Bill Summary

# H.F. 4706

First engrossment

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| Subject | Health finance omnibus bill |
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## Article 1: Department of Health Finance

This article establishes new programs at the Department of Health, modifies existing programs, establishes new duties for the commissioner, and modifies existing duties. Appropriations are necessary to implement the activities in this article.

| Section | Description - Article 1: Department of Health Finance |
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| 1 | **Provider balance billing requirements.**<br>Adds § 62J.811. Requires health care providers and health facilities to comply with the federal No Surprises Act, which governs surprise billing for emergency care, nonemergency care from out-of-network providers at in-network facilities, and air ambulances. Authorizes the commissioner of health to accept and investigate complaints about violations and to enforce this section.<br><br>**Subd. 1. Requirements.** Requires health care providers and health facilities to comply with the federal No Surprises Act, including any regulations adopted |

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under that act, to the extent it imposes requirements that apply in this state but are not required under state law.

**Subd. 2. Compliance and investigations.** Requires the commissioner of health to seek cooperation of health care providers and facilities in complying with this section, and allows the commissioner to conduct compliance reviews. Allows individuals to file complaints with the commissioner if a provider or facility fails to comply with the federal No Surprises Act or with this section. Provides that the commissioner must investigate complaints and specifies requirements for investigations, notices of investigation results, and enforcement. Classifies data collected by the commissioner during an investigation as protected nonpublic data or confidential data. Requires penalty amounts collected to be deposited in the general fund and appropriated to the commissioner for purposes of this section.

This section is effective the day following final enactment.

2 **Compliance with 2021 federal law.**

Adds subd. 3 to § 62Q.021. Requires health plan companies, health providers, and health facilities to comply with the federal No Surprises Act, including any regulations adopted under the act, to the extent it imposes requirements that apply in this state but are not required under state law. Requires enforcement by the commissioner of health for entities regulated by the commissioner of health, and enforcement by the commissioner of commerce for entities regulated by the commissioner of commerce.

3 **Coverage restrictions or limitations.**

Amends § 62Q.55, subd. 5. Requires cost-sharing requirements that apply to emergency services obtained from an out-of-network provider to count toward an enrollee's in-network deductible, and requires coverage and charges for emergency services to comply with the federal No Surprises Act, including federal regulations adopted under that act.

4 **Consumer protections against balance billing.**

Amends § 62Q.556. Modifies state law prohibiting balance billing to conform with the federal No Surprises Act. Changes made include referring to federal law to define the circumstances under which an enrollee is protected when receiving services from a nonparticipating provider at a participating hospital or ambulatory surgical center; prohibiting balance billing when an enrollee receives services from a nonparticipating provider or facility providing emergency services or other services specified in federal law; allowing balance billing in certain circumstances if an enrollee gives informed consent that complies with federal law; requiring a health plan company and nonparticipating provider to resolve disputes on payment using the federal independent dispute resolution process instead of through arbitration; requiring

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annual reporting of data; and allowing the commissioner of commerce or commissioner of health to enforce this section.

5 **Change in health plans.**

Amends § 62Q.56, subd. 2. Authorizes continuity of care for up to 120 days for an enrollee who is pregnant (rather than an enrollee who is pregnant beyond the first trimester). Under this subdivision, if an enrollee is subject to a change in health plans, the enrollee's new health plan company must grant an enrollee's request for authorization to receive services from the enrollee's current health care provider for up to 120 days if the enrollee is receiving a course of treatment for certain conditions.

6 **Standards of review.**

Amends § 62Q.73, subd. 7. Provides that the standard of review for external review of an adverse determination made regarding a health care service or claim, to be based on whether the adverse determination was in compliance with state and federal law, in addition to whether the determination was in compliance with the enrollee's health benefit plan as in current law.

7 **Non-claims-based payments.**

Adds subd. 5b to § 62U.04. Para. (a) requires health plan companies and third-party administrators, beginning in 2024, to submit to the all-payer claims database, non-claims-based payments made to health care providers. Requires the data to be submitted in a form, manner, and frequency specified by the commissioner. Specifies what non-claims-based payments include; requires these payments to be attributed to health care providers to the extent possible; and requires these payments to be combined with other data in analyses of health care spending.

Para. (b) classifies data collected under this subdivision as nonpublic data, allows summary data to be derived from nonpublic data, and requires the commissioner to establish procedures to protect the integrity and confidentiality of the data.

Para. (c) requires the commissioner to consult with the listed entities in developing the data reported and standardized reporting forms.

8 **Restricted uses of the all-payer claims data.**

Amends § 62U.04, subd. 11. Allows non-claims-based payment data to be used for the listed allowable uses of data held in the all-payer claims database. Allows data in the all-payer claims database to be used on an ongoing basis to analyze variations in health care costs, quality, utilization, and illness burden based on geographic areas or populations (under current law data may be used for this purpose only until July 1, 2023).

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9 **Outcomes reporting; savings determination.**

Amends § 62U.10, subd. 7. Allows the commissioner to use data on non-claims-based payments, along with other data in the all-payer claims database, to make annual determinations of actual total private and public health care and long-term care spending related to certain health indicators. Also strikes obsolete language.

10 **Advisory council on water supply systems and wastewater treatment facilities.**

Adds § 115.7411. Establishes an advisory council on water supply systems and wastewater treatment facilities of 11 members to advise the commissioner of health and commissioner of the Pollution Control Agency on issues related to water supply systems and wastewater treatment facilities and operators. Specifies membership, and requires at least a certain number of appointees to be from outside the seven-county metro area and one of the wastewater treatment facility operators to be from the Metropolitan Council. Provides that terms, compensation, and removal of members are governed by section 15.059. Requires election of a chair after appointment of new members, and requires the Department of Health representative to serve as secretary.

11 **License, permit, and survey fees.**

Amends § 144.122. Amends health care facility licensing fees collected by the commissioner of health, to require the commissioner to charge hospitals an annual licensing base fee of $1,150 per hospital, plus a fee of $15 per licensed bed/bassinet. Provides the revenue is deposited in the state government special revenue fund and credited toward trauma hospital designations.

12 **Definitions.**

Amends § 144.1501, subd. 1. Adds definitions for the following terms for the health professional education loan forgiveness program: acupuncture practitioner, advanced practice provider (which replaces the term midlevel practitioner), public health employee, and underserved patient population.

13 **Creation of account.**

Amends § 144.1501, subd. 2. Modifies eligibility for loan forgiveness, to make eligible:

- medical residents, mental health professionals, and alcohol and drug counselors who agree to provide at least 25 percent of their yearly services to patients in an underserved patient population;
- nurses who agree to practice in a school district or charter school;
- acupuncture practitioners who agree to practice in designated rural areas;
- mental health professionals who agree to provide clinical supervision in their designated field; and

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- public health employees serving in a public health department in an area of high need.

Modifies a term used and makes a change to dentist eligibility to conform with the addition of a definition for underserved patient population.

14 **Eligibility.**

Amends § 144.1501, subd. 3. Adds public health employees and acupuncture practitioners to the list of professionals eligible for loan forgiveness. Allows public health employees to receive loan forgiveness within three years after completing required training. Exempts nurses who agree to teach from the requirement that the service obligation must begin by March 31 following completion of required training.

15 **Loan forgiveness.**

Amends § 144.1501, subd. 4. Limits funds available for public health employee loan forgiveness to funds available in fiscal year 2022, and requires the commissioner to distribute available funds for public health employee loan forgiveness according to areas of high need. In considering applications from mental health professionals, requires the commissioner to give preference to applicants who work in rural or culturally specific organizations. Exempts nurses who agree to teach from the four-year maximum for the nurse's service obligation and for loan forgiveness.

16 **Home and community-based services employee scholarship and loan forgiveness program.**

Amends § 144.1503. Expands this program to allow home and community-based services (HCBS) providers to also fund loan repayments for educational loans of their employees, and expands the professionals eligible for a scholarship or loan repayment to include individuals studying to become an assisted living director.

**Subd. 1. Creation.** Expands the HCBS employee scholarship program, to allow HCBS providers to use grant funds to fund repayment of qualified educational loans for employees studying in certain fields, and to fund employee scholarships and loan repayments for persons seeking licensure as an assisted living director.

**Subd. 1a. Definition.** Defines qualified educational loan for purposes of this section.

**Subd. 2. Provision of grants.** Makes a change to conform with expansion of this program to provide loan forgiveness.

**Subd. 3. Eligibility.** Expands the list of HCBS providers eligible for a grant under this section to establish a scholarship and loan program, to include assisted living

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facilities. Allows grant funds to be used to repay educational loans of people employed by an eligible provider.

**Subd. 4. Home and community-based services employee scholarship and loan forgiveness program.** Modifies program requirements, to require a program proposed by an HCBS provider to also repay educational loans of employees in a course of study expected to lead to career advancement with the provider or in long-term care. Specifies that the program may also cover costs of employees studying to become a licensed assisted living director.

**Subds. 5-7.** Updates the name of the program and allows the program to also provide loan repayment.

**Subd. 8. Reporting requirements.** Modifies the information that participating providers must report to the commissioner of health to include information on loan repayments made under the program.

17 **Hospital nursing loan forgiveness program.**

Adds § 144.1504. Establishes a hospital nursing loan forgiveness program for nurses participating in the federal public student loan forgiveness program and providing direct patient care in a nonprofit hospital.

**Subd. 1. Definition.** Defines terms for this section: nurse, PSLF program.

**Subd. 2. Eligibility.** To be eligible for loan forgiveness under this section, requires a nurse to be enrolled in the federal public student loan forgiveness (PSLF) program, be employed full-time as a registered nurse by a nonprofit hospital, and be providing direct patient care. Specifies application requirements, and requires an applicant selected to participate to sign a contract to continue to provide direct patient care at the nonprofit hospital during the repayment period.

**Subd. 3. Loan forgiveness.** Requires the commissioner to make annual payments directly to participants in the amount equal to the minimum loan repayment the participant paid under the PSLF program for the previous loan year. Requires the participant to verify that the amount of loan repayment disbursement received is applied toward the loan for which forgiveness is sought under the PSLF program.

**Subd. 4. Penalty for nonfulfillment.** Requires the commissioner to collect the total amount paid to a participant under this section if the participant does not fulfill the service commitment in this section or if the participant does not meet the eligibility requirements for the PSLF program. Authorizes the commissioner to waive collection of money under this subdivision if emergency circumstances

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prevent fulfillment of the service commitment or if the PSLF program is discontinued before the participant completes the service commitment.

18 **Health professionals clinical training expansion and rural and underserved clinical rotations grant programs.**

Amends § 144.1505. Establishes a rural and underserved clinical rotations grant program, in which the commissioner of health awards grants to health professional training sites to add rural and underserved rotations or clinical training experiences for certain health professionals. Lists allowable uses of funds.

19 **Primary care rural residency training grant program.**

Adds § 144.1507. Establishes a primary care rural residency training grant program, in which the commissioner of health awards grants to eligible programs to plan and implement rural residency training programs. Limits grants to $250,000 per resident per year for the first year and $225,000 for each following year. Lists allowable uses of grant funds. Establishes an application process and a process for consideration of grant applications and grant awards. Allows the commissioner to require and collect from grantees information necessary to evaluate the program. Provides that appropriations made to the program do not cancel and are available until expended.

20 **Mental health provider supervision grant program.**

Adds § 144.1508. Establishes a program to provide grants to mental health providers to fund supervision of interns and clinical trainees and to subsidize the cost of licensing applications and examination fees for clinical trainees.

**Subd. 1. Definitions.** Defines terms for this section: mental health professional, underrepresented community.

**Subd. 2. Grant program established.** Directs the commissioner of health to award grants to eligible mental health providers to fund supervision of interns and clinical trainees working toward becoming a licensed mental health professional and to subsidize the costs of mental health professional licensing applications and examination fees.

**Subd. 3. Eligible providers.** Provides that to be eligible for a grant, a mental health provider must either provide at least 25 percent of its yearly services to state public program enrollees or patients receiving sliding fee discounts, or primarily serve persons from communities of color or underrepresented communities.

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**Subd. 4. Application; grant award.** Requires a mental health provider seeking a grant to apply to the commissioner, and requires the commissioner to review applications and to determine grant amounts awarded.

**Subd. 5. Allowable uses of grant funds.** Allows a mental health provider to use grant funds to pay for direct supervision hours for interns and clinical trainees, to establish a program to provide supervision to multiple interns or clinical trainees, and to pay mental health professional licensing application and examination fees.

**Subd. 6. Program oversight.** Allows the commissioner to require grant recipients to provide the commissioner with information needed to evaluate the program.

21 **Mental health professional scholarship grant program.**

Adds § 144.1509. Establishes a mental health professional scholarship grant program administered by the commissioner of health.

**Subd. 1. Definitions.** Defines terms for this section: mental health professional, underrepresented community.

**Subd. 2. Grant program established.** Establishes a mental health professional scholarship program for mental health providers to fund employee scholarships for master's level education programs to become mental health professionals.

**Subd. 3. Provision of grants.** Directs the commissioner of health to award grants to mental health providers to provide tuition reimbursement for master's level programs and reimbursement for certain related costs for individuals who have worked for the mental health provider for at least the past two years in one or more of the listed roles.

**Subd. 4. Eligibility.** Provides that to be eligible for a grant, a mental health provider must either provide at least 25 percent of its yearly services to state public program enrollees or patients receiving sliding fee discounts, or primarily serve persons from communities of color or underrepresented communities.

**Subd. 5. Request for proposals.** Directs the commissioner to publish a request for proposals specifying eligibility requirements, employee scholarship program criteria, provider selection criteria, documentation requirements, the maximum award amount, and method of evaluation.

**Subd. 6. Application requirements.** Requires an eligible provider seeking grant under this section to apply to the commissioner, and lists information that an application must contain.

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**Subd. 7. Selection process.** Requires the commissioner to determine a maximum award amount and to select grant recipients based on information provided in the application.

**Subd. 8. Grant agreements.** Provides that funds awarded to a grant recipient do not lapse until the grant agreement expires.

**Subd. 9. Allowable uses of grant funds.** Allows a mental health provider to use grant funds to provide tuition reimbursement for a master's level program that will allow an employee to qualify as a mental health professional, and for resources and supports that support an employee in a master's level program.

**Subd. 10. Reporting requirements.** Requires a mental health provider receiving a grant under this section to report certain information to the commissioner.

22 **Clinical health care training.**

Adds § 144.1511. Allows the commissioner of health to distribute funds for clinical training to eligible entities hosting clinical trainees from a clinical medical education training program and teaching institution, for professions determined by the commissioner to be in a high need area and in a profession for which there is a shortage of providers. Specifies criteria for eligible entities hosting clinical trainees and establishes application procedures. Requires teaching institutions receiving funds under this section to sign and submit a grant verification report verifying that the correct grant amount was forwarded to each eligible entity, and requires teaching institutions to provide other information required by the commissioner to evaluate the grant program.

23 **Career guidance and support services.**

Amends § 144.1911, subd. 4. Allows the commissioner of health to award grants to eligible postsecondary educational institutions to provide career guidance and support services to immigrant international medical graduates. Strikes obsolete language.

24 **Change of sex.**

Adds § 144.2182. Establishes a process in the Vital Records Act to have the sex assigned to a person on the person's original birth certificate changed or removed, and prohibits disclosure of the original birth certificate except according to court order or other law.

**Subd. 1. Request to make change.** Allows a person whose birth is registered in Minnesota, or that person's parent or guardian if the person is a minor, to

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request that the commissioner of health change or remove the sex assigned to that person on the person's original birth certificate.

**Subd. 2. Documentation required.** Requires a person making a request under this section to submit required forms and fees to the commissioner and provide acceptable documentation that granting the request will not harm the integrity and accuracy of vital records. Specifies what acceptable documentation may include.

**Subd. 3. Court orders.** Allows a person, or a person's parent or guardian if the person is a minor, to file a petition in district court to change or remove the sex assigned to that person on the person's original birth certificate. Requires the court to issue an order if the court finds the request is not based on an intent to defraud or mislead, is made in good faith, and is in the minor's best interest if the birth certificate subject is a minor.

**Subd. 4. Records sealed.** When the commissioner makes a requested change to a birth certificate under this section, requires the commissioner to provide a certified copy of the corrected birth certificate to the requester and to classify the original birth certificate as confidential data that cannot be disclosed except according to court order or other law governing access to original birth records after adoption.

25 **Authority of commissioner; safe drinking water.**

Amends § 144.383. Adds to the authority of the commissioner of health related to drinking water, the authority to maintain a database of lead service lines, provide technical assistants to community water systems, and ensure lead service line inventory data is accessible to the public with relevant educational materials.

26 **Health facilities construction plan submittal and fees.**

Amends § 144.554. Increases fees that hospitals, nursing homes, boarding care homes, residential hospices, supervised living facilities, outpatient surgical centers, and end-stage renal dialysis facilities must pay to the commissioner of health for plan review and approval for construction projects.

27 **Definitions.**

Adds § 144.7501. Defines terms for sections establishing requirements for hospital nurse staffing committees and hospital core staffing plans: commissioner; daily staffing schedule, direct care registered nurse, hospital.

This section is effective April 1, 2024.

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28 **Hospital nurse staffing committees.**

Adds § 144.7503. Requires a hospital to establish a hospital nurse staffing committee or assign duties to an existing committee; establishes requirements for committee membership, compensation, and meeting frequency; and establishes committee duties.

**Subd. 1. Hospital nurse staffing committee required.** Requires a hospital to establish a hospital nurse staffing committee, or to assign duties to an existing committee that meets the membership requirements for a hospital nurse staffing committee.

**Subd. 2. Committee membership.** Requires at least 35 percent of the committee's membership to be direct care registered nurses, at least 15 percent of the committee's membership to be other direct care workers, and no more than 50 percent of the committee's membership to be appointed by the hospital.

**Subd. 3. Compensation.** Requires a hospital to compensate a hospital employee at the employee's existing rate of pay for participating in committee meetings, and requires a hospital to relieve direct care registered nurse members of other work duties during meeting times.

**Subd. 4. Meeting frequency.** Requires a committee to meet at least quarterly.

**Subd. 5. Committee duties.** Requires a committee to create and update an evidence-based core staffing plan to guide the creation of daily staffing schedules for each inpatient care unit at the hospital. Lists other required duties of the committee.

This section is effective April 1, 2024.

29 **Hospital core staffing plan.**

Amends § 144.7055. In a section governing hospital core staffing plans, specifies information that must be included in a plan, requires a core staffing plan to comply with listed criteria, lists information that must be considered in developing the plan, establishes reporting requirements and requirement for posting core staffing plans and licensing actions, and requires submission of core staffing plans to the commissioner.

**Subd. 1. Definitions.** Strikes a definition of patient acuity tool, modifies the definition of core staffing plan to refer to the requirements in subdivision 2, and makes a conforming change to the definition of inpatient care unit.

**Subd. 2. Hospital core staffing plans.** Moves the duty to establish a core staffing plan from the chief nursing executive or a designee of a hospital to the hospital

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nurse staffing committee. Lists what information must be included in a core staffing plan, and requires a core staffing plan to comply with the listed criteria.

**Subd. 2a. Development of hospital core staffing plans.** Makes a change to conform with assigning the duty to develop a core staffing plan to the hospital nurse staffing committee. Lists information that the hospital nurse staffing committee must consider when developing a core staffing plan.

**Subd. 3. Standard electronic reporting of core staffing plans.** In a subdivision requiring hospitals to report core staffing plans to the Minnesota Hospital Association (MHA), also requires hospitals to submit to the MHA updates to a core staffing plan, and requires the MHA to update the Minnesota Hospital Quality Report website with updated core staffing plans within 30 days after receiving the updated plan.

**Subd. 4. Standard electronic reporting of electronic patient care report.** Removes obsolete language and makes a technical change.

**Subd. 5. Mandatory submission of core staffing plan to commissioner.** Requires a hospital to submit its core staffing plan and updates to the commissioner and specifies that core staffing plans held by the commissioner are public.

This section is effective April 1, 2024.

30 **Implementation of hospital core staffing plans.**

Adds § 144.7056. Requires a hospital to implement the core staffing plan, and allows the hospital to seek to amend the plan through arbitration. Requires public posting of core staffing plans and compliance with them, requires a hospital to provide patients and visitors with copies of the posted information, and establishes requirements for documenting compliance and retention of records documenting compliance.

**Subd. 1. Plan implementation required.** Requires a hospital to implement the core staffing plan approved by the hospital nurse staffing committee.

**Subd. 2. Public posting of core staffing plans.** Requires a hospital to post the core staffing plan for each inpatient care unit in a public area on the unit.

**Subd. 3. Public posting of compliance with plan.** Requires the hospital to post a notice stating whether a unit's current staffing complies with that unit's core staffing plan, and specifies what each notice must include and where it must be posted.

**Subd. 4. Public distribution of core staffing plan and notice of compliance.** Requires a hospital to post a notice that copies of the materials in subdivisions 2

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and 3 are available on request to patients and visitors, and requires the hospital to provide the materials to individuals requesting them within four hours after the request.

**Subd. 5. Documentation of compliance.** Requires a hospital to document compliance with its core staffing plan, to maintain records documenting compliance for at least five years, and to provide its nurse staffing committee with access to this documentation.

**Subd. 6. Dispute resolution.** Allows a hospital to attempt to amend a core staffing plan through arbitration and specifies what the arbitration process must include. During the dispute resolution process, requires the hospital to implement the core staffing plan as written. If the dispute resolution process results in an amendment to the core staffing plan, requires the hospital to implement the amended plan.

This section is effective June 1, 2024.

31 **Retaliation prohibited.**

Adds § 144.7059. Prohibits a hospital or a health-related licensing board from retaliating against or disciplining a hospital employee for challenging the process for forming a nurse staffing committee, challenging a core staffing plan, objecting to a patient assignment that would lead to the nurse violating medical restrictions, or reporting unsafe staffing conditions.

This section is effective April 1, 2024.

32 **Drug overdose and substance abuse prevention.**

Adds § 144.8611. Establishes duties for the commissioner of health to prevent drug overdoses and substance abuse.

**Subd. 1. Strategies.** Requires the commissioner of health to support collaboration and coordination between state and community partners to expand funding to address the drug overdose epidemic by establishing regional overdose prevention teams, funding services through the Homeless Overdose Prevention Hub, and providing grants for a recovery-friendly workplace initiative.

**Subd. 2. Regional teams.** Requires the commissioner to establish community-based prevention grants and contracts for eight regional overdose prevention teams aligned with the eight EMS regions. Directs regional teams to implement prevention programs appropriate for the region.

**Subd. 3. Homeless Overdose Prevention Hub.** Requires the commissioner to issue a grant to provide emergency and short-term housing subsidies through the

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Homeless Overdose Prevention Hub. (The Homeless Overdose Prevention Hub primarily serves urban American Indians and is managed by the Native American Community Clinic.)

**Subd. 4. Workplace health.** Requires the commissioner to establish a grants and contracts program to support the recovery-friendly workplace initiative.

**Subd. 5. Eligible grantees.** Describes organizations eligible to receive grants under subdivision 4 to support workplace health. Allows at least one statewide organization and up to five smaller organizations to be selected for grants under subdivision 4.

