MN HOUSE RESEARCH

Bill Summary

H.F. 2930

First engrossment

Subject	Omnibus health finance bill
Authors	Liebling
Analyst	Randall Chun Elisabeth Klarqvist Sarah Sunderman Annie Mach Danyell A. Punelli
Date	April 17, 2023

Table of Contents

Article 1: Department of Human Services Health Care

This article makes changes in the operation of the medical assistance and MinnesotaCare programs. Areas addressed by the article include, but are not limited to: hospital reimbursement, covered services, the Drug Formulary Committee, value-based drug purchasing, managed care withholds, dental rebasing, and telehealth and audio-only communication.

Section	Description - Article 1: Department of Human Services Health Care
1	**Payment on behalf of enrollees in government health programs.** Requires health insurers, as a condition of operating in Minnesota, to comply with the requirements of the Consolidated Appropriations Act of 2022 and related federal regulations, to the extent they impose a state requirement that is not also required by state law.
2	**Definitions.** Amends § 62A.673, subd. 2. Allows audio-only communication between a provider and patient to qualify as telehealth until July 1, 2025 (this provision expires July 1, 2023, under current law).
3	**Education on contraceptive options.** Amends § 256.01, by adding subd. 43. Directs 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.
4	**Qualifying overpayment.** Amends § 256.0471, subd. 1. Limits the authority for the commissioner to recover overpayments that result from MA and MinnesotaCare benefits provided during a period for which an appeal is pending, to benefits received during an unsuccessful appeal of an adverse eligibility determination. States that this section is effective July 1, 2023.
5	**Hospital payment rates.** Amends § 256.969, subd. 2b. Sets the base years for the hospital rebasing that is to be effective July 1, 2023, as calendar years 2018 and 2019. States that this section is effective July 1, 2023.

Section	Description - Article 1: Department of Human Services Health Care
6	**Disproportionate numbers of low-income patients served.** Amends § 256.969, subd. 9. Modifies criteria identifying Hennepin County Medical Center, to allow that entity to continue to receive disproportionate share hospital payments at the same level.
7	**Long-term hospital rates.** Amends § 256.969, subd. 25. Requires payments to long-term care hospitals, for admissions occurring on or after July 1, 2023, to be the higher of the per diem amount computed using the cost-based methodology for critical access hospitals, or the per diem rate as of July 1, 2021. States that this section is effective July 1, 2023.
8	**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, consistent with payment procedures for drugs administered in an outpatient setting. (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, 2024.
9	**Competitive bidding.** Amends § 256B.04, subd. 14. Allows the commissioner to use volume purchase through competitive bidding and negotiation to provide quitline services. States that this section is effective January 1, 2024.
10	**Adults who were in foster care at the age of 18.** Amends § 256B.055, subd. 17. Beginning July 1, 2023, allows MA to be paid for a person under age 26 who was in foster care on the date of turning age 18, and enrolled in another state's Medicaid program while in foster care. States that this section is effective the day following final enactment.
11	**Gender affirming services.** Amends § 256B.0625, subd. 3a. Updates statute, to state that MA covers gender affirming services.

Section	Description - Article 1: Department of Human Services Health Care

12 **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 coverage of dental services for adults who are not pregnant to specific services. The amendments to paragraphs (b) and (c) make conforming changes.

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

13 **Formulary committee.**

Amends § 256B.0625, subd. 13c. Makes the following changes to the membership of the formulary committee:

- increases the number of physicians from four to at least five;
- requires one physician to be an actively practicing psychiatrist, one a specialist in the diagnosis and treatment of rare diseases, one a specialist in pediatrics, and one who actively treats persons with disabilities;
- requires one pharmacist to practice outside the metropolitan counties, one to practice in the metropolitan counties, and one to be a practicing hospital pharmacist;
- increases the number of consumer representatives from one to at least four, and requires these individuals to have a personal or professional connection to MA; and
- adds one representative designated by the Minnesota Rare Disease Advisory Council.

Makes the following changes to committee operation:

- requires the committee to meet at least once per year (current law requires meetings at least twice per year); and
- provides that the committee does not expire (under current law, the committee expires June 30, 2023).

14 **Payment prices.**

Amends § 256B.0625, subd. 13c. Provides that the requirement that the commissioner report to the legislature on the cost of dispensing every three years does not expire. States that this section is effective the day following final enactment.

15 **Value-based purchasing arrangements.**

Amends § 256B.0625, by adding subd. 13k. (a) Allows the commissioner to enter into a value-based purchasing arrangement under MA or MinnesotaCare with a drug

Section	Description - Article 1: Department of Human Services Health Care

manufacturer based on agreed-upon metrics. Allows the commissioner to contract with a vendor. Describes value-based purchasing arrangements and requires such an arrangement to provide the same or greater value or discount in the aggregate as would claiming the mandatory federal drug rebate.

(b) States that this section shall not be interpreted as requiring a manufacturer or the commissioner to enter into a value-based purchasing arrangement.

(c) States that this section shall not be interpreted as altering or modifying coverage requirements under the federal Medicaid rebate.

(d) Requires the commissioner to request any state plan amendment necessary to implement a value-based payment arrangement, and allows the commissioner to delay implementation until the amendment is approved.

States that this section is effective July 1, 2023.

16 **Abortion services.**

Amends § 256B.0625, subd. 16. Strikes language limiting medical assistance coverage of abortion services to situations in which the abortion is a medical necessity to prevent the death of the mother, as certified by two physicians, or is the result of rape or incest. These limitations were found unconstitutional under the state constitution in Doe v. Gomez, a 1995 Minnesota Supreme Court case. Requires medical assistance coverage of abortion services determined to be medically necessary by the treating provider and delivered according to state law.

This section is effective the day following final enactment.

17 **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. States that this section is effective January 1, 2024.

18 **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 coverage under this subdivision must be 100 percent of the Medicare rate for continuous home care hospice services. Requires the commissioner to seek federal financial participation for the payments. Requires

Section	Description - Article 1: Department of Human Services Health Care

payment to be made with state-only funds if federal financial participation is not obtained. 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 this section is effective January 1, 2024.

19 **Doula services.**

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

20 **Other clinic services.**

Amends § 256B.0625, subd. 30. Effective July 1, 2023, 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.

21 **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, 2024, or upon federal approval, whichever is later.

22 **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.

Section **Description - Article 1: Department of Human Services Health Care**

(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 nicotine cessation counseling services provided through a quitline. Allows quitline services to be provided through audio-only communication, and allows the commissioner to utilize 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 drug dosage amounts or frequency, or imposing duration or quantity limits;
5) prohibiting the simultaneous use of multiple drugs;
6) requiring or authorizing step therapy; or
7) requiring or using prior authorization.

States that this section is effective January 1, 2024.

23 **Recuperative care services.**

Amends § 256B.6025, by adding subd. 69. (a) Requires MA to cover recuperative care services. Defines “recuperative care” as a model of care that prevents hospitalization or provides postacute medical care and support services for recipients experiencing homelessness who meet specified criteria.

(b) States that recuperative care may be provided in any setting, including but not limited to homeless shelters, congregate care settings, single room occupancy settings, or support housing, so long as the entity is able to provide the recipient with specified services.

(c) To be eligible for a covered service, requires a recipient to be: (1) 21 years of age or older; (2) experiencing homelessness, (3) be in need of acute care for a period of not more than 60 days; (4) meet certain clinical criteria; and (5) not have behavioral health needs that are greater than can be managed by the provider.

Section	Description - Article 1: Department of Human Services Health Care

(d) Specifies that payment for recuperative care consists of two components: (1) bundled payment for services provided to the member of at least $300 per day; and (2) payment using state funds for facility costs, equivalent to the MA room and board rate and annual adjustments. Allows providers to be reimbursed only for the first component and specifies other requirements. Lists examples of services that may be provided within the bundled payment.

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

(f) Specifies procedures for temporary absences due to admission to a health care facility.

(g) Requires the commissioner to submit an initial report to the legislature by February 1, 2025, and a final report by February 1, 2027, on coverage of recuperative care services. Specifies report criteria.

States that this section is effective January 1, 2024.

24 **Commissioner's duties.**

Amends § 256B.196, subd. 2. Prohibits the commissioner from making supplemental payments to providers of outpatient hospital, physician, ambulance, and other health care services affiliated with governmental entities (Hennepin County, Ramsey County, the University of Minnesota), that fail to submit to the commissioner within 24 months of the initial request, the data needed to compute the payments. States that this section is effective July 1, 2023.

25 **Managed care contracts.**

Amends § 256B.69, subd. 5a. Strikes the specific performance targets specified in law that are tied to the withhold of five percent of managed care and county-based purchasing plan capitation payments. The performance targets eliminated are related to: emergency department utilization rates, hospital admission rates, and subsequent hospitalization rates. States that this section is effective January 1, 2024.

26 **Physician reimbursement.**

Amends § 256B.76, subd. 1. A new paragraph (i) 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.

Section	Description - Article 1: Department of Human Services Health Care

27 **Dental reimbursement.**

Amends § 256B.76, subd. 2. A new paragraph (k) sets payment for dental services provided on or after January 1, 2024, at the lower of submitted charges or a percentile of 2018 charges, so that total aggregate expenditures do not exceed the total spend as outlined in applicable paragraphs of this section. States that this paragraph does not apply to federally qualified health centers, rural health centers, state-operated dental clinics, or Indian health centers.

A new paragraph (l) requires the commissioner, by January 1, 2028, and every three years thereafter, to rebase payment rates for dental services to a percentile of submitted charges for the applicable base year. Total aggregate expenditures must not exceed the total spend as outlined in paragraph (k) plus the change in the Medicare Economic Index (MEI). For 2028, requires the change in the MEI to be measured from the midyear of 2025 and 2027. For subsequent rebasings, requires the change in the MEI to be measured between the years that are one year after the rebasing years. Requires the base year for each rebasing to be the calendar year that is two years prior to the effective date of the rebasing. States that this section does not apply to federally qualified health centers, rural health centers, state-operated dental clinics, or Indian health centers.

Also makes changes throughout subdivision, striking obsolete language.

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

28 **Reimbursement for family planning services.**

Amends § 256B.764. Increases payment rates for family planning and abortion services by ten percent, for services provided on or after January 1, 2024. States that the increase does not provide to federally qualified health centers, rural health centers, or Indian health services.

29 **Covered health services.**

Amends § 256L.03, subd. 1. Strikes language limiting public funds used to cover abortions under MinnesotaCare to cases in which the life of the female would be endangered or substantial and irreversible impairment of a major bodily function would result if the fetus were carried to term, or where the pregnancy is the result of rape or incest.

This section is effective the day following final enactment.

Section	Description - Article 1: Department of Human Services Health Care
30	**Cost-sharing.** Amends § 256L.03, subd. 5. Prohibits cost-sharing under MinnesotaCare for drugs used for tobacco and nicotine cessation. States that this section is effective January 1, 2024.
31	**Commissioner of human services; extension of COVID-19 human services program modifications.** Amends Laws 2021, First Special Session chapter 7, article 6, section 26. Extends from July 1, 2023, to July 1, 2025, the expiration date for DHS COVID-19-related modifications expanding access to telemedicine services for the Children's Health Insurance Program, MA, and MinnesotaCare (CV16) and allowing a telemedicine alternative for school-linked mental health services and intermediate school district mental health services. These modifications include allowing reimbursement for audio-only services.
32	**Repealer.** Repeals Minnesota Rules, part 9505.0235 (limitations on MA abortion coverage), effective the day following final enactment.

Article 2: Health Care Affordability and Delivery

This article makes changes in health care delivery under MA and MinnesotaCare. The article:

- allows MA enrollees to opt out of managed care;
- carves outpatient prescription drugs out of MA and MinnesotaCare managed care contracts;
- requires the commissioner of human services to establish a direct provider payment system for MinnesotaCare enrollees and certain MA enrollees;
- establishes a Health Care Affordability Commission and requires this commission to establish health care spending growth targets;
- provides continuous MA eligibility for children;
- requires the commissioner of human services to establish the MinnesotaCare public option to allow persons with incomes above the current income limit to enroll in the program; and
- requires the commissioner of health to contract for an analysis of health care reform models and the development of a related analytic tool.

Section	Description - Article 2: Health Care Affordability and Delivery

1 **Health Care Affordability Commission.**

Adds § 62J.0411.

Subd. 1. Definitions. Defines the following terms: commission, commissioner, health care entity, health care provider, health plan, health plan company, and hospital.

Subd. 2. Commission membership. (a) Requires the commissioner of health to establish a 15-member Health Care Affordability Commission. Specifies membership and requirements for members.

(b) Requires members to have specified knowledge and expertise.

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

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

Subd. 4. Chair; other officers. Requires the governor to annually designate a member to serve as chair. Specifies related requirements.

Subd. 5. Compensation. Provides that commission members are compensated under the procedures that apply to administrative boards and agencies.

Subd. 6. Meetings. States the commission meetings are subject to the Open Meeting Law. Requires the commission to meet publicly on at least a monthly basis until initial targets are established, and then at least quarterly.

Subd. 7. Hearings. Requires the commission to hold public hearings at least annually to present findings from growth target monitoring, and to hold regular public hearings to take testimony.

Subd. 8. Staff; technical assistance; contracting. (a) Requires the commission to hire an executive director and staff.

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

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

Section	Description - Article 2: Health Care Affordability and Delivery

Subd. 9. Administration. Requires the commissioner to provide office space and other support to the commission and the Health Care Affordability Advisory Council.

Subd. 10. Duties of the commissioner. Requires the commissioner, in consultation with the commissioners of commerce and human services, to provide staff support to the commission, including performing and procuring consulting and analytic services. Specifies requirements related to these duties.

Subd. 11. Access to information. (a) Allows the commission or commissioner to request data in usable format from state agencies, at no cost.

(b) Allows the commission 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. Allows the commission to grant the commissioner access to this data.

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

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

(e) Allows the commissioner to collect necessary data under the authority of chapter 62J.

2 **Duties of the commission; general.**

Adds § 62J.0412.

Subd. 1. Health care delivery and payment. (a) Directs the commission to monitor the administration and reform of health care delivery and payment systems in the state. Requires the commission 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 commission to establish goals to reduce health care disparities and ensure access to quality care for persons with disabilities or chronic or complex health conditions.

Section	Description - Article 2: Health Care Affordability and Delivery

Subd. 2. Duties of the commission; market trends. Requires the commission 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, access to care, and satisfaction;
2) improved health of all populations, including a reduction in health disparities; and
3) a reduction in the growth of health care costs.

Subd. 3. Duties of the commission; recommendations for reform. 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.

3 **Duties of the commission; growth targets.**

Adds § 62J.0413.

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

Subd. 2. Methodologies for growth targets. (a) Requires the commission to:

1) establish a statement of purpose;
2) develop a methodology to establish health care spending growth targets and the economic indicators to be used in establishing the initial and subsequent target levels;
3) establish growth targets that meet specified criteria; and
4) establish a methodology for calculating health care cost growth that meets specified criteria.

Section **Description - Article 2: Health Care Affordability and Delivery**

(b) Requires the commission, when developing the methodology, to determine which health care entities are subject to targets, and at what level of aggregation.

Subd. 3. Data on performance. Requires the commission to identify the data to be used for tracking performance toward meeting growth targets, and adopt methods of data collection.

Subd. 4. Reporting requirements. Requires the commissioner to establish reporting requirements for health care providers and health plan companies, related to calculating health care cost growth.

Subd. 5. Establishment of growth targets. (a) Requires the commission, by June 15, 2024, to establish annual health care spending growth targets for each of the next five calendar years. Allows the commission to continue to establish annual growth targets for subsequent years.

(b) Requires the commissioner to regularly review the program methodology, and revise growth target levels as appropriate. Requires a two-thirds majority vote to make any change to growth target levels.

Subd. 6. Additional criteria for growth targets. (a) In developing the program, allows the commission to:

1) evaluate and ensure the program does not place a disproportionate burden on communities most impacted by health disparities, the providers serving these communities, or individuals who reside in rural areas or have high health care needs;
2) consider payment models that ensure financial sustainability of rural health care delivery systems and the ability to provide population health;
3) consider the addition of quality of care performance measures or minimum primary care spending goals;
4) allow 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 encourage the growth of 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 stakeholders.

