the following persons when acting in the course of their practice or employment:

(i) licensed practitioners and their employees, agents, or delegates;

(ii) licensed pharmacies and their employees or agents;

(iii) licensed pharmacists;

(iv) registered nurses and licensed practical nurses;

(v) registered medical technologists;

(vi) medical interns and residents;

(vii) licensed drug wholesalers and their employees or agents;

(viii) licensed hospitals;

(ix) bona fide hospitals in which animals are treated;

(x) licensed nursing homes;

(xi) licensed morticians;

(xii) syringe and needle manufacturers and their dealers and agents;

(xiii) persons engaged in animal husbandry;

(xiv) clinical laboratories and their employees;

(xv) persons engaged in bona fide research or education or industrial use of hypodermic syringes and needles provided such persons cannot use hypodermic syringes and needles for the administration of drugs to human beings unless such drugs are prescribed, dispensed, and administered by a person lawfully authorized to do so; ~~and~~

(xvi) persons who administer drugs pursuant to an order or direction of a licensed practitioner; and

(xvii) syringe services providers and their employees and agents;

(2) a person who self-administers drugs pursuant to either the prescription or the direction of a practitioner, or a family member, caregiver, or other individual who is designated by such person to assist the person in obtaining and using needles and syringes for the administration of such drugs;

(3) a person who is disposing of hypodermic syringes and needles through an activity or program developed under section 325F.785; ~~or~~

(4) a person who sells~~, possesses,~~ or handles hypodermic syringes and needles pursuant to subdivision 2~~.~~; or

(5) a participant receiving services from a syringe services provider, who accesses or receives new syringes or needles from a syringe services provider or returns used syringes or needles to a syringe services provider.

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

Sec. 7. Minnesota Statutes 2022, section 151.40, subdivision 2, is amended to read:

Subd. 2. **Sales ~~of limited quantities~~ of clean needles and syringes.** (a) A registered pharmacy or a licensed pharmacist may sell, without the prescription or direction of a practitioner, unused hypodermic needles and syringes ~~in quantities of ten or fewer,~~ provided the pharmacy or pharmacist complies with all of the requirements of this subdivision.

(b) At any location where hypodermic needles and syringes are kept for retail sale under this subdivision, the needles and syringes shall be stored in a manner that makes them available only to authorized personnel and not openly available to customers.

(c) A registered pharmacy or licensed pharmacist that sells hypodermic needles or syringes under this subdivision may give the purchaser the materials developed by the commissioner of health under section 325F.785.

(d) A registered pharmacy or licensed pharmacist that sells hypodermic needles or syringes under this subdivision must certify to the commissioner of health participation in an activity, including but not limited to those developed under section 325F.785, that supports proper disposal of used hypodermic needles or syringes.

Sec. 8. Minnesota Statutes 2022, section 151.74, subdivision 3, is amended to read:

Subd. 3. **Access to urgent-need insulin.** (a) MNsure shall develop an application form to be used by an individual who is in urgent need of insulin. The application must ask the individual to attest to the eligibility requirements described in subdivision 2. The form shall be accessible through MNsure's website. MNsure shall also make the form available to pharmacies and health care providers who prescribe or dispense insulin, hospital emergency departments, urgent care clinics, and community health clinics. By submitting a completed, signed, and dated application to a pharmacy, the individual attests that the information contained in the application is correct.

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

(1) have a valid insulin prescription; and

(2) present the pharmacist with identification indicating Minnesota residency in the form of a valid Minnesota identification card, driver's license or permit, individual taxpayer identification number, or Tribal identification card as defined in section 171.072, paragraph (b). If the individual in urgent need of insulin is under the age of 18, the individual's parent or legal guardian must provide the pharmacist with proof of residency.

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

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

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

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

(1) applying for medical assistance or MinnesotaCare;

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

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

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

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

Sec. 9. Minnesota Statutes 2022, section 151.74, subdivision 4, is amended to read:

Subd. 4. **Continuing safety net program; general.** (a) Each manufacturer shall make a patient assistance program available to any individual who meets the requirements of this

subdivision. Each manufacturer's patient assistance programs must meet the requirements of this section. Each manufacturer shall provide the Board of Pharmacy with information regarding the manufacturer's patient assistance program, including contact information for individuals to call for assistance in accessing their patient assistance program.

(b) To be eligible to participate in a manufacturer's patient assistance program, the individual must:

(1) be a Minnesota resident with a valid Minnesota identification card that indicates Minnesota residency in the form of a Minnesota identification card, driver's license or permit, individual taxpayer identification number, or Tribal identification card as defined in section 171.072, paragraph (b). If the individual is under the age of 18, the individual's parent or legal guardian must provide proof of residency;

(2) have a family income that is equal to or less than 400 percent of the federal poverty guidelines;

(3) not be enrolled in medical assistance or MinnesotaCare;

(4) not be eligible to receive health care through a federally funded program or receive prescription drug benefits through the Department of Veterans Affairs; and

(5) not be enrolled in prescription drug coverage through an individual or group health plan that limits the total amount of cost-sharing that an enrollee is required to pay for a 30-day supply of insulin, including co-payments, deductibles, or coinsurance to $75 or less, regardless of the type or amount of insulin needed.

(c) Notwithstanding the requirement in paragraph (b), clause (4), an individual who is enrolled in Medicare Part D is eligible for a manufacturer's patient assistance program if the individual has spent $1,000 on prescription drugs in the current calendar year and meets the eligibility requirements in paragraph (b), clauses (1) to (3).

(d) An individual who is interested in participating in a manufacturer's patient assistance program may apply directly to the manufacturer; apply through the individual's health care practitioner, if the practitioner participates; or contact a trained navigator for assistance in finding a long-term insulin supply solution, including assistance in applying to a manufacturer's patient assistance program.

Sec. 10. Minnesota Statutes 2022, section 152.01, subdivision 18, is amended to read:

Subd. 18. **Drug paraphernalia.** (a) Except as otherwise provided in paragraph (b), "drug paraphernalia" means all equipment, products, and materials of any kind, except those items

used in conjunction with permitted uses of controlled substances under this chapter or the Uniform Controlled Substances Act, which are knowingly or intentionally used primarily in (1) manufacturing a controlled substance, (2) injecting, ingesting, inhaling, or otherwise introducing into the human body a controlled substance, or (3) ~~testing the strength, effectiveness, or purity of a controlled substance, or (4)~~ enhancing the effect of a controlled substance.