**Subd. 6. Evaluation.** Requires the commissioner of health to evaluate each component of this program.

**Subd. 7. Report.** Requires grant recipients to report program outcomes to the commissioner in a form and manner established by the commissioner.

33 **Elevated blood lead level.**

Amends § 144.9501, subd. 9. Modifies the definition of elevated blood lead level in the Lead Poisoning Prevention Act that triggers public health response activities, from 10 micrograms of lead or greater per deciliter of whole blood, to 3.5 micrograms of lead or greater per deciliter of whole blood. (This standard is also lower than the standard established by order of the commissioner of health, of 5 micrograms of lead or greater per deciliter of whole blood.)

34 **Climate resiliency.**

Adds § 144.9981. Requires the commissioner of health to implement a climate resiliency program to increase awareness of climate change, track public health impacts of climate change and extreme weather events, provide technical assistance to support climate resiliency, and coordinate with other state agencies on this topic. Directs the commissioner to manage a grant program for climate resiliency planning. Requires grants to be awarded through a request for proposals process to the listed types of organizations to plan for health impacts of extreme weather events and to develop adaptation actions. Requires grant recipients to use funds to develop a plan or implement strategies to reduce health impacts from extreme weather events. Lists information an application must include.

35 **Long COVID; supporting survivors and monitoring impact.**

Adds § 145.361. Establishes a program for the commissioner of health to conduct community needs assessments and establish a surveillance system to address long COVID. Lists purposes of this program. Also requires the commissioner to identify priority actions to support long COVID survivors and their families, implement

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evidence-informed priority actions, and award grants and contracts to organizations to serve communities disproportionately impacted by COVID-19 and long COVID and to organizations to support survivors of long COVID and their families.

36 **988; National Suicide Prevention Lifeline number.**

Adds subd. 6 to § 145.56. Expands the National Suicide Prevention Lifeline to improve quality of care and access to behavioral health services.

37 **Definitions.**

Adds subd. 7 to § 145.56. Defines terms for a section on suicide prevention: National Suicide Prevention Lifeline, 988 Hotline or Lifeline Center, 988 administrator, Veterans Crisis Line, department, commissioner.

38 **988 National Suicide Prevention Lifeline.**

Adds subd. 8 to § 145.56. Requires the commissioner of health to administer the designated lifeline and oversee a Lifeline Center or network of Lifeline Centers to answer contacts from individuals accessing the National Suicide Prevention Lifeline. Establishes requirements for designated Lifeline Centers. Requires the department to collaborate with the National Suicide Prevention Lifeline and the Veterans Crisis Line networks to ensure consistent public messaging about 988 services.

39 **Universal, voluntary home visiting program.**

Adds § 145.871. Directs the commissioner of health to award grants for universal, voluntary home visiting services for families expecting or caring for an infant.

**Subd. 1. Grant program.** Paragraph (a) directs the commissioner of health to award grants to community health boards, nonprofit organizations, Tribal nations, and health care providers to establish voluntary home visiting services for families expecting or caring for an infant, including families adopting an infant.

Paragraph (b) provides that the home visiting services must: (1) provide a range of one to six visits that occur prenatally or within the first four months of the infant's birth or adoption; and (2) improve outcomes in two or more of the specified areas.

Paragraph (c) requires that the home visiting services are available to all families statewide by June 30, 2025. Prior to the services being available statewide, the commissioner of health must prioritize applicants serving high-risk or high-need populations.

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**Subd. 2. Home visiting services.** Paragraph (a) lists the minimum requirements for the home visiting services established under the section.

Paragraph (b) provides that the home visiting services may be offered through telephone or video communication when the commissioner of health determines such methods are necessary to protect the health and safety of the individuals receiving the visits and the home visiting workforce.

**Subd. 3. Administrative costs.** Allows the commissioner of health to use up to seven percent of the annual appropriation for administration, training, and technical assistance, and to conduct ongoing evaluations of the program. Provides that the commissioner of health may contract for training, capacity building, technical assistance, and evaluation support.

40 **AIDS prevention grants.**

Amends § 145.924. Permits the commissioner to manage a program and award grants to expand access to harm reduction services and improve linkages to care to prevent HIV/AIDS, hepatitis, and other infectious disease for people experiencing homelessness or housing instability.

41 **Community solutions for healthy child development grant program.**

Adds § 145.9271. Requires the commissioner to establish a community solutions for healthy child development grant program.

**Subd. 1. Establishment.** Requires the commissioner to establish a community solutions for healthy child development grant program, to improve child development outcomes for children of color and American Indian children from prenatal to grade 3 and their families, reduce racial disparities in children's health and development, and promote racial and geographic equity.

**Subd. 2. Commissioner's duties.** Lists duties for the commissioner: to develop a request for proposals; provide outreach, technical assistance, and program development support to increase capacity for new and existing service providers to meet statewide standards; review proposals and award grants; communicate with the ethnic councils, the Indian Affairs Council, and the Children's Cabinet; establish an accountability process; provide grantees with access to data to help them establish and implement community-led solutions; maintain data on outcomes; and contract with a third party for evaluation.

**Subd. 3. Community solutions advisory council; establishment; duties; compensation.** Requires the commissioner to convene a 12-member community solutions advisory council and lists advisory council membership and duties.

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Allows compensation for advisory council members according to section 15.059, subdivision 3.

**Subd. 4. Eligible grantees.** Provides organizations eligible for grants under this section include organizations that work with Black, Indigenous, and people of color communities; Tribal nations and organizations; and organizations that focus on healthy child development.

**Subd. 5. Strategic consideration and priority of proposals; eligible populations; grant awards.** Requires the commissioner to develop a request for proposals for healthy child development grants. Requires proposals to focus on increasing racial equity and healthy child development and reducing health disparities in children from Black, nonwhite people of color, and American Indian communities. Lists criteria for organizations to which the commissioner must give priority in awarding grants. Requires the first round of grants to be awarded by April 15, 2023.

**Subd. 6. Geographic distribution of grants.** Requires the commissioner and advisory council, to the extent possible, to award grants to organizations within counties that have a higher proportion of Black, nonwhite people of color, and American Indians than the state average.

**Subd. 7. Report.** Requires grantees to report grant outcomes to the commissioner in a format and manner specified by the commissioner.

42 **Lead remediation in schools and child care settings grant program.**

Adds § 145.9272. Requires the commissioner to establish a grant program to remediate identified sources of lead in drinking water in schools and child care settings. Requires the commissioner to award grants through a request for proposals process, and lists criteria for schools and child care settings that will be prioritized for grants. Requires grant recipients to use funds to address sources of lead contamination in their facilities.

43 **Skin-lightening products public awareness and education grant program.**

Adds § 145.9275. Directs the commissioner of health to award grants to community-based organizations that serve ethnic communities and focus on issues of colorism, skin-lightening products, and chemical exposures. Requires priority to be given to certain organizations in awarding grants. Requires grant recipients to use grant funds for public awareness and education activities on the dangers of skin-lightening products containing mercury and hydroquinone; to identify products that contain mercury and hydroquinone; to develop a train-the-trainers curriculum to train community leaders and others; to build self-esteem and wellness of young people

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who use skin-lightening products or are at risk of starting the practice; and to build capacity of organizations to combat skin-lightening practices.

44 **Community health workers; reducing health disparities with community-led care.**

Adds § 145.9282. Requires the commissioner to support coordination between state and community partners to expand the community health worker profession across the state. Requires the commissioner to issue a grant to a nonprofit community organization that serves and supports community health workers statewide, to expand and strengthen the community health worker workforce. Requires the commissioner to evaluate the community health worker initiative using measures of workforce capacity, employment opportunity, reach of services, and return on investment. Requires grant recipients to report grant program outcomes in a format and manner specified by the commissioner.

45 **Reducing health disparities among people with disabilities; grants.**

Adds § 145.9283. Requires the commissioner to support coordination between state and community partners to address barriers to health care and preventive services among people with disabilities, by:

- identifying priorities and action steps to address identified gaps in services and resources;
- conducting a community needs assessment and establishing a health surveillance and tracking plan;
- issuing grants to support establishment of inclusive, evidence-based, chronic disease prevention and management services; and
- providing technical assistance regarding accessible preventive health care to public health personnel and health care providers.

46 **Public Health AmeriCorps.**

Adds § 145.9292. Allows the commissioner to award a grant to a statewide, nonprofit organization to support Public Health AmeriCorps members.

47 **Healthy beginnings, healthy families act.**

Adds § 145.987. Establishes a Minnesota collaborative to prevent infant mortality, authorizes grants to improve infant health, establishes the Help Me Connect online navigator, authorizes a universal screening program to identify young children at risk for developmental and behavioral concerns, and permits grants to implement model jail practices to benefit children of incarcerated parents.

**Subd. 1. Purpose.** Lists purposes of the act.

**Subd. 2. Minnesota collaborative to prevent infant mortality.** Establishes the Minnesota collaborative to prevent infant mortality to decrease infant mortality

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among populations with significant disparities, address leading causes of poor infant health outcomes, and promote the use of data-informed, community-driven strategies to improve infant health outcomes. Requires the commissioner to establish a statewide partnership program to engage communities, exchange best practices, and promote policies to improve birth outcomes.

**Subd. 3. Grants authorized.** Requires the commissioner to award grants to eligible applicants for activities to improve infant health by reducing preterm births, sleep-related deaths, and congenital malformations and by addressing the social and environmental determinants of health. Lists entities eligible for grants and lists allowable uses of grant funds. Lists criteria to be used to evaluate grant applications, and requires grant recipients to report activities to the commissioner in a format and manner specified by the commissioner.

**Subd. 4. Technical assistance.** Requires the commissioner to provide content expertise, technical expertise, training, and advice on data-driven strategies. Allows the commissioner to award contracts to appropriate entities to provide technical assistance.

**Subd. 5. Help Me Connect.** Establishes the Help Me Connect online navigator program to connect pregnant women and parenting families with young children with local services to support healthy child development and family well-being.

**Subd. 6. Duties of Help Me Connect.** Requires Help Me Connect to assist with collaboration across sectors by providing early childhood provider outreach and linking children and families to appropriate community-based services. Also requires Help Me Connect to provide community outreach by maintaining a resource directory of health care, early childhood education, and child care programs; developmental disability assessment and intervention programs; mental health services, family and social support programs, child advocacy and legal services, and other information. Help Me Connect must facilitate provider-to-provider referrals and be a centralized access point for parents and professionals.

**Subd. 7. Universal and voluntary developmental and social-emotional screening and follow-up.** Requires the commissioner to establish a universal, voluntary, development and social-emotional screening to identify young children at risk for developmental and behavioral concerns and to provide follow-up services by connecting families with community-based resources and programs. Requires the commissioner to work with the commissioners of human services and education to implement this subdivision. Lists duties for the commissioner under this subdivision.

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**Subd. 8. Grants authorized.** Requires the commissioner to award grants to community health boards and Tribal nations to support follow-up services for children with developmental or social-emotional concerns.

**Subd. 9. Model jails practices for incarcerated parents.** Allows the commissioner to make special grants to counties and nonprofit organizations to implement model jails practices to benefit children of incarcerated parents. Defines model jails practices.

**Subd. 10. Grants authorized.** Requires the commissioner to award grants to eligible county jails to implement model jails practices, and separate grants to local governments and nonprofit organizations to support children of incarcerated parents and their caregivers.

**Subd. 11. Technical assistance and oversight.** Requires the commissioner to provide content expertise, training, and advice on evidence-based strategies, and to award contracts to appropriate entities to assist with these activities.

48 **Minnesota school health initiative.**

Adds § 145.988.

**Subd. 1. Purpose.** Provides that the purpose of the Minnesota School Health Initiative is to implement evidence-based practices to strengthen and expand health promotion and health care delivery activities in schools using the Whole School, Whole Community, Whole Child model and the school-based health center model.

**Subd. 2. Definitions.** Defines terms for this section: school-based health center or comprehensive school-based health center, and sponsoring organization.

**Subd. 3. Expansion of Minnesota school-based health centers.** Requires the commissioner to provide grants to school districts and school-based health centers to support existing centers and support the growth of school-based health centers in the state. Allows grant funds to be used to support school-based health centers that comply with the listed criteria.

**Subd. 4. School-based health center services.** Lists services that may be provided by a school-based health center.

**Subd. 5. Sponsoring organization.** Requires a sponsoring organization that agrees to operate a school-based health center to enter into a memorandum of agreement with the school or district, and specifies what the agreement must address.

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**Subd. 6. Oral health in school settings.** Requires the commissioner to administer a program to provide competitive grants to schools, oral health providers, and other groups to establish, expand, or strengthen oral health services in schools. Allows grant funds to be used to support oral health services in schools that comply with the listed criteria.

**Subd. 7. Whole School, Whole Community, Whole Child grants.** Requires the commissioner to provide competitive grants to schools, local public health organizations, and community organizations using the Whole School, Whole Community, Whole Child model to increase collaboration between public health and education and improve child development. Allows grant funds to be used to support programs that comply with the listed criteria.

**Subd. 8. Technical assistance and oversight.** Requires the commissioner to provide content expertise, training, and technical expertise to entities receiving grants under subdivisions 6 and 7, and to award contracts to appropriate entities to assist with training and technical assistance.

49 **Funding formula for community health boards.**

Amends § 145A.121, subd. 1. Amends a subdivision governing the funding formula for community health boards, to provide that funding to community health boards for foundational public health responsibilities must be distributed based on a formula established by the commissioner in consultation with the State Community Health Services Advisory Committee.

50 **Use of funds.**

Amends § 145A.131, subd. 5. Requires a community health board to use funding distributed for foundational public health responsibilities to fulfill foundational public health responsibilities, unless all foundational public health responsibilities are fulfilled. By July 1, 2026, community health boards must use all local public health funds to first fulfill foundational public health responsibilities, and then use these funds for local priorities.

51 **Tribal governments; foundational public health responsibilities.**

Adds subd. 2b to § 145A.14. Requires the commissioner to distribute grants to Tribal governments for foundational public health responsibilities as defined by each Tribal government.

52 **Scope.**

Amends § 149A.01, subd. 2. Specifies that persons registered by the commissioner of health may perform the listed actions; this addition is to conform with the establishment of registration for transfer care specialists.

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| 53 | **Exceptions to licensure.**<br>Amends § 149A.01, subd. 3. Specifies that transfer care specialists are not required to be licensed by the commissioner of health as a mortician or funeral director in order to perform duties under this chapter. |
| 54 | **Dead human body or body.**<br>Adds subd. 12c to § 149A.02. Provides that the term dead human body or body, as used in chapter 149A, includes an identifiable human body part that is detached from a human body. |
| 55 | **Direct supervision.**<br>Amends § 149A.02, subd. 13a. Adds references to registrant and registration to a subdivision defining direct supervision, to conform with establishment of registration for transfer care specialists. |
| 56 | **Registrant.**<br>Adds subd. 37d to § 149A.02. Defines registrant in chapter 149A as a person registered as a transfer care specialist. |
| 57 | **Transfer care specialist.**<br>Adds subd. 37e to § 149A.02. Defines transfer care specialist in chapter 149A as a person registered with the commissioner and authorized to perform removal of a dead human body under the direct supervision of a licensed mortician. |
| 58 | **Duties of commissioner.**<br>Amends § 149A.03. Adds to the duties of the commissioner of health related to mortuary science, to register transfer care specialists, enforce laws related to registration, and collect registration fees. |
| 59 | **Denial; refusal to reissue; revocation; suspension; limitation of license, registration, or permit.**<br>Amends § 149A.09. Adds transfer care specialist registration to a section authorizing the commissioner of health to take licensing actions against mortuary science licenses, registrations, and permits and authorizing the commissioner to restore licenses, registrations, and permits in certain circumstances. |
| 60 | **Publication of disciplinary actions.**<br>Amends § 149A.11. Requires the commissioner of health to publish disciplinary actions taken against transfer care specialists, in addition to actions taken against morticians, funeral directors, and interns under chapter 149A. |

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61 **Transfer care specialist.**

Adds § 149A.47. Establishes registration procedures for transfer care specialists and authorizes them to remove dead human bodies from places of death under the direct supervision of a licensed mortician.

**Subd. 1. General.** Permits a transfer care specialist to remove a dead human body from the place of death under the direct supervision of a licensed mortician.

**Subd. 2. Registration.** Requires an applicant for registration as a transfer care specialist to submit to the commissioner an application with the listed information, proof of completing a training program, and the required fees.

**Subd. 3. Duties.** Permits a registered transfer care specialist to remove a dead human body from the place of death to a licensed funeral establishment. Requires a transfer care specialist to work under the direct supervision of a licensed mortician.

**Subd. 4. Training program.** Requires a transfer care specialist to complete a seven-hour training program that is approved by the commissioner and covers the listed topics. Requires the training program to be completed every five years.

**Subd. 5. Registration renewal.** Provides that registrations expire one year after the date of issuance. Establishes requirements for registration renewal.

62 **Prohibited conduct.**

Amends § 149A.60. Allows the commissioner of health to discipline a person regulated under chapter 149A for failing to comply with the person's registration.

63 **Licensees, registrants, and interns.**

Amends § 149A.61, subd. 4. Adds registered transfer care specialists to the individuals who may report to the commissioner any conduct that is a ground for disciplinary action under chapter 149A.

64 **Courts.**

Amends § 149A.61, subd. 5. Adds registered transfer care specialists to the list of persons for whom a court must report to the commissioner if a court finds the person mentally ill, mentally incompetent, or guilty of certain crimes, or if a court appoints a guardian or conservator.

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| 65 | **Immunity; reporting.**<br>Amends § 149A.62. Provides immunity from civil liability or criminal prosecution for a registered transfer care specialist who reports violations of chapter 149A in good faith. |
| 66 | **Professional cooperation.**<br>Amends § 149A.63. Requires registered transfer care specialists to cooperate with the commissioner in any inspection or investigation by the commissioner or a designee. |
| 67 | **Mortuary science fees.**<br>Amends § 149A.65, subd. 2. Establishes a fee of $687 for initial and renewal registration as a transfer care specialist. |
| 68 | **Advertising.**<br>Amends § 149A.70, subd. 3. Adds registered transfer care specialists to the list of individuals prohibited from publishing false, misleading, or deceptive advertising. |
| 69 | **Solicitation of business.**<br>Amends § 149A.70, subd. 4. Adds registered transfer care specialists to the individuals prohibited from soliciting business for valuable consideration to dispose of a dead human body. |
| 70 | **Reimbursement prohibited.**<br>Amends § 149A.70, subd. 5. Adds transfer care specialists to the individuals prohibited from offering, soliciting, or accepting a commission or other reimbursement for recommending a dead human body to be disposed of by a specific program or establishment. |
| 71 | **Unprofessional conduct.**<br>Amends § 149A.70, subd. 7. Adds registered transfer care specialists to the individuals prohibited from engaging in unprofessional conduct. |
| 72 | **Removal from place of death.**<br>Amends § 149A.90, subd. 2. Modifies a subdivision governing persons authorized to remove dead human bodies from the place of death, to permit registered transfer care specialists to do so. |

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73 **Certificate of removal.**

Amends § 149A.90, subd. 4. Adds transfer care specialists to the list of individuals who may remove dead human bodies from the place of death if a certificate of removal has been completed for the body.

74 **Retention of certificate of removal.**

Amends § 149A.90, subd. 5. In a subdivision governing the use and retention of certificates of removal, requires a transfer care specialist who performs a removal and is not employed by the funeral establishment to which the body was taken, to retain a copy of the certificate of removal on file at the transfer care specialist's business address for three years after the date of removal.

75 **Generally.**

Amends § 149A.94, subd. 1. Changes the time period a body may be kept in refrigeration, from six days after death or release of the body from the coroner or medical examiner as in current law, to:

- up to 30 days if the funeral establishment provides notice by the 14th day that the body will be kept in refrigeration for more than 14 days and that the person with the right to control final disposition may make other arrangements; and
- more than 30 days, if the funeral establishment reports certain information to the commissioner. Each report allows the funeral establishment to keep a body in refrigeration for an additional 30 days, and failure to submit this report subjects a funeral establishment to enforcement under chapter 149A.

76 **Bona fide labor organization.**

Adds subd. 1a to § 152.22. Defines bona fide labor organization for statutes governing the medical cannabis program.

77 **Indian lands.**

Adds subd. 5d to § 152.22. Defines Indian lands for statutes governing the medical cannabis program.

78 **Labor peace agreement.**

Adds subd. 5e to § 152.22. Defines labor peace agreement for statutes governing the medical cannabis program.

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79 **Tribal medical cannabis board.**

Adds subd. 15 to § 152.22. Defines Tribal medical cannabis board for statutes governing the medical cannabis program.

80 **Tribal medical cannabis program.**

Adds subd. 16 to § 152.22. Defines Tribal medical cannabis program for statutes governing the medical cannabis program.

81 **Tribal medical cannabis program patient.**

Adds subd. 17 to § 152.22. Defines Tribal medical cannabis program patient for statutes governing the medical cannabis program.

82 **Medical cannabis manufacturer registration and renewal.**

Amends § 152.25, subd. 1. Modifies medical cannabis manufacturer registration and renewal requirements, to:

- require the commissioner to register at least four and up to ten medical cannabis manufacturers, with the commissioner registering additional manufacturers beginning December 1, 2022;
- require renewal of at least one manufacturer registration to occur each year, once more than two manufacturers are registered;
- require an entity seeking registration or registration renewal to attest to having entered into a labor peace agreement with a labor organization;
- require the commissioner to publish application scoring criteria for registration or registration renewal;
- require a manufacturer that is a business entity to be formed or organized under Minnesota law, as a condition of registration or registration renewal; and
- list additional criteria the commissioner must consider when determining whether to register a manufacturer or renew a registration.

Also strikes language requiring the commissioner to require manufacturers to contract with a laboratory to test medical cannabis. The language being stricken duplicates language in § 152.29, subd. 1.

83 **Background study.**

Adds subd. 1d to § 152.25. Before the commissioner registers a manufacturer or renews a registration, requires a background study of each officer, director, and controlling person of the manufacturer. Specifies background study requirements, and prohibits the commissioner from registering a manufacturer or renewing a registration if an officer, director, or controlling person committed certain acts.

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84 **Report.**

Amends § 152.29, subd. 4. Requires medical cannabis manufacturers to report to the commissioner of health on a weekly basis, information on each Tribal medical cannabis program patient who obtains medical cannabis from the manufacturer.

85 **Distribution to Tribal medical cannabis program patient.**

Adds subd. 5 to § 152.29. Allows a medical cannabis manufacturer to distribute medical cannabis to Tribal medical cannabis program patients. Before distribution, requires a Tribal medical cannabis program patient to provide the manufacturer with a valid medical cannabis registration verification from a Tribal medical cannabis program, and a valid photo identification. Provides that the manufacturer can distribute medical cannabis to Tribal medical cannabis program patients only in a form allowed under state law.

86 **Tribal medical cannabis program; manufacturers.**

Adds § 152.291. Provides that a Tribal medical cannabis program operated by a federally recognized Tribe in Minnesota shall be recognized as a medical cannabis manufacturer. Allows a manufacturer registered with a Tribal medical cannabis program to transport medical cannabis to testing laboratories and to other Indian lands. Requires a transport vehicle to be staffed with at least two manufacturer employees, and requires the employees to carry identification and a transportation manifest.