Section	Description - Article 2: Health Care Affordability and Delivery

(b) Requires the commissioner, based on an analysis of drivers of health care spending and evidence from public testimony, to explore strategies, new policies, and legislative proposals to achieve growth targets or limit health care spending.

Subd. 7. Reports. Requires the commission to submit to the legislature: (1) progress updates on the growth target program, by February 15, 2024, and February 15, 2025; and (2) annual reports on health care spending trends related to growth targets, by March 31, 2026, and by March 31 annually thereafter. Specifies criteria for these reports.

4 **Health Care Affordability Advisory Council.**

Adds § 62J.0414. Requires the commissioner to appoint a Health Care Affordability Advisory Council to provide technical assistance to the commission. Specifies requirements for council members and governance, and specifies council duties. Provides that the council does not expire.

5 **Notice to health care entities.**

Adds § 62J.0415.

Subd. 1. Notice. Requires the commission to notify all health care entities that have been identified by the commission as exceeding the spending growth target for a specified period as determined by the commission.

Subd. 2. Performance improvement plans. (a) States that the commission 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 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 commission 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

Section	Description - Article 2: Health Care Affordability and Delivery

plan for commission approval. If the entity does not successfully complete the plan, directs the commission 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 commission to remove the identity of the entity from the commission's website. Allows the commission to assist entities in implementing performance plans or otherwise ensure compliance with this subdivision.

(g) Allows the commission to assess to a health care entity a civil penalty of not more than $500,000 as a last resort, if the commission 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 failed to provide required information, or knowingly provided false information.

6 **Identify strategies for reduction of administrative spending and low-value care.**

Adds § 62J.0416. Requires the commissioner of health to develop recommendations for strategies to reduce administrative spending by health care organizations and group purchasers and to reduce low-value care delivered to Minnesota residents, and lists specific actions to develop these recommendations. Requires the commissioner to deliver these recommendations to certain members of the legislature by March 31, 2025.

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

Adds § 62J.0417. Requires the commissioner to develop a plan to assess the ability of rural communities and rural health care providers to adopt alternative payment systems and to recommend steps to implement them. Also allows the commissioner to develop recommendations for pilot projects to ensure the financial viability of rural health care entities, and to share findings with the Health Care Affordability Commission.

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 Commission.

9 **Transitional cost-sharing reductions.**

Amends § 62V.05, by adding subd. 13.

Section	Description - Article 2: Health Care Affordability and Delivery

(a) Directs MNsure to develop and implement a system, for the 2024, 2025, and 2026 plan years, to provide cost-sharing reductions to eligible individuals who choose to enroll in a gold health plan.

(b) Defines an "eligible individual" as a person who: (1) is a resident of Minnesota; and (2) is enrolled in a gold health plan offered in the enrollee's county of residence.

(c) Provides that the monthly transitional cost-sharing reduction subsidy for an eligible individual is $75 per month.

(d) Requires MNsure to establish procedures to determine an individual's eligibility for the subsidy and make payments to health carriers for eligible individuals enrolled in gold level plans.

10 **Direct payment system for MA and MinnesotaCare.**

Adds § 256.9631.

Subd. 1. Direct payment system established. (a) Requires the commissioner of human services to establish a direct payment system for MA and MinnesotaCare, under which eligible individuals may receive services through the MA fee-for-service system, county-based purchasing plans, or county-owned HMOs. Requires the system to be implemented by January 1, 2027.

(b) Provides that persons who are not eligible individuals shall continue to receive services through managed care and county-based purchasing plans, subject to the opt-out provisions for persons who are blind or have a disability, and the current law exemptions from managed care enrollment.

Subd. 2. Definitions. Defines "eligible individuals" as MA enrollees eligible as families and children and adults without children, and all MinnesotaCare enrollees. Defines "qualified hospital provider" as a nonstate government teaching hospital with high MA utilization and a level 1 trauma center, and providers owned or affiliated with the hospital.

Subd. 3. Managed care service delivery. (a) Allows counties to operate existing and new county-based purchasing plans.

(b) Allows counties to operate existing and new county-owned HMOs.

(c) Requires county-based purchasing plans and county-owned HMOs to receive capitation payments as under current law, unless the county board or boards elect fee-for-service reimbursement.

Section	Description - Article 2: Health Care Affordability and Delivery

(d) Allows eligible individuals to opt-out of enrollment in a county-based purchasing plan or county-owned HMO.

Subd. 4. Fee-for-service reimbursement. (a) Requires the commissioner to reimburse health care providers directly for MA and MinnesotaCare covered services, using the fee-for-service payment methods for MA. Requires payments to be made to individual providers, clinics, and hospitals.

(b) Requires the commissioner, at the election of county boards, to directly reimburse participating providers of county-based purchasing plans or county-owned HMOs at the fee-for-service rate.

(c) Requires the commissioner to ensure that payments to a qualified hospital provider are equivalent to the payments that would have been received based on managed care direct payment arrangements.

Subd. 5. Termination of managed care contracts. Requires the commissioner to terminate managed care contracts for eligible individuals by December 31, 2026, except that the commissioner may continue to contract with county-based purchasing plans and county-owned and operated HMOs.

Subd. 6. System development and administration. (a) Requires the commissioner, under the direct payment system, to:

1) provide benefits management, claims processing, and enrollee support services;
2) coordinate the direct payment system with county agencies and MNsure, and with service delivery to MA enrollees who are age 65 or older, blind, or have disabilities, or who are exempt from managed care enrollment;
3) establish and maintain provider payment rates sufficient to ensure high quality care and enrollee access;
4) develop and monitor quality measures for health care service delivery; and
5) develop provider incentives and innovative methods of health care delivery to ensure the efficient provision of high-quality care and reduce health care disparities.

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

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

Section	Description - Article 2: Health Care Affordability and Delivery

Subd. 7. Implementation plan. Requires the commissioner to present an implementation plan to the legislature by January 15, 2025. Allows the commissioner to contract for technical assistance in developing the implementation plan and conducting related studies and analysis. Requires the plan to include:

1) a timeline for development and implementation;
2) the procedures to be used to transition enrollees to the direct payment system in a manner that ensures continuity of care;
3) any changes to fee-for-service payment rates necessary to ensure provider access and quality care, and reduce health disparities;
4) recommendations on providing effective care coordination;
5) recommendations on whether the direct payment system should include supplemental payments for care coordination;
6) recommendations on whether the direct payment system should include funding to providers for outreach initiatives;
7) recommendations on whether and how the direct payment system should be expanded to deliver services and care coordination to persons who are blind or have a disability;
8) procedures to compensate providers for any loss of savings from the 340B drug program; and
9) recommendations for any statutory changes necessary to implement the direct payment system.

(c) Requires the commissioner, in developing the implementation plan, to:

1) calculate the projected cost of a direct payment system relative to the cost of the current system;
2) assess current gaps in care coordination;
3) evaluate approaches used by other states to provide care coordination under a fee-for-service system;
4) estimate the loss in provider financial savings relative to the 340B program that would result from elimination of managed care contracts, and develop a method to reimburse providers for these potential losses;
5) consult with the commissioner of health and the contractor or contractors analyzing the Minnesota Health Plan and other reform models; and
6) conduct other analyses necessary to develop the implementation plan.

11 **Disproportionate numbers of low-income patients served.**

Amends § 256.969, subd. 9. Modifies the maximum additional payment adjustment for hospitals with high levels of administering high-cost drugs to MA fee-for-service

Section	Description - Article 2: Health Care Affordability and Delivery

enrollees, including 340B drugs. Also allows children's hospitals to qualify for the additional payment adjustment. States that this section is effective January 1, 2026, or the January 1 following certification of the modernized pharmacy claims processing system, whichever is later.

12 **Period of eligibility.**

Amends § 256B.056, subd. 7. Provides continuous eligibility under MA for 12 months for children under age 19.

Provides continuous eligibility under MA for 12 months for children age 19 and older, but under age 21.

Provide continuous eligibility for children under age six, through the month in which the child reaches age six.

Allows continuous eligibility to be terminated if: the child or the child's representative requests voluntary termination; the child ceases to be a resident; the child dies; or the agency determines eligibility was erroneously granted due to agency error, or fraud, abuse, or perjury.

States that the section is effective July 1, 2025, or upon federal approval, whichever is later, except that the provision of continuous eligibility for children under age 19 is effective January 1, 2024.

13 **Cost-sharing.**

Amends § 256B.0631, subd. 1. Eliminates MA cost-sharing and deductibles, effective for services provided on or after January 1, 2024.

14 **Collection.**

Amends § 256B.0631, subd. 3. Makes a conforming change related to the elimination of MA cost-sharing. States that this section is effective January 1, 2024.

15 **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, 2024, effective date.

16 **Prescription drugs.**

Amends § 256B.69, subd. 6d. The amendment to paragraph (a) requires the commissioner to exclude or modify coverage for outpatient prescription drugs dispensed by a pharmacy from MA and MinnesotaCare prepaid managed care contracts. Allows the commissioner to include, exclude, or modify coverage for

Section	Description - Article 2: Health Care Affordability and Delivery

prescription drugs administered to enrollees, from MA and MinnesotaCare prepaid managed care contracts.

A new paragraph (b) requires managed care and county-based purchasing plans to reimburse pharmacies for drug costs at a level not exceeding the fee-for-service rate, but excluding the payment limitation for 340B drugs. Requires the plans to pay a dispensing fee equal to one-half of the fee-for-service dispensing fee. Specifies contract requirements and provides that the paragraph is not to be implemented if federal approval is not obtained, or withdrawn.

States that paragraph (a) is effective January 1, 2026, or the January 1 following certification of the modernized pharmacy claims processing system, whichever is later. Paragraph (b) is effective January 1, 2024, or upon federal approval, whichever is later.

17 **Medicare special needs plans; medical assistance basic health care.**

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, 2024, effective date.

18 **Enrollee support system.**

Amends § 256B.69, subd. 36. Requires the DHS enrollee support system to provide potential enrollees with access to counseling on opting out of managed care. Provides a January 1, 2024, effective date.

19 **In general.**

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, 2024, effective date.

20 **Hospital outpatient reimbursement.**

Amends § 256B.75. Increases the reimbursement rate for critical access hospitals providing high levels of 340B drugs, in proportion to each hospital's share of total reimbursement for 340B drugs to all critical access hospitals. Provides that the increase shall not exceed …. percentage points. States that this section is effective January 1, 2026, or the January 1 following certification of the modernized pharmacy claims processing system, whichever is later.

21 **General requirements.**

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

Section	Description - Article 2: Health Care Affordability and Delivery

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, 2027, or upon federal approval.

22 **Ineligibility.**

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, 2027, or upon federal approval.

23 **Citizenship requirements.**

Amends § 256L.04, subd. 10. Allows undocumented noncitizens to be eligible for MinnesotaCare. Provides an effective date of January 1, 2025.

24 **Persons eligible for public option.**

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 individuals only during an annual open enrollment period or special enrollment period, as designated by MNsure. States that the section is effective January 1, 2027, or upon federal approval.

25 **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, 2027, or upon federal approval.

26 **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). Also makes conforming changes, by striking the premium scale listed in current law. (This premium scale is not currently applied, given that MinnesotaCare as part of federal compliance uses the lower premium scales required by ARPA for 2021 through 2025).

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, 2027. Exempts persons 20 years of age or younger from these premiums.

Section	Description - Article 2: Health Care Affordability and Delivery

States that the section is effective January 1, 2024, except that the sliding premium scale for persons eligible for the public option is effective January 1, 2027, or upon federal approval.

27 **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 January 15, 2025. Requires the plan to include:

1) recommendations for any changes to the public option needed to receive federal funding;
2) recommendations for ensuring sufficient provider participation in MinnesotaCare;
3) estimates of state costs;
4) 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
5) draft legislation necessary to implement the public option and plan recommendations.

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

28 **Request for federal approval.**

(a) Requires the commissioner of human services to seek any federal waivers, approvals, and law changes necessary to implement the MinnesotaCare public option, 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.

(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

Section	Description - Article 2: Health Care Affordability and Delivery

allows the commissioner of human services to contract for technical and actuarial assistance.

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

29 **Analysis of benefits and costs of universal health care system reform models.**

Directs the commissioner of health to contract for an analysis of the benefits and costs of proposals for a universal health care financing system and other reform models, and the development of an analytical tool.

Subd. 1. Definitions. Defines the following terms: all necessary care, direct payment system, MinnesotaCare public option, other reform models, and total public and private health care spending.

Subd. 2. Initial assumptions. Establishes certain assumptions that must be used in performing the analysis under this section.

Subd. 3. Contract for analysis of proposals; analytic tool. Requires the commissioner of health to contract for an analysis of: (1) the benefits and costs of a legislative proposal for a universal health care financing system, compared with the current health care financing system; and (2) the MinnesotaCare public option, direct payment system, and other reform models, compared with the current health care financing system.

(b) Requires the contractor or contractors to develop and use an analytic tool, and to make this available for use by the commissioner.

(c) Specifies the process to be used to select a contractor.

Subd. 4. Requirements for analytic tool. (a) States that the analytic tool must be able to assess and model the impact of the Minnesota Health Plan, direct payment system, MinnesotaCare public option, and other reform models on a range of factors, including but not limited to: covered persons, benefit completeness, underinsurance, system capacity, and health care spending. Specifies criteria the tool must meet in examining each factor.

(b) Requires that the analytic tool must:

1) have the capacity to conduct interactive microsimulations;
2) allow comparisons between reform models on the factors specified in paragraph (a); and
3) allow comparisons based on differing assumptions about the characteristics and operation of the delivery approaches.

Section	Description - Article 2: Health Care Affordability and Delivery
	Subd. 5. Analyses by the commissioner. Allows the commissioner, in cooperation with the commissioners of human services and commerce, and the legislature, to use the analytic tool to assist in the development, design, and analysis of reform models under consideration by the legislature and state agencies, and to supplement the analyses conducted by the contractor or contractors. **Subd. 6. Report and delivery of analytic tool.** (a) Requires the contractor or contractors, by January 15, 2026, to report findings and recommendations to the commissioner and the legislature, on the design and implementation of the Minnesota Health Plan, MinnesotaCare public option, and the direct payment system. Requires the findings and recommendations to address the feasibility and affordability of the proposals, and their impact on the factors listed in subdivision 4. (b) Requires the contractor or contractors to make the analytic tool available to the commissioner by January 15, 2026.

Article 3: Department of Health

This article makes changes to existing Health Department programs and activities and establishes new programs and authorizes new activities at the Department of Health. It also modifies public health statutes and repeals statutes and rules on a number of subjects.

Section	Description - Article 3: Department of Health
1	**Health.** Amends § 12A.08, subd. 3. Amends a statute establishing duties for the commissioner of health for communities affected by a natural disaster, to add Tribal nations to the list of entities with which the commissioner may cooperate in implementing this section, and adds Tribal nations to the entities eligible for grants from the commissioner under this section.
2	**Health data generally.** Amends § 13.3805, subd. 1. In a subdivision governing health data, strikes a paragraph that allows summary data derived from data collected under section 145.413 to be provided according to section 13.05, subd. 7. This paragraph is being stricken to conform with the repeal of section 145.413, subd. 1, which was repealed in 2003. This section is effective the day following final enactment.

Section	Description - Article 3: Department of Health

3 **Exceptions.**

Amends § 16A.151, subd. 2. Section 16A.151, subdivision 1, requires money recovered by the state in litigation or a settlement to be deposited in the general fund, and subdivision 2 establishes exceptions to this requirement. Paragraph (h) establishes an additional exception, requiring money the state receives from legal action related to alleged violations of laws regarding electronic nicotine delivery systems or other alleged violations of law that contribute to youth nicotine use, to be deposited in a new tobacco use prevention account. Exempts attorney fees and costs awarded to the state or Attorney General's Office, contract attorneys, or other state agency attorneys. This section is effective the day following final enactment.