(b) "Drug paraphernalia" does not include the possession, manufacture, delivery, or sale of: (1) ~~hypodermic needles or syringes in accordance with section 151.40, subdivision 2~~ hypodermic syringes or needles or any instrument or implement which can be adapted for subcutaneous injections; or (2) products that detect the presence of fentanyl or a fentanyl analog in a controlled substance.

EFFECTIVE DATE. This section is effective August 1, 2023, and applies to crimes committed on or after that date.

Sec. 11. Minnesota Statutes 2022, section 152.205, is amended to read:

152.205 LOCAL REGULATIONS.

Sections 152.01, subdivision 18, and ~~152.092~~ 152.093 to 152.095 do not preempt enforcement or preclude adoption of municipal or county ordinances prohibiting or otherwise regulating the manufacture, delivery, possession, or advertisement of drug paraphernalia.

Sec. 12. Minnesota Statutes 2022, section 256L.03, subdivision 5, is amended to read:

Subd. 5. **Cost-sharing.** (a) Co-payments, coinsurance, and deductibles do not apply to children under the age of 21 and to American Indians as defined in Code of Federal Regulations, title 42, section 600.5.

(b) The commissioner shall adjust co-payments, coinsurance, and deductibles for covered services in a manner sufficient to maintain the actuarial value of the benefit to 94 percent. The cost-sharing changes described in this paragraph do not apply to eligible recipients or services exempt from cost-sharing under state law. The cost-sharing changes described in this paragraph shall not be implemented prior to January 1, 2016.

(c) The cost-sharing changes authorized under paragraph (b) must satisfy the requirements for cost-sharing under the Basic Health Program as set forth in Code of Federal Regulations, title 42, sections 600.510 and 600.520.

(d) Cost-sharing for prescription drugs and related medical supplies to treat chronic disease must comply with the requirements of section 62Q.481.

EFFECTIVE DATE. This section is effective January 1, 2024.

Sec. 13. Minnesota Statutes 2022, section 256L.03, subdivision 5, is amended to read:

Subd. 5. **Cost-sharing.** (a) Co-payments, coinsurance, and deductibles do not apply to children under the age of 21 and to American Indians as defined in Code of Federal Regulations, title 42, section 600.5.

(b) The commissioner shall adjust co-payments, coinsurance, and deductibles for covered services in a manner sufficient to maintain the actuarial value of the benefit to 94 percent. The cost-sharing changes described in this paragraph do not apply to eligible recipients or services exempt from cost-sharing under state law. The cost-sharing changes described in this paragraph shall not be implemented prior to January 1, 2016.

(c) The cost-sharing changes authorized under paragraph (b) must satisfy the requirements for cost-sharing under the Basic Health Program as set forth in Code of Federal Regulations, title 42, sections 600.510 and 600.520.

(d) Co-payments, coinsurance, and deductibles do not apply to additional diagnostic services or testing that a health care provider determines an enrollee requires after a mammogram, as specified under section 62A.30, subdivision 5.

EFFECTIVE DATE. This section is effective January 1, 2024.

Sec. 14. **REPEALER.**

Minnesota Statutes 2022, section 152.092, is repealed.

ARTICLE 13
FORECAST ADJUSTMENTS

Section 1. **DEPARTMENT OF HUMAN SERVICES FORECAST ADJUSTMENT.**

The dollar amounts shown in the columns marked "Appropriations" are added to or, if shown in parentheses, are subtracted from the appropriations in Laws 2021, First Special Session chapter 7, article 15, and Laws 2021, First Special Session chapter 7, article 16, from the general fund, or any other fund named, to the commissioner of human services for the purposes specified in this article, to be available for the fiscal year indicated for each purpose. The figure "2023" used in this article means that the appropriations listed are available for the fiscal year ending June 30, 2023.

APPROPRIATIONS
Available for the Year

			Ending June 30
			2023

Sec. 2. **COMMISSIONER OF HUMAN SERVICES**

Subdivision 1. **Total Appropriation**		**$**	**(1,453,441,000)**
Appropriations by Fund			
	2023		
General	(1,228,684,000)		
Health Care Access	(203,530,000)		
Federal TANF	(21,227,000)		
Subd. 2. **Forecasted Programs**			
(a) **Minnesota Family Investment Program (MFIP)/Diversionary Work Program (DWP)**			
Appropriations by Fund			
	2023		
General	(99,000)		
Federal TANF	(21,227,000)		
(b) **MFIP Child Care Assistance**			(36,957,000)
(c) **General Assistance**			(1,632,000)
(d) **Minnesota Supplemental Aid**			783,000
(e) **Housing Support**			180,000
(f) **Northstar Care for Children**			(18,038,000)
(g) **MinnesotaCare**			(203,530,000)
This appropriation is from the health care access fund.			
(h) **Medical Assistance**			
Appropriations by Fund			
	2023		
General	(1,172,921,000)		
Health Care Access	0		
(i) **Behavioral Health Fund**			(6,404,000)

Sec. 3. **EFFECTIVE DATE.**

Sections 1 and 2 are effective the day following final enactment.

ARTICLE 14

APPROPRIATIONS

Section 1. **HEALTH AND HUMAN SERVICES APPROPRIATIONS.**

The sums shown in the columns marked "Appropriations" are appropriated to the agencies and for the purposes specified in this article. The appropriations are from the general fund, or another named fund, and are available for the fiscal years indicated for each purpose. The figures "2024" and "2025" used in this article mean that the appropriations listed under them are available for the fiscal year ending June 30, 2024, or June 30, 2025, respectively. "The first year" is fiscal year 2024. "The second year" is fiscal year 2025. "The biennium" is fiscal years 2024 and 2025.

	APPROPRIATIONS	
	Available for the Year	
	Ending June 30	
	2024	**2025**

Sec. 2. **COMMISSIONER OF HUMAN SERVICES**

Subdivision 1. **Total Appropriation** **$ 3,088,283,000 $ 3,123,222,000**

Appropriations by Fund

	2024	2025
General	2,006,239,000	1,724,385,000
State Government Special Revenue	4,846,000	5,294,000
Health Care Access	999,810,000	1,318,111,000
Federal TANF	75,165,000	75,269,000

The amounts that may be spent for each purpose are specified in the following subdivisions.