87 **Patient duties.**

Amends § 152.30. Current law allows a patient to receive medical cannabis and medical cannabis products only from a manufacturer. This section also allows a patient to receive medical cannabis from a Tribal medical cannabis program.

88 **Protections for registry program participation or participation in a Tribal medical cannabis program.**

Amends § 152.32.

**Subd. 1. Presumption.** Extends the presumption that a patient enrolled in the registry program is engaged in the authorized use of medical cannabis to also include Tribal medical cannabis program patients. Allows the presumption to be rebutted by evidence that the Tribal medical cannabis program patient's use of medical cannabis was not for a purpose authorized by the Tribal medical cannabis program.

**Subd. 2. Criminal and civil protections.** Para. (a) provides that the use or possession of medical cannabis or medical cannabis products by a Tribal medical cannabis program patient is not a violation of chapter 152.

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Para. (c) extends protections from civil penalties or disciplinary action for participation in a Tribal medical cannabis program, to members of a Tribal medical cannabis board, Tribal medical cannabis board staff, and agents and contractors of the Tribal medical cannabis board.

Para. (g) prohibits information obtained from a Tribal medical cannabis program patient under the medical cannabis statutes from being submitted as evidence in a criminal proceeding unless independently obtained or in connection with a proceeding involving a violation of the medical cannabis statutes.

Para. (i) extends the protections from disciplinary action for attorneys providing legal assistance to prospective or registered manufacturers, to also include protection from disciplinary action by a Tribal court and to include providing legal assistance to a Tribal medical cannabis program.

Para. (j) provides that possession of a verification issued by a Tribal medical cannabis program by a person entitled to possess a verification does not constitute probable cause or reasonable suspicion and cannot be used to support a search of the person or property.

**Subd. 3. Discrimination prohibited.** Prohibits certain discriminatory conduct based on a person's status as a Tribal medical cannabis program patient.

89 **Intentional diversion; criminal penalty.**

Amends § 152.33, subd. 1. In a subdivision establishing a criminal penalty for transferring medical cannabis to a person other than allowed by law, adds language providing a manufacturer may transfer medical cannabis to a Tribal medical cannabis program patient.

90 **Fees; deposit of revenue.**

Amends § 152.35. Lowers the fees charged to enroll patients in the medical cannabis program, from $50 for patients enrolled in a state public health care program or receiving certain disability benefits and $200 for all other patients, to $40 for all patients. Lowers the registration application fee for manufacturer registration from $20,000 to $10,000.

91 **Mental health cultural community continuing education grant program.**

Amends Laws 2021, First Special Session chapter 7, article 3, § 44. Expands the allowable uses of grants distributed under the mental health cultural community continuing education grant program, to allow funds to be used to cover the cost of supervision when required for professionals to become supervisors; and to cover supervision costs for mental health practitioners pursuing licensure at the professional level. Also modifies eligibility criteria for grants, to allow individuals to

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receive a grant if they practice in a mental health professional shortage area, and to remove a requirement in current law that they work for a community mental health provider.

92 **Benefit and cost analysis of a universal health reform proposal.**

Requires the commissioner of health to contract for an analysis of the costs and benefits of a proposal for a universal health care financing system and of the current health care financing system, and to report the results of the analysis by January 15, 2023.

93 **Nursing workforce report.**

Requires the commissioner to provide a public report on Minnesota's supply of active registered nurses, trends in retention of registered nurses by hospitals, reasons registered nurses are leaving direct care positions at hospitals, and reasons registered nurses are choosing not to renew their licenses and are leaving the profession.

94 **Emmett Louis Till Victims Recovery Program.**

Establishes the Emmett Louis Till Victims Recovery Program, in which the commissioner of health issues grants to provide health, wellness, and other services to victims who experienced trauma resulting from government-sponsored activities and to their families and heirs.

**Subd. 1. Short title.** Provides that this section shall be known as the Emmett Louis Till Victims Recovery Program.

**Subd. 2. Program established; grants.** Requires the commissioner of health to establish the Emmett Louis Till Victims Recovery Program to address health and wellness needs of victims who experienced trauma from government-sponsored activities, and their families and heirs. For this program, requires the commissioner, in consultation with family members and community-based organizations, to award competitive grants for projects to provide the listed services to victims who experienced trauma from government-sponsored activities and to their families and heirs. In awarding grants, requires the commissioner to prioritize grant awards to organizations experienced in providing support and services to victims and families who experienced trauma from government-sponsored activities.

**Subd. 3. Evaluation.** Requires grant recipients to provide the commissioner with information required by the commissioner to evaluate the grant program.

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**Subd. 4. Reports.** Requires the commissioner to submit a status report by January 15, 2023, on grant program activities to date, services offered, and an assessment of the need to continue to offer services.

95 **Identify strategies for reduction of administrative spending and low-value care; report.**

Requires the commissioner to develop recommendations for strategies to reduce the volume and growth of administrative spending by health care organizations and group purchasers, and to reduce the amount of low-value care delivered to Minnesota residents. Requires the commissioner to report these recommendations to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services by December 15, 2024.

96 **Initial implementation of the Keeping Nurses at the Bedside Act.**

Requires hospitals to establish and convene a hospital nurse staffing committee by April 1, 2024; implement core staffing plans by June 1, 2024; and submit core staffing plans to the commissioner by June 1, 2024.

97 **Lead service line inventory grant program.**

Requires the commissioner of health to establish a grant program to provide municipalities with financial assistance to produce an inventory of lead service lines within their jurisdiction. Allows a municipality to use grant funds to survey households to determine service line composition, create databases or visualizations of lead service lines, and comply with inventory requirements in the federal Lead and Copper Rule.

98 **Payment mechanisms in rural health care.**

Requires the commissioner to develop a plan to assess the readiness of rural communities and providers to adopt value-based, global budgeting, or alternative payment systems and recommend steps needed to implement them. Requires the commissioner to develop recommendations for pilot projects by January 1, 2025, and to share the findings with the Minnesota Health Care Spending Growth Target Commission.

99 **Program to distribute COVID-19 tests, masks, and respirators.**

Directs the commissioner of health to distribute COVID-19 tests, masks, and respirators to individuals in Minnesota at no cost to the individuals receiving them.

**Subd. 1. Definitions.** Defines terms for this section: antigen test, COVID-19 test, KN95 respirator, mask, and respirator.

**Subd. 2. Program established.** Requires the commissioner of health to administer a program to distribute COVID-19 tests, masks, and respirators to

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individuals in Minnesota at no cost to individuals receiving them. Allows masks and respirators distributed to include child-sized masks and respirators. Specifies how COVID-19 tests, masks, and respirators may be distributed, and allows the commissioner to prioritize distribution to communities and populations disproportionately impacted by COVID-19 or who have difficulty accessing tests, masks, or respirators.

**Subd. 3. Process to order COVID-19 tests, masks, and respirators.** Allows the commissioner to establish a process for individuals to order COVID-19 tests, masks, and respirators to be shipped directly to the individual.

**Subd. 4. Notice.** Allows an entity distributing certain respirators to include a notice that individuals with certain medical conditions should consult with a health care provider before using a respirator.

**Subd. 5. Coordination.** Allows the commissioner to coordinate this program with other state and federal programs.

100 **Report on transparency of health care payments.**

Requires the commissioner of health to report to the legislature by February 15, 2023, on the volume and distribution of health care spending across payment models used by health plan companies and third-party administrators, with a focus on value-based care models and primary care spending. Among other things, requires the report to include recommendations on changes needed to gather better data about the use of value-based payments by health plan companies and third-party administrators. Lists duties of the commissioner and requires health plan companies and third-party administrators to comply with data requests within 60 days after receiving the request. Classifies data collected under this section as nonpublic data, allows summary data to be derived from nonpublic data, and requires the commissioner to establish procedures to protect the integrity and confidentiality of the data.

101 **Safety improvements for state-licensed long-term care facilities.**

Requires the commissioner of health to develop and implement a temporary, competitive grant program for state-licensed long-term care facilities to improve their ability to reduce transmission of COVID-19 and similar conditions. Directs the commissioner to award improvement grants to assisted living facilities, supervised living facilities, boarding care facilities that are not federally certified, and nursing homes that are not federally certified, for projects to update, remodel, or replace outdated equipment, systems, technology, or space. Lists projects that may receive grants. Establishes processes to apply for grants, for consideration of grant

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applications, and for grant awards. Allows the commissioner to collect information necessary to evaluate the program. Provides that this section expires June 30, 2025.

102 **Study of the development of a statewide registry for provider orders for life-sustaining treatment.**

Directs the commissioner of health to study and report on creating a statewide registry of provider order for life-sustaining treatment forms.

**Subd. 1. Definitions.** Defines terms for this section: commissioner, life-sustaining treatment, POLST, and POLST form. (POLST is an acronym for provider order for life-sustaining treatment.)

**Subd. 2. Study.** Directs the commissioner of health, in consultation with an advisory committee containing members from the communities listed in paragraph (c), to study the creation of a statewide registry of provider order for life-sustaining treatment (POLST) forms. Requires the registry to allow submission of completed POLST forms and to allow forms to be accessed by providers and EMS personnel in a timely manner. Requires the commissioner to develop recommendations on the listed items. Requires the commissioner to establish an advisory committee with members representing certain health care providers, nursing homes, EMS providers, hospice and palliative care providers, the disability community, lawyers, medical ethicists, and the religious community.

**Subd. 3. Report.** Requires the commissioner to submit a report on the study and recommendations to the chairs and ranking minority members of certain legislative committees by February 1, 2023.

103 **Revisor instruction.**

Requires the revisor to:

- codify the mental health cultural community continuing education grant program in statute;
- correct cross-references to definitions in the health professional education loan forgiveness program;
- move certain definitions in existing law to a new definitions section for the nurse staffing committee and core staffing plan sections; and
- move two sections establishing home visiting programs from chapter 145A to chapter 145.

# Article 2: Department of Health Policy

This article makes policy-only changes to programs at the Department of Health and duties of the commissioner of health.

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1 **Resident assessment schedule.**

Amends § 144.0724, subd. 4. Amends the schedule of required resident assessments conducted for residents of nursing homes and boarding care homes, to provide that a significant change in status assessment is not required:

- after all speech, occupational, and physical therapies have ended, if the most recent OBRA comprehensive or quarterly assessment completed does not result in a rehabilitation case mix classification; or
- after isolation for an infectious disease has ended, if isolation was not coded on the most recent OBRA comprehensive or quarterly assessment completed.

2 **Byproduct material.**

Amends § 144.1201, subd. 2. Changes the term defined in this subdivision, from by-product nuclear material to byproduct material, for statutes governing radioactive materials and radiation-producing equipment. Also modifies the definition to include tailings or wastes produced by extraction or concentration of uranium or thorium; any discrete source of radium-226 produced after extraction for a commercial, medical, or research activity; and any discrete source of naturally occurring radioactive material.

3 **Radioactive material.**

Amends § 144.1201, subd. 4. Makes a conforming change to a term used in a definition of radioactive material.

4 **Establishment; membership.**

Amends § 144.1481, subd. 1. Increases the membership of the Health Department's Rural Health Advisory Committee from 16 members to 21 members, and adds the following members: a member of a Tribal Nation, a local public health representative, a health professional or advocate who works with people with mental illness (under current law one of the consumer members must be an advocate for persons who are mentally ill or developmentally disabled), a representative who works with individuals experiencing health disparities, and an individual with expertise in economic development or who is an employer outside the seven-county metropolitan area. Modifies a term used to describe another member, and requires one of the consumer members to be from a community experiencing health disparities.

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| 5 | **Cost.**<br>Amends § 144.292, subd. 6. Clarifies that a patient is exempt from paying any fee for copies of medical records to appeal a denial of certain federal disability benefits, if the patient is receiving public assistance or is represented by a volunteer attorney or attorney from a civil legal services program. |
| 6 | **ST elevation myocardial infarction.**<br>Amends § 144.497. Amends duties of the commissioner of health related to ST elevation myocardial infarction response and treatment in the state, to delete requirements that the commissioner (1) post quarterly summary reports on ST elevation myocardial infarction response and treatment data and (2) annually report to certain legislative committees on progress toward improving quality of care and patient outcomes for ST elevation myocardial infarctions. |
| 7 | **Restricted construction or modification.**<br>Amends § 144.551, subd. 1. Adds two exceptions to the moratorium on hospital construction or modifications:<br>▪ to allow North Shore Health in Grand Marais to add licensed beds, so long as the total number of beds after the addition does not exceed 25 beds; and<br>▪ to allow Children's Hospital in St. Paul to add 22 licensed beds for pediatric inpatient behavioral health services. Children's Hospital may add beds prior to completion of the public interest review, provided the hospital submits its plan by the 2022 deadline and adheres to the timeline for public interest review. |
| 8 | **Definitions.**<br>Amends § 144.565, subd. 4. Amends the definition of diagnostic imaging facility to provide that a dental clinic or office is not a diagnostic imaging facility when it performs diagnostic imaging using dental cone beam computerized tomography. Makes a conforming change to the definition of diagnostic imaging service. This modification exempts dental clinics and offices from annual reporting requirements for diagnostic imaging facilities on utilization, billing, and services and on providers with economic or financial interest in the facility. |
| 9 | **Screening for eligibility for health coverage or assistance.**<br>Adds subd. 4 to § 144.586. Requires a hospital to screen a patient who is uninsured or whose insurance coverage status is not known, for eligibility for charity care, public health care programs, and a premium tax credit. If a patient is eligible for charity care, a public health care program, or a premiums tax credit, requires the hospital to help the patient obtain the health coverage or assistance. Allows a patient |

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to decline to participate in the screening process or to apply for health coverage or assistance. Defines terms for this subdivision: hospital, navigator, premium tax credit, and presumptive eligibility.

This section is effective November 1, 2022.

10 **Electronic monitoring.**

Amends § 144.6502, subd. 1. Amends the definition of electronic monitoring for a section governing electronic monitoring in certain long-term care settings, to remove the requirement that the electronic monitoring device must be placed by the resident in the resident's room or private living unit.

11 **Designated support person for pregnant patient.**

Adds subd. 10a to § 144.651. Amends the Health Care Bill of Rights, to require a health care provider or health care facility to allow at least one designated support person to be physically present with a pregnant patient when the patient is receiving health care services. Defines designated support person and specifies that a certified doula or traditional midwife is not counted toward the limit of one designated support person for a pregnant patient.

12 **Classification of data on individuals.**

Amends § 144.69. Changes the name of the cancer surveillance system to the cancer reporting system. Allows a Department of Health employee to interview patients named in cancer reports after notifying an attending health care provider, rather than after obtaining the consent of an attending health care provider. Allows the cancer reporting system to:

- share information containing personal identifiers collected by the cancer reporting system with statewide cancer registries of other states for purposes consistent with Minnesota's cancer reporting system, provided the receiving registry maintains the classification of the information as private; and
- share information excluding direct identifiers collected by the cancer reporting system with the CDC's National Program of Cancer Registries and the National Cancer Institute's cancer registry.

13 **Lead hazard reduction.**

Amends § 144.9501, subd. 17. Amends the definition of lead hazard reduction in the Lead Poisoning Prevention Act, to include swab team services. Also specifies that lead hazard reduction does not include: (1) renovation activity that is primarily intended to repair or restore a structure or dwelling instead of abate or control lead paint hazards; or (2) activities that disturb less than 20 square feet on exterior surfaces or less than two square feet in an interior room (similar exceptions are currently found

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in the definition of regulated lead work and are being replaced by the exceptions in this definition and the definition of renovation).

14 **Regulated lead work.**

Amends § 144.9501, subd. 26a. Amends the definition of regulated lead work in the Lead Poisoning Prevention Act, to: (1) add lead hazard reduction to the definition; (2) modify who issues lead orders, to allow them to be issued by a community health board and the commissioner; and (3) strike a paragraph listing actions that do not constitute regulated lead work (these exceptions are being replaced by exceptions being added to the definitions of lead hazard reduction and renovation).

15 **Renovation.**

Amends § 144.9501, subd. 26b. Amends the definition of renovation in the Lead Poisoning Prevention Act, to: (1) specify that it means modification of a pre-1978 property for compensation; and (2) specify that renovation does not include activities that disturb painted surfaces of less than 20 square feet on exterior surfaces or less than six square feet in an interior room (these exceptions are replacing exceptions currently found in the definition of regulated lead work).

16 **Licensing, certification, and permitting.**

Amends § 144.9505, subd. 1. Exempts an individual who owns property on which lead hazard reduction is performed, or an adult related to the property owner, from being required to be licensed by the Health Department in order to perform lead hazard reduction (current law allows property owners and relatives to perform any regulated lead work, not just lead hazard reduction, on a property without being licensed). Requires a person that employs individuals to perform any of the listed types of lead work outside of the person's property to be certified as a certified lead firm, and makes a conforming change in a sentence exempting certain individuals from being required to be employed by a certified lead firm if the individual performs certain types of lead work.

17 **Certified renovation firm.**

Amends § 144.9505, subd. 1h. Modifies requirements to obtain certification as a renovation firm, to require certification of any person who performs renovation activities (under current law a person must be certified as a renovation firm if the person employs individuals to perform renovation activities outside the person's property).

18 **Definitions.**

Amends § 144A.01. Amends the section defining terms for nursing homes and the Board of Executives for Long Term Services and Supports, by:

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- changing terms that are defined;
- modifying the definitions of controlling individual and managerial official; and
- adding definitions for change of ownership, direct ownership interest, indirect ownership interest, licensee, management agreement, manager, and owner.

This section is effective August 1, 2022.

19 **Forms; requirements.**

Amends § 144A.03, subd. 1. Modifies the information that must be included with an application for a nursing home license, to require names and contact information for additional individuals connected with the nursing home; licensed bed capacity; the license fee; documentation of compliance with background study requirements for the listed individuals; a copy of any executed lease agreement or management agreement; an organizational chart; whether certain individuals have been convicted of certain crimes or found civilly liable for certain acts; whether certain individuals have been subject to any revocation or suspension of the specified authority or accreditation; whether certain individuals have a record of defaulting on payments of money collected for others; certain signatures; identification of all states where the applicant or individual with a five percent or more ownership interest has been subject to certain licensing actions; and statistical information required by the commissioner. Changes terms used.

This section is effective August 1, 2022.

20 **Controlling individual restrictions.**

Amends § 144A.04, subd. 4. States that the commissioner of health has discretion to bar a controlling individual of a nursing home if the individual was a controlling individual of another long-term care facility, health care facility, or agency, and committed certain acts or was in that position at the facility or agency when certain violations occurred. Specifies that a controlling individual barred under this subdivision has the right to appeal under chapter 14.

This section is effective August 1, 2022.

21 **Managerial official or licensed administrator; employment prohibitions.**

Amends § 144A.04, subd. 6. Changes a term used, and removes language prohibiting a nursing home from employing a managerial official because the managerial official held a similar position at another nursing home when one or more repeated violations occurred that created an imminent risk to direct resident care or safety.

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This section is effective August 1, 2022.

22 **Transfer of license prohibited.**

Amends § 144A.06. Prohibits transfers of nursing home licenses, and specifies circumstances in which a new nursing home license must be obtained due to a change of ownership.

**Subd. 1. Transfers prohibited.** Eliminates language requiring notice to the commissioner of health when a controlling person makes a transfer of interest in a nursing home, and instead states that a nursing home license may not be transferred.

**Subd. 2. New license required; change of ownership.** Requires the commissioner of health to adopt rules prescribing procedures to license nursing homes in cases of a change of ownership. Requires a prospective licensee to apply for a new license before operating a currently licensed nursing home. Requires the licensee to change when one of the listed events occurs.

**Subd. 3. Compliance.** Requires the commissioner to consult with the commissioner of human services regarding the prospective licensee's history of financial and cost reporting compliance, and the prospective licensee's financial operations in any nursing home in which the prospective licensee has an interest.

**Subd. 4. Facility operation.** Provides that the current licensee remains responsible for the operation of the nursing home until the nursing home is licensed to the prospective licensee.

This section is effective August 1, 2022.

23 **Consideration of applications.**

Adds § 144A.32. Before issuing a provisional license or license or renewing an existing license, requires the commissioner to consider the applicant's compliance history in providing care in another facility. Specifies what compliance history includes. Lists circumstances under which the commissioner may take a licensing action against the applicant. Provides that if the license is denied, the applicant has reconsideration rights under chapter 14.

This section is effective August 1, 2022.

24 **Membership.**

Amends § 144A.4799, subd. 1. Increases the membership of the Home Care and Assisted Living Program Advisory Council from eight to 13 people, and adds as members one person representing the Office of Ombudsman for Mental Health and Developmental Disabilities; two assisted living facility licensees; one person

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representing long-term care providers, home care providers, and assisted living facility providers; and two public members, one who lives or has lived in an assisted living facility and one with a family member who lives or has lived in an assisted living facility.

25 **Duties.**

Amends § 144A.4799, subd. 3. Modifies duties of the Home Care and Assisted Living Program Advisory Council to require the advisory council to provide advice regarding the regulation of licensed assisted living providers. Also makes technical changes.

26 **Palliative care.**

Amends § 144A.75, subd. 12. Modifies the definition of palliative care in the hospice provider statutes, to mean specialized medical care for people with a serious illness or life-limiting condition and focused on reducing pain, symptoms, and stress of a serious illness or condition. Provides that palliative care may be provided with curative treatment.

27 **Serious injury.**

Adds subd. 62a to § 144G.08. Adds a definition of serious injury to the chapter governing licensure of assisted living facilities.

28 **Consideration of applications.**

Amends § 144G.15. Specifies that the commissioner must consider an applicant's compliance history in providing care in Minnesota or any other state, before issuing an assisted living facility license or renewing a license. Allows the commissioner to take an action against an assisted living facility license if an owner, controlling individual, managerial official, or assisted living director has a history of noncompliance with laws that was detrimental to the health, welfare, or safety of a resident or client.

29 **License renewal.**

Amends § 144G.17. As a condition of renewing an assisted living facility license, requires a licensee to provide information showing that the licensee provided assisted living services to at least one resident in the preceding license year at the assisted living facility listed on the license.

30 **Change of licensee.**

Adds subd. 4 to § 144G.19. Provides that a change in licensee due to a change in ownership does not require a facility to meet the design, Life Safety Code, and plan requirements for assisted living facilities that otherwise apply to new licenses, new construction, modifications, renovations, alterations, changes of use, or additions.