4 **Retrospective review.**

Amends § 62J.17, subd. 5a. Requires the commissioner to notify a health care facility or provider of the results of the commissioner's retrospective review of a major spending commitment when the commissioner determines the expenditure was not appropriate (and no longer requires the commissioner to notify facilities and providers if the commissioner determines the expenditure was appropriate).

5 **Statewide health care provider directory.**

Adds § 62J.571. Requires the commissioner, in consultation with stakeholders, to assess whether it is feasible to develop, manage, and maintain a statewide electronic directory of health care providers.

6 **Provider balance billing requirements.**

Adds § 62J.811. Requires health care providers and health care facilities to comply with the federal No Surprises Act and associated regulations. Defines provider or facility as any health care provider or facility subject to the No Surprises Act. Requires the commissioner, to the extent possible, to seek cooperation from providers and facilities in complying with this section, and allows the commissioner to provide support and assistance to obtain compliance.

7 **Medical and dental practices; current standard charges.**

Adds § 62J.826. Requires hospitals, outpatient surgical centers, and certain other medical and dental practices to make available to the public a list of their current standard charges for items and services provided by the practice.

Subd. 1. Definitions. Defines terms for this section: CDT code, chargemaster, commissioner, CPT code, dental service, diagnostic laboratory testing, diagnostic radiology service, hospital, medical or dental practice, outpatient surgical center, and standard charge.

Subd. 2. Requirement; current standard changes. Requires hospitals, outpatient surgical centers, and any other medical or dental practice that has annual

Section	Description - Article 3: Department of Health

revenue of greater than $50,000,000 and that derives a majority of its revenue from one or more of the listed services, to make available to the public a list of their current standard charges for all items and services provided by the medical or dental practice.

Subd. 3. Required file format and content. Requires medical and dental practices subject to this section to make available to the public, and to report to the commissioner, their current standard charges using the format and data elements recommended by the Centers for Medicare and Medicaid Services (CMS), in a manner and frequency specified by the commissioner. If CMS modifies or replaces this format, requires the form of the file to be modified or replaced to conform with new CMS specifications. Requires prices included in the file to be expressed as dollar amounts. Requires practices to test their files for compliance with the requirements as to form, before making the file available to the public and reporting it to the commissioner. Requires hospitals to comply with this section by January 1, 2024, and requires outpatient surgical centers and other medical and dental practices to comply with this section by January 1, 2025.

8 **Definitions.**

Amends § 62J.84, subd. 2. In a section governing prescription drug price transparency, adds definitions for the following terms: 30-day supply, course of treatment, drug product family, national drug code, pharmacy or pharmacy provider, pharmacy benefit manager or PBM, pricing unit, reporting entity, and wholesale drug distributer or wholesaler.

9 **Prescription drug price increases reporting.**

Amends § 62J.84, subd. 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 over the past 12 months;
- 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;

Section	Description - Article 3: Department of Health

- clarifying the reporting of the ten highest prices in other countries in the previous calendar year, if the drug is a brand name prescription drug; and
- requiring specified information to be reported if the drug was acquired by the manufacturer during the previous 12-month period.

10 **New prescription drug price reporting.**

Amends § 62J.84, subd. 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.

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

Amends § 62J.84, subd. 6. Expands the information the commissioner must post on the department website, to include a list of prescription drugs of substantial public interest, and information reported by manufacturers, pharmacies, pharmacy benefit managers, and wholesalers for prescription drugs determined to represent a substantial public interest.

12 **Consultation.**

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

13 **Enforcement and penalties.**

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

14 **Legislative report.**

Amends § 62J.84, subd. 9. 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.

Section	Description - Article 3: Department of Health
15	**Notice of prescription drugs of substantial public interest.** Adds subd. 10 to § 62J.84. By January 31, 2024, 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. 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, 2024, requires a manufacturer to submit the listed information, in a form and manner specified by the commissioner, for any prescription drug that the department determines is a drug of substantial public interest, 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, 2024, requires a pharmacy to submit to the commissioner the listed information, in a form and manner specified by the commissioner, for any prescription drug that the department determines is a drug of substantial public interest. Allows the pharmacy to submit any documentation needed to support information reported.
18	**PBM prescription drug substantial public interest reporting.** Adds subd. 13 to § 62J.84. Beginning January 1, 2024, requires a PBM to submit to the commissioner the listed information, in a form and manner specified by the commissioner, for any prescription drug that the department determines is a drug of substantial public interest. Allows the PBM to submit any documentation needed to support the information reported.
19	**Wholesale drug distributor prescription drug substantial public interest reporting.** Adds subd. 14 to § 62J.84. Beginning January 1, 2024, requires a wholesale drug distributor to submit to the commissioner the listed information, in a form and manner specified by the commissioner, for any prescription drug that the department determines is a drug of substantial public interest. Allows the wholesale drug distributor to submit any documentation needed to support the information reported.

Section	Description - Article 3: Department of Health

20 **Registration requirements.**

Adds subd. 15 to § 62J.84. Beginning January 1, 2024, requires a reporting entity subject to this chapter to register with the department in a form and manner specified by the commissioner. (A reporting entity is defined as a manufacturer, pharmacy, PBM, wholesale drug distributor, or any other entity required to submit data under this section.)

21 **Rulemaking.**

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

22 **No Surprises Act.**

Adds subd. 6b to § 62Q.01. Defines No Surprises Act in chapter 62Q.

23 **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.

24 **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.

25 **Consumer protections against balance billing.**

Amends § 62Q.556. Modifies state law prohibiting balance billing to conform with the federal No Surprises Act, establishes reporting requirements, and authorizes enforcement.

Subd. 1. Nonparticipating provider balance billing prohibition. Modifies prohibited provider practices to specify balance billing is prohibited (1) for services provided by a nonparticipating provider at a participating facility as described in the federal No Surprises Act; and (2) for services provided by a nonparticipating provider or facility providing emergency services, or other services described in the No Surprises Act. Allows balance billing if an enrollee gives informed consent that complies with federal law.

Section	Description - Article 3: Department of Health

Subd. 2. Cost-sharing requirements and independent dispute resolution. Modifies terms to conform with changes in subdivision 1, and requires a health plan company and nonparticipating provider to resolve disputes on payment using the federal independent dispute resolution process instead of through arbitration. Strikes language requiring the commissioner to maintain a list of arbitrators and listing information an arbitrator must consider when making a decision.

Subd. 3. Annual data reporting. Requires health plan companies to annually report to the commissioner of health, data on claims, amounts billed, and amounts paid for nonparticipating provider services, and data on enrollee complaints received about the rights and protections established in the No Surprises Act.

Subd. 4. Enforcement. Provides that any provider or facility that is subject to the No Surprises Act is subject to this section and section 62J.811. Authorizes the commissioner of commerce and commissioner of health to enforce this section, and permits a health-related licensing board to investigate any violations by a provider and enforce this section.

26 **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 as in current law). 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.

27 **Definition.**

Amends § 62Q.73, subd. 1. Amends the definition of adverse determination for the section governing external review of decisions on health care claims and services, to include a decision on a health plan's coverage of nonparticipating provider services.

28 **Standard 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.

Section	Description - Article 3: Department of Health
29	**Encounter data.** Amends § 62U.04, subd. 4. In para. (a), requires dental plan companies, in addition to health plan companies and third-party administrators as in current law, to submit encounter data to the all-payer claims database (APCD). Requires encounter data submitted to include data on contractual value-based payments, and for claims incurred on or after January 1, 2023, requires the data to include enrollee race and ethnicity to the extent available. In para. (c), strikes language allowing summary data to be derived from nonpublic data, and allows data on providers collected under this subdivision to be released or published according to subdivision 11.
30	**Pricing data.** Amends § 62U.04, subd. 5. In para. (a), requires dental plan companies to submit to the APCD, data on contracted prices with dental care providers. (Current law requires health plan companies and third-party administrators to submit to the APCD, data on contracted prices with health care providers.) Requires data on contracted prices to include data on supplemental contractual value-based payments paid to health care providers. In para. (c), allows data on providers collected under this subdivision to be released or published according to subdivision 11.
31	**Self-insurers.** Amends § 62U.04, subd. 5a. Requires a third-party administrator to notify self-insurers whose health plans are administered by the third-party administrator that the self-insurer may elect to have the third-party administrator submit encounter data and data on contracted prices from the self-insurer's health plan to the APCD. Requires third-party administrators to report to the commissioner of health, the self-insurers that elect to have data on their health plans submitted to the APCD and self-insurers that decline to have data on their health plans submitted to the APCD. (In 2016, the U.S. Supreme Court held that requiring self-insured health plans covered by the Employee Retirement Income Security Act, or ERISA, to submit data to a state's APCD is preempted under ERISA.)
32	**Nonclaims-based payments.** Adds subd. 5b to § 62U.04. Beginning January 1, 2025, requires health plan companies and third-party administrators to submit to the APCD, data on nonclaims-based payments made to health care providers. Defines nonclaims-based payments, and requires nonclaims-based payments to be attributed, to the extent possible, to a health care provider and to be combined with encounter data and data on contracted prices in analyses of health care spending. Classifies this data as nonpublic data, allows summary data to be derived from this nonpublic data, and requires the

Section	Description - Article 3: Department of Health

commissioner to take steps to protect the integrity and confidentiality of this data. Requires the commissioner to consult with health plan companies, providers, and the commissioner of human services to develop the data reported and reporting forms.

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

Amends § 62U.04, subd. 11. In para. (a), allows data from self-insurer health plans and nonclaims-based payment data submitted to the APCD, in addition to encounter data and data on contracted prices under current law, to be used for the purposes in this subdivision and subdivision 13. Strikes language prohibiting public use files from identifying payers. Allows data in the APCD to be used to conduct analyses of the impact of health care transactions on health care costs, consolidation, and quality.

In paras. (a) and (b), allows public use files of summary data compiled by the commissioner and studies and evaluations by the commissioner using APCD data to identify hospitals, clinics, and medical practices, as long as no individual health professionals are identified and the commissioner finds the data to be accurate and suitable for publication.

Strikes obsolete paragraphs (c) and (e) regarding the use of encounter data for a study due in 2015 and requiring consultation with a work group to create public use files.

Also allows data in the APCD to be used on an ongoing basis to analyze variations in cost, quality, utilization, and illness burden based on geographic area or population (under para. (d), which is being stricken, data may be used for this purpose only until July 1, 2023).

34 **Expanded access to and use of the all-payer claims data.**

Adds subd. 13 to § 62U.04. Requires the commissioner or the entity under contract with the commissioner to make data submitted to the APCD available to individuals and organizations researching or working to transform health care outcomes, access, quality, disparities, or spending, provided the use of the data serves a public benefit. Prohibits the data from being used for certain purposes. To implement making data available for expanded uses, requires the commissioner to establish requirements for data access, an application process, data use agreements, an oversight process for data access and use, technical assistance, and a fee schedule; and to create a research advisory group to advise the commissioner on applications for data use.

35 **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

Section	Description - Article 3: Department of Health

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.

36 **Lead in school drinking water.**

Amends § 121A.335. Modifies requirements for testing and remediation of lead in drinking water by schools.

Subd. 1. Model plan. Requires the state model plan developed by the commissioners of health and education to include recommendations for lead remediation efforts when water lead exceeds five parts per billion (ppb).

Subd. 2. School plans. By July 1, 2024, requires a school district or charter school to revise its lead testing plan to include policies and procedures to ensure consistent water quality. Requires the plan to be based on documents from the United States Environmental Protection Agency, and requires the plan to be publicly available upon request.

Subd. 3. Frequency of testing. If a school district or charter school finds lead at a specific location, requires the district or charter school to implement a plan to ensure student exposure to lead is reduced to at or below five ppb. Requires a school district or charter school to shut off or make a water fixture unavailable when testing shows the presence of lead exceeding five ppb. Requires a district or charter school to test again for the presence of lead after completing remediation activities.

Subd. 4. Ten-year facilities plan. No changes.

Subd. 5. Reporting. Requires school districts and charter schools to send parents an annual notice of the district's or charter school's annual testing or remediation plan and information about how to find test results. Requires districts and charter schools to update online lead testing and remediation information annually. Requires districts and charter schools to remediate the presence of lead when testing is above five ppb. Requires districts and charter schools to annually report test results and remediation efforts to the commissioner of health, beginning July 1, 2024. Requires the commissioner of health to post test results and remediation efforts on the department website, by school site. Requires districts and charter schools to maintain a record of lead testing results and remediation activities for at least 15 years.

Section	Description - Article 3: Department of Health

Subd. 6. Public water systems. States that a district or charter school is not financially responsible for remediating elevated lead levels if lead in the school's drinking water is caused by lead infrastructure owned by the public water supply utility. Requires a district or charter school to try to coordinate needed replacements of lead service lines with the public water supply utility. Allows a district or charter school to defer remediation activities: (1) until after the elevated lead level in the public water's infrastructure is remediated and postremediation testing does not detect an elevated lead level; or (2) if the public water supply exceeds a federal action level or is in violation of the federal Lead and Copper Rule.

Subd. 7. Commissioner recommendations. Requires the commissioner of health to report to the legislature by January 1, 2026, and every five years thereafter on recommended changes to this section, including suggested changes on the level of lead that requires remediation.

37 **Minnesota one health antimicrobial stewardship collaborative.**

Adds § 144.0526. Directs the commissioner of health to establish a Minnesota One Health Antimicrobial Stewardship Collaborative. Directs the commissioner to maintain the position of director to lead antimicrobial stewardship initiatives, communicate with professionals and the public about preserving the efficacy of antibiotic medications, consult and collaborate with experts in various fields, ensure veterinary settings have education and strategies to practice appropriate prescribing and prevent transmission of antimicrobial-resistant microbes, and support initiatives to improve understanding of the impact of antimicrobial use and resistance.

38 **Comprehensive drug overdose and morbidity prevention act.**

Adds § 144.0528. Establishes a program to prevent drug overdoses and morbidity caused by drug overdoses.

Subd. 1. Definition. Defines drug overdose and morbidity for this section.

Subd. 2. Establishment. Directs the commissioner to establish a program to conduct drug overdose and prevention activities and perform epidemiologic investigations and surveillance to monitor, address, and prevent drug overdoses. Lists strategies the commissioner must use in the program, including advancing access to nonnarcotic pain management, implementing culturally specific intervention and prevention programs, enhancing overdose prevention and supportive services for people experiencing homelessness, equipping employers to promote employee health and wellbeing, expanding use of the Minnesota Drug Overdose and Substance Use Surveillance Activity, implementing Tackling Overdose with Networks (TOWN) community prevention programs, addressing drug overdoses and morbidity in those who are pregnant or have just given birth,

Section	Description - Article 3: Department of Health

and designing a system to address impacts of drug overdoses and morbidity on pregnant persons, their infants, and children.

Subd. 3. Partnerships. Allows the commissioner to consult with the listed state agencies, local public health agencies, providers and insurers, and others to carry out this section.

Subd. 4. Grants authorized. Allows the commissioner to award grants to entities and organizations focused on addressing and preventing impacts of drug overdoses and morbidity. Lists activities that may be funded with grants. Requires an entity receiving a grant under this section to collect and make available to the commissioner data on activities funded with a grant. Allows the commissioner to use this data to inform existing programs and develop new programs.

Subd. 5. Promotion; administration. In fiscal years 2026 and beyond, permits the commissioner to spend up to 25 percent of money appropriated for the comprehensive drug overdose and morbidity program to administer and evaluate the programs authorized under this section and provide technical assistance.

Subd. 6. External contributions. Allows the commissioner to accept contributions and apply for grants to supplement state appropriations for the programs in this section.

Subd. 7. Program evaluation. Requires the commissioner of health to submit a report every even-numbered year to the legislative committees with jurisdiction over health on the expenditure of funds under this section, and lists information that must be included in each report.

Subd. 8. Measurement. Requires the commissioner to assess and evaluate grants and contracts awarded using available data sources.