Subd. 2. **TANF Maintenance of Effort**

(a) **Nonfederal Expenditures.** The commissioner shall ensure that sufficient

qualified nonfederal expenditures are made each year to meet the state's maintenance of effort requirements of the TANF block grant specified under Code of Federal Regulations, title 45, section 263.1. In order to meet these basic TANF maintenance of effort requirements, the commissioner may report as TANF maintenance of effort expenditures only nonfederal money expended for allowable activities listed in the following clauses:

(1) MFIP cash, diversionary work program, and food assistance benefits under Minnesota Statutes, chapter 256J;

(2) the child care assistance programs under Minnesota Statutes, sections 119B.03 and 119B.05, and county child care administrative costs under Minnesota Statutes, section 119B.15;

(3) state and county MFIP administrative costs under Minnesota Statutes, chapters 256J and 256K;

(4) state, county, and Tribal MFIP employment services under Minnesota Statutes, chapters 256J and 256K;

(5) expenditures made on behalf of legal noncitizen MFIP recipients who qualify for the MinnesotaCare program under Minnesota Statutes, chapter 256L;

(6) qualifying working family credit expenditures under Minnesota Statutes, section 290.0671;

(7) qualifying Minnesota education credit expenditures under Minnesota Statutes, section 290.0674; and

(8) qualifying Head Start expenditures under Minnesota Statutes, section 119A.50.

(b) **Nonfederal Expenditures; Reporting.** For the activities listed in paragraph (a), clauses (2) to (8), the commissioner may report only expenditures that are excluded from the definition of assistance under Code of Federal Regulations, title 45, section 260.31.

(c) **Limitations; Exceptions.** The commissioner must not claim an amount of TANF maintenance of effort in excess of the 75 percent standard in Code of Federal Regulations, title 45, section 263.1(a)(2), except:

(1) to the extent necessary to meet the 80 percent standard under Code of Federal Regulations, title 45, section 263.1(a)(1), if it is determined by the commissioner that the state will not meet the TANF work participation target rate for the current year;

(2) to provide any additional amounts under Code of Federal Regulations, title 45, section 264.5, that relate to replacement of TANF funds due to the operation of TANF penalties; and

(3) to provide any additional amounts that may contribute to avoiding or reducing TANF work participation penalties through the operation of the excess maintenance of effort provisions of Code of Federal Regulations, title 45, section 261.43(a)(2).

(d) **Supplemental Expenditures.** For the purposes of paragraph (c), the commissioner

may supplement the maintenance of effort claim with working family credit expenditures or other qualified expenditures to the extent such expenditures are otherwise available after considering the expenditures allowed in this subdivision.

(e) **Reduction of Appropriations; Exception.** The requirement in Minnesota Statutes, section 256.011, subdivision 3, that federal grants or aids secured or obtained under that subdivision be used to reduce any direct appropriations provided by law does not apply if the grants or aids are federal TANF funds.

(f) **IT Appropriations Generally.** This appropriation includes funds for information technology projects, services, and support. Notwithstanding Minnesota Statutes, section 16E.0466, funding for information technology project costs must be incorporated into the service level agreement and paid to the Minnesota IT Services by the Department of Human Services under the rates and mechanism specified in that agreement.

(g) **Receipts for Systems Project.** Appropriations and federal receipts for information technology systems projects for MAXIS, PRISM, MMIS, ISDS, METS, and SSIS must be deposited in the state systems account authorized in Minnesota Statutes, section 256.014. Money appropriated for information technology projects approved by the commissioner of the Minnesota IT Services funded by the legislature and approved by the commissioner of management and budget may be transferred from one

project to another and from development to operations as the commissioner of human services considers necessary. Any unexpended balance in the appropriation for these projects does not cancel and is available for ongoing development and operations.

(h) **Federal SNAP Education and Training Grants.** Federal funds available during fiscal years 2024 and 2025 for Supplemental Nutrition Assistance Program Education and Training and SNAP Quality Control Performance Bonus grants are appropriated to the commissioner of human services for the purposes allowable under the terms of the federal award. This paragraph is effective the day following final enactment.

Subd. 3. **Central Office; Operations**

	Appropriations by Fund	
General	267,092,000	241,948,000
State Government Special Revenue	4,721,000	5,169,000
Health Care Access	9,347,000	11,244,000
Federal TANF	1,090,000	1,194,000

(a) **Administrative Recovery; Set-Aside.** The commissioner may invoice local entities through the SWIFT accounting system as an alternative means to recover the actual cost of administering the following provisions:

(1) the statewide data management system authorized in Minnesota Statutes, section 125A.744, subdivision 3;

(2) repayment of the special revenue maximization account as provided under Minnesota Statutes, section 245.495, paragraph (b);

(3) repayment of the special revenue maximization account as provided under Minnesota Statutes, section 256B.0625, subdivision 20, paragraph (k);

(4) targeted case management under Minnesota Statutes, section 256B.0924, subdivision 6, paragraph (g);

(5) residential services for children with severe emotional disturbance under Minnesota Statutes, section 256B.0945, subdivision 4, paragraph (d); and

(6) repayment of the special revenue maximization account as provided under Minnesota Statutes, section 256F.10, subdivision 6, paragraph (b).

(b) **Base Level Adjustment.** The general fund base is $212,294,000 in fiscal year 2026 and $230,052,000 in fiscal year 2027. The state government special revenue base is $4,765,000 in fiscal year 2026 and $4,765,000 in fiscal year 2027.

Subd. 4. **Central Office; Children and Families**

	Appropriations by Fund	
General	18,791,000	18,797,000
Federal TANF	2,582,000	2,582,000

Subd. 5. **Central Office; Health Care**

	Appropriations by Fund	
General	33,442,000	33,650,000
Health Care Access	28,168,000	28,168,000

(a) **Dental Home Pilot Project.** $312,000 in fiscal year 2024 and $347,000 in fiscal year 2025 are from the general fund to establish and evaluate the dental home pilot project.

The general fund base for this appropriation is $347,000 in fiscal year 2026, $347,000 in fiscal year 2027, $347,000 in fiscal year 2028, and $0 in fiscal year 2029.

(b) **Base Level Adjustment.** The general fund base is $47,017,000 in fiscal year 2026 and $61,778,000 in fiscal year 2027.

Subd. 6. **Central Office; Continuing Care for Older Adults**

	Appropriations by Fund	
General	38,726,000	34,688,000
State Government Special Revenue	125,000	125,000

Subd. 7. **Central Office; Behavioral Health, Housing, and Deaf and Hard of Hearing Services** 26,963,000 26,305,000

(a) **Evaluation of Outcomes; PATH Grants.** $150,000 in fiscal year 2025 is for evaluating outcomes for the additional grant funding for the expansion of base funding for the PATH grants. This is a onetime appropriation.

(b) **Online Locator.** $1,720,000 in fiscal year 2024 and $1,720,000 in fiscal year 2025 are for an online behavioral health program locator with continued expansion of the provider database allowing people to research and access mental health and substance use disorder treatment options.