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| 31 | **Conditions.**<br>Amends § 144G.20, subd. 1. Authorizes the commissioner to take certain licensing actions if an owner, controlling individual, or employee of an assisted living facility interferes with or impedes access to residents by the Office of Ombudsman for Mental Health and Developmental Disabilities. |
| 32 | **Mandatory revocation.**<br>Amends § 144G.20, subd. 4. If the commissioner revokes an assisted living facility license because a controlling individual is convicted of certain crimes related to facility operations or resident safety or care, requires the commissioner to notify the Office of Ombudsman for Mental Health and Developmental Disabilities 30 days before the revocation. |
| 33 | **Owners and managerial officials; refusal to grant license.**<br>Amends § 144G.20, subd. 5. Provides that a prohibition on granting an assisted living facility license to an owner or managerial official whose facility license has been revoked because of noncompliance with applicable laws and rules, applies to individuals whose license was revoked in Minnesota or any other state. |
| 34 | **Controlling individual restrictions.**<br>Amends § 144G.20, subd. 8. Expands the commissioner's authority to bar a controlling individual of an assisted living facility if the person was a controlling individual of another provider or setting and incurred certain violations or was convicted of certain crimes, to include having been a controlling individual of a home care provider or having had status as an enrolled PCA provider agency or PCA. |
| 35 | **Exception to controlling individual restrictions.**<br>Amends § 144G.20, subd. 9. Extends an exception from being barred as a controlling individual, to provide that the controlling individual restrictions do not apply to a controlling individual of an assisted living facility if the individual lacked legal authority to change decisions related to the operation of the home care that incurred violations. (Under current law this exception applies to controlling individuals of a nursing home or assisted living facility.) |
| 36 | **Notice to residents.**<br>Amends § 144G.20, subd. 12. Requires the controlling individual to notify the Office of Ombudsman for Mental Health and Developmental Disabilities, in addition to the other individuals, if the commissioner takes action to revoke or suspend an assisted living facility license. Also requires the Office of Ombudsman for Mental Health and Developmental Disabilities to be provided with monthly information on the department's actions and the status of proceedings. |

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37 **Plan required.**

Amends § 144G.20, subd. 15. Adds the Office of Ombudsman for Mental Health and Developmental Disabilities to the list of individuals who must be provided with certain information by an assisted living facility if the facility's license is revoked, not renewed, or suspended. Requires the assisted living facility to cooperate with the Office of Ombudsman for Mental Health and Developmental Disabilities, in addition to other individuals, during the transfer of residents to other facilities and providers.

38 **Correction orders.**

Amends § 144G.30, subd. 5. Allows a correction order to be issued when the commissioner finds that an agent of the facility, in addition to other individuals, is not in compliance with the chapter governing assisted living facilities.

39 **Fine amounts.**

Amends § 144G.31, subd. 4. Modifies how fines for violations of assisted living provisions are calculated, to:

- require a Level 3 violation to correspond to a fine of $3,000 per violation, rather than per violation per incident;
- require a Level 4 violation to correspond to a fine of $4,000 per violation, rather than per incident; and
- require a maltreatment violation to correspond to a fine of $1,000 per incident or $5,000 per incident.

40 **Deposit of fines.**

Amends § 144G.31, subd. 8. Changes the purpose for which fines collected for violations of assisted living facility statutes may be spent, to require them to be spent to improve resident quality of care and outcomes in assisted living facilities, rather than being spent for special projects to improve home care as in current law.

This section is effective retroactively for fines collected on or after August 1, 2021.

41 **Resident grievances; reporting maltreatment.**

Amends § 144G.41, subd. 7. Removes a requirement that an assisted living facility must include contact information for both state and applicable regional offices of the Office of Ombudsman for Long-Term Care and Office of Ombudsman for Mental Health and Developmental Disabilities, as part of information that must be posted regarding resident grievance procedures. Also requires the notice to include information about contacting the Office of Health Facility Complaints.

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| 42 | **Protecting resident rights.**<br>Amends § 144G.41, subd. 8. Strikes a requirement that assisted living facilities must provide residents with both state and regional contact information for the ombudsman offices, and specifies that one of the advocacy or legal services organizations for which an assisted living facility must provide names and contact information to residents must be the designated protection and advocacy organization that provides advice and representation to individuals with disabilities. |
| 43 | **Disaster planning and emergency preparedness plan.**<br>Amends § 144G.42, subd. 10. Makes a technical change. |
| 44 | **Contract information.**<br>Amends § 144G.50, subd. 2. Modifies information that must be included in an assisted living contract, to require delineation of the grounds under which residents may have housing terminated or be subject to emergency relocation. Also requires the facility's health facility identification number, rather than license number, to be included on the contract in a conspicuous place and manner.<br><br>This section is effective the day following final enactment, except that paragraph (a) is effective for assisted living contracts executed on or after August 1, 2022. |
| 45 | **Prerequisite to termination of a contract.**<br>Amends § 144G.52, subd. 2. Requires a facility to notify a resident whose assisted living contract may be terminated that the resident may invite a representative of the Office of Ombudsman for Mental Health and Developmental Disabilities, in addition to the other listed individuals, to a meeting that must be held before an assisted living facility may issue a notice of termination of an assisted living contract. In emergency relocations when an in-person meeting is not possible, requires the facility to hold the meeting via telephone, video, or other electronic means (current law permits the facility to attempt to schedule and participate in the meeting by these means). |
| 46 | **Content of notice of termination.**<br>Amends § 144G.52, subd. 8. Requires a notice of termination of an assisted living contract to include information on how to contact the Office of Ombudsman for Mental Health and Developmental Disabilities. |
| 47 | **Emergency relocation.**<br>Amends § 144G.52, subd. 9. Requires a notice provided to assisted living facility residents in the event of an emergency relocation to include contact information for the Office of Ombudsman for Mental Health and Developmental Disabilities. |

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| 48 | **Nonrenewal of housing.**<br>Amends § 144G.53. Requires a notice provided to assisted living facility residents in the event of nonrenewal of housing to include contact information for the Office of Ombudsman for Mental Health and Developmental Disabilities. |
| 49 | **Duties of facility.**<br>Amends § 144G.55, subd. 1. Requires an assisted living facility to ensure a resident's coordinated move to a safe location and service provider if a facility reduces services to the extent that the resident needs to obtain a new service provider or if the facility has its license restricted. Requires a notice provided to assisted living facility residents in the event of a reduction or elimination of services to include contact information for the Office of Ombudsman for Mental Health and Developmental Disabilities. |
| 50 | **Relocation plan.**<br>Amends § 144G.55, subd. 3. Clarifies that an assisted living facility must prepare a relocation plan for a resident's move to a safe location or appropriate service provider. |
| 51 | **Notice required.**<br>Amends § 144G.56, subd. 3. Requires a notice provided to assisted living facility residents in the event of a facility-initiated transfer to include contact information for the Office of Ombudsman for Mental Health and Developmental Disabilities. |
| 52 | **Change in facility operations.**<br>Amends § 144G.56, subd. 5. Requires the Office of Ombudsman for Mental Health and Developmental Disabilities to be notified in all cases of curtailment, reduction, or capital improvements in an assisted living facility that require residents to be transferred, instead of being notified when appropriate as in current law. |
| 53 | **Closure plan required.**<br>Amends § 144G.57, subd. 1. Requires a notice provided to certain individuals in the event an assisted living facility elects to voluntarily close the facility, to also be provided to the Office of Ombudsman for Mental Health and Developmental Disabilities. |
| 54 | **Commissioner's approval required prior to implementation.**<br>Amends § 144G.57, subd. 3. Permits the commissioner to require an assisted living facility to work with the Office of Ombudsman for Mental Health and Developmental Disabilities, in addition to other listed individuals, to assist in resident relocation if the assisted living facility elects to voluntarily close the facility. |

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| 55 | **Notice to residents.**<br>Amends § 144G.57, subd. 5. Requires a notice of assisted living facility closure provided to facility residents to include the contact information for the ombudsman for mental health and developmental disabilities. |
| 56 | **Initial reviews, assessments, and monitoring.**<br>Amends § 144G.70, subd. 2. Makes a technical change. |
| 57 | **Service plan, implementation, and revisions to service plan.**<br>Amends § 144G.70, subd. 4. Requires an assisted living facility, when providing residents with information about changes to facility fees for services, to also provide information on how to contact the Office of Ombudsman for Mental Health and Developmental Disabilities. |
| 58 | **Demonstrated capacity.**<br>Amends § 144G.80, subd. 2. Modifies the criteria the commissioner must consider when evaluating an application for licensure as an assisted living facility with dementia care, to require the commissioner to consider the experience of the applicant's assisted living director, managerial official, and clinical nurse supervisor in managing residents with dementia or their previous long-term care experience. |
| 59 | **Assisted living bill of rights; notification to resident.**<br>Amends § 144G.90, subd. 1. Makes a technical change to a required notice to assisted living facility residents. |
| 60 | **Notice to residents.**<br>Adds subd. 6 to § 144G.90. Specifies content of a notice that must be provided to an assisted living facility resident, legal representative, or designated representative as part of any notice required under chapter 144G or rules to include information on the Office of Ombudsman for Long-Term Care or Office of Ombudsman for Mental Health and Developmental Disabilities. |
| 61 | **Personal and treatment privacy.**<br>Amends § 144G.91, subd. 13. Removes language from the Assisted Living Bill of Rights providing that assisted living facility staff are not required to knock and seek consent to enter a resident's space where knocking and seeking consent are clearly inadvisable. |

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| 62 | **Access to counsel and advocacy services.**<br>Amends § 144G.91, subd. 21. Amends the Assisted Living Bill of Rights, to provide that assisted living facility residents have the right to access to representatives of the Office of Ombudsman for Mental Health and Developmental Disabilities. |
| 63 | **Retaliation prohibited.**<br>Amends § 144G.92, subd. 1. Prohibits an assisted living facility from retaliating against a resident for seeking assistance from or reporting a crime or concern to the Office of Ombudsman for Mental Health and Developmental Disabilities. |
| 64 | **Consumer advocacy and legal services.**<br>Amends § 144G.93. Adds the Office of Ombudsman for Mental Health and Developmental Disabilities to the list of organizations for which an assisted living facility must provide residents with the names and contact information, upon execution of an assisted living contract. |
| 65 | **Office of Ombudsman for Long-Term Care and Office of Ombudsman for Mental Health and Developmental Disabilities.**<br>Amends § 144G.95. Provides that the Office of Ombudsman for Mental Health and Developmental Disabilities and its representatives are immune from liability for performing duties specified in law, and adds a cross-reference to the section classifying data collected or received by the Office of Ombudsman for Mental Health and Developmental Disabilities. |
| 66 | **Health Equity Advisory and Leadership (HEAL) Council.**<br>Adds § 145.9231. Requires the commissioner of health to establish a Health Equity Advisory and Leadership (HEAL) Council to guide the commissioner on improving the health of communities most impacted by health inequities. Provides the council consists of 18 members who represent the listed groups. Requires the council to be organized and administered under section 15.059, except that members do not receive per diem compensation. Lists council duties: advising the commissioner on health equity issues and priorities, assisting the agency in efforts to advance health equity, and assisting the agency in developing and monitoring performance measures to advance health equity. Provides that the advisory council shall remain in existence until health inequities in the state are eliminated and specifies what that means for this subdivision. |
| 67 | **General.**<br>Amends § 146B.04, subd. 1. Provides that the commissioner of health must receive an individual's application for a temporary license to work as a guest artist at least 14 |

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calendar days before the applicant conducts a body art procedure (a body art procedure means physical body adorning, including tattooing and body piercing).

68 **Medical cannabis paraphernalia.**

Amends § 152.22, subd. 8. Changes a term used in the medical cannabis statutes from medical cannabis product to medical cannabis paraphernalia.

69 **Medical cannabis manufacturer registration.**

Amends § 152.25, subd. 1. In a subdivision governing registration of medical cannabis manufacturers, strikes an obsolete date and instead requires a medical cannabis manufacturer, as a condition of registration, to begin supplying medical cannabis within eight months of initial registration. Requires the commissioner to implement a state-centralized medical cannabis electronic database to monitor and track medical cannabis inventories from seed or clone source through cultivation, processing, testing, and distribution or disposal. Requires manufacturers and laboratories to submit to the commissioner information needed to maintain the database.

70 **Commissioner duties.**

Amends § 152.27, subd. 2. In a subdivision governing duties of the commissioner for the medical cannabis program, strikes language authorizing a health care practitioner to certify that a patient is physically or developmentally disabled and requires assistance in administering or obtaining medical cannabis (a health care practitioner certification that a patient needs assistance in administering or obtaining medical cannabis was formerly required for a patient to obtain a registered designated caregiver, but this requirement was removed in 2021).

71 **Manufacturer; requirements.**

Amends § 152.29, subd. 1. Changes a term used in a subdivision governing manufacturer operations, from medical cannabis products to medical cannabis paraphernalia. Also requires a laboratory under contract with a manufacturer to collect medical cannabis samples from the manufacturer's production facility for testing, or contract with a third party other than the manufacturer to collect samples for testing. Requires the cost of collecting samples to be paid by the manufacturer.

72 **Manufacturer; distribution.**

Amends § 152.29, subd. 3. Changes a term used in a subdivision governing distribution of medical cannabis, from medical cannabis products to medical cannabis paraphernalia.

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73 **Transportation of medical cannabis; transport staffing.**

Amends § 152.29, subd. 3a. Modifies a subdivision governing the transportation of medical cannabis and staffing of transport vehicles, to:

- allow medical cannabis manufacturers to contract with a third party for armored car services to deliver medical cannabis to distribution facilities;
- allow a third-party testing laboratory to staff a transport motor vehicle with one or more employees when transporting medical cannabis from a production facility to the testing laboratory;
- allow Department of Health staff to transport medical cannabis and other samples to a laboratory for testing and during special investigations if there is a potential threat to public health. Requires the transport motor vehicle to be staffed by at least two Department of Health employees; and
- allow a Tribal medical cannabis program operated by a federally recognized Indian Tribe located in Minnesota to transport samples of medical cannabis to testing laboratories and to other Indian lands in the state. Requires transport vehicles to be staffed by at least two employees of the Tribal medical cannabis program.

74 **Patient duties.**

Amends § 152.30. In a section establishing duties for patients registered in the medical cannabis program, changes a term used, from medical cannabis products to medical cannabis paraphernalia.

75 **Criminal and civil protections.**

Amends § 152.32, subd. 2. In a subdivision establishing criminal and civil protections related to participation in the medical cannabis program, changes a term used, from medical cannabis products to medical cannabis paraphernalia.

76 **Impact assessment of medical cannabis therapeutic research.**

Amends § 152.36. In a section establishing a task force on medical cannabis therapeutic research and establishing duties for the task force, strikes obsolete language regarding reports, initial appointments, and the first task force meeting.

77 **Commissioner of health; recommendation regarding exception to hospital construction moratorium.**

By February 1, 2023, requires the commissioner of health to provide a recommendation to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services finance regarding whether the statute establishing exceptions to the moratorium on hospital construction and modifications should be amended to allow critical access hospitals

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| | with an attached nursing home and fewer than 25 beds to add licensed beds, as long as the total number of beds does not exceed 25 beds. |
| 78 | **Revisor instruction.**<br>Directs the revisor to:<br>▪ change the term “cancer surveillance system” to “cancer reporting system” in statutes and rules; and<br>▪ update cross-references to conform with amendments in chapter 144A. |
| 79 | **Repealer.**<br>Repeals § 144G.07, subd. 6 (providing that section 144G.07 does not affect rights and remedies available to vulnerable adults under section 626.557. Section 144G.07, subdivisions 1 to 5, expired July 31, 2021, and subdivision 6 is the only remaining text in that section). |

## Article 3: Health Care Finance

This article contains provisions related to medical assistance, MinnesotaCare, and health care affordability and access. This article establishes a Health Care Affordability Board, increases income, asset, and spenddown limits under MA for persons who are elderly or have disabilities, eliminates cost-sharing under MA and MinnesotaCare, allows enrollees to opt out of MA managed care, provides a MinnesotaCare public option, and makes other changes related to Minnesota health care programs.

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| 1 | **Definitions.**<br>Adds § 62J.86. Defines “advisory council” and “board.” |
| 2 | **Health Care Affordability Board.**<br>Adds § 62J.87.<br>**Subd. 1. Establishment.** States that the Health Care Affordability Board is established and shall be governed as a board to protect consumers, the government, health plan companies, providers, and other health care system stakeholders from unaffordable health care costs. Requires the board to be operational by January 1, 2023. |

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**Subd. 2. Membership.** (a) Provides that the board consists of 13 members, appointed as specified by the governor and the legislature.

(b) Requires board members to have knowledge and demonstrated expertise in one or more specified areas of health care.

(c) Prohibits board members from participating in board proceedings in which the member has a direct or indirect financial interest, other than as an individual consumer of health care services.

(d) Requires the LCC to coordinate appointments to ensure that board members are appointed by August 1, 2022, and the requirements related to knowledge and expertise are met.

**Subd. 3. Terms.** Specifies term lengths and related requirements.

**Subd. 4. Chair; other officers.** Requires the governor to designate an acting chair from among the governor's appointments, with the board to elect a chair at the first meeting. Specifies related requirements.

**Subd. 5. Staff; technical assistance; contracting.** (a) Requires the board to hire an executive director and staff.

(b) Requires the attorney general to provide legal services to the board.

(c) Requires the Health Economics Division within MDH to provide technical assistance to the board in analyzing health care trends and costs and setting health care spending growth targets.

(d) Allows the board to employ or contract for professional and technical assistance, including actuarial assistance.

**Subd. 6. Access to information.** (a) Allows the board to request and receive publicly available information from state agencies, at no cost.

(b) Allows the board to request and receive from state agencies unique or custom data sets, and be charged the rate that applies to any public or private entity.

(c) Requires information provided to the board by a state agency to be de-identified.

(d) States that any data provided to the board retains their original classification under the Data Practices Act.

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**Subd. 7. Compensation.** Provides that board members do not receive compensation but may be reimbursed for expenses.

**Subd. 8. Meetings.** States the board meetings are subject to the Open Meeting Law. Requires the board to meet publicly at least quarterly and specifies related criteria.

3 **Health Care Affordability Advisory Council.**

Adds § 62J.88. Requires the governor to appoint a Health Care Affordability Advisory Council to advise the board on health care cost and access issues and represent the views of patients and other stakeholders. Specifies requirements for board members and for advisory council duties, terms, compensation, and meetings. Provides that the council does not expire.

4 **Duties of the board.**

Adds § 62J.89.

**Subd. 1. General.** (a) Directs the board to monitor the administration and reform of health care delivery and payments systems in the state. Requires the board to:

1) set health care spending and growth targets for the state;
2) enhance provider organization transparency;
3) monitor the adoption and effectiveness of alternative payment methodologies;
4) foster innovative health care delivery and payment models;
5) monitor and review the impact of health care marketplace changes; and
6) monitor patient access to necessary health care services.

(b) Requires the board to establish goals to reduce health care disparities and ensure access to quality care for persons with disabilities or chronic or complex health conditions.

**Subd. 2. Market trends.** Requires the board to monitor efforts to reform the health care delivery and payment system in the state to understand emerging trends in the commercial and large self-insured markets, and state public health care programs, in order to identify opportunities for the state 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.

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**Subd. 3. Recommendations for reform.** Requires the board to make recommendations for legislative policy, market, or other reforms to:

1) lower the rate of growth in commercial health care costs and public health care program spending;
2) positively impact the state 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 inequities.

**Subd. 4. Office of Patient Protection.** Requires the board to establish an Office of Patient Protection, to be operational by January 1, 2024. Requires the office to assist consumers with issues related to access and quality of care, and advise the legislature on ways to reduce consumer health care spending and improve consumer experience by reducing complexity for consumers.

5 **Health care spending growth targets.**

Adds § 62J.90.

**Subd. 1. Establishment and administration.** Requires the board to establish and administer the health care spending growth target program to limit health care spending in the state, and requires the board to report regularly to the legislature and public on progress toward these targets.

**Subd. 2. Methodology.** (a) Requires the board to develop a methodology to establish annual health care spending growth targets and the economic indicators to be used in establishing the initial and subsequent target levels.

(b) Requires the health care spending growth target to:

1) use a clear and operational definition of total state health care spending;
2) promote a predictable and sustainable rate of growth for total health care spending, measured by an established economic indicator such as the rate of increase of the state's economy or personal income, or a combination;
3) defines the health care markets and the entities to which the targets apply;
4) take into consideration the potential for variability in targets across public and private payers;
5) account for patient health status; and
6) incorporate health equity benchmarks.

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(c) Requires the board, in developing, implementing, and evaluating the growth target program, to:

1) consider the incorporation of quality of care and primary health care spending goals;
2) ensure the program does not place a disproportionate burden on communities most impacted by health disparities, the providers serving these communities, and individuals who reside in rural areas or have high health care needs;
3) consider payment models that ensure financial sustainability of rural health care delivery systems and the ability to provide population health;
4) allow for setting growth targets that encourage health care entities to serve populations with greater health care risks, by incorporating risk adjustment and equity adjustment;
5) ensure that growth targets do not constrain the Minnesota workforce, do not limit the use of collective bargaining or set a floor or ceiling on compensation, and promote workforce stability and the maintenance of high-quality jobs; and
6) consult with the advisory council and other stakeholders.

**Subd. 3. Data.** Requires the board to identify necessary data and methods of data collection, and specifies criteria.

**Subd. 4. Setting growth targets; related duties.** (a) Requires the board, by June 15, 2023, and by June 15 of each succeeding calendar year through June 15, 2027, to establish annual health care spending growth targets for the next calendar year. Requires annual targets to be set for the five-year period from January 1, 2024, through December 31, 2028.

(b) Requires the board to periodically review growth target program methodology, economic indicators, and other factors, and allows the board to revise annual growth targets after a public hearing. If the board revises a growth target, requires the board to provide public notice at least 60 days before the start of the calendar year to which the revised target will apply.

(c) Requires the board, based on an analysis of drivers of health care spending and public testimony, to evaluate strategies and new policies that can contribute toward meeting health care growth targets and limiting spending growth, without increasing disparities in access.

**Subd. 5. Hearings.** Requires the board to hold hearings, at least annually, to present findings from growth target monitoring. Requires the board to hold regular public hearings as needed to perform its duties, and to take stakeholder

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testimony on health care spending growth, setting and revising growth targets, and the impact of spending growth and growth targets on health care access and quality.

6 **Notice to health care entities.**

Adds § 62J.91.

**Subd. 1. Notice.** (a) Requires the board to notify all health care entities that have been identified by the board as exceeding the spending growth target for any given year.

(b) States that "health care entity" shall be defined by the board. Provides a definition of this term that the board must consider.

**Subd. 2. Performance improvement plans.** (a) States that the board must require some or all entities provided notice that they have exceeded the growth target to file and implement a performance improvement plan. Requires the board to provide the entities with written notice of this requirement.

(b) Requires the entity, within 45 days of receiving notice, to either file a performance improvement plan, or file an application to waive the requirement or extend the timeline for filing the plan.

(c) Specifies the process and requirements for filing an application to waive or extend the timeline for filing a performance improvement plan.

(d) Specifies the timeline for filing a performance improvement plan and requirements for the plan. These plan requirements include specific identifiable and measurable expected outcomes and a timetable for implementation that must not exceed 18 months.

(e) Specifies the process the board must follow in approving a performance improvement plan or determining the plan is unacceptable or incomplete.

(f) Requires health care entities to work to implement the performance improvement plan in good faith, and allows entities to file amendments to the plan for board approval. If the entity does not successfully complete the plan, directs the board to: (1) extend the implementation timetable of the existing plan; (2) approve amendments to the plan; (3) require a new performance plan; or (4) waive or delay the requirement to file any additional plans. If the entity successfully completes the performance plan, requires the board to remove the identity of the entity from the board's website. Allows the board to assist entities

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in implementing performance plans or otherwise ensure compliance with this subdivision.

(g) Allows the board to assess to a health care entity a civil penalty of not more than $500,000 as a last resort, if the board determines the entity has: (1) willfully neglected to file a performance plan within the timeline; (2) failed to file an acceptable plan in good faith; (3) failed to implement the performance plan in good faith; or (4) knowingly filed to provide required information, or knowingly provided false information.