39 **Cultural communications.**

Adds § 144.0752. Requires the commissioner of health to establish a cultural communications program to advance culturally and linguistically appropriate communications services for communities most impacted by health disparities, and a position to ensure the department follows certain national standards for culturally and linguistically appropriate services. Requires the commissioner to oversee a program to align department operations with these national standards, ensure services respond to the diversity of Minnesotans, and ensure culturally and linguistically appropriate policies and practices are used in department work. Describes organizations eligible for contracts under this section.

Section	Description - Article 3: Department of Health

40 **Office of African American Health; duties.**

Adds § 144.0754. Directs the commissioner to establish an Office of African American Health to address the public health needs and health disparities of African American Minnesotans. Lists duties of the office: convening the African American Health State Advisory Council to advise the commissioner on ways to improve the health of African American Minnesotans; developing recommendations to improve health outcomes for African Americans; conducting community engagement activities; conducting data analysis and research; distributing grants and developing programs to improve African American health outcomes; and developing and administering immersion experiences at the Department of Health for students to improve the diversity of the public health workforce.

41 **African American Health State Advisory Council.**

Adds § 144.0755. Directs the commissioner of health to establish an African American Health State Advisory Council to advise the commissioner on reducing health inequities and disparities that affect African Americans in Minnesota.

Subd. 1. Establishment; purpose. Directs the commissioner of health to establish an African American Health State Advisory Council to advise the commissioner on reducing health inequities and disparities that affect African Americans in Minnesota.

Subd. 2. Members. Requires the council to be between 12 and 20 members with representatives from the listed groups. Directs the governor to appoint council members and the commissioner to appoint a chair or chairs.

Subd. 3. Terms. Provides terms of council members are for two years, and allows members to be reappointed for two additional terms.

Subd. 4. Duties of commissioner. Establishes duties for the commissioner: engage with the council, identify department practices that maintain health inequities and disparities and recommend plans to address these, support interagency collaboration, and support member participation in the council.

Subd. 5. Duties of council. Establishes duties for the council: identify health disparities affecting African Americans, recommend review of laws or policies that would address health disparities, recommend policies or strategies to address disparities, form work groups and develop tasks for them, and report to the commissioner on activities.

Subd. 6. Duties of council members. Establishes duties for council members: attend scheduled meetings, maintain open communications, identify issues that

Section	Description - Article 3: Department of Health

affect timely completion of tasks, participate in activities to advance the council's duties, and participate in work groups.

Subd. 7. Staffing; office space; equipment. Directs the commissioner to provide the advisory council with staff support, office space, and access to equipment and services.

Subd. 8. Reimbursement. Compensation and reimbursement for expenses are governed by section 15.059, subd. 3.

42 **African American health special emphasis grant program.**

Adds § 144.0756. Establishes an African American health special emphasis grant program.

Subd. 1. Establishment. Directs the commissioner to establish an African American health special emphasis grant program administered by the Office of African American Health. Lists purposes of the program: identify disparities impacting African American health and develop community-based solutions to address identified disparities.

Subd. 2. Requests for proposals; accountability; data collection. Directs the office to develop a request for proposals; provide outreach and technical assistance to potential qualifying organizations; review responses; establish an accountability process; provide grant recipients with data to assist them in implementing effective solutions; and collect and maintain outcomes data.

Subd. 3. Eligible grantees. Provides that organizations eligible for grants under this section include organizations or entities that work with African American communities or focus on addressing disparities impacting the health of African American communities.

Subd. 4. Strategic consideration and priority of proposals; grant awards. In developing the requests for proposals and awarding grants, directs the commissioner and office to consider building on existing community capacity. Requires proposals to focus on addressing health equity issues for U.S.-born African American communities; addressing health impacts of historical trauma; reducing health disparities; and incorporating a multisector approach.

Subd. 5. Report. Requires grant recipients to report program outcomes to the commissioner on forms and according to timelines established by the commissioner.

Section	Description - Article 3: Department of Health

43 **Office of American Indian Health.**

Adds § 144.0757. Establishes an Office of American Indian Health to address the public health needs and health disparities of American Indian Tribal communities in Minnesota. Lists duties of the office: coordinating with Tribal Nations and urban American Indian organizations to identify causes of health disparities and develop ways to achieve health equity, strengthening capacity of American Indian and community organizations and Tribal Nations to address health disparities, administering state and federal grants, providing leadership to develop health and wellness strategies, providing technical assistance to develop culturally appropriate activities to address public health emergencies, developing and administering department immersion experiences for American Indian students, and identifying and promoting workforce development strategies. Allows the office to contract or provide grants to qualifying entities to carry out these duties.

44 **American Indian health special emphasis grants.**

Adds § 144.0758. Directs the commissioner to establish the American Indian health special emphasis grant program.

Subd. 1. Establishment. Directs the commissioner to establish the American Indian health special emphasis grant program and lists program purposes: develop programs to address health disparities of Minnesota's American Indian populations; identify disparities in American Indian health; and develop community-based solutions to address identified disparities.

Subd. 2. Commissioner's duties. Directs the commissioner to develop a request for proposals; provide outreach and technical assistance to potential qualifying organizations; review responses; establish an accountability process; provide grant recipients with data to assist them in implementing effective solutions; and collect and maintain outcomes data.

Subd. 3. Eligible grantees. Specifies that organizations eligible to receive grants are Minnesota Tribal Nations and urban American Indian community-based organizations.

Subd. 4. Strategic consideration and priority of proposals; grant awards. In developing proposals and awarding grants, requires the commissioner to consider building on existing capacity of Tribal Nations and urban American Indian community-based organizations. Suggests proposals should focus on addressing health equity issues, addressing the health impact of historical trauma, reducing health disparities, and incorporating a multisector approach.

Subd. 5. Report. Requires grant recipients to report program outcomes to the commissioner in a form and manner established by the commissioner.

Section	Description - Article 3: Department of Health

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

Amends § 144.122. Amends a section governing license, permit, and survey fees for health care facilities, to require the commissioner to charge hospitals an annual licensing base fee of $1,826 per hospital, plus $23 per licensed bed or bassinet. Deposits the fees in the state government special revenue fund for use for trauma hospital designations.

46 **Establishment; membership.**

Amends § 144.1481, subd. 1. Increases the size of the Rural Health Advisory Committee at the Health Department from 16 to 22 members. Adds the following members: an allied dental personnel; a member of a Tribal Nation; a representative of a local public health agency or community health board; 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 have a mental illness); a representative of a community organization working with individuals experiencing health disparities; and an individual with expertise in economic development or an employer outside the seven-county metropolitan area. Modifies the description of one other member, requires one of the two consumer members to be from a community experiencing health disparities, and moves the consumer who is an advocate for persons with developmental disabilities to its own line.

47 **Definitions.**

Amends § 144.1501, subd. 1. Adds definitions for hospital nurse and PSLF program to the definitions for the health professional education loan forgiveness program.

48 **Creation of account.**

Amends § 144.1501, subd. 2. Amends eligibility requirements for the health professional education loan forgiveness program, to:

- expand eligibility to medical residents specializing in psychiatry, rather than pediatric psychiatry as in current law;
- expand eligibility to nurses working in assisted living facilities; and
- provide eligibility for nurses enrolled in the federal Public Service Loan Forgiveness (PSLF) program who work for a nonprofit hospital and provide direct patient care.

49 **Eligibility.**

Amends § 144.1501, subd. 3. Modifies eligibility for the health professional education loan forgiveness program, to allow persons obtaining required supervision hours for licensure in one of the listed professions to be eligible to apply for loan forgiveness. Requires hospital nurses who are also receiving loan forgiveness under the PSLF program to include in the application for loan forgiveness, proof of enrollment in the

Section	Description - Article 3: Department of Health

PSLF program and employment as a hospital nurse; requires a hospital nurse to agree to continue working as a hospital nurse for the repayment period under the PSLF program; and does not require these nurses to begin service by March 31 following completion of required training as is required for other participants. Specifies that a nurse who agrees to teach must agree to teach for a minimum of two years to be eligible for loan forgiveness under the health professional education loan forgiveness program, and does not require a nurse to begin the service obligation by March 31 following completion of required training.

50 **Loan forgiveness.**

Amends § 144.1501, subd. 4. Requires the commissioner to select applicants to participate in the hospital nursing education loan forgiveness program and requires the commissioner, for each year a participant is eligible for loan forgiveness, to make annual disbursements to participants in the amount of the minimum loan payments the participant must pay under the PSLF program for the prior loan year. Also allows a nurse who agrees to teach to receive loan forgiveness while the nurse meets the teaching obligation requirement, provided the loan forgiveness does not exceed the balance of the nurse's qualifying educational loans.

51 **Penalty for nonfulfillment.**

Amends § 144.1501, subd. 5. Modifies a subdivision governing penalties for nonfulfillment of requirements for participation in the loan forgiveness program, to require the commissioner to collect amounts paid under the program to a hospital nurse who does not meet the eligibility requirements for the PSLF program. Allows the commissioner to waive penalties for hospital nurses if the PSLF program is discontinued before the hospital nurse's service commitment is completed.

52 **Employee recruitment education loan forgiveness program.**

Adds § 144.1504. Establishes a program to provide loan forgiveness to advanced practice registered nurses, physicians, or physician assistants who agree to practice in rural areas that are shortage areas.

Subd. 1. Definitions. Defines the following terms for this section: advanced practice registered nurse, designated rural area, emergency circumstances, physician, physician assistant, qualified educational loan.

Subd. 2. Creation of account. Establishes a health professional employee education loan forgiveness program account, and directs the commissioner to make grants from the account to eligible providers for a loan forgiveness recruitment and retention program for employees who are APRNs, physicians, or physician assistants and agree to practice in rural areas that are shortage areas.

Section	Description - Article 3: Department of Health

Subd. 3. Eligibility. Provides that providers eligible for a grant under this section must provide services in designated rural areas that are shortage areas for a profession. Requires employees of an eligible provider to agree to work an average of 30 hours per week for at least five years for the provider to maintain eligibility for loan forgiveness.

Subd. 4. Request for proposals. Requires the commissioner to publish a request for proposals that specify provider eligibility requirements, loan forgiveness program criteria, provider selection criteria, required documentation, the maximum number of loan forgiveness slots per provider, and methods of evaluation.

Subd. 5. Application requirements. Establishes requirements for eligible providers to apply for loan forgiveness for their employees, and for employees to apply for loan forgiveness.

Subd. 6. Selection process. Requires the commissioner to determine the maximum number of slots for loan forgiveness per eligible employer, and lists criteria for the commissioner to use to make selections.

Subd. 7. Reporting requirements. Requires participating providers whose employees receive loan forgiveness to report the listed information to the commissioner, according to a schedule established by the commissioner. Before receiving loan repayment disbursements, requires employees to submit a confirmation of practice form to the commissioner with the listed information. Also requires employees to provide the commissioner with verification that the loan repayment disbursement was applied to the designated loans. Allows employees to move to a different eligible provider to remain eligible for loan repayment.

Subd. 8. Penalty for nonfulfillment. If an employee does not fulfill the service commitment, requires the commissioner to collect from the employee the total amount paid under the loan forgiveness program plus interest. Allows the commissioner to waive the collection requirement in emergencies.

Subd. 9. Rules. Allows the commissioner to adopt rules to implement this section.

53 **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

Section	Description - Article 3: Department of Health

to existing training programs for certain health professionals. Lists allowable uses of funds.

54 **Primary care 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 year for the first three years for planning and development and $225,000 per resident per year 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. Allows encumbrances for grants under this section issued by June 30 of each year to be certified for up to three years after the year in which the funds were appropriated.

55 **Clinical health care training.**

Adds § 144.1508. 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 the listed professions. 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.

56 **Fetal death record and certificate of birth resulting in stillbirth.**

Amends § 144.2151. Updates and clarifies processes for establishing fetal death records and requesting certificates of birth resulting in stillbirth.

Subd. 1. Registration. Requires a fetal death record to be established for each fetal death reported to the state registrar according to section 144.222. Strikes language describing an obsolete process, in which a record of birth resulting in stillbirth must be filed with the state registrar if the parents request to have a record of birth resulting in stillbirth prepared.

Subd. 2. Information to parents. Modifies information that must be provided to parents in cases of stillbirth, to require parents to be informed that they may provide a full name or only a last name for the fetal death record, that they may request a certificate of birth resulting in stillbirth and an informational copy of the fetal death record, and that certain parties may correct or amend the fetal death record.

Section	Description - Article 3: Department of Health

Subd. 3. Responsibilities of state registrar. Strikes language permitting parents to file a record of birth resulting in stillbirth (other language in this section allows a certificate of birth resulting in stillbirth to be requested after a fetal death record is established). Moves responsibilities of the state registrar related to fetal death records and certificates of birth resulting in stillbirth from subdivision 5 to this subdivision and updates these duties to reflect that fetal death records and certificates of birth resulting in stillbirth are vital records.

Subd. 4. Delayed registration. Strikes language that permits parents to request a record of birth resulting in stillbirth (subdivision 3 requires the state registrar to establish a process for requesting certificates of birth resulting in stillbirth). Allows a parent, medical examiner, or coroner to submit a request for a delayed registration of fetal death with evidence to support the request.

Subd. 5. Responsibilities of state registrar. Strikes this subdivision (updated responsibilities of the state registrar are now in subdivision 3).

57 **Fetal death reports and registration.**

Amends § 144.222. In subdivision 1, makes technical changes to the requirement that a fetal death must be registered or reported to the state registrar within five days after death, for a fetus of 20 or more weeks of gestation. Strikes subdivision 2, which requires an infant death caused by sudden infant death syndrome to be reported to the state registrar within five days after death (section 144.221, subdivision 1, requires all deaths to be reported to the state registrar within five days after death).

58 **Fetal death report required.**

Amends § 144.222, subd. 1. In a subdivision in the Vital Records Act requiring the death of a fetus of 20 weeks or more gestation, not including abortions, to be reported to the commissioner of health, changes the citation to the definition of abortion from section 145.4241 (the abortion definition in that section is being repealed) to section 145.411, subd. 5.

This section is effective the day following final enactment.

59 **Birth record surcharge.**

Amends § 144.226, subd. 3. Clarifies that the state registrar or local office issuing a certified birth or stillbirth record or statement that a record cannot be found, must forward the birth record surcharge amounts collected each month following collection to the commissioner of management and budget, for deposit as required under law.

Section	Description - Article 3: Department of Health

60 **Vital records surcharge.**

Amends § 144.226, subd. 4. Clarifies that the state registrar or local office issuing a vital record or statement that a record cannot be found, must forward the vital record surcharge amounts collected each month following collection to the commissioner of management and budget, for deposit as required under law.

61 **Nonresidential mental health services.**

Adds § 144.3431. Allows a minor who is 16 or older to consent to nonresidential mental health services, and the consent of no other person is required. Defines nonresidential mental health services as outpatient services provided to a minor not residing in a hospital, inpatient unit, or licensed residential treatment facility or program. (Outpatient services are defined as mental health services, excluding day treatment and community support services programs, provided to children with emotional disturbance who live outside a hospital, and include clinical activities like individual, group, and family therapy; individual treatment planning; diagnostic assessments; medication management; and psychological testing.)

62 **Connector.**

Adds subd. 2a to § 144.382. Defines connector in the Safe Drinking Water Act as gooseneck, pigtail, and other service line connectors; a connector is a short section of piping that can be bent and used to connect rigid service piping.

63 **Galvanized requiring replacement.**

Adds subd. 3a to § 144.382. Defines galvanized requiring replacement in the Safe Drinking Water Act as a galvanized service line that is or was connected to a lead service line, lead status unknown service line, or lead connector.

64 **Galvanized service line.**

Adds subd. 3b to § 144.382. Defines galvanized service line as a service line made of iron or piping dipped in zinc to prevent corrosion and rusting.

65 **Lead connector.**

Adds subd. 3c to § 144.382. Defines lead connector in the Safe Drinking Water Act as a connector made of lead.

66 **Lead service line.**

Adds subd. 3d to § 144.382. Defines lead service line in the Safe Drinking Water Act as a portion of pipe made of lead that connects the water main to the building inlet.