(c) **Base Level Adjustment.** The general fund base is $24,421,000 in fiscal year 2026 and $24,339,000 in fiscal year 2027.

Subd. 8. **Forecasted Programs; MFIP/DWP** 77,000 108,000

Subd. 9. **Forecasted Programs; General Assistance** 52,018,000 74,455,000

Emergency General Assistance. The amount appropriated for emergency general assistance is limited to no more than $6,729,812 in fiscal year 2024 and $6,729,812 in fiscal year 2025. Funds to counties shall be allocated by the commissioner using the allocation method under Minnesota Statutes, section 256D.06.

Subd. 10. **Forecasted Programs; Minnesota Supplemental Aid** 58,320,000 59,865,000

Subd. 11. **Forecasted Programs; Housing Support** 211,692,000 224,225,000

Subd. 12. **Forecasted Programs; MinnesotaCare** 89,306,000 60,533,000

These appropriations are from the health care access fund.

Subd. 13. **Forecasted Programs; Medical Assistance**

	Appropriations by Fund	
General	1,091,518,000	805,855,000
Health Care Access	869,524,000	1,214,701,000

Base Level Adjustment. The health care access fund base is $570,233,000 in fiscal year 2026, $1,147,261,000 in fiscal year 2027, and $612,099,000 in fiscal year 2028.

Subd. 14. **Forecasted Programs; Alternative Care** 79,000 230,000

Subd. 15. **Forecasted Programs; Behavioral Health Fund** 847,000 1,766,000

Subd. 16. **Grant Programs; Health Care Grants**

	Appropriations by Fund	
General	7,311,000	7,311,000
Health Care Access	3,465,000	3,465,000

(a) **Indian Health Board.** $2,500,000 in fiscal year 2024 and $2,500,000 in fiscal year 2025 are from the general fund for funding to the Indian Health Board of Minneapolis to support

continued access to health care coverage through Minnesota health care programs, improve access to quality care, and increase vaccination rates among urban American Indians. The general fund base for this appropriation is $2,500,000 in fiscal year 2026 and $0 in fiscal year 2027.

(b) **Base Level Adjustment.** The general fund base is $7,311,000 in fiscal year 2026 and $4,811,000 in fiscal year 2027.

Subd. 17. **Grant Programs; Disabilities Grants**	500,000	1,000,000

(a) **Transition to Community Initiative.** $500,000 in fiscal year 2024 and $1,000,000 in fiscal year 2025 are for the transition to community grant initiative grant funding under the Laws 2021, First Special Session chapter 7, article 17, section 6.

(b) **Base Level Adjustment.** The general fund base is $1,000,000 in fiscal year 2026, and $100,00 in fiscal year 2027.

Subd. 18. **Grant Programs; Housing Support Grants**	19,464,000	11,464,000

Heading Home Corps. $1,100,000 in fiscal year 2024 and $1,100,000 in fiscal year 2025 are for the AmeriCorps Heading Home Corps program.

Subd. 19. **Grant Programs; Adult Mental Health Grants**	127,912,000	137,925,000

(a) **White Earth Nation; Adult Mental Health Initiative.** $300,000 in fiscal year 2024 and $300,000 in fiscal year 2025 are for adult mental health initiative grants to the White Earth Nation. This is a onetime appropriation.

(b) **Transition to Community Initiative.** $750,000 in fiscal year 2024 and $750,000 in fiscal year 2025 are for the transition to community grant initiative grant funding under Laws 2021, First Special Session chapter 7, article 17, section 6.

(c) **Mobile Crisis Grants.** $4,000,000 in fiscal year 2024 and $8,000,000 in fiscal year 2025 are for the mobile crisis grants under the Laws 2021, First Special Session chapter 7, article 17, section 11. This is a onetime appropriation.

(d) **Mobile Crisis Funds to Tribal Nations.** $1,000,000 in fiscal year 2024 and $1,000,000 in fiscal year 2025 are for mobile crisis funds to Tribal Nations. This is a onetime appropriation.

(e) **Base Level Adjustment.** The general fund base is $127,297,000 in fiscal year 2026 and $127,297,000 in fiscal year 2027.

Subd. 20. **Grant Programs; Child Mental Health Grants** 50,128,000 43,426,000

(a) **School-Linked Behavioral Health Services.** $11,248,000 in fiscal year 2024 and $8,400,000 in fiscal year 2025 are for school-linked behavioral health services and for school-linked behavioral health services in intermediate school districts. The base for this appropriation is $2,500,000 in fiscal year 2026 and $2,500,000 in fiscal year 2027.

(b) **Psychiatric Residential Treatment Facility Specialization Grants.** $1,050,000 in fiscal year 2024 and $1,050,000 in fiscal year 2025 are for psychiatric residential treatment facilities specialization grants for

staffing costs to treat and support behavioral health conditions and support children and families.

(c) **Base Level Adjustment.** The general fund base is $37,526,000 in fiscal year 2026 and $37,526,000 in fiscal year 2027.

Subd. 21. **Grant Programs; Chemical Dependency Treatment Support Grants**

	Appropriations by Fund	
General	1,350,000	1,350,000

Subd. 22. **Technical Activities** 71,493,000 71,493,000

This appropriation is from the federal TANF fund.

Sec. 3. **COMMISSIONER OF HEALTH**

Subdivision 1. **Total Appropriation** **$ 473,547,000 $ 435,321,000**

	Appropriations by Fund	
	2024	2025
General	327,115,000	278,748,000
State Government Special Revenue	83,373,000	85,902,000
Health Care Access	38,857,000	41,557,000
Federal TANF	11,713,000	11,713,000

The amounts that may be spent for each purpose are specified in the following subdivisions.

Subd. 2. **Health Improvement**

	Appropriations by Fund	
General	272,015,000	272,758,000
State Government Special Revenue	12,392,000	12,682,000
Health Care Access	38,857,000	41,557,000
Federal TANF	11,713,000	11,713,000

(a) **Telehealth; Payment Parity.** Of the amount appropriated in Laws 2021, First

Special Session chapter 7, article 16, section 3, subdivision 2, $1,200,000 from the general fund in fiscal year 2023 is for the studies of telehealth expansion and payment parity and is available until June 30, 2024.

(b) **Adolescent Mental Health Promotion.** $2,790,000 in fiscal year 2024 and $2,790,000 in fiscal year 2025 are from the general fund for adolescent mental health promotion. Of this appropriation each year, $2,250,000 is for grants and $540,000 is for administration. This is a onetime appropriation.