7 **Reporting requirements.**

Adds § 62J.92.

**Subd. 1. General requirement.** Requires the board to present the reports required by this section to specified legislative committees, and to make these reports available to the public. Allows the board to contract with a third-party vendor for technical assistance in preparing the reports.

**Subd. 2. Progress reports.** Requires the board to submit progress reports on the development and implementation of the health care spending growth target program by February 15, 2024, and February 15, 2025. Specifies requirements for these reports.

**Subd. 3. Health care spending trends.** Requires the board to report, by December 15, 2024, and every December 15 thereafter, a report on health care spending trends and the health care spending growth target program. Specifies information that must be included in the reports.

8 **Restricted uses of the all-payer claims data.**

Amends § 62U.04, subd. 11. Allows the commissioner of health or the commissioner's designee to use the all-payer claims database to provide technical assistance to the Health Care Affordability Board.

9 **Education on contraceptive options.**

Amends § 256.01, by adding subd. 43. Requires the commissioner to require hospitals and relevant primary care providers serving MA and MinnesotaCare enrollees to develop and implement protocols to provide these enrollees with information on the full range of contraceptive options. Requires this to be done in a medically ethical, culturally competent, and noncoercive manner. Specifies related requirements. Requires hospitals and providers to make the protocols available to the commissioner upon request.

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10 **Long-acting reversible contraceptives.**

Amends § 256.969, by adding subd. 31. (a) Requires the commissioner to provide separate reimbursement to hospitals for long-acting reversible contraceptives provided immediately postpartum in the hospital setting. States that this payment must be in addition to diagnostic related group reimbursement for labor and delivery.

(b) Directs the commissioner to require managed care and county-based purchasing plans to comply with this subdivision when providing services to MA enrollees.

States that this section is effective January 1, 2023.

11 **Projects.**

Amends § 256B.021, subd. 4. Makes a conforming change, removing a reference to MA and MinnesotaCare cost-sharing. Provides a January 1, 2023, effective date.

12 **Dental utilization report.**

Amends § 256B.0371, subd. 4. Requires the annual DHS reports to the legislature on dental utilization to include, beginning with the report due March 15, 2023, the following information on dental provider enrollment:

1) the number of dentists enrolled as MA dental providers and the congressional districts each dentist serves;
2) the number of enrolled dentists who provided services under fee-for-service within the previous coverage year and the number of patients in specified increments;
3) the number of enrolled dentists who provided services through a managed care or county-based purchasing plan within the previous coverage year and the number of patients in specified increments; and
4) the number of dentists who provided services to a new patient enrolled in MA or MinnesotaCare within the previous coverage year.

Requires the March 15, 2023, report to include the information listed above for each of the following years: 2017, 2018, 2019, 2020, and 2021.

13 **Competitive bidding.**

Amends § 256B.04, subd. 14. Makes a conforming change, removing a reference to MA and MinnesotaCare cost-sharing. Provides a January 1, 2023, effective date.

14 **Competitive bidding.**

Amends § 256B.04, subd. 14. Allows the commissioner to use volume purchase through competitive bidding and negotiation for quitline services.

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15 **Adults who were in foster care at the age of 18.**

Amends § 256B.055, subd. 17. Allows MA to be paid, beginning January 1, 2023, for a person under age 26 who was in foster care and enrolled in another state's Medicaid program while in foster care, in accordance with specified federal law. States that the section is effective January 1, 2023.

16 **Asset limitations for certain individuals.**

Amends § 256B.056, subd. 3. Increases the MA asset limit for persons who are age 65 and older or have disabilities, from $3,000 to $20,000 for a household of one and from $6,000 to $40,000 for a household of two. For individuals enrolled in MA during the COVID-19 federal public health emergency who are subject to asset limits, requires excess assets to be disregarded until 95 days after the individual's first renewal occurring after expiration of the COVID-19 public health emergency. States that the asset limit increase is effective January 1, 2025, or upon federal approval, whichever is later, and the asset disregard provision is effective July 1, 2022, or upon federal approval, whichever is later.

17 **Income.**

Amends § 256B.056, subd. 4. Increases the MA income limit for persons with disabilities and persons age 65 or older from 100 percent of FPG to 133 percent of FPG effective January 1, 2025. The MA spenddown limit for these groups is also increased to this percentage of FPG. (The spenddown limit for these groups is currently 81 percent of FPG and is scheduled to increase to 100 percent of FPG effective July 1, 2022.)

18 **Period of eligibility.**

Amends § 256B.057, subd. 7. Allows a child under age 21, once determined eligible for MA, to be continuously eligible for the program for up to 12 months, unless:

1) the child reaches age 21;
2) the child requests voluntary termination of coverage;
3) the child ceases to be a Minnesota resident;
4) the child dies; or
5) the agency determines that eligibility was erroneously granted to the child due to agency error or enrollee fraud, abuse, or perjury.

States that the section is effective January 1, 2024, or upon federal approval, whichever is later.

19 **Dental services.**

Amends § 256B.0625, subd. 9. The amendment to paragraph (a) states that MA covers medically necessary dental services, and strikes language that limits MA

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coverage of dental services for adults who are not pregnant to specific services. The amendment to paragraph (b) makes conforming changes and does not change coverage under current law. States that the section is effective January 1, 2023, or upon federal approval, whichever is later.

20 **Transportation costs.**

Amends § 256B.0625, subd. 17. Requires the commissioner, effective the first day of each calendar quarter in which the price of gasoline exceeds $3.00 per gallon, to adjust the mileage rate paid to nonemergency medical transportation providers by one percent, up or down, for every increase or decrease of ten cents in the price of gasoline.

Provides a July 1, 2022, effective date.

21 **Payment for ambulance services.**

Amends § 256B.0625, subd. 17a. Requires the commissioner, effective the first day of each calendar quarter in which the price of gasoline exceeds $3.00 per gallon, to adjust the mileage rate paid to ambulance service providers by one percent, up or down, for every increase or decrease of ten cents in the price of gasoline.

Provides a July 1, 2022, effective date.

22 **Nonemergency medical transportation provisions related to managed care.**

Amends § 256B.0625, subd. 18h. Requires managed care and county-based purchasing plans to provide a fuel adjustment for nonemergency medical transportation payment rates when the price of gasoline exceeds $3.00 per gallon.

23 **Hospice care.**

Amends § 256B.0625, subd. 22. States that hospice respite and end-of-life care under subdivision 22a are not hospice services under MA.

24 **Residential hospice facility; hospice respite and end-of-life care for children.**

Amends § 256B.0625, by adding subd. 22a.

(a) Provides MA coverage for hospice respite and end-of-life care if the care is for recipients under age 21 who elect to receive hospice care from a licensed hospice provider that is a residential hospice facility. States that hospice care services under subdivision 22 are not hospice respite or end-of-life care.

(b) States that payment rates for services under this subdivision shall be 100 percent of the Medicare rate for continuous home care hospice services as published by the Centers for Medicare and Medicaid Services. Requires payment to be made from state funds, but directs the commissioner to seek federal financial participation for

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the payments. Requires payment to be made to the residential hospice facility and provides that these payments are not included in any limits or cap amount that applies to hospice services payments to the elected hospice services provider.

(c) Provides that certification of the residential hospice facility by Medicare must not be a requirement for MA payment for hospice respite and end-of-life care under this subdivision.

States that the section is effective January 1, 2023.

25 **Doula services.**

Amends § 256B.0625, subd. 28b. Requires the commissioner to enroll doula agencies and individual treating doulas in order to provide direct reimbursement. States that the section is effective January 1, 2024, or upon federal approval, whichever is later.

26 **Other clinic services.**

Amends § 256B.0625, subd. 30. Effective July 1, 2022, allows an enrolled Indian Health Service facility or a Tribal health center operating under a 638 contract to elect to also enroll as a Tribal FQHC, and provides that requirements that apply to FQHCs under this subdivision do not apply unless necessary to comply with federal regulations. Directs the commissioner to establish an alternative payment method for Tribal FQHCs that uses the same methods and rates applicable to a Tribal facility or health center that does not enroll as a Tribal FQHC.

27 **Medical supplies and equipment.**

Amends § 256B.0625, subd. 31. Provides that MA covers seizure detection devices as durable medical equipment if the seizure detection device is medically appropriate and the recipient's health care provider has identified that the device would: (i) likely reduce bodily harm or death as a result of a seizure; or (ii) provide data to the provider necessary to appropriately diagnose or treat the health condition that causes the seizure activity. Also defines seizure detection device.

States that the section is effective January 1, 2023, or upon federal approval, whichever is later.

28 **Tobacco and nicotine cessation.**

Amends § 256B.0625, by adding subd. 68. (a) States that MA 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. Provides that MA must cover these services and drugs consistent with evidence-based or evidence-informed best practices.

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(b) Requires MA to cover in-person individual and group tobacco and nicotine cessation education and counseling, if provided by a health care provider within scope of practice. Provides a partial list of providers who may provide these services.

(c) Requires MA to cover telephone cessation counseling services provided through a quitline, and allows these services to be provided through audio-only communications. Allows the commissioner to use volume purchasing for quitline services.

(d) Requires MA to cover all prescription and over-the-counter drugs approved by the Food and Drug Administration for cessation of tobacco and nicotine use or treatment of tobacco and nicotine dependence, that are part of a Medicaid rebate agreement.

(e) Allows services to be provided by telemedicine.

(f) Prohibits the commissioner from:

1) restricting or limiting the type, duration, or frequency of cessation services;
2) prohibiting the simultaneous use of multiple cessation services;
3) requiring counseling prior to or as a condition of receiving drugs;
4) limiting pharmacotherapy drug dosage amounts or dosing frequency, or imposing duration limits;
5) prohibiting the simultaneous use of multiple drugs;
6) requiring or authorizing step therapy; or
7) requiring or using prior authorization or requiring a copayment or deductible.

(g) Provides that the commissioner must require all participating entities under contract to comply with this subdivision when serving MA and MinnesotaCare enrollees. Defines "participating entity" as a health carrier, county-based purchasing plan, accountable care organization, county integrated health care delivery network pilot, a network of health care providers established to provide services under MA or MinnesotaCare, or any other entity that has entered into capitation or risk-based payment arrangement or is paid under a reimbursement methodology with financial incentives to reduce the total cost of care.

States that the section is effective January 1, 2023, or upon federal approval, whichever is later.

29 **Medical assistance co-payments.**

Amends § 256B.0631. Prohibits the MA program from requiring deductibles, co-payments, coinsurance, or any other form of enrollee cost-sharing for services

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provided on or after January 1, 2023. Provides that existing cost-sharing requirements for MA apply only for services provided through December 31, 2022.

30 **Cost-sharing.**

Amends § 256B.0631, subd. 1. Prohibits MA co-payments for tobacco and nicotine cessation services and for drugs when used for tobacco and nicotine cessation.

31 **Client error overpayment.**

Adds § 256B.161.

**Subd. 1. Scope.** Specifies the procedures that must be followed under MA when a local agency or DHS determines a person is liable for recovery of medical assistance incorrectly paid as a result of client error or a person is determined ineligible for medical assistance following an appeal. Provides that medical assistance incorrectly paid when the recipient is under age 21 is generally not recoverable from the recipient or recipient's estate.

**Subd. 2. Recovering client error overpayment.** (a) Prohibits the local agency or DHS from attempting recovery when the liable person voluntarily repays the overpayment amount or establishes a payment plan to repay the amount within 90 days. Requires recovery to be pursued when the liable person has not repaid any amount within six months of entering into the agreement.

(b) Specifies the procedures to be followed by the local agency or DHS when recovering overpayments.

**Subd. 3. Writing off client error overpayment.** Prohibits the local agency or DHS from attempting recovery of overpayments of less than $350, unless specified conditions apply. Allows the local agency or DHS to write off any remaining balance after five years, upon a determination that it is no longer cost effective to attempt recovery of the remaining balance.

32 **Limitation of choice; opportunity to opt out.**

Amends § 256B.69, subd. 4. Requires the commissioner to provide all MA enrollees required to enroll in managed care with the opportunity to opt out, and receive care under fee-for-service. Also makes conforming changes. Provides a January 1, 2023, effective date.

33 **Medical education and research fund.**

Amends § 256B.69, subd. 5c. If the federal waiver that allows federal financial participation in the medical education and research fund is not renewed, terminates an existing transfer of $21,6714,000 each fiscal year to the fund and also terminates certain payments from the fund. Requires the state share of an existing transfer of

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| | $49,552,000 each fiscal year to the fund to be distributed according the alternative method specified in statute. |
| 34 | **Medicare special needs plans; medical assistance basic health care.**<br>Amends § 256B.69, subd. 28. Makes a conforming change, in the section of law allowing persons with disabilities to opt out of MA managed care. Provides a January 1, 2023, effective date. |
| 35 | **Enrollee support system.**<br>Amends § 256B.69, subd. 36. Requires the DHS enrollee support system to provide access to counseling on opting out of managed care. Provides a January 1, 2023, effective date. |
| 36 | **In general.**<br>Amends § 256B.692, subd. 1. Makes a conforming change, adding a reference to the opt-out provision in a section dealing with county-based purchasing plans. Provides a January 1, 2023, effective date. |
| 37 | **Information provided by commissioner.**<br>Amends § 256B.6925, subd. 1. Makes a conforming change, adding a reference to the opt-out provision and removing a reference to mandatory enrollment, in a section dealing with information provided to enrollees. |
| 38 | **Information provided by commissioner.**<br>Amends § 256B.6925, subd. 1. Makes a conforming change, removing a reference to MA cost-sharing. Provides a January 1, 2023, effective date. |
| 39 | **Information provided by managed care organizations.**<br>Amends § 256B.6925, subd. 2. Makes a conforming change, removing a reference to MA cost-sharing. Provides a January 1, 2023, effective date. |
| 40 | **Rate development standards.**<br>Amends § 256B.6928, subd. 3. Makes a conforming change, removing a reference to MA cost-sharing. Provides a January 1, 2023, effective date. |
| 41 | **Physician reimbursement.**<br>Amends § 256B.76, subd. 1. Allows MA to reimburse for the cost incurred to pay the Department of Health for metabolic testing of newborns who are MA recipients, when the sample is collected outside of an inpatient hospital or freestanding birth center (because the birth took place outside of these locations) or because it is not medically appropriate to collect the sample during the inpatient stay. |

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| 42 | **Children; MinnesotaCare health care reform waiver.**<br>Amends § 256L.03, subd. 1a. Makes a conforming change, removing a reference to MinnesotaCare cost-sharing. Provides a January 1, 2023, effective date. |
| 43 | **Cost-sharing.**<br>Amends § 256L.03, subd. 5. Prohibits the MinnesotaCare program from requiring deductibles, co-payments, coinsurance, or any other form of enrollee cost-sharing for services provided on or after January 1, 2023. Provides that existing MinnesotaCare requirements related to cost-sharing apply only for services provided through December 31, 2022. |
| 44 | **Cost-sharing.**<br>Amends § 256L.03, subd. 5. Prohibits cost-sharing under MinnesotaCare for tobacco and nicotine cessation services and for drugs used for tobacco and nicotine cessation. |
| 45 | **General requirements.**<br>Amends § 256L.04, subd. 1c. Makes a conforming change related to the elimination of the MinnesotaCare income limit for persons eligible under the public option, by clarifying that persons eligible for MinnesotaCare with incomes less than or equal to 200 percent of FPG are not qualified individuals and therefore are not eligible to obtain coverage through MNsure (this section does not change the status of these individuals under current law). States that the section is effective January 1, 2025, or upon federal approval, subject to certification that implementation will not result in the loss of basic health program funding. |
| 46 | **Ineligibility.**<br>Amends § 256L.04, subd. 7a. Makes a conforming change, by exempting persons enrolled under the public option from a provision that prohibits adults from being enrolled in MinnesotaCare if their income is greater than the program income limit. States that the section is effective January 1, 2025, or upon federal approval, subject to certification that implementation will not result in the loss of basic health program funding. |
| 47 | **Citizenship requirements.**<br>Amends § 256L.04, subd. 10. Allows undocumented noncitizens who are children under age 19 to be eligible for MinnesotaCare. Provides an effective date of January 1, 2024. |
| 48 | **Persons eligible for public option.**<br>Amends § 256L.04, by adding subd. 15. Allows families and individuals with incomes above the MinnesotaCare income limit, who meet all other program eligibility requirements, to be eligible for MinnesotaCare. Allows enrollment of these |

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individuals only during an annual open enrollment period or special enrollment period, as designated by MNsure. States that the section is effective January 1, 2025, or upon federal approval, subject to certification that implementation will not result in the loss of basic health program funding.

49 **General requirements.**

Amends § 256L.07, subd. 1. Makes a conforming change, by exempting persons whose income increases above 200 percent of FPG from MinnesotaCare disenrollment if they continue enrollment through the public option. States that the section is effective January 1, 2025, or upon federal approval, subject to certification that implementation will not result in the loss of basic health program funding.

50 **Sliding fee scale; monthly individual or family income.**

Amends § 256L.15, subd. 2.

The amendment to paragraph (c) requires the commissioner to continue the lower premiums for MinnesotaCare enrollees (reflecting compliance with federal ARPA requirements) on an ongoing basis, without regard to any sunset of the ARPA requirements. Also makes conforming changes, by striking the premium scale listed in current law. (This premium sale is not currently applied, given that MinnesotaCare as part of federal compliance uses the lower premium scales required by ARPA for 2021 and 2022).

A new paragraph (d) requires the commissioner to establish a sliding premium scale for persons eligible through the public option, to be effective January 1, 2025. Exempts persons 20 years of age or younger from these premiums.

States that the section is effective January 1, 2023, except that the sliding premium scale for persons eligible for the public option is effective January 1, 2025, or upon federal approval, subject to certification that implementation will not result in the loss of basic health program funding.

51 **Client error overpayment.**

Adds § 256L.161.

> **Subd. 1. Scope.** Specifies the procedures under MinnesotaCare that must be followed when a local agency or DHS determines a person is liable for recovery of medical assistance incorrectly paid as a result of client error or is determined ineligible for medical assistance following an appeal. Provides that medical assistance incorrectly paid when the recipient is under age 21 is generally not recoverable from the recipient or recipient's estate.

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**Subd. 2. Recovering client error overpayment.** (a) Prohibits the local agency or DHS from attempting recovery when the liable person voluntarily repays the overpayment amount or establishes a payment plan to repay the amount within 90 days. Requires recovery to be pursued when the liable person has not repaid any amount within six months of entering into the agreement.

(b) Specifies the procedures to be followed by the local agency or DHS when recovering overpayments.

**Subd. 3. Writing off client error overpayment.** Prohibits the local agency or DHS from attempting recovery of overpayments of less than $350, unless specified conditions apply. Allows the local agency or DHS to write off any remaining balance after five years, upon a determination that it is no longer cost effective to attempt recovery of the remaining balance.

52 **Grants for periodic data matching.**

Amends Laws 2015, chapter 71, article 14, section 2, subdivision 5, as further amended. Maintains the general fund base for fiscal years 2020 and 2021 for grants to counties for costs related to periodic data matching.

53 **Waivers and modifications; federal funding extensions.**

Amends Laws 2020, First Special Session chapter 7, section 1, subd. 1, as further amended. Extends COVID-19 DHS waivers and modifications related to preserving health care coverage for MA and MinnesotaCare until the enrollee's first renewal following resumption of MA and MinnesotaCare renewals after the end of the federal COVID-19 public health emergency.

54 **Response to COVID-19 public health emergency.**

Amends Laws 2021, First Special Session chapter 7, article 1, § 36. Prohibits the commissioner of human services from collecting unpaid MA-EPD and MinnesotaCare premiums until the enrollee's first renewal after the resumption of MA renewals following the end of the federal public health emergency.

Allows periodic data matching to be suspended for up to 12 months following the resumption of MA and MinnesotaCare renewals after the end of the federal public health emergency.

Directs the commissioner of human services to take necessary actions to comply with federal guidance related to the appropriate redetermination of MA enrollee eligibility following the end of the federal public health emergency and allows the commissioner to waive current Minnesota statutes to the minimum level necessary

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to achieve federal compliance. Requires the commissioner to report to the legislature on changes implemented within 90 days.

55 **Dental home pilot project.**

**Subd. 1. Establishment; requirements.** (a) Requires the commissioner to establish a dental home pilot project, to increase the access of MA and MinnesotaCare enrollees to dental care, and improve patient experience and oral health clinical outcomes. Specifies related requirements.

(b) Requires the design and operation of the pilot project to be consistent with the recommendations made by the Dental Services Advisory Committee to the legislature.

(c) Requires the commissioner to establish baseline requirements and performance measures for dental homes that address access and patient experience and oral health clinical outcomes.

**Subd. 2. Project design and timeline.** (a) Requires the commissioner to issue a preliminary project description and a request for information, to obtain stakeholder feedback and input on specified project design issues.

(b) Requires the commissioner to consider this feedback and input and issue a request for proposals for pilot project participation.

(c) Requires the pilot project to be implemented by July 1, 2023, and to include initial testing and the collection and analysis of data, to evaluate whether the baseline requirements and performance measures are appropriate. Requires the commissioner, under this phase, to provide grants to individual providers and provider networks that are in addition to regular MA and MinnesotaCare payments.

(d) Allows the pilot project to test and analyze value-based payments to providers, to determine whether varying provider payments based on performance measures is appropriate and effective.

(e) Requires the commissioner to ensure provider diversity in selecting project participants. Specifies criteria for the commissioner to consider in selecting providers.

(f) Requires the commissioner to regularly consult with stakeholders in designing and implementing the pilot project, and as relevant to continue to seek input on project design issues specified in paragraph (a).

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**Subd. 3. Reporting.** (a) Requires the commissioner, beginning February 15, 2023, and each February 15 thereafter for the duration of the project, to annually report to the legislature on the design, implementation, operation, and results of the demonstration project.

(b) Requires the commissioner, within six months of the end of the project, to report on the results of the demonstration project to the legislature, and include recommendations on whether the demonstration project, or specific features of the project, should be extended to all MA and MinnesotaCare dental providers.

56 **Small employer public option.**

Requires the commissioner of human services, in consultation with representatives of small employers, to develop a small employer public option that allows employees of businesses with fewer than 50 employees to receive employer contributions towards MinnesotaCare. Requires the commissioner to present recommendations to the legislature, by December 15, 2023. States that the section is effective the day following final enactment.

57 **Transition to MinnesotaCare public option.**

(a) Requires the commissioner of human services to continue to administer MinnesotaCare as a basic health program, and to seek federal waivers, approvals, and law changes as required.

(b) Requires the commissioner to present an implementation plan for the MinnesotaCare public option to the legislature, by December 15, 2023. Requires the plan to include:

1) recommendations for any changes to the public option needed to receive federal funding;
2) recommendations for implementing any small employer public option in a manner that would allow any employee payments towards premiums to be pretax;
3) recommendations for ensuring sufficient provider participation in MinnesotaCare;
4) estimates of state costs;
5) a description of the proposed premium scale for persons eligible through the public option, including an analysis of the extent to which the premium scale: (i) ensures that premiums are affordable for persons enrolled under the public option; and (ii) avoids premium cliffs for persons transitioning to or enrolled under the public option; and
6) draft legislation necessary to implement the public option and plan recommendations.