67 **Lead status unknown service line or unknown service line.**

Adds subd. 3e to § 144.382. Defines lead status unknown service line or unknown service line in the Safe Drinking Water Act as a service line that has not been

Section	Description - Article 3: Department of Health

demonstrated to meet or that does not meet the definition of lead free in the federal Safe Drinking Water Act.

68 **Nonlead service line.**

Adds subd. 3f to § 144.382. Defines nonlead service line in the Safe Drinking Water Act as a service line determined through an evidence-based record, method, or technique not to be a lead service line or galvanized service line requiring replacement.

69 **Service line.**

Adds subd. 4a to § 144.382. Defines service line in the Safe Drinking Water Act as a portion of pipe that connects the water main to the building inlet.

70 **Classification of service lines.**

Adds § 144.3835. During a lead service line inventory, allows a water system to classify the actual material of the service line instead of classifying it as a nonlead service line. States that it is not required to physically verify a service line's material composition for its lead status to be identified. For a lead service line inventory and lead service line replacement plan, requires a service line to be classified as a lead service line or a galvanized service line requiring replacement if it has a lead connector. Allows a galvanized service line to be classified as a nonlead service line only if it can be documented that it was never connected to a lead service line or lead connector.

71 **Tobacco use prevention account; establishment and uses.**

Adds § 144.398. Defines the following terms for this section: electronic delivery device, tobacco, tobacco-related devices, and nicotine delivery product. Creates a tobacco use prevention account in the special revenue fund, and requires the commissioner of management and budget to deposit in the account any money the state receives from legal action related to alleged violations of laws regarding electronic nicotine delivery systems or other alleged violations of law that contribute to youth nicotine use. Appropriates the money in the account each fiscal year to the commissioner of health for:

- tobacco and electronic delivery device use prevention and cessation projects;
- a public information program to promote nonsmoking;
- the development of health promotion and education materials about tobacco and electronic delivery device use prevention and cessation;
- tobacco and electronic delivery device use prevention activities; and
- statewide tobacco cessation services.

Section	Description - Article 3: Department of Health

This section is effective the day following final enactment.

72 **Standards for licensure.**

Amends § 144.55, subd. 3. For new licenses, new construction, change of use, or change of occupancy for which plan review packages are received on or after January 1, 2024, requires a hospital to meet the minimum standards in the 2022 edition of *Guidelines for Design and Construction of Hospitals* from the Facility Guidelines Institute (FGI). Establishes a process for the commissioner of health to update the edition of the guidelines publication with which hospitals must comply, and provides that compliance with the updated edition shall not be sooner than 12 months after publication of a notice in the State Register. Requires hospitals to comply with state and local laws, ordinances, and codes for fire safety, building, and zoning. Strikes language authorizing the commissioner to adopt rules establishing standards for new construction. This section is effective January 1, 2024.

73 **Violence against health care workers.**

Amends § 144.566. Establishes additional requirements for the development, content, implementation, and review of preparedness and incident response action plans to acts of violence.

Subd. 1. Definitions. Adds a definition of workplace violence hazards to the definitions subdivision.

Subd. 2. Action plans and action plan reviews required. Requires preparedness and incident response action plans to acts of violence to be updated at least annually, and requires the plan to be in writing; be specific to the hazards and corrective measures of the hospital; and be available to health care workers at all times.

Subd. 3. Action plan committees. Makes technical changes to conform with the restructuring of this section.

Subd. 4. Required elements of action plans; generally. Requires action plans to include procedures to actively involve health care workers in developing, implementing, and reviewing the plan; list who is responsible for implementing the plan; and include procedures to ensure compliance.

Subd. 5. Required elements of action plans; evaluation of risk factors. Requires action plans to include tools, checklists, and other ways to identify and evaluate workplace violence hazards, and to specify the frequency of environmental assessments.

Section	Description - Article 3: Department of Health

Subd. 6. Required elements of action plans; review of workplace violence incidents. Requires action plans to include procedures for reviewing all workplace violence incidents that occurred in the previous year.

Subd. 7. Required elements of action plans; reporting workplace violence. Requires action plans to include the listed procedures related to reporting and responding to workplace violence.

Subd. 8. Required elements of action plans; coordination with other employers. Requires action plans to include methods the hospital will use to coordinate implementation of the plan with other employers whose employees work in the same facility, unit, service, or operation. Requires all employees working in the same facility, unit, service, or operation to be provided with certain required training.

Subd. 9. Required elements of action plans; white supremacist affiliation and support prohibited. Requires action plans to include a statement that hospital security personnel are prohibited from being affiliated with or supporting white supremacist groups, causes, or ideologies, or participating in or promoting international or domestic extremist groups.

Subd. 10. Required elements of action plan; training. Requires action plans to include procedures to develop and provide training, cultural competency training, and procedures for communicating with health care workers about workplace violence issues.

Subd. 11. Training required. Modifies a hospital's existing duties to provide training to health care workers on safety during acts of violence, to specify when the training must occur and to require training to include information on the hospital's action plans and resources available to workers to cope with acts of violence.

Subd. 12. Annual review and update of action plans. Modifies the subjects a hospital must review as part of its annual review and update of its action plans, and requires a hospital to incorporate corrective actions into the action plan to address workplace violence hazards.

Subd. 13. Action plan updates. Following the annual review, requires a hospital to update the action plans to include corrective actions the hospital will implement to address hazards and vulnerabilities noted during the annual review.

Subd. 14. Requests for additional staffing. Requires a hospital to establish a process for a health care worker to officially request additional staffing; requires

Section	Description - Article 3: Department of Health

the hospital to document all requests for additional staffing due to concerns over an act of violence; requires the hospital to provide a written reason for a denial if the request is denied; and requires a hospital to make this documentation available to the commissioner upon request. Allows the commissioner to use this documentation for certain purposes.

Subd. 15. Disclosure of action plans. Requires action plans and reviews to be made available to all direct care staff and collective bargaining units, removes the requirement that action plans be made available to law enforcement, and requires a hospital to submit its action plan and the results of its most recent annual review to the commissioner.

Subd. 16. Legislative report required. Requires the commissioner to compile the information into a single report and submit it to certain members of the legislature by January 15 each year. Provides this subdivision does not expire.

Subd. 17. Interference prohibited. This subdivision is existing law; technical change only.

Subd. 18. Penalties. Increases the maximum fine amount the commissioner may impose for failure to comply with this section, from $250 to $10,000. Requires the commissioner to allow a hospital 30 days to correct a violation before assessing a fine.

74 **Requirements for screening for eligibility for health coverage or assistance.**

Adds § 144.587. Requires hospitals to screen patients to determine if they are eligible for certain health coverage or assistance, and to assist patients in applying for charity care, completing an insurance affordability program application, or applying for a premium tax credit. Permits patients to decline to participate in the screening process or to accept services, and requires hospitals to provide notice of the availability of charity care.

Subd. 1. Definitions. Defines the following terms for this section and sections 144.588 and 144.589: charity care, hospital, Minnesota attorney general/hospital agreement, most favored insurer, navigator, premium tax credit, presumptive eligibility, revenue recapture, uninsured service or treatment, and unreasonable burden.

Subd. 2. Screening. Requires a hospital to screen certain patients for eligibility for charity care, eligibility for state or federal public health care programs, and eligibility for a premium tax credit. Requires the hospital to attempt to complete the screening within 30 days after the patient receives services.

Section	Description - Article 3: Department of Health

Subd. 3. Charity care. Upon completion of a screening, requires a hospital to either assist the patient in applying for charity care or determine the patient is ineligible for charity care. Allows a hospital to take one of the listed steps related to payment, collections, or declining to provide health care only after the hospital determines the patient is ineligible for charity care. Prohibits hospitals from imposing application procedures for charity care that are an unreasonable burden for individual patients. Limits the information a hospital may request to verify assets and income, and prohibits hospitals from requiring duplicate forms of asset verification.

Subd. 4. Public health care program; premium tax credit. Lists steps a hospital must take if a patient is presumptively eligible for a public health care program, and lists steps a hospital may take if a patient is eligible for a premium tax credit.

Subd. 5. Patient may decline services. Provides that a patient may decline to participate in the screening process, apply for charity care, complete an insurance affordability program application, schedule an appointment with a navigator organization, or accept information about navigator services.

Subd. 6. Notice. Requires a hospital to post notice of the availability of charity care in certain locations in the hospital, and requires a hospital to make available on the facility website, the hospital's charity care policy, a plain-language summary of the policy, and the hospital's charity care application form.

This section is effective November 1, 2023.

75 **Certification of expert review.**

Adds § 144.588. Requires a hospital to complete an affidavit of expert review, certifying that the hospital has complied with certain elements of the Minnesota attorney general/hospital agreement, before referring a patient's account to a debt collection agency.

Subd. 1. Requirement; referral to third-party debt collection agency. In order for a hospital to refer a patient's debt to a third-party debt collection agency, requires the hospital to complete an affidavit of expert review completed by a designated employee of the hospital and certifying that the hospital: (1) confirmed the information required of the hospital according to the Minnesota attorney general/hospital agreement; and (2) complied with the requirements in section 144.587 to conduct a patient screening and provide other assistance, unless the patient declined to participate in the screening or pursue assistance.

Section	Description - Article 3: Department of Health

Subd. 2. Penalty for noncompliance. Provides that failure to comply with subdivision 1 shall result in the commissioner of health assessing a fine on the hospital.

This section is effective November 1, 2023.

76 **Billing of uninsured patients.**

Adds § 144.589. Prohibits a hospital from charging a patient whose annual household income is less than $125,000 for an uninsured service or treatment in an amount that exceeds the amount the hospital would be reimbursed from its most favored insurer. (This requirement is also part of the Minnesota hospital/attorney general agreement.)

This section is effective November 1, 2023.

77 **Requirements for certain health care entity transactions.**

Adds § 144.593. Establishes notice and review requirements for health care entities seeking to enter into a transaction and authorizes the attorney general to seek review if a health care entity or transaction violates this section or is contrary to the public interest.

Subd. 1. Definitions. Defines terms for this section: captive professional entity, commissioner, health care entity, health care provider, health care provider group practice, hospital, medical foundation, and transaction.

Subd. 2. Notice required. Para. (a) provides the notice requirements in this subdivision apply to a transaction in which the health care entity involved in the transaction has average revenue of at least $10,000,000 per year, or an entity created by the transaction is projected to have average revenue of at least $10,000,000 per year.

Para. (b) requires a health care entity, at least 180 days before the proposed completion date of a transaction, to provide notice to the attorney general and the commissioner of health and comply with this subdivision.

Para. (c) requires a health care entity to affirmatively disclose the following, 180 days before the proposed completion date of the transaction: the entities involved in the transaction, the leadership of these entities, the services provided and attributed revenue for each entity, existing and proposed primary service areas for each location, certain information about the relationships between the entities and the affected health care providers and practices, the terms of the transaction agreement, the acquisition price, markets with expected post-merger synergies, potential areas of expansion, plans to close facilities or reduce workforce, experts used to evaluate the transaction, the numbers of positions at

Section Description - Article 3: Department of Health

each location before and after the transaction, and any other information requested by the attorney general or commissioner.

Para. (d) requires a health care entity to affirmative produce the following, 180 days before the proposed completion date of the transaction: current governing documents for all involved entities, the transaction agreement, any collateral agreements, expert or consultant reports or valuations, results of any projections or modeling, a financial and economic analysis prepared by an independent expert, an impact analysis prepared by an independent expert, documents related to charitable assets, copies of filings submitted to federal regulators, certifications by each board member and CEO, financial statements and tax filings, and any other information or documents requested by the attorney general or commissioner.

Para. (e) allows the commissioner to adopt rules to implement this section.

Paras. (f) and (g) allow the attorney general to extend or waive the notice and waiting period.

Para. (h) allows public listening sessions to be held.

Para. (i) allows the attorney general or commissioner to bring an action in district court to compel compliance with this subdivision.

Subd. 3. Prohibited transactions. Prohibits a health care entity from entering into a transaction that will substantially lessen competition or tend to create a monopoly or monopsony.

Subd. 4. Additional requirements for nonprofit health care entities. Requires a nonprofit health care entity, or a subsidiary of a nonprofit health care entity, to ensure the following before entering into a transaction: the transaction complies with chapter 317A (nonprofit corporations) and 501B (charitable trusts), the transaction does not constitute a breach of charitable trust, the nonprofit entity will receive full and fair value for its public benefit assets, the value of the public benefit assets has not been manipulated, the transaction proceeds will be used for the public benefit, the transaction will not result in a breach of fiduciary duty, and executives will not benefit from the transaction.

Subd. 5. Attorney general enforcement and supplemental authority. Allows the attorney general to bring an action in court to enjoin or unwind a transaction or seek other relief if a health care entity or transaction violates this section, if the transaction is contrary to the public interest, or both. Lists factors informing whether a transaction is contrary to the public interest. Allows the attorney general to enforce this section under section 8.31 (this section includes attorney

Section	Description - Article 3: Department of Health

general authority to investigate violations of law, seek injunctive relief, and impose civil penalties). States that a court may enjoin a transaction or provide other relief if the entities involved in the transaction do not provide information required by the attorney general or commissioner. Requires the attorney general to consult with the commissioner to determine whether a transaction is contrary to the public interest, allows sharing of data, and classifies data shared.

Subd. 6. Supplemental authority of commissioner. Allows the commissioner to use data submitted under this section or under other law to analyze the impact of health care transactions on health care access, market consolidation, and health care quality. Requires the commissioner to issue periodic reports on transactions subject to this section and their impacts on health care cost, quality, and competition.

Subd. 7. Relation to other law. Provides the powers and authority under this section are in addition to the rights, powers, and authority in other law, and provides nothing in this section suspends obligations imposed by other laws on entities involved in a transaction.

This section is effective the day following final enactment and applies to transactions completed on or after that date.

78 **Trauma Advisory Council established.**

Amends § 144.608, subd. 1. Strikes paragraph cross-references to definitions in the health professional education loan forgiveness program definitions section. Makes other technical corrections.

79 **Limitation of services.**

Amends § 144.615, subd. 7. Strikes language prohibiting an abortion from being administered at a birth center.

This section is effective the day following final enactment.

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

Adds subd. 10a to § 144.615. Requires a health care provider or facility to allow at least one designated support person of a pregnant patient's choosing to be physically present while the patient is receiving health care services. Provides that certified doulas and traditional midwives do not count toward the limit of one designated support person.

81 **Correction orders.**

Amends § 144.653, subd. 5. Amends a subdivision authorizing the commissioner of health to issue correction orders to enforce statutes governing hospitals, to allow

Section	Description - Article 3: Department of Health

issuance of a correction order for a violation of the hospital staffing requirements established in sections 144.7051 to 144.7058.

82 **Request for variance or waiver.**

Amends § 144.6535, subd. 1. Allows a hospital to request a variance or waiver from the standards in the *Guidelines for Design and Construction of Hospitals*, and strikes language authorizing a variance or waiver from Minnesota Rules, chapter 4640 (hospital licensing and operation) or 4645 (hospital construction and equipment). (The standards in the publication are replacing the design and construction standards currently found in rules, and the rules are being repealed.) Also makes conforming changes. This section is effective January 1, 2024.

83 **Criteria for evaluation.**

Amends § 144.6535, subd. 2. Makes changes to conform with the hospital design and construction standards in the *Guidelines for Design and Construction of Hospitals* replacing the standards in rules, which are being repealed. This section is effective January 1, 2024.

84 **Effect of alternative measures or conditions.**

Amends § 144.6535, subd. 4. Makes changes to conform with the hospital design and construction standards in the *Guidelines for Design and Construction of Hospitals* replacing the standards in rules, which are being repealed. This section is effective January 1, 2024.

85 **Classification of data on individuals.**

Amends § 144.69. Changes the name of the cancer surveillance system to the cancer reporting system. Allows Health Department employees to interview patients named in cancer reports, or their relatives, after notifying the patient's attending health professional, and allows the cancer reporting system to share certain data in the system with other state and national cancer registries.