(c) **Advancing Equity Through Capacity Building and Resource Allocation.** $1,986,000 in fiscal year 2024 and $1,986,000 in fiscal year 2025 are from the general fund to advance equity in procurement and grantmaking. Of this appropriation each year, $1,000,000 is for grants and $986,000 is for administration. This is a onetime appropriation.

(d) **Community Solutions for Healthy Child Development Grants.** $4,980,000 in fiscal year 2024 and $5,055,000 in fiscal year 2025 are from the general fund to improve child development outcomes and well-being of children of color and American Indian children and their families, under Minnesota Statutes, section 145.9257. Of this appropriation in fiscal year 2024, $4,000,000 is for grants and $980,000 is for administration and in fiscal year 2025, $4,000,000 is for grants and $1,055,000 is for administration.

(e) **Comprehensive Overdose and Morbidity Prevention Act.** $8,164,000 in fiscal year

2024 and $8,164,000 in fiscal year 2025 are from the general fund for comprehensive overdose and morbidity prevention strategies under Minnesota Statutes, section 144.0528. Of this appropriation each year, $6,250,000 is for grants and $1,644,000 is for administration.

(f) **Emergency Preparedness and Response.** $12,400,000 in fiscal year 2024 and $12,400,000 in fiscal year 2025 are from the general fund for public health emergency preparedness and response, the sustainability of the strategic stockpile, and COVID-19 pandemic response transition. Of this appropriation each year, $8,400,000 is for grants and $4,000,000 is for administration. The general fund base for this appropriation is $11,400,000 in fiscal year 2026, of which $8,400,000 is for grants and $3,000,000 is for administration, and $11,400,000 in fiscal year 2027, of which $8,400,000 is for grants and $3,000,000 is for administration.

(g) **Healthy Beginnings, Healthy Families.** $12,052,000 in fiscal year 2024 and $11,853,000 in fiscal year 2025 are from the general fund for a comprehensive approach to ensure healthy outcomes for children and families. Of this appropriation in fiscal year 2024, $8,750,000 is for grants and $3,302,000 is for administration and in fiscal year 2025, $8,750,000 is for grants and $3,103,000 is for administration. This is a onetime appropriation.

(h) **No Surprises Act Enforcement.** $1,210,000 in fiscal year 2024 and $1,090,000

in fiscal year 2025 are from the general fund for implementation of the federal No Surprises Act portion of the Consolidated Appropriations Act, 2021, under Minnesota Statutes, section 62Q.021, and assessment of feasibility of a statewide provider directory. The general fund base for this appropriation is $855,000 in fiscal year 2026 and $855,000 in fiscal year 2027.

(i) **African American Health.** $2,182,000 in fiscal year 2024 and $2,182,000 in fiscal year 2025 are from the general fund to establish an Office of African American Health at the Minnesota Department of Health under Minnesota Statutes, section 144.0755, and for grants under Minnesota Statutes, section 144.0756. Of this appropriation each year, $1,000,000 is for grants and $1,182,000 is for administration. The general fund base for this appropriation is $2,182,00 in fiscal year 2026, of which $1,000,000 is for grants and $1,182,000 is for administration, and $2,117,000 in fiscal year 2027, of which $1,000,000 is for grants and $1,117,000 is for administration.

(j) **American Indian Health.** $2,089,000 in fiscal year 2024 and $2,089,000 in fiscal year 2025 are from the general fund for the Office of American Indian Health at the Minnesota Department of Health under Minnesota Statutes, section 144.0757. Of this appropriation each year, $1,000,000 is for grants and $1,089,000 is for administration.

(k) **Public Health System Transformation.** $17,120,000 in fiscal year 2024 and

$17,120,000 in fiscal year 2025 are from the general fund for public health system transformation. Of this appropriation each year:

(1) $15,000,000 is for grants to community health boards under Minnesota Statutes, section 145A.131, subdivision 1, paragraph (f);

(2) $750,000 is for grants to Tribal governments under Minnesota Statutes, section 145A.14, subdivision 2b;

(3) $500,000 is for a public health AmeriCorps program grant under Minnesota Statutes, section 144.0759; and

(4) $870,000 is for oversight and administration of activities under this paragraph.

The base for this appropriation is $8,000,000 in fiscal year 2026 and $8,000,000 in fiscal year 2027.

(l) **Health Care Workforce.** $6,120,000 in fiscal year 2024 and $7,400,000 in fiscal year 2025 are from the general fund to revitalize the Minnesota health care workforce. The general fund base for this appropriation is $6,850,000 in fiscal year 2026 and $7,100,000 in fiscal year 2027. Of this appropriation:

(1) $750,000 in fiscal year 2024 and $2,000,000 in fiscal year 2025 are for rural training tracks and rural clinicals grants under Minnesota Statutes, section 144.1508;

(2) $220,000 in fiscal year 2024 and $200,000 in fiscal year 2025 are for immigrant

international medical graduate training grants under Minnesota Statutes, section 144.1911;

(3) $3,250,000 in fiscal year 2024 and $3,300,000 in fiscal year 2025 are for site-based clinical training grants under Minnesota Statutes, section 144.1505. The base for this appropriation is $3,000,000 in fiscal year 2026 and $3,000,000 in fiscal year 2027;

(4) $500,000 in fiscal year 2024 and $500,000 in fiscal year 2025 are for mental health for health care professionals grants. These appropriations are available until June 30, 2027, and are onetime appropriations;

(5) $400,000 in fiscal year 2024 and $400,000 in fiscal year 2025 are for primary care employee recruitment education loan forgiveness under Minnesota Statutes, section 144.1504;

(6) $750,000 in fiscal year 2024 and $750,000 in fiscal year 2025 are for administration of the grant programs and loan forgiveness programs under this paragraph; and

(7) $250,000 in fiscal year 2024 and $250,000 in fiscal year 2025 are for workforce research and data on shortages, maldistribution of health care providers in Minnesota, and determinants of practicing in rural areas.

(m) **School Health.** $1,432,000 in fiscal year 2024 and $1,932,000 in fiscal year 2025 are from the general fund for school-based health centers under Minnesota Statutes, section 145.903. Of this appropriation each year, $800,000 is for grants and $632,000 is for

administration. The general fund base for this appropriation is $2,983,000 in fiscal year 2026, of which $2,300,000 is for grants and $683,000 is for administration, and $2,983,000 in fiscal year 2027, of which $2,300,000 is for grants and $683,000 is for administration.

(n) **Long COVID.** $3,146,000 in fiscal year 2024 and $3,146,000 in fiscal year 2025 are from the general fund to address long COVID and post-COVID conditions. Of this appropriation each year, $900,000 is for grants and $2,246,000 is for administration. This is a onetime appropriation.