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| | States that the section is effective the day following final enactment. |
| 58 | **Request for federal approval.**<br>(a) Requires the commissioner of human services to seek any federal waivers, approvals, and law changes necessary to implement this act, including but not limited to those necessary to allow the state: (1) to continue to receive basic health program payments and other federal funding; (2) to receive federal payments equal to the value of premium tax credits and cost-sharing reductions that MinnesotaCare enrollees with incomes greater than 200 percent of FPG would otherwise have received; and (3) to receive federal payments equal to the value of emergency medical assistance that would otherwise have been paid to the state for services provided to eligible enrollees.<br><br>(b) Requires the commissioner of human services to consult with the commissioner of commerce and the Board of Directors of MNsure in implementing this section, and allows the commissioner of human services to contract for technical and actuarial assistance.<br><br>States that the section is effective the day following final enactment. |
| 59 | **Delivery reform analysis report.**<br>Requires the commissioner of human services to present to the legislature, by January 15, 2024, a report comparing service delivery and payment models for MinnesotaCare and certain MA enrollees. Requires the current delivery model to be compared with at least two alternative models, which must include a state-based model in which the state bears insurance risk and may contract with a third-party administrator for claims processing and plan administration. Specifies other report requirements. |
| 60 | **Recommendations; Office of Patient Protection.**<br>(a) Requires the commissioners of human services, health, and commerce, and the MNsure board, to present a report to the legislature by January 15, 2023, on the organization and duties of the Office of Patient Protection. Specifies the scope of recommendations.<br><br>(b) Requires the commissioners and board to consult with specified stakeholders as they develop recommendations.<br><br>(c) Allows the commissioners and board to contract with a third party to develop the report and recommendations. |

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| 61 | **Repealer.**<br>Repeals § 256B.063 (provision related to MA cost-sharing), effective January 1, 2023. |

## Article 4: Health Care Policy

This article makes changes related to the administration of DHS health care programs.

| Section | Description - Article 4: Health Care Policy |
|---|---|
| 1 | **Consumer information.**<br>Amends § 62J.2930, subd. 3. Makes a conforming change, updating a cross-reference to the ombudsperson for managed care. |
| 2 | **Subsidized foster children.**<br>Amends § 256B.055, subd. 2. Clarifies that automatic MA eligibility for children in foster care who are not Title IV-E eligible also applies to those children placed in foster care under other provisions of Minnesota statutes. Provides that this section is effective the day following final enactment. |
| 3 | **Treatment of trusts.**<br>Amends § 256B.056, subd. 3b. Inserts a policy statement related to trusts, that is in a section repealed in the bill (§ 501C.1206), into a new section of law. |
| 4 | **Asset limitations for families and children.**<br>Amends § 256B.056, subd. 3c. Moves language in current law that exempts children under age 21 from the MA asset limit to the section of law dealing with asset limits for families and children. The exemption in current law is in a section dealing with persons who have disabilities or are age 65 or older; the bill repeals that section. |
| 5 | **Treatment of annuities.**<br>Amends § 256B.056, subd. 11. Makes a conforming change in a cross-reference to reflect changes made in § 256B.0595, subd. 1. |
| 6 | **Prohibited transfers.**<br>Amends § 256B.0595, subd. 1. Strikes language that made certain transfers from annuities subject to the look-back period for purposes of determining MA eligibility (this provision no longer applies due to changes in federal law). Provides that this section is effective the day following final enactment. |

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7 **Telehealth services.**

Amends § 256B.0625, subd. 3b. Provides that the face-to-face requirement for telehealth coverage under MA may be met through the use of accessible telemedicine video-based platforms, as well as through the use of interactive audio and visual communications. Also makes related changes.

8 **Investigational drugs, biological products, devices, and clinical trials.**

Amends § 256B.0625, subd. 64. Strikes language prohibiting MA and the EPSDT program from covering services related to the use of drugs, biological products, or devices that are part of clinical trials. States that MA does not cover items or services provided solely to satisfy data collection and analysis for a clinical trial, that are not for direct clinical management of the enrollee.

9 **Ombudsperson for managed care.**

Adds § 256B.6903. Provides updated and more detailed language to govern the operation of the DHS ombudsperson for managed care.

**Subd. 1. Definitions.** Defines terms.

**Subd. 2. Ombudsperson.** Requires the commissioner to designate an ombudsperson to advocate for managed care enrollees. Requires prepaid health plans to inform enrollees at the time of enrollment about the ombudsperson.

**Subd. 3. Duties and cost.** (a) Requires the ombudsperson to ensure that enrollees receive covered services by:

1) providing assistance and education to enrollees upon request, related to benefits or services, billing and access, or the grievance, appeal, or state fair hearing process;
2) using an informal review process related to benefits, with enrollee permission and at the discretion of the ombudsperson;
3) assisting enrollees, when requested, with prepaid health plan grievances, appeals, or the state fair hearing process;
4) overseeing, reviewing, and approving enrollee documents related to grievances, appeals, and state fair hearings;
5) reviewing state fair hearing and requests for external review; overseeing entities under contract to provide external reviews, processes, and payments; and using aggregated results of external reviews to recommend benefit policy changes; and
6) training managed care advocates.

(b) Prohibits the ombudsperson for charging an enrollee for services performed.

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**Subd. 4. Powers.** Gives the ombudsperson authority to:

1) gather information and evaluate any practice or other action by a prepaid health plan, state human services agency, county, or Tribe; and
2) prescribe the methods by which complaints are made, received, and acted upon.

**Subd. 5. Data.** (a) Requires the data analyst employed by the ombudsperson to review and analyze prepaid health plan data on denial, termination, and reduction notices, grievances, appeals, and state fair hearings. Assigns specified duties.

(b) Requires data observations and trends under this subdivision to be shared with the ombudsperson, prepaid health plans, and commissioner's partners.

**Subd. 6. Collaboration and independence.** (a) Requires the ombudsperson to work in collaboration with the commissioner and the commissioner's partners, when this does not interfere with the ombudsperson's duties.

(b) States that the ombudsperson may act independently of the commissioner when providing information or testimony to the legislature, and contacting and making reports to federal and state officials.

**Subd. 7. Civil actions.** Provides that the ombudsperson is not civilly liable for actions under this section, if the action was taken in good faith, within the scope of authority, and did not constitute willful or reckless misconduct.

States that the section is effective the day following final enactment.

10 **Ombudsman.**

Amends § 256B.77, subd. 13. Makes a conforming change, updating a cross-reference to the ombudsperson for managed care.

11 **Repealer.**

(a) Repeals § 256B.057, subd. 7 (language exempting children from any MA asset requirement that is placed in a section of law related to persons with disabilities or over age 65), effective July 1, 2022.

(b) Repeals § 256B.69, subd. 20 (ombudsperson for managed care), the day following final enactment. Also repeals § 501C.1206, the day following final enactment. This section contains language that previously functioned to make irrevocable trusts revocable for purposes of determining financial eligibility for MA for long-term care costs. The repeal of this section reflects a 2021 Minnesota Court of Appeals decision

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| | that held that federal law, rather than this provision of state law, applied to these eligibility determinations. |

## Article 5: Health-Related Licensing Boards

This article modifies practice supervision requirements for certain mental health professionals to allow all hours to be completed via telesupervision, modifies certain dental licensure requirements and fees, and expands the practice of pharmacy to allow pharmacists to administer any prescribed intramuscular or subcutaneous medication and place drug monitoring devices. The article also modifies the date after which completion of a podiatry residency program is required and provides temporary requirements governing ambulance service operations and the provision of emergency medical services.

| Section | Description - Article 5: Health-Related Licensing Boards |
|---|---|
| 1 | **Supervision requirement; postgraduate experience.**<br>Amends § 148B.33 by adding subd. 1a. Requires the Board of Marriage and Family Therapy to allow applicants to satisfy supervised postgraduate experience requirements entirely with supervision provided via real-time, two-way interactive audio and visual communication. Provides an immediate effective date. |
| 2 | **Supervision.**<br>Amends § 148B.5301, subd. 2. Requires the Board of Behavioral Health and Therapy to allow licensed professional clinical counselor applicants to satisfy supervised professional practice requirements entirely with supervision received via real-time, two-way interactive audio and visual communication. Provides an immediate effective date. |
| 3 | **Types of supervision.**<br>Amends § 148E.100, subd. 3. Modifies social worker supervision requirements; requires the Board of Social Work to allow licensed social workers to satisfy supervision requirements entirely with supervision received via eye-to-eye electronic media, while maintaining visual contact. Provides an immediate effective date. |
| 4 | **Types of supervision.**<br>Amends § 148E.105, subd. 3. Modifies graduate social worker supervision requirements; requires the Board of Social Work to allow licensed graduate social workers who do not engage in clinical practice to satisfy supervision requirements entirely with supervision received via eye-to-eye electronic media, while maintaining visual contact. Provides an immediate effective date. |

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5 **Types of supervision.**

Amends § 148E.106, subd. 3. Modifies graduate social worker supervision requirements; requires the Board of Social Work to allow licensed graduate social workers engaged in clinical practice to satisfy supervision requirements entirely with supervision received via eye-to-eye electronic media, while maintaining visual contact. Provides an immediate effective date.

6 **Supervision; clinical social work practice after licensure as licensed independent social worker.**

Amends § 148E.110, subd. 7. Modifies licensed independent social worker supervision requirements; requires the Board of Social Work to allow licensed independent social workers engaged in clinical practice to satisfy supervision requirements entirely with supervision received via eye-to-eye electronic media, while maintaining visual contact. Provides an immediate effective date.

7 **Specialty dentists.**

Amends § 150A.06, subd. 1c. Removes the following requirements for specialty dentist licensure:

- two character references for each specialty area;
- licensed physician statement attesting to the applicant's physical and mental condition;
- a statement from an ophthalmologist or optometrist attesting to the applicant's visual acuity; and
- a notarized photograph.

8 **Guest license.**

Amends § 150A.06, subd. 2c. Strikes language limiting fees for guest licensure; makes technical changes.

9 **Display of name and certificates.**

Amends § 150A.06, subd. 6. Makes clarifying change to require all licensees and registrants to display renewal certificates.

10 **Licensure by credentials for dental therapy.**

Amends § 150A.06 by adding subd. 12. Adds subdivision allowing dental therapists to apply for licensure based on an evaluation of the applicant's education, experience, and performance record. Allows the board to interview an applicant to determine specified qualifications; allows the board the discretion to waive specific licensure requirements. Specifies when a board must license an applicant or deny an

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| | application for licensure; allows a licensure candidate under this subdivision to appeal a denied application. |
| 11 | **Licenses or registration certificates.**<br>Amends § 150A.09. Makes clarifying changes. |
| 12 | **Application and initial license or registration fees.**<br>Amends § 150A.091, subd. 2. Modifies fees by combining existing fees; adds guest license fee; makes clarifying change. |
| 13 | **Biennial license or registration renewal fees.**<br>Amends § 150A.091, subd. 5. Makes clarifying change. |
| 14 | **Duplicate license or certificate fee.**<br>Amends § 150A.091, subd. 8. Removes fee for wallet-sized license and renewal certificates. |
| 15 | **Licensure by credentials.**<br>Amends § 150A.091, subd. 9. Modifies fees for licensure by credentials; adds dental therapist licensure by credential fee. |
| 16 | **Failure to practice with a current license.**<br>Amends § 150A.091 by adding subd. 21. Establishes penalty fees and administrative actions for when a licensee practices without a current license and pursues reinstatement. |
| 17 | **Delegating regulated procedures to an individual with a terminated license.**<br>Amends § 150A.091 by adding subd. 22. Establishes penalty fees and administrative actions for when a dentist or dental therapist delegates regulated procedures to another dental professional whose license has been terminated. |
| 18 | **Practice of pharmacy.**<br>Amends § 151.01, sudb. 27. Modifies the definition of “practice of pharmacy” by allowing pharmacists to provide intramuscular and subcutaneous administration of any drug under a prescription drug order, rather than only drugs used for the treatment of alcohol or opioid dependence.<br><br>Adds clause (13), allowing pharmacists to participate in the placement of drug monitoring devices under a prescription, protocol, or collaborative practice agreement. |

| Section | Description - Article 5: Health-Related Licensing Boards |
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19 **License requirements.**

Amends § 153.16, subd. 1. Modifies podiatry licensing requirements to allow podiatrists who graduated from podiatric medical school before 1990 (previously 1986) to be licensed without successful completion of a residency program. Provides an immediate effective date.

20 **Temporary requirements governing ambulance service operations and the provision of emergency medical services.**

**Subd. 1. Application.** Allows an ambulance service to operate, and emergency medical technicians, advanced emergency medical technicians, and paramedics to provide, services according to this section, notwithstanding chapter 144E.

**Subd. 2. Definitions.** Defines the following terms for purposes of this section:

- "Advanced emergency medical technician"
- "Advanced life support"
- "Ambulance"
- "Ambulance service personnel"
- "Basic life support"
- "Board"
- "Emergency medical technician"
- "Paramedic"
- "Primary service area"

**Subd. 3. Staffing.** Paragraph (a) allows an ambulance providing basic life support to be staffed with one EMT and a driver, for emergency ambulance calls in the service's primary service area.

Paragraph (b) allows an ambulance providing advanced life support to be staffed with a driver and one paramedic, registered nurse who meets certain requirements, or physician assistant who meets certain requirements, for emergency ambulance calls in the service's primary service area.

Paragraph (c) requires the ambulance service director and medical director to approve ambulance staffing under this subdivision.

Paragraph (d) requires an ambulance service staffing an ambulance under this subdivision to immediately notify the Emergency Medical Services Regulatory Board (EMSRB); specifies notice requirements.

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Paragraph (e) allows the EMSRB to temporarily suspend, prohibit an ambulance driver under this subdivision from driving, or put conditions on the driver's ability to drive, for specified acts committed.

**Subd. 4. Use of expired emergency medications and medical supplies.** Allows ambulance service personnel to use an emergency medication or medical supply for up to six months after the product's expiration date when the ambulance service experiences a shortage, under specified conditions; requires consultation with the Board of Pharmacy and record keeping, with written records submitted to the EMSRB.

**Subd. 5. Provision of emergency medical services after certification expires.** Allows an ambulance service director to authorize an emergency medical technician, advanced emergency medical technician, or paramedic to provide emergency medical services for up to three months after the certification of the emergency medical technician, advanced emergency medical technician, or paramedic expires; requires the ambulance service to notify the EMSRB when such authorization occurs.

**Subd. 6. Reports.** Requires the EMSRB to provide quarterly reports to the legislature on actions taken under this section; specifies dates for reports and information that must be included.

**Subd. 7. Expiration.** Provides a January 1, 2024, expiration for the section.

Provides an immediate effective date.

21 **Repealer.**

Repeals § 150A.091, subdivisions 3 (initial license or permit fees), 15 (verification of licensure fee), and 17 (advanced dental therapy examination fee).

## Article 6: Prescription Drugs

This article contains provisions related to prescription drug costs, transparency, and coverage.

| Section | Description - Article 6: Prescription Drugs |
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1 **Filing.**

Amends § 62A.02, subd. 1.

Requires health carriers to include the health plan's prescription drug formulary, when filing premium rates with the commissioner of commerce. Requires proposed

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formulary revisions to be filed with the commissioner by August 1 of the application years.

2 **Definitions.**

Amends § 62J.497, subd. 1. Adds definitions of NCPDP Real-Time Prescription Benefit Standard, pharmacy benefit manager, and real-time prescription benefit tool to the statute governing the electronic prescription drug program.

3 **Standards for electronic prescribing.**

Amends § 62J.497, subd. 3. In a subdivision establishing standards for electronic prescribing, a new paragraph (f) requires group purchasers and pharmacy benefit managers to use a real-time prescription benefit tool that complies with the NCPDP Real-Time Prescription Benefit Standard and that notifies a prescriber of at least the listed information for a prescribed drug.

This section is effective January 1, 2023.

4 **Prescription drug price transparency.**

Amends § 62J.84.

The amendment to subdivision 2 adds definitions of: course of treatment, National Drug Code, rebate, and 30-day supply.

The amendment to subdivision 3 modifies reporting requirements for prescription drugs for which the price was $100 or greater for a 30-day supply or course of treatment lasting less than 30 days, and for which the increase in price exceeds specified thresholds, by:

- requiring reporting for biosimilar drugs with a price increase of 50 percent or more;
- requiring the manufacturer to provide a description of the drug, and to list the following information separately: National Drug Code, product name, dosage form, strength, and package size;
- clarifying the meaning of introductory price and requiring reporting of the price of the drug on the last day of each of the five calendar years preceding the price increase;
- requiring direct costs incurred and financial assistance provided to be reported for the previous 12-month period;
- clarifying the reporting of the ten highest prices in other countries; and
- requiring specified information to be reported if the drug was acquired by the manufacturer during the previous 12-month period.

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The amendment to subdivision 4 modifies reporting requirements for new prescription drugs with prices that exceed specified thresholds, by:

- clarifying that the tier price threshold also applies to a course of treatment lasting less than 30 days; and
- requiring the manufacturer to provide a description of the drug, and to list the following information separately: National Drug Code, product name, dosage form, strength, and package size.

The amendment to subdivision 5 modifies reporting requirements for newly acquired prescription drugs for which the price and price increases exceed specified thresholds, by:

- applying the provision to biosimilar drugs; and
- requiring the manufacturer to provide a description of the drug, and to list the following information separately: National Drug Code, product name, dosage form, strength, and package size.

5 **Definitions.**

Amends § 62J.84, subd. 2. Applies the definitions in this subdivision (related to prescription drug transparency reporting) to § 62J.841. Also specifies that "manufacturer" does not include an entity licensed as a drug manufacturer solely because it repackages or relabels drugs.

6 **Definitions.**

Amends § 62J.84, subd. 2. Adds definitions for drug product family, pharmacy or pharmacy provider, pharmacy benefit manager, pricing unit, reporting entity, and wholesale drug distributor or wholesaler to a subdivision defining terms for the Prescription Drug Price Transparency Act.

7 **Public posting of prescription drug price information.**

Amends § 62J.84, subd. 6. Requires the commissioner of health to post drug pricing and related information reported under § 62J.841, subd. 2, on the agency website. Also provides that the prohibition on posting trade secret information does not apply to this drug pricing and related information, reported under § 62J.841, subd. 2, paragraph (e), if that information is classified by the manufacturer as trade secret information. (This information is classified as public data under paragraph (e) of that subdivision; paragraph (e) also prohibits a manufacturer from classifying the information reported as trade secret information.)

8 **Public posting of prescription drug price information.**

Amends § 62J.84, subd. 6. Adds the following to the list of prescription drugs and information that must be posted on the Health Department's website: prescription

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drugs and information reported by manufacturers, pharmacies, pharmacy benefit managers (PBMs), and wholesalers for prescription drugs determined to represent a substantial public interest.

9 **Consultation.**

Amends § 62J.84, subd. 7. Allows the commissioner to consult with a private entity or consortium for assistance in collecting and posting the drug pricing and related information collected under § 62J.841. (Under current law, the commissioner may consult with this entity or consortium to implement prescription drug transparency reporting.)

10 **Consultation.**

Amends § 62J.84, subd. 7. Permits the commissioner to consult with all reporting entities, not just manufacturers, to establish a standard reporting format that minimizes administrative burden.

11 **Enforcement and penalties.**

Amends § 62J.84, subd. 8. Allows the commissioner of health to impose civil penalties on manufacturers for:

1) failing to submit timely reports or notices as required by section 62J.841;
2) failing to provide information required by section 62J.841;
3) providing inaccurate or incomplete information under section 62J.841; and
4) classifying drug price and other information submitted under section 62J.841 as trade secret information or increasing the wholesale acquisition cost for drugs subject to price reporting and included in a health plan formulary, for the next calendar year.

Also makes conforming changes.

12 **Enforcement and penalties.**

Amends 62J.84, subd. 8. Provides that penalties apply to any reporting entity that fails to register or that fails to submit timely or complete reports, and authorizes the commissioner to impose a penalty for failing to register with the commissioner.

13 **Legislative report.**

Amends § 62J.84, subd. 9. Modifies requirements for the annual report to the legislature related to drug transparency, to:

1) include reporting related to section 62J.841; and

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2) to require the commissioner to assess whether reporting promotes pricing transparency for health carriers and assists health carriers in managing drug costs and limiting formulary changes due to cost increases during a coverage year.

14 **Legislative report.**

Amends § 62J.84, subd. 9. In addition to existing requirements for content of an annual report to the legislature, requires the annual report on implementation of the prescription drug price transparency actions to include summary information submitted to the commissioner by manufacturers, pharmacies, PBMs, and wholesalers for prescription drugs determined to represent a substantial public interest.

15 **Notice of prescription drugs of substantial public interest.**

Adds subd. 10 to § 62J.84. By January 31, 2023, and quarterly thereafter, requires the commissioner to post on the department's website a list of prescription drugs that the department determines represent a substantial public interest and for which the department intends to request data under subdivisions 11 to 14. Describes drug product families that the department should consider. Requires the department to provide notice to reporting entities of drugs so designated, and limits this designation to 500 or fewer prescription drugs in any one notice.

16 **Manufacturer prescription drug substantial public interest reporting.**

Adds subd. 11 to § 62J.84. Beginning January 1, 2023, requires a manufacturer to submit the listed information, in a form and manner specified by the commissioner, for any prescription drug included in a notification to report issued by the department which the manufacturer manufactures or repackages, for which the manufacturer sets a wholesale acquisition cost, and for which the manufacturer has not submitted data under this section in the 120 days prior to the notification from the department. Allows the manufacturer to submit any documentation needed to support the information reported.

17 **Pharmacy prescription drug substantial public interest reporting.**

Adds subd. 12 to § 62J.84. Beginning January 1, 2023, requires a pharmacy to submit to the commissioner the listed information for any prescription drug included in a notification to report issued by the department to the pharmacy. Allows the pharmacy to submit any documentation needed to support information reported.

18 **Pharmacy benefit manager (PBM) prescription drug substantial public interest reporting.**

Adds subd. 13 to § 62J.84. Beginning January 1, 2023, requires a PBM to submit to the commissioner the listed information for any prescription drug included in a

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notification to report issued by the department to the PBM. Allows the PBM to submit any documentation needed to support the information reported.

19 **Wholesaler prescription drug substantial public interest reporting.**

Adds subd. 14 to § 62J.84. Beginning January 1, 2023, requires a wholesaler to submit to the commissioner the listed information for any prescription drug included in a notification to report issued by the department to the wholesaler. Allows the wholesaler to submit any documentation needed to support the information reported.

20 **Registration requirement.**

Adds subd. 15 to § 62J.84. Beginning January 1, 2023, requires a reporting entity to register with the department in a form and manner specified by the commissioner.

21 **Rulemaking.**

Adds subd. 16 to § 62J.84. Allows the commissioner to use the expedited rulemaking process under section 14.389.

22 **Reporting prescription drug prices; formulary development and price stability.**

Adds § 62J.841.

**Subd. 1. Definitions.** Defines the following terms: average wholesale price, national drug code, wholesale acquisition cost, and unit.