Subd. 1. Data collected by the cancer reporting system. Changes the name of the cancer surveillance system to the cancer reporting system. Allows Department of Health employees to interview patients named in cancer reports, or their relatives, after notifying an attending health care provider, rather than after obtaining consent from an attending health care provider as in current law. Requires research protections for patients to be consistent with section 13.04, subd. 2 (the Tennessen warning statute); and with federal rules governing protection of human research subjects.

Subd. 2. Transfers of information to state cancer registries and federal government agencies. Allows the cancer reporting system to:

Section	Description - Article 3: Department of Health

- share information on a non-Minnesota resident that contains personal identifiers and is collected by the cancer reporting system with the statewide cancer registry of the nonresident's home state 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.

86 **Definitions.**

Adds § 144.7051. Defines the following terms: concern for safe staffing form, commissioner, daily staffing schedule, direct-care registered nurse, and hospital. This section is effective July 1, 2025.

87 **Hospital nurse staffing committee.**

Adds § 144.7053. 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. Provides the commissioner is not required to verify compliance with this section with an onsite visit.

Subd. 2. Staffing 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 50 percent of the committee's membership to be appointed by the hospital.

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

Subd. 4. Staffing committee meeting frequency. Requires a hospital nurse staffing committee to meet at least quarterly.

Subd. 5. Staffing committee duties. Requires a hospital nurse staffing committee to create, implement, and update an evidence-based core staffing plan to guide

Section	Description - Article 3: Department of Health

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 July 1, 2025.

88 **Hospital nurse workload committee.**

Adds § 144.7054. Requires a hospital to establish a hospital nurse workload committee; establishes requirements for committee membership, compensation, and meeting frequency; and establishes committee duties.

Subd. 1. Hospital nurse workload committee required. Requires a hospital to establish and maintain a hospital nurse workload committee for each unit. Provides the commissioner is not required to verify compliance with this section with an onsite visit.

Subd. 2. Workload 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 50 percent of the committee's membership to be appointed by the hospital. If a hospital has a staffing committee established through collective bargaining, provides the composition of that committee prevails.

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

Subd. 4. Workload committee meeting frequency. Requires a hospital nurse workload committee to meet at least monthly when the committee has received an unresolved concern for safe staffing form.

Subd. 5. Workload committee duties. Requires a committee to create, implement, and maintain dispute resolution procedures to use to resolve staffing concerns raised in concern for safe staffing forms; and to attempt to resolve staffing issues stemming from a violation of a hospital's core staffing plan.

This section is effective July 1, 2025.

89 **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

Section	Description - Article 3: Department of Health

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. Transfers the duty to establish a core staffing plan from the chief nursing executive or a designee of a hospital to the hospital nurse staffing committee. Provides the commissioner is not required to verify compliance with this section with an onsite visit. 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 complete or update 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. 2b. Failure to develop hospital core staffing plans. If a hospital nurse staffing committee cannot approve a hospital core staffing plan by majority vote, requires the committee members to enter into expedited arbitration.

Subd. 2c. Objections to hospital core staffing plans. If hospital management objects to a core staffing plan, allows the hospital to try to amend the core staffing plan through arbitration. During this process, requires the hospital to continue to implement the core staffing plan as written. If dispute resolution results in a change to the core staffing plan, requires the hospital to implement the amended plan.

Subd. 2d. Mandatory submission of core staffing plan to commissioner. Requires a hospital to submit to the commissioner core staffing plans approved by the nurse staffing committee, and to submit any substantial updates to a previously approved plan within 30 days of approval of the update or the conclusion of arbitration.

Subd. 3. Standard electronic reporting developed. Strikes obsolete language.

This section is effective July 1, 2025.

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

Adds § 144.7056. Requires a hospital to implement the core staffing plans. Requires public posting of core staffing plans, compliance with core staffing plans, and emergency department wait times, and also requires compliance with core staffing

Section **Description - Article 3: Department of Health**

plans to be posted or made available in patient rooms. Requires management to receive approval from 50 percent of registered nurses staffing the unit before lowering the unit's staffing level. Requires hospitals to provide patients and visitors with copies of certain posted information, and establishes requirements for documenting compliance and retaining records of compliance. Allows employees, patients, and family members to submit a concern for safe staffing form, prohibits retaliation, and establishes a penalty for retaliation.

Subd. 1. Plan implementation required. Requires a hospital to implement the core staffing plans approved by its hospital nurse staffing committee. Provides the commissioner is not required to verify compliance with this section with an onsite visit.

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

Subd. 3. Public posting of compliance with plan. For each core staffing 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. Posting of compliance in patient rooms. Requires a hospital to post on the patient whiteboard or make available through the patient's television, the number of patients a nurse on the patient's unit should be assigned under the core staffing plan and the number of patients actually assigned to a nurse during the current shift.

Subd. 5. Deviations from core staffing plans. Requires hospital management to consult with and receive agreement from at least 50 percent of the direct care registered nurses staffing the unit before lowering the staffing level of the unit.

Subd. 6. Public posting of emergency department wait times. Requires a hospital to maintain on its website and publicly display in its emergency department the approximate wait time for patients who are not in critical need of emergency care.

Subd. 7. Disclosure of staffing plan upon admission. Requires a hospital to explain its core staffing plan to each patient upon admission.

Subd. 8. 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 and 3 are available on request to patients on the unit and visitors of patients on the unit, and requires the hospital to provide the materials to individuals requesting them within four hours after the request.

Section	Description - Article 3: Department of Health

Subd. 9. Reporting noncompliance. Allows a hospital employee, patient, or patient's family member to submit a concern for safe staffing form, and prohibits a hospital from interfering with or retaliating against a hospital employee for doing so. Allows the commissioner of labor and industry to investigate reports of retaliation against a hospital employee for submitting a concern for safe staffing form, and to fine the hospital up to $250,000 for each instance of substantiated retaliation.

Subd. 10. Documentation of compliance. Requires a hospital to document compliance with its core nursing plan, to maintain compliance records for each unit for five years, and to provide its nurse staffing committee with access to these records.

This section is effective October 1, 2025.

91 **Hospital nurse staffing reports.**

Adds § 144.7057. Requires a hospital nurse staffing committee to submit quarterly nurse staffing reports to the commissioner, specifies report content, requires the commissioner to provide a uniform format or form for the reports, and allows the commissioner to impose a fine for failing to report an elective surgery when the unit is out of compliance with its core staffing plan.

Subd. 1. Nurse staffing report required. Requires hospital nurse staffing committees to submit quarterly nurse staffing reports to the commissioner.

Subd. 2. Nurse staffing report. Requires a nurse staffing report to include the listed information.

Subd. 3. Public posting of nurse staffing reports. Requires the commissioner to include on the department website each quarterly nurse staffing report submitted to the commissioner.

Subd. 4. Standardized reporting. Requires the commissioner to develop and provide a uniform format or standard form to be used by the hospital nurse staffing committee to submit quarterly nurse staffing reports under this section. Establishes requirements for the uniform format or standard form.

Subd. 5. Penalties. Allows the commissioner to impose an immediate fine of up to $5,000 for each instance of failing to report an instance of a hospital accepting an elective surgery when the unit is out of compliance with its core staffing plan. Allows a facility to request a hearing on the fine assessed.

This section is effective October 1, 2025.

Section	Description - Article 3: Department of Health

92 **Grading of compliance with core staffing plans.**

Adds § 144.7058. Requires the commissioner to develop a grading system to grade hospitals on their compliance with core staffing plans, to annually grade hospitals, and to post the hospital compliance grades on the department website.

Subd. 1. Grading compliance with core staffing plans. By January 1, 2026, requires the commissioner to develop a grading system to evaluate a hospital's compliance with its core staffing plan. Requires the commissioner to assign each hospital a grade based on the hospital's nurse staffing report, and to assign a failing grade if the hospital has not been in compliance with its staffing plan for six or more months during the reporting year.

Subd. 2. Grading factors. When grading a hospital's compliance with its core staffing plan, requires the commissioner to consider the listed factors.

Subd. 3. Public disclosure of compliance grades. Beginning January 1, 2027, requires the commissioner to publish compliance grades for each hospital on the department website with links to the hospital's core staffing plan, nurse staffing reports, and an explanation of the compliance grade.

This section is effective January 1, 2026.

93 **Retaliation against nurses prohibited.**

Adds § 144.7059. Defines terms for this section: emergency, nurse, and taking action against. Prohibits a hospital, other health care facility licensed by the commissioner of health (not including a nursing facility, ICF/DD, or boarding care home), or a hospital or facility agent, from taking action against a nurse for failing to accept a patient assignment when the nurse declined to accept the additional assignment because doing so may endanger the patient's life, health, or safety or may be a ground for disciplinary action. Provides this section applies to nurses employed by the state regardless of the type of facility where the nurse is employed or the facility's license. Provides this section does not impair rights under a collective bargaining agreement, and states a nurse may be required to accept an additional patient assignment in an emergency. Requires the commissioner of labor and industry to enforce this section, and allows the commissioner to impose a fine of up to $5,000 for each violation of this section.

94 **Establishment of reporting system.**

Amends § 144.7067, subd. 1. Requires facilities to report to the adverse health event reporting system administered by the commissioner of health, whether a unit where an adverse event occurred was in compliance with the core staffing plan for the unit when the adverse event occurred. This section is effective October 1, 2025.

Section	Description - Article 3: Department of Health
95	**Elevated blood lead level.** Amends § 144.9501, subd. 9. Modifies the definition of elevated blood lead level in the Lead Poisoning Prevention Act, from a blood lead test with a result equal to or greater than 10 micrograms of lead or greater per deciliter of whole blood, to 3.5 micrograms of lead or greater per deciliter of whole blood. (The standard in this bill 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.)
96	**Lead hazard reduction.** Amends § 144.9501, subd. 17. Amends the definition of lead hazard reduction in the Lead Poisoning Prevention Act to add 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 painted surfaces that total less than 20 square feet on exterior surfaces or less than two square feet in an interior room (an exception similar to the one being added as para. (c) is currently found in the definition of regulated lead work, and that exception is being replaced by the exceptions added to this definition and the definition of renovation).
97	**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 the commissioner of health in addition to a community health board as in current law; and (3) strike a paragraph listing actions that do not constitute regulated lead work (this exception is being replaced by exceptions being added to the definitions of lead hazard reduction and renovation in this bill).
98	**Renovation.** Amends § 144.9501, subd. 26b. Amends the definition of renovation in the Lead Poisoning Prevention Act, to: (1) specify that it means modification made for compensation; and (2) specify that renovation does not include minor repair and maintenance activities or total demolition of a freestanding structure. Defines minor repair and maintenance as activities, other than window replacement or certain demolition activities, that disturb painted surfaces that total less than 20 square feet on exterior surfaces or less than six square feet in an interior room.
99	**Compensation.** Adds subd. 33 to § 144.9501. Defines compensation in the Lead Poisoning Prevention Act as money or other mutually agreed upon payment given or received for regulated lead work.

Section	Description - Article 3: Department of Health

100 **Individual.**

Adds subd. 34 to § 144.9501. Defines individual in the Lead Poisoning Prevention Act as a natural person.

101 **Licensing, certification, and permitting.**

Amends § 144.9505, subd. 1. In para. (d), clarifies that an individual residential property owner who performs regulated lead work on their own residence is exempt from the requirements for licensure and firm certification for regulated lead work (current law allows property owners and relatives to perform any regulated lead work on a property, not just residential property, without being licensed). States this exemption does not apply to renovation performed for compensation, when a child with an elevated blood lead level has been identified in the residence or building, or when the residence is occupied by individuals not related to the property owner.

Strikes para (e), which requires a person that employs individuals to perform regulated lead work outside the person's property to be certified as a certified lead firm and requires an individual who performs certain types of lead work to be employed by a certified lead firm.

102 **Certified lead firm.**

Amends § 144.9505, subd. 1g. Expands who must be certified as a lead firm, to include a person who performs regulated lead work (other than renovation). (Current law requires a person who employs individuals to perform regulated lead work other than renovation to be certified as a lead firm.) Also strikes language exempting a person from certification if the regulated lead work is performed on the person's own property.

103 **Certified renovation firm.**

Amends § 144.9505, subd. 1h. Expands who must be certified as a renovation firm, to include a person who performs renovation. (Current law requires a person who employs individuals to perform renovation to be certified as a renovation firm.) Specifies that the renovation work must be performed for compensation, and strikes language exempting a person from certification if the renovation work is performed on the person's own property.

104 **Regulated lead work standards and methods.**

Amends § 144.9508, subd. 2. In para. (k), requires rules adopted by the commissioner governing renovation of pre-1978 affected properties to be consistent with rules adopted under the federal Toxic Substances Control Act, and strikes language limiting rules adopted by the commissioner to renovation of pre-1978 properties where a child or pregnant female resides.

Section	Description - Article 3: Department of Health

105 **New license required; change of ownership.**

Amends § 144A.06, subd. 2. Amends the circumstances that constitute a change of ownership of a nursing home to specify a change of ownership occurs, and the new owner must apply for a new license, if within the past 24 months 50 percent or more of the licensee's ownership interest is transferred to multiple different persons (in addition to transfers to one different person as in current law), or to multiple persons (in addition to one person as in current law) who had a less than five percent ownership interest in the facility when the first transaction occurred.

106 **Moratorium.**

Amends § 144A.071, subd. 2. Provides that all construction projects approved by the commissioner of health under section 144A.073, subdivision 3, after March 1, 2020, as exceptions to the moratorium on nursing home construction, are subject to the fair rental value property rate (instead of a historical property rate that would otherwise apply). Also changes paragraph lettering and clause and item numbering and makes conforming changes. This section is effective retroactively from March 1, 2020.

107 **Amendments to approved project.**

Amends § 144A.073, subd. 3b. Modifies criteria used by the commissioner of health to approve amendments to the design of construction projects that were previously approved as exceptions to the moratorium, to make the criteria conform with the fair rental value property rate system. Provides that reimbursement for amendments to approved projects is independent of actual construction costs and shall be based on the allowable appraised value of the completed project, and prohibits a project from being amended to reduce its scope. Removes obsolete dates. This section is effective retroactively from March 1, 2020.

108 **Survey process.**

Amends § 144A.474, subd. 3. In a subdivision governing the survey process for home care providers, strikes a reference in clause (5) to housing with services establishments (which are no longer registered in the state) and instead refers to the establishment where the provider is providing services; and in clause (9) removes requirements that an exit conference occur on-site and that there must be documentation that the exit conference occurred, and requires the exit conference to occur within one business day after the survey.

109 **Follow-up surveys.**

Amends § 144A.474, subd. 9. In a subdivision governing follow-up surveys, strikes language requiring a follow-up survey to be conducted if the provider has any violations determined to be widespread.

Section	Description - Article 3: Department of Health

110 **Reconsideration.**

Amends § 144A.474, subd. 12. In a subdivision governing reconsideration of a correction order issued to a home care provider, requires a request for reconsideration to be received by the commissioner within 15 business days after the home care provider received the correction order, rather than 15 calendar days as in current law.

111 **Termination of service plan.**

Amends § 144A.4791, subd. 10. In a subdivision listing information that must be included in the written notice of termination if a home care provider terminates a client's service plan, adds a requirement that the written notice must include a statement that the client may contact the Office of Ombudsman for Long-Term Care for an advocate to assist regarding the termination. Also strikes references to housing with services contracts and housing with services establishment, and instead requires a statement, if applicable, that the termination of home care services does not constitute a notice of termination of any housing contract.

112 **Fines and penalties.**

Amends § 144G.16, subd. 7. Provides that fines and penalties collected from assisted living facilities for failing to provide the required notice when terminating an assisted living contract shall be deposited in a dedicated special revenue account, and annually appropriates money in the account to the commissioner to implement recommendations of the Home Care and Assisted Living Program Advisory Council.