(o) **Home Visiting for Priority Populations.** $2,500,000 in fiscal year 2024 and $2,500,000 in fiscal year 2025 are from the general fund to expand home visiting for priority populations under Minnesota Statutes, section 145.875. Of this appropriation each year, $2,250,000 is for grants and $250,000 is for administration.

(p) **Clinical Dental Education Innovation Grants.** $1,182,000 in fiscal year 2024 and $1,182,000 in fiscal year 2025 are from the general fund for clinical dental education innovation grants under Minnesota Statutes, section 144.1913. Of this appropriation each year, $1,122,000 is for grants and $60,000 is for administration.

(q) **Medical Education and Research Costs.** $300,000 in fiscal year 2024 and $300,000 in fiscal year 2025 are from the general fund for administration of the medical education and research costs program under Minnesota Statutes, section 62J.692.

(r) **Health Care Affordability Commission and Advisory Council.** $4,131,000 in fiscal year 2024 and $4,773,000 in fiscal year 2025 are from the general fund for the costs of the Health Care Affordability Commission and the Health Care Affordability Advisory Council, including the costs to the commissioner to provide technical and administrative support. The general fund base for this appropriation is $4,787,000 in fiscal year 2026 and $4,784,000 in fiscal year 2027.

(s) **Economic Analysis; Analytic Tool.** $4,420,000 in fiscal year 2024 and $580,000 in fiscal year 2025 are from the general fund to contract for and conduct an economic analysis of the benefits and costs of universal health care system reform models and to develop a related analytic tool. The general fund base for this appropriation is $580,000 in fiscal year 2026 and $0 in fiscal year 2027. This appropriation is available until June 30, 2027.

(t) **Keeping Nurses at the Bedside Act.** $11,553,000 in fiscal year 2024 and $11,558,000 in fiscal year 2025 are from the general fund for the Keeping Nurses at the Bedside Act. Of these appropriations:

(1) $5,000,000 in fiscal year 2024 and $5,000,000 in fiscal year 2025 are for mental health grants for health care professionals under Laws 2022, chapter 99, article 1, section 46;

(2) notwithstanding the priorities and distribution requirements under Minnesota Statutes, section 144.1501, $5,050,000 in

fiscal year 2024 and $5,050,000 in fiscal year 2025 are for the health professional education loan forgiveness program under Minnesota Statutes, section 144.1501, of which:

(i) $5,000,000 in fiscal year 2024 and $5,000,000 in fiscal year 2025 are for distribution to eligible nurses who have agreed to work as hospital nurses in accordance with Minnesota Statutes, section 144.1501, subdivision 2, paragraph (a), clause (7); and

(ii) $50,000 in fiscal year 2024 and $50,000 in fiscal year 2025 are for distribution to eligible nurses who have agreed to teach in accordance with Minnesota Statutes, section 144.1501, subdivision 2, paragraph (a), clause (3); and

(4) $1,503,000 in fiscal year 2024 and $1,508,000 in fiscal year 2025 are for the commissioner of health to administer Minnesota Statutes, section 144.7057; to perform the grading duties described in Minnesota Statutes, section 144.7058; to continue the prevention of violence in health care programs and to create violence prevention resources for hospitals and other health care providers to use to train their staff on violence prevention; for work to identify potential links between adverse events and understaffing; and for a report on the current status of the state's nursing workforce employed by hospitals.

(u) **Supporting Healthy Development of Babies During Pregnancy and Postpartum.** $260,000 in fiscal year 2024 is from the general fund for a grant to the Amherst H.

Wilder Foundation for the African American Babies Coalition initiative for community-driven training and education on best practices to support healthy development of babies during pregnancy and postpartum. The grant must be used to build capacity in, train, educate, or improve practices among individuals, from youth to elders, serving families with members who are Black, Indigenous, or People of Color during pregnancy and postpartum. This appropriation is available until June 30, 2025.

(v) **Critical Access Dental Infrastructure Program.** $20,000,000 in fiscal year 2024 is from the general fund for the critical access dental infrastructure program. This appropriation is available until June 30, 2026.

(w) **Workplace Safety Grants Program.** $10,000,000 in fiscal year 2024 is from the general fund for the workplace safety grants program for health care entities and human services providers. This appropriation is available until June 30, 2025.

(x) **Analyses and Reports; Health Care Transactions.** $2,000,000 in fiscal year 2024 is from the general fund to conduct analyses of the impacts of health care transactions on health care cost, quality, and competition, and to issue public reports on health care transactions in Minnesota and their impacts. This appropriation is available until June 30, 2025.

(y) **Provider Orders for Life-sustaining Treatment Registry.** $530,000 in fiscal year 2024 and $1,655,000 in fiscal year 2025 are

from the general fund to study and implement a statewide registry for provider orders for life-sustaining treatment. The general fund base for this appropriation is $658,000 in fiscal year 2026 and $658,000 in fiscal year 2027.

(z) **Emmett Louis Till Victims Recovery Program.** $500,000 in fiscal year 2024 is from the general fund for the Emmett Louis Till victims recovery program. This appropriation is available until June 30, 2025.

(aa) **Task Force on Pregnancy Health and Substance Use Disorders.** $100,000 in fiscal year 2024 is from the general fund for the Task Force on Pregnancy Health and Substance Use Disorders. This appropriation is available until December 1, 2024.

(bb) **Labor Trafficking Services Programs.** $546,000 in fiscal year 2024 and $546,000 in fiscal year 2025 are from the general fund for grants for comprehensive, trauma-informed, and culturally specific services for victims of labor trafficking or labor exploitation. This is a onetime appropriation.

(cc) **TANF Appropriations.** (1) TANF funds must be used as follows:

(i) $3,579,000 in fiscal year 2024 and $3,579,000 in fiscal year 2025 are from the TANF fund for home visiting and nutritional services listed under Minnesota Statutes, section 145.882, subdivision 7, clauses (6) and (7). Funds must be distributed to community health boards according to Minnesota Statutes, section 145A.131, subdivision 1;

(ii) $2,000,000 in fiscal year 2024 and $2,000,000 in fiscal year 2025 are from the TANF fund for decreasing racial and ethnic disparities in infant mortality rates under Minnesota Statutes, section 145.928, subdivision 7;

(iii) $4,978,000 in fiscal year 2024 and $4,978,000 in fiscal year 2025 are from the TANF fund for the family home visiting grant program under Minnesota Statutes, section 145A.17. $4,000,000 in each fiscal year must be distributed to community health boards under Minnesota Statutes, section 145A.131, subdivision 1. $978,000 in each fiscal year must be distributed to Tribal governments under Minnesota Statutes, section 145A.14, subdivision 2a;

(iv) $1,156,000 in fiscal year 2024 and $1,156,000 in fiscal year 2025 are from the TANF fund for family planning grants under Minnesota Statutes, section 145.925; and

(v) the commissioner may use up to 6.23 percent of the funds appropriated from the TANF fund each fiscal year to conduct the ongoing evaluations required under Minnesota Statutes, section 145A.17, subdivision 7, and training and technical assistance as required under Minnesota Statutes, section 145A.17, subdivisions 4 and 5.