**Subd. 2. Price reporting.** (a) Requires drug manufacturers, beginning July 31, 2023, and each July 31 thereafter, to report the information in paragraph (b) for each drug with a wholesale acquisition cost of $100 or more (for a 30-day supply or course of treatment lasting less than 30 days), for the next calendar year.

(b) Requires manufacturers to report a drug's:

1) national drug code, labeler code, and manufacturer name associated with the labeler code;
2) brand name, if applicable;
3) generic name, if applicable;
4) wholesale acquisition cost (WAC) for one unit;
5) measure that constitutes a WAC unit;
6) average wholesale price; and
7) status as brand name or generic.

(c) Requires the effective date of the information in (b) to be included in the report to the commissioner.

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(d) Requires a manufacturer to report information in the form and manner specified by the commissioner.

(e) Classifies the information reported under this subdivision as public data not on individuals, and prohibits manufacturers from classifying the information as trade secret.

(f) Provides that the failure of a manufacturer to report required information is grounds for disciplinary action by the Board of Pharmacy.

**Subd. 3. Public posting of prescription drug price information.** Requires the commissioner, by October 1 of each year, beginning October 1, 2023, to post the information reported under subdivision 2 on the department's website.

**Subd. 4. Price change.** (a) If a drug is subject to price reporting under subdivision 2 and has been included in a health plan formulary that has been approved by the commissioner of commerce, allows the manufacturer to increase the WAC of that drug for the next calendar year only after providing at least 90 days' written notice.

(b) States that a manufacturer's failure to comply with paragraph (a) is grounds for disciplinary action by the Board of Pharmacy.

23 **Definitions.**

Adds § 62J.841. Defines the following terms: Consumer Price Index, generic or off-patent drug, manufacturer, prescription drug, wholesale acquisition cost, and wholesale distributor.

24 **Excessive price increases prohibited.**

Adds § 62J.842.

**Subd. 1. Prohibition.** Prohibits a manufacturer from imposing, or causing to be imposed, an excessive price increase, whether directly or through a wholesale distributor, pharmacy, or similar intermediary, on the sale of any generic or off-patent drug sold, dispensed, or delivered to consumers in the state.

**Subd. 2. Excessive price increase.** Provides that a price increase is excessive when:

1) the price increase, adjusted by the CPI, exceeds: (i) 15 percent of the WAC over the immediately preceding calendar year; or (ii) 40 percent of the WAC over the three immediately preceding calendar years; and

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2) the price increase, adjusted by the CPI, exceeds $30 for a 30-day supply, or course of treatment lasting less than 30 days.

**Subd. 3. Exemption.** States that it is not a violation of this section for a wholesale distributor or pharmacy to increase the price of a generic or off-patent drug if the increase is directly attributable to additional costs imposed by the manufacturer.

25 **Registered agent and office within the state.**

Adds § 62J.843. Requires manufacturers of generic or off-patent drugs made available in the state to maintain a registered agent and office within the state.

26 **Enforcement.**

Adds § 62J.844.

**Subd. 1. Notification.** Requires the commissioner of management and budget and any other state agency that provides or purchases a pharmacy benefit, and any entity under contract with a state agency to provide a pharmacy benefit, other than an entity under contract with the Department of Human Services, to notify the manufacturer of the drug, the attorney general, and the Board of Pharmacy of any price increase of a generic or off-patent drug that violates section 62J.842.

**Subd. 2. Submission of drug cost statement and other information by manufacturer; investigation by attorney general.** (a) Requires the manufacturer, within 45 days of receiving notice under subdivision 1, to submit a drug cost statement to the attorney general. Requires the statement to:

1) itemize the cost components related to drug production;
2) identify the circumstances and timing of any increase in materials or manufacturing costs that caused any price increase, in the preceding calendar year or preceding three calendar years as applicable; and
3) provide any other information the manufacturer believes to be relevant.

(b) Allows the attorney general to investigate whether a violation has occurred, is occurring, or is about to occur, in accordance with section 8.31, subdivision 2 (general investigative powers of the attorney general).

**Subd. 3. Petition to court.** (a) Allows a court, on petition of the attorney general, to issue an order:

1) compelling the manufacturer to provide the drug cost statement, and answer interrogatories, produce records or documents, or be examined under oath, as required by the attorney general;

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2) restraining or enjoining a violation of sections 62J.841 to 62J.845, including restoring drug prices to levels that comply with section 62J.842;
3) requiring the manufacturer to account for all revenues resulting from a violation of section 62J.842;
4) repaying all consumers, including third-party payers, any money acquired as a result of a price increase that violates section 62J.842;
5) requiring that all revenues generated from a violation of section 62J.842 be remitted to the state and deposited into a special fund, to be used to reduce consumer drug costs, if the manufacturer is unable to determine the individual transactions necessary to make repayments under clause (4);
6) imposing a civil penalty of up to $10,000 per day for each violation of section 62J.842;
7) providing for the recovery of costs and disbursements incurred by the attorney general in bringing an action; and
8) providing any other appropriate relief, including any other equitable relief as determined by the court.

(b) Provides that for purposes of paragraph (a), clause (6), requires every individual transaction in violation of section 62J.842 to be considered a separate violation.

**Subd. 4. Private right of action.** States that any action brought by a person injured by a violation of this section is for the benefit of the public.

27 **Prohibition on withdrawal of generic or off-patent drugs for sale.**

Adds § 62J.845.

**Subd. 1. Prohibition.** Prohibits a manufacturer of a generic or off-patent drug from withdrawing that drug from sale or distribution in the state for purposes of avoiding the prohibition on excessive price increases.

**Subd. 2. Notice to board and attorney general.** Requires any manufacturer that intends to withdraw a generic or off-patent drug from sale or distribution in the state to provide 180 days' written notice of withdrawal to the Board of Pharmacy and the attorney general.

**Subd. 3. Financial penalty.** Allows the attorney general to assess a $500,000 penalty on any manufacturer that it determines has failed to comply with the requirements of this section.

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28 **Severability.**

Adds § 62J.846. Provides that the provisions of sections 62J.841 to 62J.845 are severable.

29 **Citation.**

Adds § 62J.85. States that sections 62J.85 to 62J.95 may be cited as the "Prescription Drug Affordability Act."

30 **Definitions.**

Adds § 62J.86. Defines the following terms: advisory council, biologic, biosimilar, board, brand name drug, generic drug, group purchaser, manufacturer, prescription drug product, and wholesale acquisition cost (WAC).

31 **Prescription Drug Affordability Board.**

Adds § 62J.87.

**Subd. 1. Establishment.** Requires the Legislative Coordinating Commission to establish the Prescription Drug Affordability Board to protect consumers, state and local governments, health plan companies, providers, pharmacies, and other stakeholders from unaffordable costs of certain prescription drugs.

**Subd. 2. Membership.** (a) Provides that the board consists of seven members – three appointed by the governor, one by the majority leader and one by the minority leader of the Senate, and one by the speaker of the House and one by the House minority leader.

(b) Requires members to have knowledge and expertise in pharmaceutical economics and finance or health care economics and finance, and not be an employee or board member of, or consultant to, a manufacturer or trade association for manufacturers or a pharmacy benefit manager or trade association for pharmacy benefit managers.

(c) Requires initial appointments to be made by January 1, 2023.

**Subd. 3. Terms.** States that appointees serve four-year terms, except that initial appointees shall serve staggered terms. Prohibits members from serving more than two consecutive terms. Allows members to resign at any time by giving written notice.

**Subd. 4. Chair; other officers.** Specifies the procedure to be used for designating and electing the chair, vice-chair, and other officers.

**Subd. 5. Staff; technical assistance.** (a) Requires the board to hire an executive director and other staff, and specifies required qualifications for the executive

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director. Allows the board to employ or contract for professional and technical assistance.

(b) Requires the attorney general to provide legal services to the board.

**Subd. 6. Compensation.** States that members shall not receive compensation but may be reimbursed for expenses.

**Subd. 7. Meetings.** Applies the open meetings law to the board. Requires the board to meet publicly at least every three months to review prescription drug product information that is submitted, and to allow for public comment. Specifies other requirements related to meetings.

32 **Prescription Drug Affordability Advisory Council.**

Adds § 62J.88.

**Subd. 1. Establishment.** Requires the governor to appoint an advisory council to advise the commission on drug cost issues and represent stakeholder views. Specifies criteria related to knowledge and expertise of members.

**Subd. 2. Membership.** Specifies membership.

**Subd. 3. Terms.** Requires initial appointments to be made by January 1, 2022, and specifies requirements for staggered and regular terms and removal and vacancies.

**Subd. 4. Compensation.** Provides that members receive compensation according to the standard procedures that apply to advisory councils and committees.

**Subd. 5. Meetings.** States that the council is subject to the Open Meeting Law and requires the council to meet at least every three months.

**Subd. 6. Exemption.** Provides that the council does not expire.

33 **Conflicts of interest.**

Adds § 62J.89.

**Subd. 1. Definition.** Defines “conflict of interest.”

**Subd. 2. General.** Requires board and advisory council members, board staff, and third-party contractors to disclose any conflicts of interest prior to entering into any appointment, employment, or contract. Specifies recusal and disclosure requirements.

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**Subd. 3. Prohibitions.** Prohibits board and advisory council members, board staff, or third-party contractors from accepting gifts, bequeaths, or donations that raise the specter of a conflict of interest or have the appearance of injecting bias.

34 **Prescription drug price information; decision to conduct cost review.**

Adds § 62J.90.

**Subd. 1. Drug price information from the commissioner of health and other sources.** (a) Requires the commissioner of health to provide the board with the information provided to the commissioner by drug manufacturers under § 62J.84, subd. 3, 4, and 5, within 30 days of the date the information is received.

(b) Directs the board to subscribe to one or more prescription drug pricing files.

**Subd. 2. Identification of certain prescription drug products.** (a) Requires the board, in consultation with the advisory council, to identify the following drug products:

(1) brand name drugs or biologics for which the WAC increases by more than 10 percent or by more than $10,000 during any 12- month period or course of treatment if less than 12 months, after adjusting for changes in the CPI;

(2) brand name drugs or biologics that have been introduced at a WAC of $30,000 or more per calendar year or course of treatment;

(3) biosimilar drugs that have been introduced at a WAC that is not at least 15 percent lower than the referenced brand name biologic; and

(4) generic drugs for which the WAC is: (i) $100 or more, after adjusting for changes in the CPI, for: (A) a 30-day supply; (B) a supply lasting less than 30 days; or (C) one unit of the drug if FDA labeling does not recommend a finite dosage; and (ii) increased by 200 percent or more during the preceding 12-month period, after adjusting for changes in the CPI.

(b) Requires the board, in consultation with the advisory council, to identify prescription drug products not described in paragraph (a), that may impose costs that create significant affordability challenges for the state health care system or patients, including but not limited to drugs to address public health emergencies.

(c) Requires the board to make available to the public the names and price information of the prescription drug products identified under this subdivision, with the exception of information determined by the board to be proprietary.

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**Subd. 3. Determination to proceed with review.** (a) Allows the board to initiate a review of the cost of a prescription drug product identified by the board under this section.

(b) Requires the board to consider public requests for a cost review of any prescription drug product identified under this section.

(c) If there is no consensus on whether to review a drug, allows any member of the board to request a vote on whether to review.

35 **Prescription drug product reviews.**

Adds § 62J.91.

**Subd. 1. General.** Upon a decision to proceed with a cost review, requires the board to conduct the review and determine whether appropriate utilization of the drug, based on the FDA label and standard medical practice, has led or will lead to affordability challenges for the state health care system or for patients.

**Subd. 2. Review considerations.** Specifies the factors the board may consider in reviewing the cost of a prescription drug product. The specified factors are: selling price of the drug; average monetary price concession, discount, or rebate provided to group purchasers; price of therapeutic alternatives; the average concession, discount, or rebate provided for these alternatives; cost to group purchasers; impact on patient access relative to cost and insurance design; the value of patient access programs; financial impact relative to baseline effects of existing alternatives; co-pays and cost-sharing; any information provided by the manufacturer; and any other factors determined by the board.

**Subd. 3. Further review factors.** If the commission, after considering the factors listed under subdivision 2, is unable to determine whether the drug has produced or will produce an affordability challenge, allows the commission to consider the following additional factors: research and development costs; direct-to-consumer marketing costs; gross and net manufacturer revenues; specified factors related to the selection of the introductory price or price increase; and additional factors determined by the board to be relevant.

**Subd. 4. Public data; proprietary information.** (a) Requires submissions to the board related to a drug cost review to be made public, with the exception of information the board determines is proprietary.

(b) Requires the board to establish standards for proprietary information.

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(c) Requires the board to provide public notice and an opportunity for public comment prior to establishing standards under paragraph (b).

36 **Determinations; compliance; remedies.**

Adds § 62J.92.

**Subd. 1. Upper payment limit.** (a) If the board determines that spending on a prescription drug product creates an affordability challenge, directs the board to establish an upper payment limit after considering the cost of administering the drug, cost of delivering the drug to consumers, the range of prices at which the drug is sold in the U.S. and the range of pharmacy reimbursement in Canada, and other relevant pricing and administrative cost information.

(b) States that the upper payment limit applies to all public and private purchases, payments, and payer reimbursements for the drug product intended for individuals in the state in person, by mail, or other means.

**Subd. 2. Noncompliance.** (a) Requires noncompliance by an entity to comply with an upper payment limit set by the board to be referred to the attorney general.

(b) If the attorney general finds that an entity was noncompliant, allows the attorney general to pursue remedies under chapter 8 or appropriate criminal charges if there is evidence of intentional profiteering.

(c) Provides that an entity that obtains price concessions from a manufacturer that result in a lower net cost to the stakeholder than the limit established by the board shall not be considered noncompliance.

(d) Allows the attorney general to provide guidance to stakeholders on activities that could be considered noncompliant.

**Subd. 3. Appeals.** Allows appeals of board decisions and specifies procedures.

37 **Reports.**

Adds § 62J.93. Requires the board, beginning March 1, 2023, and each March 1 thereafter, to report to the governor and legislature on general price trends in prescription drug products and the number of drugs subject to the board's cost review and analysis, including the result of any analysis and the number and disposition of appeals and judicial reviews.

38 **ERISA plans and Medicare drug plans.**

Adds § 62J.94. (a) States that nothing in sections 62J.85 to 62J.95 shall be construed to require ERISA plans or Medicare Part D plans to comply with board decisions.

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Provides that these plans are free to exceed the upper payment limit set by the board.

(b) Requires providers who dispense and administer drugs in the state to bill all payers no more than the upper payment limit without regard to whether or not an ERISA plan or Medicare Part D plan chooses to reimburse the provider in an amount greater than the upper payment limit.

(c) Defines an ERISA plan or group health plan.

39 **Severability.**

Adds § 62J.95. Provides that sections 62J.85 to 62J.94 are severable.

40 **Prohibition on use of step therapy for antiretroviral drugs.**

Adds § 62Q.1842.

**Subd. 1. Definitions.** Defines “health plan” and “step therapy protocol.” Health plan is defined to include managed care and county-based purchasing plans, and integrated health partnerships, under MA and MinnesotaCare, as well as private sector plans.

**Subd. 2. Prohibition on use of step therapy protocols.** Prohibits a health plan that covers antiretroviral drugs for the prevention of HIV/AIDS, from limiting or excluding coverage by requiring prior authorization for the drugs or by requiring an enrollee to follow a step therapy protocol.

41 **Cost-sharing for prescription drugs and related medical supplies to treat chronic disease.**

Adds § 62Q.481.

**Subd. 1. Cost-sharing limits.** Requires a health plan to limit 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 and to no more than $50 per month in total for all related medical supplies. States that this coverage is not subject to any deductible.

(b) Provides that if application of this section before an enrollee has met their deductible would result in health savings account ineligibility, then this section shall apply to the drug or related medical supply only after the deductible has been met.

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**Subd. 2. Definitions.** Defines the following terms: chronic disease, cost-sharing, and related medical supplies. “Chronic disease” is defined as diabetes, asthma, and allergies requiring the use of epinephrine auto-injectors.

States that the section is effective January 1, 2023, and applies to health plans offered, issued, and renewed on or after that date.

42 **Coverage for drugs to prevent the acquisition of human immunodeficiency virus.**

Adds § 62Q.54.

(a) Requires a health plan that provides prescription drug coverage to also cover, in accordance with this section:

1) any antiretroviral drug approved by the FDA for preventing HIV that is prescribed, dispensed, or administered by a pharmacist meeting the requirements of section 151.37, subd. 17; and
2) any laboratory testing necessary for therapy that uses the drugs, that is ordered, performed, and interpreted by a pharmacist who meets the requirements of section 151.37, subd. 17.

(b) Requires a health plan to provide the same terms of coverage for drugs to prevent HIV that are prescribed or administered by a pharmacist who meets the requirements of section 151.37, subd. 17, as would apply had the drug been prescribed or administered by a physician, physician assistant, or advanced practice registered nurse. Allows plans to require pharmacists or pharmacies to meet reasonable medical management requirements, if other providers must meet the same requirements.

(c) Requires a health plan to reimburse an in-network pharmacy or pharmacist for the drugs and testing described in paragraph (a) at a rate equal to that provided to a physician, physician assistant, or advanced practice registered nurse providing similar services.

(d) Provides that a health plan is not required to cover the drugs and testing described in paragraph (a) if provided by a pharmacist or pharmacy that is out-of-network, unless the plan covers similar services provided by out-of-network providers. Requires plans to ensure that their provider network includes in-network pharmacies that provide the services described in paragraph (a).

43 **Prescription drug benefit transparency and management.**

Adds § 62Q.83.

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**Subd. 1. Definitions.** Defines the following terms for this section: drug, enrollee contract term, formulary, health plan company, and prescription.

**Subd. 2. Prescription drug benefit disclosure.** Paragraph (a) requires a health plan company that provides prescription drug coverage and uses a formulary to make the plan's formulary and related benefit information available at least 30 days before annual renewal dates.

Paragraph (b) requires formularies to be organized and disclosed consistent with the most recent version of the United States Pharmacopeia's Model Guidelines.

Paragraph (c) requires the specific enrollee benefit terms, including cost-sharing and expected out-of-pocket costs, to be identified for each item or category of items on the formulary.

**Subd. 3. Formulary changes.** Paragraph (a) allows a health plan company, at any time during a contract term, to expand its formulary, reduce copayments or coinsurance, or move a drug to a benefit category that reduces an enrollee's cost.

Paragraph (b) allows a health plan company to remove a brand name drug from the formulary or place a brand name drug in a benefit category that increases the enrollee's cost if the health plan company also adds a generic or multisource brand name drug rated as therapeutically equivalent, or a biologic drug rated as interchangeable, that is at a lower cost to the enrollee. The health plan company must also provide at least 60 days' notice before making this change.

Paragraph (c) allows a health plan company to change utilization review requirements or move drugs to a benefit category that increases an enrollee's cost during the contract term with at least 60 days' notice. Specifies that these changes do not apply to enrollees currently taking these drugs for the duration of the enrollees' contract terms.

Paragraph (d) allows a health plan company to remove a drug from the plan's formulary if the drug has been deemed unsafe by the Food and Drug Administration or withdrawn by the FDA or the product manufacturer, or when an independent source of research, clinical guidelines, or evidence-based standards issues drug-specific warnings or recommends changes in drug use.

**Subd. 4. Not severable.** States that this section is not severable from specified amendments and enactments in this act. If any of these provisions is found to be void for any reason, this section is also void.

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This section is effective January 1, 2024, and applies to health plans offered, sold, issued, or renewed on or after that date.

44 **Alternative biological products.**

Adds § 62W.0751.

**Subd. 1. Definitions.** Defines the following terms: biological product, biosimilar or biosimilar product, interchangeable biological product, and reference biological product.

**Subd. 2. Pharmacy and provider choice related to dispensing reference biological products, interchangeable biological products, or biosimilar products.** (a) Prohibits a PBM or health carrier from requiring or demonstrating a preference for a reference biological product administered to a patient by a physician or health care provider or any product that is biosimilar to the reference biological product or an interchangeable biological product.

(b) If a PBM or health carrier elects coverage of a product listed in paragraph (a), and there are two or less biosimilar products available relative to the reference product, requires the PBM or health carrier to elect equivalent coverage for all of the products that are biosimilar to the reference biological or interchangeable biological products.

(c) If a PBM or health carrier elects coverage of a product listed in paragraph (a), and there are greater than two biosimilar products available relative to the reference product, requires the PBM or health carrier to elect preferential coverage for all of the products that are biosimilar to the reference biological or interchangeable biological products.

(d) Prohibits a PBM or health carrier from imposing limits on access to a product required to be covered in paragraph (b) that are more restrictive than the limits imposed on a product listed in paragraph (a) or that have the effect of giving preferred status to the product listed in paragraph (a).

(d) States that this section applies only to new administrations of a reference biological product, and that nothing in the section requires a patient on an active course of treatment to switch from a prescribed reference biological product.

Provides a January 1, 2023, effective date.

45 **Clinician-administered drugs.**

Adds § 62W.15.

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**Subd. 1. Definitions.** Defines "affiliated pharmacy" and "clinician-administered drug."

**Subd. 2. Prohibition on requiring coverage as a pharmacy benefit.** Prohibits a PBM or health carrier from requiring that a clinician-administered drug, or the administration of a clinician-administered drug, be covered as a pharmacy benefit.

**Subd. 3. Enrollee choice.** Provides that a PBM or health carrier:

1) shall permit an enrollee to obtain a clinician-administered drug from a health care provider authorized to administer the drug, or a pharmacy;
2) shall not interfere with the enrollee's right to obtain the clinician-administered drug from their provider or pharmacy of choice, and shall not offer financial or other incentives to influence the enrollee's choice;
3) shall not require the clinician-administered drug to be dispensed by a pharmacy selected by the PBM or health carrier; and
4) shall not limit or exclude coverage for a clinician-administered drug when it is not dispensed by a pharmacy selected by the PBM or health carrier, if the drug would otherwise be covered.

**Subd. 4. Cost-sharing and reimbursement.** Provides that a PBM or health carrier:

1) may impose coverage or benefit limitations on an enrollee who obtains a clinician-administered drug from a health care provider or pharmacy, only if these limitations would also be imposed if the drug was obtained from an affiliated pharmacy or a pharmacy selected by the PBM or health carrier; and
2) may impose cost-sharing requirements on an enrollee who obtains a clinician-administered drug from a health care provider or pharmacy, only if this cost-sharing would also be imposed if the drug was obtained from an affiliated pharmacy or a pharmacy selected by the PBM or health carrier.

**Subd. 5. Other requirements.** Provides that a PBM or health carrier:

1) shall not require or encourage the dispensing of a clinician-administered drug in a manner inconsistent with supply chain security controls and chain of distribution set by the Drug Supply Chain Security Act;
2) shall not require a specialty pharmacy to dispense a clinician-administered medication directly to a patient with the intent that the patient transport the medication to a health care provider for administration; and

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3) may offer, but shall not require, the use of a home infusion pharmacy to dispense or administer clinician-administered drugs to enrollees, and the use of an infusion site external to the provider's office or clinic.

States that this section is effective January 1, 2023.

46 **Practitioner.**

Amends § 151.01, subd. 23. Includes in the definition of "practitioner" a pharmacist authorized to prescribe drugs to prevent HIV under section 151.37, subd. 17.