113 **Notification of changes in information.**

Amends § 144G.18. Establishes a fine of $1,000 if an assisted living facility fails to provide the required notice before changing a manager or authorized agent. Provides that fines and penalties collected under this subdivision shall be deposited in a dedicated special revenue account, and annually appropriates money in the account to the commissioner to implement recommendations of the Home Care and Assisted Living Program Advisory Council.

114 **Fines and penalties.**

Amends § 144G.57, subd. 8. Establishes a fine of $1,000 if an assisted living facility fails to comply with a section governing planned closures. Provides that fines and penalties collected under this subdivision shall be deposited in a dedicated special revenue account, and annually appropriates money in the account to the commissioner to implement recommendations of the Home Care and Assisted Living Program Advisory Council.

Section	Description - Article 3: Department of Health

115 **Terms.**

Amends § 145.411, subd. 1. Modifies a reference to the sections to which the definitions in section 145.411 apply, by replacing a reference to a section being repealed.

This section is effective the day following final enactment.

116 **Abortion.**

Amends § 145.411, subd. 5. Amends the definition of abortion by replacing the term "pregnant woman" with "individual" and adding a requirement that the instrument, medicine, or drug must be supplied, prescribed, or administered with the intention of terminating a pregnancy.

This section is effective the day following final enactment.

117 **Recognition; care.**

Amends § 145.423, subd. 1. Modifies a subdivision governing the recognition of and treatment provided to a born alive infant as a result of an abortion, to instead state that an infant who is born alive must be fully recognized as a human person and require medical personnel to take reasonable measures to care for the infant. Strikes language requiring medical personnel to take reasonable measures to preserve the life and health of the born alive infant. This section is effective the day following final enactment.

118 **988 suicide and crisis lifeline.**

Adds § 145.561. Requires the commissioner to administer the designation of and oversight for a 988 Lifeline Center or network of centers; establishes requirements for the designated centers and specifies Health Department duties; and establishes a 988 telecommunication fee, deposits the fees in a special revenue account, and appropriates money from the account to the commissioner for activities related to the 988 suicide and crisis lifeline.

Subd. 1. Definitions. Defines the following terms for this section: commissioner, department, 988, 988 administrator, 988 contact, 988 Lifeline Center, 988 Suicide and Crisis Lifeline (988 Lifeline), Veterans Crisis Line.

Subd. 2. 988 Lifeline. Requires the commissioner of health to administer the designation of and oversight for a 988 Lifeline Center or network of 988 Lifeline Centers to answer contacts from individuals accessing the Suicide and Crisis Lifeline. Establishes requirements for designated 988 Lifeline Centers. Requires the department to adopt rules to allow appropriate information sharing and communication between crisis and emergency response systems. Requires the department to collaborate with the 988 Lifeline program, Veterans Crisis Line,

Section	Description - Article 3: Department of Health

and other networks to ensure consistent public messaging about 988 services. Requires the department to work with representatives of the listed organizations to develop procedures to govern interactions between 988 and 911 services in Minnesota. Requires the department to provide an annual report about 988 Lifeline usage.

Subd. 3. 988 special revenue account established. Establishes a 988 special revenue account in the special revenue fund to maintain a statewide 988 suicide prevention crisis system. Provides that the 988 special revenue account shall consist of a 988 telecommunication fee, a prepaid wireless 988 fee, appropriations of state money into the account, grants and gifts, interest and other earnings of the account, and money from any other source deposited or transferred into the account. Lists allowable uses of money in the account, and allows money in the account to be expended for these purposes. Appropriates money in the account to the commissioner for the allowable uses. Requires the commissioner to submit annual reports to the Federal Communications Commission on deposits into and expenditures from the account.

Subd. 4. 988 telecommunication fee. Requires the commissioner to impose a monthly statewide fee on each wireline, wireless, or IP-enabled voice service to support the statewide 988 suicide prevention and crisis system. Requires the fee to be between 12 cents and 25 cents per month beginning January 1, 2024, to be collected by the service provider and transferred to the commissioner of public safety for deposit in the 988 special revenue account. Lists allowable uses of revenue generated by the fee, and requires the revenue to be used to supplement, and not supplant, existing suicide prevention funding. Requires the fee amount to be adjusted as needed to provide for continuous operation of the lifeline centers and 988 hotline, volume increases, and maintenance; and requires the commissioner of health to report to the Federal Communications Commission on revenue generated by the fee.

Subd. 5. 988 fee for prepaid wireless telecommunications services. Provides that prepaid wireless telecommunications services are subject to the prepaid wireless 988 fee, not the 988 telecommunication fee.

Subd. 6. Biennial budget; annual financial report. Requires the commissioner to prepare a biennial budget to maintain the 988 system, and to submit an annual report to the legislature on expenditures to maintain the system, fees collected, the balance in the 988 account, administrative expenses, and the most recent forecast of revenues and expenditures for the account.

Subd. 7. Waiver. Allows a wireless or wire-line telecommunications service provider to seek a waiver from the commissioner for all or any portion of the

Section	Description - Article 3: Department of Health

requirements of this section. Allows the commissioner to waive a requirement upon a demonstration that the requirement is economically infeasible.

119 **Administration.**

Amends § 145.87, subd. 4. Strikes language authorizing the commissioner to use up to seven percent of the annual appropriation for the home visiting program for pregnant women and families with young children for training, technical assistance, and administration (the commissioner's authority to provide training and technical assistance and to administer the program is maintained).

120 **School-based health centers.**

Adds § 145.903. Authorizes grants to school districts and school-based health centers to support existing school-based health centers and support the growth of school-based health centers.

Subd. 1. Definitions. Defines terms for this section: school-based health center or comprehensive school-based health center, and sponsoring organization.

Subd. 2. 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. Requires the commissioner to provide a grant to a nonprofit organization to facilitate a community of practice among school-based health centers. Requires grant recipients to report activities and performance measures in a time and format specified by the commissioner. Requires the commissioners of health and education to coordinate activities funded under this section with other efforts to avoid duplication.

Subd. 3. School-based health center services. Lists services that may be provided by a school-based health center.

Subd. 4. Sponsoring organizations. 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. Requires a sponsoring organization to bill private insurers and public programs for services provided by a school-based health center, to the greatest extent possible.

Section	Description - Article 3: Department of Health

121 **HIV prevention grants.**

Amends § 145.924. Requires the commissioner to administer a grant program to provide funds to organizations to assist with HIV/AIDS outbreaks. Updates terminology for populations at risk of acquiring HIV.

122 **Sexual and reproductive health services grants.**

Amends § 145.925. Renames family planning grants as sexual and reproductive health services grants, modifies requirements for distribution of grants, eliminates certain requirements for grant recipients and uses of grant funds, and eliminates a criminal penalty for certain acts by a grant recipient.

Subd. 1. Goal and establishment. A new subd. 1 states that it is the goal of this state to increase access to sexual and reproductive health services for people with barriers to accessing these services, and directs the commissioner to issue grants to facilitate access to sexual and reproductive health for people of reproductive age, especially from populations that experience barriers to accessing these services.

Subd. 1a. Family planning services; defined. Strikes a subdivision defining family planning services.

Subd. 2. Prohibition. Strikes a subdivision prohibiting the commissioner from making grants under this section to nonprofit corporations that perform abortions and prohibiting a grant recipient from contracting with a nonprofit corporation that performs abortions. (This subdivision was found unconstitutional in *Planned Parenthood of Minnesota v. State of Minnesota*, a 1980 decision by the 8th Circuit that was affirmed by the U.S. Supreme Court.)

Subd. 2a. Sexual and reproductive health services defined. Defines sexual and reproductive health services for this section.

Subd. 3. Grants authorized. Strikes language prohibiting grants from being used to support family planning services for unemancipated minors in school buildings. A new subd. 3. requires the commissioner to award grants to eligible community organizations and Tribal communities in rural and metro areas of the state to expand or implement reproductive and sexual health programs for people of reproductive age, to increase access to medically accurate services. Requires the commissioner to establish scoring criteria to be used to evaluate applications. When determining grant awards and amounts, allows the commissioner to stratify geographic regions based on a region's need for sexual and reproductive health services, and allows the commissioner to consider geographic and Tribal communities' representation in grant awards. Provides

Section **Description - Article 3: Department of Health**

that current recipients of funding shall not be afforded priority over new applicants. Describes services that grant funds must be used to provide.

Subd. 4. Parental notification. Strikes a subdivision that requires a person providing family planning services funded under this section and advising an unemancipated minor to obtain abortion or sterilization, to notify the minor's parent or guardian, unless the minor is authorized to consent to health services under other law.

Subd. 5. Rules. Strikes a subdivision authorizing the commissioner to adopt rules to implement this section.

Subd. 6. Public services; individual rights. Changes a term used, from family planning services to sexual and reproductive health services. Strikes a paragraph that allows an employee of an agency providing family planning services, to refuse to offer family planning services if those services are contrary to the employee's personal beliefs. If a person or entity providing services under this section is a provider, requires information provided to, gathered about, or received from a person under this section to comply with statutes governing health records.

Subd. 7. Family planning services; information required. Strikes a subdivision requiring a grant recipient to provide the listed information to a person seeking counseling on family planning methods or procedures.

Subd. 8. Coercion; penalty. Strikes a subdivision making it a misdemeanor for a person who works for a program funded under this section to coerce a person to undergo abortion or sterilization by threatening the person with loss of state or federal assistance or disqualification from a state or federal program.

Subd. 9. Amount of grant; rules. Strikes a subdivision prohibiting the commissioner from adopting rules that limit the grant amount that may be allocated to an organization.

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

Adds § 145.9257. Directs the commissioner of health to establish a community solutions for healthy child development grant program and a community solutions advisory council to provide advice on issuing grants under the program.

Subd. 1. Establishment. Directs the commissioner of health to establish a community solutions for healthy child development grant program, and lists purposes of the program: improving child development outcomes for children of color and American Indian children from prenatal to grade 3 and their families,

Section **Description - Article 3: Department of Health**

reducing racial disparities in children's health and development, and promoting racial and geographic equity.

Subd. 2. Commissioner's duties. Lists duties for the commissioner under this program, including developing a request for proposals; providing outreach, technical assistance, and program development; reviewing responses to the RFP; ensuring communication with other entities in state government; establishing an accountability process; providing grantees with access to data; maintaining outcomes data; and contracting with an independent entity for evaluation.

Subd. 3. Community solutions advisory council; establishment; duties; compensation. Requires the commissioner, in consultation with the listed entities in the department, to appoint 12 members to a community solutions advisory council. Specifies advisory council membership and duties. Requires compensation of advisory council members according to section 15.059, subdivision 3 ($55 per day spent on council activities, plus expenses).

Subd. 4. Eligible grantees. Makes the following organizations eligible to receive grants under this program: organizations that work with communities of color and American Indian communities, Tribal Nations and Tribal organizations, and organizations that focus on supporting healthy child development.

Subd. 5. Strategic consideration and priority of proposals; eligible populations; grant awards. Directs the commissioner, in consultation with the advisory council, to develop a request for proposals for grants, and requires proposals to focus on increasing racial equity and healthy child development and reducing health disparities. In awarding grants, requires the commissioner to consider building on the capacity of communities to promote child and family well-being and address social determinants of healthy child development, and requires the commissioner to give priority to proposals from organizations that meet one of the listed criteria.

Subd. 6. Geographic distribution of grants. Requires the commissioner and advisory council to ensure that grants are prioritized and awarded to organizations in counties with a higher proportion of people of color and American Indians than the state average, to the extent possible.

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

124 **Lead remediation in school 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 licensed child care settings. Requires the commissioner to award grants through a request for

Section	Description - Article 3: Department of Health

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 and to implement best practices for water management in their buildings.

125 **Testing for lead in drinking water in child care settings.**

Adds § 145.9273. Requires licensed child care providers, by July 1, 2024, to develop a plan to test for the presence of lead in drinking water in child care facilities, and requires the plan to follow Department of Health guidance or EPA guidance. Requires the plan to include testing water fixtures in all buildings where children are served, and requires all taps to be tested at least every five years. Requires the plan to include steps to remediate if lead is present in drinking water and to verify the remediation was successful by retesting. Lists allowable remediation actions. Requires licensed child care providers to report to parents and staff, test results and information on remediation performed. Also requires licensed child care providers to annually report test results and remediation activities to the commissioner.

126 **Health Equity Advisory and Leadership (HEAL) council.**

Adds § 145.987. 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. Requires meetings to comply with the open meeting law. 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 provides a reference to the health disparities that must be considered when determining whether health inequities have been eliminated.

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

Amends § 145A.131, subd. 1. Amends a subdivision governing funding for community health boards, to specify that funding 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. Allows some of these funds to fund new organizational models.

128 **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, except that if all foundational public health responsibilities are

Section	Description - Article 3: Department of Health

fulfilled, the funding distributed for foundational public health responsibilities may be used for local priorities. By July 1, 2028, 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.

129 **Grants to Tribes.**

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.

130 **Exemptions.**

Amends § 147A.08. Strikes paragraph cross-references to definitions in the health professional education loan forgiveness program definitions section, and instead lists midlevel practitioners, nurses, and nurse-midwives as the professionals not governed by chapter 147A.

131 **Grounds listed.**

Amends § 148.261, subd. 1. Strikes language making it a ground for disciplinary action for a nurse to perform an act prohibited by section 145.412, to conform with the repeal of section 145.412.

This section is effective the day following final enactment.

132 **Hearing aid.**

Amends § 148.512, subd. 10a. Amends the definition of hearing aid in the statutes governing audiologists, to specify that it is a prescribed aid and that it does not include products that enhance human hearing.

133 **Hearing aid dispensing.**

Amends § 148.512, subd. 10b. Amends the definition of hearing aid dispensing in the audiologist statutes to remove from the definition, the acts of recommending a hearing aid and selling hearing aids at retail. Specifies that hearing aid dispensing does not include selling over-the-counter (OTC) hearing aids. Provides this definition applies to assisting with selecting, and with dispensing, prescription hearing aids.

134 **Over-the-counter hearing aid or OTC hearing aid.**

Adds subd. 10c to § 148.512. Defines over-the-counter hearing aid or OTC hearing aid in the audiologist statutes by reference to the definition in federal rules.

Section	Description - Article 3: Department of Health
135	**Prescription hearing aid.** Adds subd. 13a to § 148.512. Defines prescription hearing aid in the audiologist statutes.
136	**Over-the-counter hearing aids.** Adds subd. 4 to § 148.513. Provides that the statutes governing audiologists do not preclude licensed audiologists from dispensing or selling OTC hearing aids.
137	**Dispensing audiologist examination requirements.** Amends § 148.515, subd. 6. Amends audiologist examination and supervision requirements to specify that the examination and supervision requirements must be satisfied to dispense prescription hearing aids.
138	**Temporary licensure.** Amends § 148.5175. Provides that good cause that permits an audiologist's temporary license to be renewed twice includes not being able to take and complete the required practical examination for dispensing prescription hearing aids.
139	**Grounds for disciplinary action by commissioner.** Amends § 148.5195, subd. 3. In provisions establishing grounds for disciplinary action against audiologists and hearing aid dispensers, changes the title from "hearing instrument dispenser" to "hearing aid dispenser" and provides that grounds for disciplinary action apply to prescribing or dispensing prescription hearing aids. Removes references to recommending hearing aids.
140	**Membership.** Amends § 148.5196, subd. 1. In a subdivision establishing the Speech-Language Pathologist and Audiologist Advisory Council, modifies a term from "hearing instrument" to "hearing aid;" changes a title from "hearing instrument dispenser" to "hearing aid dispenser;" and requires audiologist members of the advisory council to have experience that includes dispensing prescription hearing aids. Removes a reference to recommending hearing aids.
141	**Hearing aid dispensing.** Amends § 148.5197. Modifies provisions governing audiologist and hearing aid dispenser contracts, use of a license number or certificate number, consumer rights information, and liability, to provide this section governs audiologist and hearing aid dispenser prescribing and dispensing of prescription hearing aids.

Section	Description - Article 3: Department of Health

142 **Restriction on sale of prescription hearing aids.**

Amends § 148.5198. Provides the consumer protections in this section apply to audiologists' and certified dispensers' dispensing of prescription hearing aids.