(2) **TANF Carryforward.** Any unexpended balance of the TANF appropriation in the first year does not cancel but is available in the second year.

(dd) **Base Level Adjustments.** The general fund base is $193,750,000 in fiscal year 2026 and $193,323,000 in fiscal year 2027. The health care access fund base is $42,157,000 in fiscal year 2026 and $41,557,000 in fiscal year 2027.

Subd. 3. **Health Protection**

	Appropriations by Fund	
General	36,608,000	32,585,000
State Government Special Revenue	70,981,000	73,220,000

(a) **Lead Remediation in Schools and Child Care Settings.** $500,000 in fiscal year 2024 and $500,000 in fiscal year 2025 are from the general fund to reduce lead in drinking water in schools and child care facilities under Minnesota Statutes, section 145.9272. Of this appropriation in fiscal year 2024, $146,000 is for grants and $354,000 is for administration and in fiscal year 2025, $239,000 is for grants and $261,000 is for administration.

(b) **Antimicrobial Stewardship.** $312,000 in fiscal year 2024 and $312,000 in fiscal year 2025 are from the general fund for the Minnesota One Health Antimicrobial Stewardship Collaborative under Minnesota Statutes, section 144.0526.

(c) **Comprehensive Overdose and Morbidity Prevention Act; Public Health Laboratory and Infectious Disease Prevention.** $1,544,000 in fiscal year 2024 and $1,544,000 in fiscal year 2025 are from the general fund for comprehensive overdose and morbidity prevention strategies under Minnesota Statutes, section 144.0528. Of this

appropriation in fiscal year 2024, $960,000 is for grants and $584,000 is for administration and in fiscal year 2025, $960,000 is for grants and $584,000 is for administration.

(d) **HIV Prevention Health Equity.** $2,267,000 in fiscal year 2024 and $2,267,000 in fiscal year 2025 are from the general fund for equity in HIV prevention. Of this appropriation each year, $1,264,000 is for grants under Minnesota Statutes, section 145.924, and $1,003,000 is for administration. This is a onetime appropriation.

(e) **Uninsured and Underinsured Adult Vaccine Program.** $1,470,000 in fiscal year 2024 and $1,470,000 in fiscal year 2025 are from the general fund for the program for vaccines for uninsured and underinsured adults. This is a onetime appropriation.

(f) **Transfer to Public Health Response Contingency Account.** The commissioner shall transfer $4,804,000 in fiscal year 2024 from the general fund to the public health response contingency account established in Minnesota Statutes, section 144.4199. This is a onetime transfer.

(g) **Base Level Adjustments.** The general fund base is $31,115,000 in fiscal year 2026 and $31,115,000 in fiscal year 2027.

Subd. 4. **Health Operations**

	Appropriations by Fund	
General	18,492,000	18,405,000

Sec. 4. **HEALTH-RELATED BOARDS**

Subdivision 1. **Total Appropriation**	**$**	**31,304,000**	**$**	**32,040,000**

Appropriations by Fund		
General Fund	468,000	468,000
State Government Special Revenue	30,760,000	31,534,000
Health Care Access	76,000	38,000

This appropriation is from the state government special revenue fund unless specified otherwise. The amounts that may be spent for each purpose are specified in the following subdivisions.

Subd. 2. **Board of Behavioral Health and Therapy**	1,022,000	1,044,000
Subd. 3. **Board of Chiropractic Examiners**	773,000	790,000
Subd. 4. **Board of Dentistry**	4,100,000	4,163,000

(a) **Administrative Services Unit; Operating Costs.** Of this appropriation, $1,936,000 in fiscal year 2024 and $1,960,000 in fiscal year 2025 are for operating costs of the administrative services unit. The administrative services unit may receive and expend reimbursements for services it performs for other agencies.

(b) **Administrative Services Unit; Volunteer Health Care Provider Program.** Of this appropriation, $150,000 in fiscal year 2024 and $150,000 in fiscal year 2025 are to pay for medical professional liability coverage required under Minnesota Statutes, section 214.40.

(c) **Administrative Services Unit; Retirement Costs.** Of this appropriation, $237,000 in fiscal year 2024 and $237,000 in fiscal year 2025 are for the administrative services unit to pay for the retirement costs of health-related board employees. This funding

may be transferred to the health board incurring retirement costs. Any board that has an unexpended balance for an amount transferred under this paragraph shall transfer the unexpended amount to the administrative services unit. If the amount appropriated in the first year of the biennium is not sufficient, the amount from the second year of the biennium is available.

(d) **Administrative Services Unit; Contested Cases and Other Legal Proceedings.** Of this appropriation, $200,000 in fiscal year 2024 and $200,000 in fiscal year 2025 are for costs of contested case hearings and other unanticipated costs of legal proceedings involving health-related boards funded under this section. Upon certification by a health-related board to the administrative services unit that costs will be incurred and that there is insufficient money available to pay for the costs out of money currently available to that board, the administrative services unit is authorized to transfer money from this appropriation to the board for payment of those costs with the approval of the commissioner of management and budget. The commissioner of management and budget must require any board that has an unexpended balance for an amount transferred under this paragraph to transfer the unexpended amount to the administrative services unit to be deposited in the state government special revenue fund.

Subd. 5. **Board of Dietetics and Nutrition Practice**	213,000	217,000

Subd. 6. **Board of Executives for Long-term Services and Supports**	705,000	736,000
Subd. 7. **Board of Marriage and Family Therapy**	443,000	456,000
Subd. 8. **Board of Medical Practice**	5,779,000	5,971,000
Subd. 9. **Board of Nursing**	6,039,000	6,275,000
Subd. 10. **Board of Occupational Therapy Practice**	468,000	480,000
Subd. 11. **Board of Optometry**	270,000	280,000
Subd. 12. **Board of Pharmacy**		
Appropriations by Fund		
General Fund	468,000	468,000
State Government Special Revenue	5,226,000	5,206,000
Health Care Access	76,000	38,000

(a) **Medication Repository Program.** $468,000 in fiscal year 2024 and $468,000 in fiscal year 2025 are from the general fund for transfer to the central repository to administer the medication repository program under Minnesota Statutes, section 151.555.