47 **Practice of pharmacy.**

Amends § 151.01, subd. 27. Includes the following in the definition of the practice of pharmacy:

- prescribing, dispensing, and administering drugs to prevent HIV, if the pharmacist meets the requirements of section 151.37, subd. 17; and
- ordering, conducting, and interpreting laboratory tests necessary for therapies that use drugs to prevent HIV, if the pharmacist meets the requirements of section 151.37, subd. 17.

48 **Biosimilar product.**

Amends § 151.01, by adding subd. 43. Defines "biosimilar" or "interchangeable biological product" as a biological product that the FDA has licensed and determined to be biosimilar.

Provides a January 1, 2023, effective date.

49 **Reference biological product.**

Amends § 151.01, by adding subd. 44. Defines "reference biological product" as the single biological product for which the FDA has approved an initial biological product license application, against which other biological products are evaluated for licensure as biosimilar or interchangeable. Provides a January 1, 2023, effective date.

50 **Forms of disciplinary action.**

Amends § 151.071, subd. 1. Allows the Board of Pharmacy to impose a civil penalty not exceeding $25,000 for each separate violation of section 62J.842.

51 **Grounds for disciplinary action.**

Amends § 151.071, subd. 2. Classifies the failure of a drug manufacturer to comply with the requirements of § 62J.841 (drug price reporting and prohibition on certain drug price changes) as grounds for disciplinary action by the Board of Pharmacy.

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| 52 | **Grounds for disciplinary action.**<br>Amends § 151.071, subd. 2. Provides that a violation of section 62J.842 or section 62J.845 by a manufacturer is grounds for the Board of Pharmacy to take disciplinary action. |
| 53 | **Delivery through common carrier; compliance with temperature requirements.**<br>Amends § 151.335.<br><br>Requires a mail order or specialty pharmacy, when complying with manufacturer temperature requirements for drugs, to include with each delivered prescription a device recognized by the United States Pharmacopeia by which the patient can easily detect improper storage or temperature variations. |
| 54 | **Drugs for preventing the acquisition of HIV.**<br>Amends § 151.37, by adding subd. 17. (a) States that a pharmacist is authorized to prescribe and administer drugs to prevent HIV in accordance with this subdivision.<br><br>(b) Requires the Board of Pharmacy, by January 1, 2023, to develop a standardized protocol for a pharmacist to follow in prescribing drugs under paragraph (a). Allows the board to consult with specified groups in developing the protocol.<br><br>(c) Before a pharmacist is authorized to prescribe a drug under paragraph (a), requires the pharmacist to successfully complete a training program specifically developed for prescribing drugs to prevent HIV, offered by a college of pharmacy, an accredited continuing education provider, or a program approved by the board. Requires the pharmacist to complete continuing education requirements as specified by the board, in order to maintain authorization to prescribe.<br><br>(d) Before prescribing a drug under paragraph (a), requires the pharmacist to follow the appropriate standardized protocol.<br><br>(e) Before dispensing a drug under paragraph (a), requires the pharmacist to provide counseling and specified information to the patient.<br><br>(f) Prohibits a pharmacist from delegating prescribing authority under this subdivision. Allows a pharmacist intern to prepare the prescription, but requires a pharmacist authorized to prescribe under this subdivision to review, approve, and sign the prescription, before the prescription is processed or dispensed.<br><br>(g) States that nothing in the subdivision prohibits a pharmacist from participating in the initiation, management, modification, and discontinuation of drug therapy according to a protocol authorized in this section and section 151.01, subd. 27 |

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(authorization for participation in drug therapy under the definition of the practice of pharmacy).

55 **Medication repository program.**

Amends § 151.555, as amended by Laws 2021, chapter 30, article 5, sections 2 to 5.

The amendment to subd. 2 specifies criteria for the contract between the board of pharmacy and the central repository. These criteria include requirements that:

1) the board transfer to the central repository any money appropriated for operating the medication repository program, and the central repository spend this money only for purposes specified in the contract;
2) the central repository report on specified performance measures to the board; and
3) the board annually audit expenditures by the central repository of funds appropriated by the legislature and transferred by the board to the repository.

Amendments throughout the section change the name of the program from the prescription drug repository program to the medication repository program, change references to “drug” to “medication,” and remove references to “prescription” drugs.

A new subdivision 15 allows the central repository to seek grants or other funds from nonprofit charitable organizations, the federal government, and other sources, to fund the operation of the medication repository program.

56 **Intractable pain.**

Amends § 152.125.

**Subd. 1. Definitions.** Provides new definitions of: drug diversion, palliative care, and rare disease. Also modifies the definition of intractable pain to list associated conditions. Makes various clarifying changes.

**Subd. 1a. Criteria for the evaluation and treatment of intractable pain.** Provides that the evaluation and treatment of intractable pain is governed by the following criteria:

1) a diagnosis of intractable pain by a treating physician and by a physician specializing in pain medicine or a physician treating the part of the body that is the source of pain, is sufficient to meet the definition of intractable pain; and

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2) the cause of the diagnosis of intractable pain must not interfere with medically necessary treatment, including but not limited to prescribing or administering a controlled substance.

**Subd. 2. Prescription and administration of controlled substances for intractable pain.** (a) Adds references to advanced practice registered nurses and physician assistants prescribing or administering a controlled substance in the course of treatment of intractable pain. Provides that these individuals shall not be subject to disciplinary action by the Board of Nursing for appropriately prescribing or administering a controlled substance for intractable pain if specified conditions are met. Adds as a new condition that physicians, advanced practice registered nurses, and physician assistants enter into a patient-provider agreement.

(b) Provides that a physician, advanced practice registered nurse, or physician assistant, acting in good faith and based on the needs of the patient, shall not be subject to civil or criminal action or investigation, disenrollment, or termination by the commissioners of health or human services, solely for prescribing a dosage that equates to an upward deviation from morphine milligram equivalent (MME) dosage recommendations or thresholds specified in state or federal opioid prescribing guidelines or policies. Specifies that these guidelines or policies include, but are not limited to: the Guideline for Prescribing Opioids for Chronic Pain issued by the Center for Disease Control and Prevention, Minnesota opioid prescribing guidelines, the Minnesota opioid prescribing improvement program, and the Minnesota quality improvement program.

(c) Prohibits a physician, advanced practice registered nurse, or physician assistant treating intractable pain from tapering a patient's controlled substance medication solely to meet a predetermined MME dosage recommendation or threshold, if the patient is stable and compliant with the treatment plan, is not experiencing serious harm from the level of medication, and is in compliance with the patient-provider agreement.

(d) Provides that a decision to taper a patient's medication dosage must be based on factors other than an MME recommendation or threshold.

(e) Prohibits a pharmacist, health plan company, or pharmacy benefit manager from refusing to fill a prescription for an opiate based solely on the prescription exceeding a predetermined MME dosage recommendation or threshold.

**Subd. 3. Limits on applicability.** Provides that the section does not apply to patients known to be using controlled substances for drug diversion. Also makes clarifying and conforming changes.

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**Subd. 4. Notice of risks.** Makes conforming changes, adding references to advanced practice registered nurses and physician assistants and the patient-provider agreement. Also requires discussions of treatment for intractable pain using controlled substances to be held with the patient's legal guardian, if applicable.

**Subd. 5. Patient-provider agreement.** (a) Before treating a patient for intractable pain, requires a physician, advanced practice registered nurse, or physician assistant, and the patient or legal guardian if applicable, to mutually agree to the treatment and enter into a patient-provider agreement. Requires the agreement to include a description of the prescriber's and patient's expectations, responsibilities, and rights according to best practices and current standards of care.

(b) Requires the agreement to be signed by the parties, and included in the patient's medical records. Requires a copy of the signed agreement to be provided to the patient.

(c) Requires the agreement to be reviewed by the patient and the provider annually. Specifies requirements related to updated and revised agreements.

(d) States that a patient-provider agreement is not required in an emergency or inpatient hospital setting.

57 **Drugs.**

Amends § 256B.0625, subd. 13. Requires MA coverage of, and reimbursement for, antiretroviral drugs to prevent HIV, and any laboratory testing necessary for therapy using these drugs, to meet the requirements that would otherwise apply to a health plan under section 62Q.524. This requirement also applies to MinnesotaCare by cross-reference in other law.

58 **Prior authorization.**

Amends § 256B.0625, subd. 13f. Prohibits MA, and MinnesotaCare by cross-reference in other law, from applying prior authorization and step therapy protocol requirements to antiretroviral drugs used to prevent HIV.

59 **Study of pharmacy and provider choice of biological products.**

Requires the commissioner of health, within the limits of existing resources, to analyze the effect of section 62W.0751 on the net price for different payors of biological products, interchangeable biological products, and biosimilar products. Requires the commissioner to report to the legislature by December 15, 2024.

## Article 7: Health Insurance

This article contains provisions regulating insurance coverage related to ectodermal dysplasia, lymphedema treatment, diagnostic services and testing after mammograms, and access to services to treat rare diseases.

| Section | Description - Article 7: Health Insurance |
|---|---|
| 1 | **Required coverage.**<br>Amends § 62A.25, subd. 2. Requires health plans to include coverage for reconstructive breast surgery due to ectodermal dysplasia.<br><br>**Effective date.** This section is effective January 1, 2023. |
| 2 | **Coverage of lymphedema treatment.**<br>Adds § 62A.255.<br><br>**Subd. 1. Scope of coverage.** States that this section applies to all health plans that are sold, issued, or renewed to a Minnesota resident.<br><br>**Subd. 2. Required coverage.** (a) Requires health plans to provide coverage for lymphedema treatment, including certain items, therapies, and treatments.<br><br>(b) Allows a health plan to require the treatments under paragraph (a) be prescribed by an in-network provider.<br><br>(c) Prohibits a health plan from apply cost-sharing requirements, benefit limitations, or service limitations that are more restrictive than those applied by the health plan for other similar services or benefits.<br><br>**Effective date.** This section is effective August 1, 2021, and applies to any health plan issued, sold, or renewed on or after that date. |
| 3 | **Required coverage.**<br>Amends § 62A.28, subd. 2. Requires health plans to include coverage for hair prostheses due to hair loss from ectodermal dysplasias.<br><br>**Effective date.** This section is effective January 1, 2023. |
| 4 | **Mammogram; diagnostic services and testing.**<br>Provides that if an enrollee requires additional diagnostic services or testing after a mammogram, a health plan must provide coverage for these services and testing with no cost sharing, including co-pays, deductible, or coinsurance.<br><br>**Effective date.** This section is effective January 1, 2023, and applies to health plans offered, issued, or sold on or after that date. |

| Section | Description - Article 7: Health Insurance |
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5 **Coverage for ectodermal dysplasias.**

Adds § 62A.3096.

**Subd. 1. Definition.** Defines ectodermal dysplasias.

**Subd. 2. Coverage.** Requires health plans to include coverage for the treatment of ectodermal dysplasias.

**Subd. 3. Dental coverage.** (a) Requires health plans to include coverage for dental treatments related to ectodermal dysplasias, including bone grafts, dental implants, orthodontia, dental prosthodontics, and dental maintenance.

(b) Clarifies that if a dental treatment is covered under a dental plan the coverage under paragraph (a) is secondary.

**Effective date.** This section is effective January 1, 2023.

6 **Unrestricted access to services for the diagnosis and treatment of rare diseases.**

Adds § 62Q.451.

(a) Prohibits a health plan company from restricting where an enrollee can receive services related to the diagnosis and treatment of a rare disease or condition. Defines "rare disease or condition" as one that affects fewer than 200,000 persons in the U.S. and meets specified criteria.

(b) States that a rare disease or condition does not include an infectious disease with widely available and known protocols that is commonly treated in an outpatient setting, even if it affects less than 200,000 persons in the U.S.

(c) Requires that cost-sharing and benefit or services limitations for the diagnosis and treatment of rare diseases or conditions cannot place a great financial burden on the enrollee or be more restrictive than those applied for in-network medical treatment.

(d) Provides that this subdivision does not apply to coverage provided through the State Employee Group Insurance Program.

**Effective date.** This section is effective July 1, 2023, and applies to health plans offered, issued, or renewed on or after that date.

7 **Services for the diagnosis, monitoring, and treatment of rare diseases.**

Amends § 256B.0625, by adding subd. 68. Requires MA coverage for services related to the diagnosis, monitoring, and treatment of a rare disease or condition to meet the requirements of § 62Q.451. Provides a January 1, 2023, effective date.

| Section | Description - Article 7: Health Insurance |
|---|---|
| 8 | **Ectodermal dysplasias.**<br>Amends § 256B.0625, by adding subd. 69. States that MA and MinnesotaCare cover treatment for ectodermal dysplasias. Requires coverage to meet the requirements of §§ 62A.25, 62A.28, and 62A.3096. Provides a January 1, 2023, effective date. |
| 9 | **Exceptions.**<br>Amends § 256B.0631, subd. 2. Exempts from MA co-payments and deductibles additional diagnostic services or testing that a health care provider determines an enrollee requires after a mammogram. Provides a January 1, 2023, effective date. |
| 10 | **Cost-sharing.**<br>Amends § 256L.03, subd. 5. Exempts from MinnesotaCare co-payments, coinsurance, and deductibles additional diagnostic services or testing that a health care provider determines an enrollee requires after a mammogram. Provides a January 1, 2023, effective date. |

## Article 8: Miscellaneous

This article makes changes to the Rare Disease Advisory Council, establishes requirements for products containing cannabinoids, reschedules marijuana and nonsynthetic THC from Schedule I to Schedule II of the state controlled substances schedule, prohibits health care providers and organ procurement organizations from making decisions about access to anatomical gifts and related services based on race or ethnicity, and extends a human services waiver for background study requirements.

| Section | Description - Article 8: Miscellaneous |
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| 1 | **Food.**<br>Amends § 34A.01, subd. 4. Amends the definition of food in chapter 34A to provide that an edible cannabinoid product is not a food. (Chapter 34A give the commissioner of agriculture certain inspection and enforcement powers related to food.) |
| 2 | **Minnesota Rare Disease Advisory Council.**<br>Amends § 137.68. Moves the Rare Disease Advisory Council from the University of Minnesota to the Council on Disability and makes changes to the membership, appointing authority, operations, and duties of the advisory council.<br>**Subd. 1. Establishment.** Renames the advisory council the Minnesota Rare Disease Advisory Council and requires the Council on Disability to house the advisory council. |

| Section | Description - Article 8: Miscellaneous |
|---|---|

**Subd. 2. Membership.** Reassigns authority to appoint public members to the advisory council from the Board of Regents or a designee to the governor, and allows the governor to appoint representatives with other areas of expertise as identified by the advisory council. Allows members to be appointed for additional terms, and strikes obsolete language.

**Subd. 3. Meetings.** Strikes obsolete language, and requires advisory council meetings and notices of meetings to comply with open meeting laws.

**Subd. 3a. Chairperson; executive director; staff; executive committee.** A new subd. 3a requires the advisory council to elect a chairperson and other necessary officers. Provides that the advisory council shall be governed by an executive committee, and allows the executive committee to appoint subcommittees and work groups. Requires the advisory council to appoint an executive director, and allows the executive director to employ and direct a staff.

**Subd. 4. Duties.** Modifies duties listed for the advisory council to include addressing problems faced by patients with rare diseases when changing health plans; identifying and addressing barriers faced by patients with a rare disease to obtaining care due to prior authorization requirements; recommending and implementing best practices to ensure health care providers are informed about recognizing and treating rare diseases; advising and consulting with the Department of Human Services; advising on and advancing policy initiatives at the state and federal levels; and receiving funds and issuing grants.

**Subd. 5. Conflict of interest.** Provides that advisory council members are subject to the advisory council's conflict of interest policy in its operating procedures, rather than the conflict of interest policy of the Board of Regents.

**Subd. 6. Annual report.** No changes.

3 **Definitions.**

Amends § 151.72, subd. 1. In a section governing the sale of cannabinoid products, adds definitions of certified hemp, edible cannabinoid product, label, matrix barcode, and nonintoxicating cannabinoid. Modifies the definition of labeling.

4 **Scope.**

Amends § 151.72, subd. 2. Provides that this section applies to any product that contains cannabinoids extracted from hemp and that is an edible cannabinoid product or intended for human or animal consumption. Provides the Board of Pharmacy does not have authority over food products that do not contain cannabinoids from hemp.

| Section | Description - Article 8: Miscellaneous |
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5 **Sale of cannabinoids derived from hemp.**

Amends § 151.72, subd. 3. Prohibits a product that contains nonintoxicating cannabinoids and is sold for human or animal consumption from containing more than 0.3 percent of any tetrahydrocannabinol, and prohibits an edible cannabinoid product from containing more than 5 milligrams of any tetrahydrocannabinol in a single serving or more than 50 milligrams of any tetrahydrocannabinol per package. Prohibits any other substance derived from hemp from being sold for human consumption to treat or prevent disease in humans or other animals, or to affect the structure or function of the bodies of humans or animals. Prohibits products containing a cannabinoid or tetrahydrocannabinol derived from hemp from being sold to individuals under 21. States that products governed by this section are not controlled substances.

6 **Testing requirements.**

Amends § 151.72, subd. 4. Modifies testing requirements for products containing cannabinoids, to require testing to confirm that the product does not contain more than trace amounts of mold or solvents or more than 0.3 percent of any tetrahydrocannabinol. States that testing the hemp, or possession of a certificate of analysis for hemp, does not meet the testing requirements for products containing cannabinoids.

7 **Labeling requirements.**

Amends § 151.72, subd. 5. Allows information required to be on the label of a product containing cannabinoids to be on the product's outer package if the product's container is too small to fit the information, or to be provided using a matrix barcode that links to a page on the manufacturer's website with the information required on the label (current law allows use of a QR code). Makes other technical and conforming changes.

8 **Additional requirements for edible cannabinoid products.**

Adds subd. 5a to § 151.72. Para. (a) requires an edible cannabinoid product to comply with this subdivision, in addition to subdivisions 4 and 5.

Para. (b) prohibits an edible cannabinoid product from looking like a person, animal, or fruit; being modeled after a product marketed to children; being made by applying tetrahydrocannabinol to a commercially available candy or snacks; containing an ingredient, other than tetrahydrocannabinol, not approved by the FDA for use in food; being packaged to resemble a commercially available food; or having packaging that includes misleading statements.

Para. (c) establishes packaging requirements for edible cannabinoid products.

| Section | Description - Article 8: Miscellaneous |
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Para. (d) requires edible cannabinoid products that contain multiple servings to indicate the serving size for individual servings.

Para. (e) lists information that must be included on the label of an edible cannabinoid product.

Para. (f) prohibits an edible cannabinoid product from containing more than 5 milligrams of a tetrahydrocannabinol in a single serving, or more than 50 milligrams of a tetrahydrocannabinol per package.

9 **Enforcement.**

Amends § 151.72, subd. 6. Provides that a product governed by this section is considered an adulterated drug if it contains any food additives found by the FDA to be unsafe for humans or animals, contains more than 0.3 percent of a tetrahydrocannabinol or more than the per-serving and per-package amounts of tetrahydrocannabinol permitted in subdivision 5a, or contains more than trace amounts of mold, solvents, pesticides, fertilizers, or heavy metals.

10 **Analog.**

Amends § 152.01, subd. 23. Amends the definition of analog in the chapter governing drugs and controlled substances, to specify that analog does not include marijuana or nonsynthetic tetrahydrocannabinols.

Makes this section effective August 1, 2022, and applicable to crimes committed on or after that date.

11 **Schedule I.**

Amends § 152.02, subd. 2. Removes marijuana and nonsynthetic tetrahydrocannabinols from Schedule I of controlled substances. (Substances in Schedule I are those with no currently accepted medical use, a lack of accepted safety for use under medical supervision, and a high potential for abuse.)

Makes this section effective August 1, 2022, and applicable to crimes committed on or after that date.

12 **Schedule II.**

Amends § 152.02, subd. 3. Adds marijuana and nonsynthetic tetrahydrocannabinols to Schedule II of controlled substances, and exempts products containing tetrahydrocannabinols from Schedule II if they meet the requirements in section 151.72. (Substances in Schedule II are those with a high potential for abuse, with use potentially leading to severe psychological or physical dependence.)

| Section | Description - Article 8: Miscellaneous |
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| | Makes this section effective August 1, 2022, and applicable to crimes committed on or after that date. |
| 13 | **Exception.**<br>Adds subd. 5 to § 152.11. Provides that marijuana and tetrahydrocannabinols are not considered Schedule II controlled substances for purposes of a section establishing prescription requirements for controlled substances. |
| 14 | **Exception.**<br>Adds subd. 6 to § 152.12. Provides that marijuana and tetrahydrocannabinols are not considered Schedule II controlled substances for purposes of a section governing the prescribing, dispensing, administration, and sale of controlled substances. |
| 15 | **Limits on applicability.**<br>Amends § 152.125, subd. 3. Provides that a section governing the prescription and administration of controlled substances for intractable pain does not apply to medical cannabis. |
| 16 | **Presumptions.**<br>Amends § 152.32, subd. 1. States that the medical cannabis statutes do not create a positive conflict with federal drug laws or regulations and are consistent with a federal statute that permits federal and state laws to govern controlled substances. |
| 17 | **Criminal and civil protections.**<br>Amends § 152.32, subd. 2. Provides that the listing of tetrahydrocannabinols in Schedule I does not apply to the use of medical cannabis under the medical cannabis program, provided medical cannabis is used in compliance with section 152.23. |
| 18 | **Nondiscrimination in access to transplants.**<br>Amends § 363A.50. Prohibits health care providers and organ procurement organizations from limiting an individual's access to anatomical gifts and related services based on an individual's race or ethnicity. Also expands the definition of auxiliary aids and services. |
| 19 | **Waivers and modifications; extension.**<br>Amends Laws 2020, First Special Session ch. 7, § 1, subd. 5, as amended. Provides that a waiver issued by the commissioner of human services for background study requirements expires January 1, 2023 (rather than 365 days after the peacetime emergency ended as in current law).<br><br>Provides that this section effective the day following final enactment. |

| Section | Description - Article 8: Miscellaneous |
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| 20 | **Federal Schedule I exemption application for medical use of cannabis.**<br>By September 1, 2022, requires the commissioner of health to apply to the Drug Enforcement Administration's Office of Diversion Control for an exception to federal controlled substances rules, and request formal acknowledgment that the listing of marihuana, marihuana extract, and tetrahydrocannabinols as controlled substances in federal Schedule I does not apply to the use of medical cannabis under the medical cannabis program. |
| 21 | **Revisor instruction.**<br>Directs the revisor of statutes to recodify the statute establishing the Rare Disease Advisory Council from chapter 137 to a section in chapter 256. |

## Article 9: Forecast Adjustments

This article adjusts appropriations from the specified funds to the commissioner of human services in fiscal years 2022 and 2023 for forecasted programs administered by the Department of Human Services.

## Article 10: Appropriations

This article appropriates money in fiscal years 2022 and 2023 from the specified funds for specified purposes to the commissioner of human services, commissioner of health, Board of Dentistry, Board of Dietetics and Nutrition Practice, Board of Pharmacy, Council on Disability, Emergency Medical Services Regulatory Board, Board of Directors of MNsure, Health Care Affordability Board, commissioner of commerce, commissioner of labor and industry, and attorney general.