(b) **Base Level Adjustment.** The state government special revenue fund base is $5,056,000 in fiscal year 2026 and $5,056,000 in fiscal year 2027. The health care access fund base is $0 in fiscal year 2026 and $0 in fiscal year 2027.

Subd. 13. **Board of Physical Therapy**	678,000	694,000
Subd. 14. **Board of Podiatric Medicine**	253,000	257,000
Subd. 15. **Board of Psychology**	2,618,000	2,734,000

Health Professionals Service Program. This appropriation includes $1,234,000 in fiscal year 2024 and $1,324,000 in fiscal year 2025 for the health professional services program.

Subd. 16. **Board of Social Work** 1,779,000 1,839,000

Subd. 17. **Board of Veterinary Medicine** 382,000 392,000

Sec. 5. **EMERGENCY MEDICAL SERVICES REGULATORY BOARD** **$ 6,800,000 $ 6,176,000**

(a) **Cooper/Sams Volunteer Ambulance Program.** $950,000 in fiscal year 2024 and $950,000 in fiscal year 2025 are for the Cooper/Sams volunteer ambulance program under Minnesota Statutes, section 144E.40.

(1) Of this appropriation, $861,000 in fiscal year 2024 and $861,000 in fiscal year 2025 are for the ambulance service personnel longevity award and incentive program under Minnesota Statutes, section 144E.40.

(2) Of this appropriation, $89,000 in fiscal year 2024 and $89,000 in fiscal year 2025 are for operations of the ambulance service personnel longevity award and incentive program under Minnesota Statutes, section 144E.40.

(b) **EMSRB Operations.** $2,421,000 in fiscal year 2024 and $2,480,000 in fiscal year 2025 are for board operations.

(c) **Regional Grants for Continuing Education.** $585,000 in fiscal year 2024 and $585,000 in fiscal year 2025 are for regional emergency medical services programs to be distributed equally to the eight emergency medical service regions under Minnesota Statutes, section 144E.52.

(d) **Ambulance Training Grants.** $361,000 in fiscal year 2024 and $361,000 in fiscal year 2025 are for training grants under Minnesota Statutes, section 144E.35.

(e) **Medical Resource Communication Center Grants.** $1,683,000 in fiscal year 2024 and $1,000,000 in fiscal year 2025 are for medical resource communication center grants under Minnesota Statutes, section 144E.53. This is a onetime appropriation.

(f) **Grants to Regional Emergency Medical Services Program.** $800,000 in fiscal year 2024 and $800,000 in fiscal year 2025 are for grants to regional emergency medical services programs, to be distributed among the eight emergency medical services regions according to Minnesota Statutes, section 144E.50.

(g) **Base Level Adjustment.** The general fund base is $5,176,000 in fiscal year 2026 and $5,176,000 in fiscal year 2027.

Sec. 6. **MNSURE.** **$ 22,373,000 $ 34,810,000**

(a) **Transfer.** The general fund appropriations must be transferred to the enterprise account established under Minnesota Statutes, section 62V.07, for the purpose of establishing a single end-to-end IT system with seamless, real-time interoperability between qualified health plan eligibility and enrollment services.

(b) **Base Level Adjustment.** The general fund base is $3,591,000 in fiscal year 2026, $3,530,000 in fiscal year 2027, and $7,055,000 in fiscal year 2028.

Sec. 7. **RARE DISEASE ADVISORY COUNCIL** **$ 314,000 $ 326,000**

Sec. 8. Laws 2021, First Special Session chapter 7, article 16, section 2, subdivision 32, as amended by Laws 2022, chapter 98, article 15, section 7, subdivision 32, is amended to read:

Subd. 32. **Grant Programs; Child Mental Health Grants**	30,167,000	30,182,000

(a) **Children's Residential Facilities.** $1,964,000 in fiscal year 2022 and $1,979,000 in fiscal year 2023 are to reimburse counties and Tribal governments for a portion of the costs of treatment in children's residential facilities. The commissioner shall distribute the appropriation to counties and Tribal governments proportionally based on a methodology developed by the commissioner. The ~~fiscal year 2022 appropriation is available until June 30, 2023~~ base for this activity is $0 in fiscal year 2025.

(b) **Base Level Adjustment.** The general fund base is $29,580,000 in fiscal year 2024 and ~~$27,705,000~~ $25,726,000 in fiscal year 2025.

Sec. 9. **ASSET DISREGARDS.**

$351,000 in fiscal year 2023 is appropriated from the general fund to the commissioner of human services to implement a temporary asset disregard program in the medical assistance program. This is a onetime appropriation.

Sec. 10. **TRANSFERS.**

Subdivision 1. **Grants.** The commissioner of human services, with the approval of the commissioner of management and budget, may transfer unencumbered appropriation balances for the biennium ending June 30, 2025, within fiscal years among the MFIP; general assistance; medical assistance; MinnesotaCare; MFIP child care assistance under Minnesota Statutes, section 119B.05; Minnesota supplemental aid program; housing support program; the entitlement portion of Northstar Care for Children under Minnesota Statutes, chapter 256N; and the entitlement portion of the behavioral health fund between fiscal years of the biennium. The commissioner shall inform the chairs and ranking minority members of the

legislative committees with jurisdiction over health and human services quarterly about transfers made under this subdivision.

Subd. 2. **Administration.** Positions, salary money, and nonsalary administrative money may be transferred within the Department of Human Services as the commissioners consider necessary, with the advance approval of the commissioner of management and budget. The commissioners shall inform the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services finance quarterly about transfers made under this section.

Sec. 11. **TRANSFERS; ADMINISTRATION.**

Positions, salary money, and nonsalary administrative money may be transferred within the Department of Health as the commissioner considers necessary with the advance approval of the commissioner of management and budget. The commissioner shall inform the chairs and ranking minority members of the legislative committees with jurisdiction over health finance quarterly about transfers made under this section.

Sec. 12. **INDIRECT COSTS NOT TO FUND PROGRAMS.**

The commissioner of health shall not use indirect cost allocations to pay for the operational costs of any program for which they are responsible.

Sec. 13. **APPROPRIATIONS GIVEN EFFECT ONCE.**

If an appropriation or transfer in this article is enacted more than once during the 2023 regular session, the appropriation or transfer must be given effect once.

Sec. 14. **EXPIRATION OF UNCODIFIED LANGUAGE.**

All uncodified language contained in this article expires on June 30, 2025, unless a different expiration date is explicit."

Amend the title accordingly