143 **Administration of opiate antagonists for drug overdose.**

Amends § 151.37, subd. 12. In a subdivision governing whom certain health care professionals may authorize to administer opiate antagonists, allows any personnel employed by or under contract with a charter, public, or private school to be authorized to administer opiate antagonists. (Under current law, only licensed school nurses and certified public health nurses working for a school may be authorized to administer opiate antagonists.) Also specifies that a licensed practical nurse is authorized to possess and administer opiate antagonists in a school setting.

144 **Hearing aid.**

Amends § 153A.13, subd. 3. In the definition of hearing instrument in the chapter governing hearing aid dispensers, changes the term defined, from "hearing instrument" to "hearing aid" and refers to the definition of that term in section 148.512, subd. 10a.

145 **Hearing aid dispensing.**

Amends § 153A.13, subd. 4. In the definition of hearing instrument dispensing in the chapter governing hearing aid dispensers, changes the term defined, from "hearing instrument dispensing" to "hearing aid dispensing" and refers to the definition of that term in section 148.512, subd. 10b.

146 **Dispenser of hearing aids.**

Amends § 153A.13, subd. 5. In the definition of dispenser of hearing instruments in the chapter governing hearing aid dispensers, changes the term defined to "dispenser of hearing aids" and provides that these dispensers dispense prescription aids. (This is a version of the professional title used by persons who dispense hearing aids. The title "hearing instrument dispenser" is also used in this chapter and is being changed to "hearing aid dispenser.")

147 **Advisory council.**

Amends § 153A.13, subd. 6. Changes the name of an advisory council from "Minnesota Hearing Instrument Dispenser Advisory Council" to "Minnesota Hearing Aid Dispenser Advisory Council" to conform with other changes in this chapter.

148 **ANSI.**

Amends § 153A.13, subd. 7. In the definition of ANSI in the chapter governing hearing instrument dispensers, strikes the existing definition of ANSI and instead refers to the

Section	Description - Article 3: Department of Health

definition of the American National Standard Specification for Audiometers in federal rules.

149 **Supervision.**

Amends § 153A.13, subd. 9. In the definition of supervision in the chapter governing hearing aid dispensers, changes a term and provides that trainees dispense prescription hearing aids.

150 **Direct supervision or directly supervised.**

Amends § 153A.13, subd. 10. In the definition of direct supervision or directly supervised in the chapter governing hearing aid dispensers, changes a term and provides that trainees dispense prescription hearing aids.

151 **Indirect supervision or indirectly supervised.**

Amends § 153A.13, subd. 11. In the definition of indirect supervision or indirectly supervised in the chapter governing hearing aid dispensers, changes a term and provides that trainees dispense prescription hearing aids.

152 **Over-the-counter hearing aid or OTC hearing aid.**

Adds subd. 12 to § 153A.13. Defines over-the-counter hearing aid or OTC hearing aid for the chapter governing hearing aid dispensers.

153 **Prescription hearing aid.**

Adds subd. 13 to § 153A.13. Defines prescription hearing aid for the chapter governing hearing aid dispensers.

154 **Application for certificate.**

Amends § 153A.14, subd. 1. In a subdivision governing applications for a certificate as a hearing aid dispenser, changes terms from “hearing instrument” to “hearing aid” and requires the applicant to provide information on training and experience in testing, fitting, and selling prescription hearing aids.

155 **Issuance of certificate.**

Amends § 153A.14, subd. 2. In a subdivision governing issuance of certificates for hearing aid dispensers, changes a term from “dispensers of hearing instruments” to “dispensers of hearing aids.”

156 **Certification by examination.**

Amends § 153A.14, subd. 2h. Requires the examination for certification as a hearing aid dispenser to test applicants on prescription hearing aid selling.

Section	Description - Article 3: Department of Health
157	**Continuing education requirement.** Amends § 153A.14, subd. 2i. Requires continuing education courses for hearing aid dispensers to be directly related to prescription hearing aid dispensing.
158	**Required use of certification number.** Amends § 153A.14, subd. 2j. Provides the requirement that a hearing aid dispenser uses the dispenser's certification number on certain sales items, applies to the sale of prescription hearing aids.
159	**Dispensing of prescription hearing aids without certificate.** Amends § 153A.14, subd. 4. Modifies criminal penalties, to make it a gross misdemeanor to dispense a prescription hearing aid without a certificate.
160	**Trainees.** Amends § 153A.14, subd. 4a. Changes a title, from "hearing instrument dispenser" to "hearing aid dispenser" and provides the authorization for trainees to dispense hearing aids applies to the dispensing of prescription hearing aids.
161	**Prescription hearing testing protocol.** Amends § 153A.14, subd. 4b. Modifies the hearing testing protocol requirements to make them apply to the dispensing of prescription hearing aids. Also corrects a cross-reference to federal rules.
162	**Reciprocity.** Amends § 153A.14, subd. 4c. Modifies a subdivision governing reciprocity to provide it applies to persons who have dispensed prescription hearing aids in other jurisdictions.
163	**Prescription hearing aids; enforcement.** Amends § 153A.14, subd. 4e. Requires certain investigation costs of the Department of Health to be apportioned among professions that dispense prescription hearing aids.
164	**Prescription hearing aids to comply with federal and state requirements.** Amends § 153A.14, subd. 6. Provides the commissioner's duties to ensure compliance with state and federal requirements apply to requirements governing dispensing of prescription hearing aids.
165	**Consumer rights.** Amends § 153A.14, subd. 9. Changes a title from "hearing instrument dispenser" to "hearing aid dispenser."

Section	Description - Article 3: Department of Health
166	**Requirement to maintain current information.** Amends § 153A.14, subd. 11. Modifies information a dispenser must provide the commissioner, to require dispensers to provide information on certain judgements related to dispensing prescription hearing aids and information on whether the dispenser stops dispensing prescription hearing aids.
167	**Over-the-counter hearing aids.** Adds subd. 12 to § 153A.14. Provides that chapter 153A does not preclude certified hearing aid dispensers from dispensing or selling OTC hearing aids.
168	**Prohibited acts.** Amends § 153A.15, subd. 1. Changes a title, and provides the grounds for disciplinary action in this subdivision apply to dispensing prescription hearing aids.
169	**Enforcement actions.** Amends § 153A.15, subd. 2. Provides the enforcement actions in this subdivision apply to persons who dispense prescription hearing aids.
170	**Penalties.** Amends § 153A.15, subd. 4. Changes a title.
171	**Expenses; fees.** Amends § 153A.17. Changes a term used. Strikes an obsolete sentence (section 16E.22 has expired).
172	**Penalty fees.** Amends § 153A.175. Changes a title and provides the penalty fee for dispensing without submitting a continuing education report applies to dispensing prescription hearing aids.
173	**Consumer information center.** Amends § 153A.18. Provides the Consumer Information Center must provide information about prescription hearing aids to actual and potential purchasers. Changes a title.
174	**Hearing Aid Dispenser Advisory Council.** Amends § 153A.20. Changes the name of the advisory council from “Hearing Instrument Dispenser Advisory Council” to “Hearing Aid Dispenser Advisory Council”; requires advisory council members to be persons who dispense or use prescription hearing aids; changes a title.

Section	Description - Article 3: Department of Health

175 **Construction project rate adjustments effective October 1, 2006.**

Amends § 256B.434, subd. 4f. Updates cross-references to conform with the technical changes to paragraph lettering and clause and item numbering in section 144A.071, subd. 2.

176 **Duties of commissioner of health.**

Amends § 256B.692, subd. 2. Strikes section 62Q.145 from the list of sections a county-based purchasing plan must assure the commissioner of health it will meet; this section is being stricken to conform with the repeal of section 62Q.145. Section 62Q.145 in turn is being repealed to conform with the repeal of section 145.412.

This section is effective the day following final enactment.

177 **Prepaid wireless fees imposed; collection; remittance.**

Amends § 403.161.

Subd. 1. Fees imposed. Amends a subdivision imposing fees on retail transactions for prepaid wireless telecommunications services, to impose a prepaid wireless 988 fee on each transaction, in the amount of the monthly charge for the 988 telecommunication fee.

Subd. 2. Exemption. No changes.

Subd. 3. Fee collected. Requires prepaid wireless 988 fees to be collected by the seller from the consumer for each retail transaction in the state for prepaid wireless telecommunications services.

Subd. 4. Sales and use tax treatment. No changes.

Subd. 5. Remittance. Provides that prepaid wireless 988 fees are the liability of the consumer purchasing prepaid wireless telecommunications services.

Subd. 6. Exclusion for calculating other charges. Prohibits prepaid wireless 988 fees from being included in the base used to calculate other taxes, fees, or surcharges imposed by a governmental entity.

Subd. 7. Fee changes. Requires the prepaid wireless 988 fee to be increased or reduced upon any change made to the 988 telecommunication fee.

178 **Administration of prepaid wireless E911 fees.**

Amends § 403.162.

Subd. 1. Remittance. Requires prepaid wireless 988 fees collected by sellers of prepaid wireless telecommunications services to be submitted to the

Section	Description - Article 3: Department of Health

commissioner of revenue according to the procedures for submission of the general sales and use tax.

Subd. 2. Seller's retention fee. Allows a seller of prepaid wireless telecommunications services to retain three percent of the prepaid wireless 988 fees collected from consumers.

Subds 3-4. No changes.

Subd. 5. Fees. Requires the commissioner of revenue to deposit the proportion of collected fees attributable to the prepaid wireless 988 fee in the 988 special revenue account. Allows the commissioner of revenue to deduct a percentage of collected fees, to be used for the commissioner's direct costs of collecting and remitting prepaid wireless 988 fees.

179 **Modification.**

Amends § 518A.39, subd. 2. In a subdivision governing modifications of child support orders, strikes a reference to section 256B.40 to conform with the repeal of that section.

This section is effective the day following final enactment.

180 **Moratorium on conversion transactions.**

Amends Laws 2017, First Special Session ch. 6, art. 5, § 11, as amended. Extends the date for the expiration of the moratorium on conversion transactions by nonprofit service plan corporations or nonprofit health maintenance organizations to July 1, 2026. (In current law the moratorium expires July 1, 2023.) This section is effective the day following final enactment.

181 **Mental health grants for health care professionals.**

Amends Laws 2022, ch. 99, art. 1, § 46. Amends a program establishing mental health grants for health care professionals, to allow a program receiving a grant to address mental health by identifying and modifying structural barriers in health care delivery that create unnecessary stress in the workplace. A new subd. 2a allows encumbrances for grants under this program issued by June 30 of each year to be certified for up to three years after the year the funds were appropriated.

182 **Appropriation; mental health grants for health care professionals.**

Amends Laws 2022, ch. 99, art. 3, § 9. Makes the fiscal year 2023 appropriation for mental health grants for health care professionals available until June 30, 2027. This section is effective the day following final enactment.

Section	Description - Article 3: Department of Health

183 **Adolescent mental health promotion; grants authorized.**

Establishes a grant program to support mental health promotion programs for adolescents.

Subd. 1. Goal and establishment. Directs the commissioner of health to issue grants to community-based organizations for mental health promotion programs for adolescents, and requires the commissioner to coordinate with other efforts to avoid duplication.

Subd. 2. Grants authorized. Lists organizations eligible for grants under this section, to implement community-based mental health promotion programs for adolescents in community settings. Requires the commissioner to establish criteria to review applications for grants. Requires grant funds to be used to support new or existing programs, including programs that train community members to facilitate discussions on adolescent mental health promotion skills, that train community members to model positive mental health skills, that train adolescents to provide peer support, and that support community dialogue on mental health promotion.

Subd. 3. Evaluation. Requires the commissioner to evaluate programs funded under this section, and requires grant recipients to provide the commissioner with information needed to conduct the evaluation.

184 **Advancing health equity through capacity building and resource allocation.**

Establishes a program to award capacity-building grants to organizations serving diverse communities, and directs the commissioner to create a framework for equitable grantmaking by the department.

Subd. 1. Establishment of grant program. Directs the commissioner of health to establish a program to award grants to organizations serving diverse communities who have been disproportionately impacted by health and other inequities, to help them procure grants and contracts from the department, and to create a framework for equitable practices in grantmaking at the department.

Subd. 2. Commissioner's duties. Requires the commissioner of health to develop a request for proposals for the infrastructure capacity building grant program, provide outreach and technical assistance, review responses, communicate with the relevant state councils and the governor's office, establish an accountability process, maintain outcomes data, and establish a process to evaluate the success of grant program.

Subd. 3. Eligible grantees. Provides that organizations eligible for grants under this section include organizations or entities that work with diverse communities.

Section	Description - Article 3: Department of Health

Subd. 4. Strategic consideration and priority of proposals; eligible populations; grant awards. Requires the commissioner to develop a request for proposals. In awarding grants, requires the commissioner to provide strategic consideration and give priority to proposals from organizations and entities led by populations of color or American Indians and those serving populations of color, American Indians, LGBTQIA+ communities, and persons with disabilities.

Subd. 5. Geographic distribution of grants. Requires the commissioner to prioritize and award grants to organizations and entities within counties that have a higher proportion of Black or African American, nonwhite Latino(a), LGBTQIA+, and disability communities.

Subd. 6. Report. Requires grant recipients to report grant outcomes to the commissioner on forms and according to timelines established by the commissioner.

185 **Climate resiliency.**

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 and award grants 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.

186 **Critical access dental infrastructure program.**

Requires the commissioner of health to award grants and forgivable loans to critical access dental providers for eligible dental infrastructure projects.

Subd. 1. Definitions. Defines terms for this section: commissioner, critical access dental provider, and dental infrastructure.

Subd. 2. Grant and loan program established. Requires the commissioner of health to award grants and forgivable loans to critical access dental providers for eligible dental infrastructure projects.

Subd. 3. Eligible projects. To be eligible for a grant or forgivable loan, requires a dental infrastructure project to be proposed by a critical access dental provider and to allow the provider to maintain or expand capacity to serve MA and MinnesotaCare enrollees.

Section	Description - Article 3: Department of Health

Subd. 4. Application. Requires the commissioner to develop forms and procedures to solicit and review applications and award grants and forgivable loans. Requires a critical access dental provider seeking a grant or forgivable loan to apply to the commissioner in a time and manner specified by the commissioner. Lists criteria on which applications must be reviewed.

Subd. 5. Program oversight. Allows the commissioner to require and collect from grant and loan recipients, information needed to evaluate the program.

187 **Direction to commissioner of health; development of analytical tools.**

Requires the commissioner of health to develop a way to analyze adverse event data, staffing data, and data from concern for safe staffing forms to examine potential causal links between adverse events and understaffing. Requires an initial means of conducting the analysis to be developed by January 1, 2025, and a public report by January 1, 2026. By January 1, 2024, requires the commissioner to report to certain members of the legislature on available data about hospitals, potential sources of additional data, and additional authority the commissioner needs to collect information from hospitals. This section is effective August 1, 2023.

188 **Direction to commissioner of health; nursing workforce report.**

Requires the commissioner of health to publish a public report by January 1, 2026, on the status of the state's workforce of nurses employed by hospitals. Lists information the commissioner must use to compile the report.

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

Establishes the Emmett Louis Till Victims Recovery Program, in which the commissioner of health awards grants for projects to address the health and wellness needs of victims who experienced trauma from certain events and their families and heirs.

Subd. 1. Short title. Provides 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 a program to address the health and wellness needs of victims who experienced trauma from certain events and of their families and heirs who experienced trauma. The commissioner, in consultation with victims, families, and heirs who experienced trauma, must award competitive grants to applicants to provide health and wellness services, remembrance and legacy preservation activities, cultural awareness services, and community resources.

Section	Description - Article 3: Department of Health

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

Subd. 4. Reports. Requires the commissioner to submit a status report and an additional report to certain members of the legislature on the operation and results of the grant program, and lists information the reports must include.

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

Establishes a Minnesota perinatal quality collaborative, authorizes grants to improve infant health, 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. Purposes. Lists purposes of the act.

Subd. 2. Minnesota perinatal quality collaborative. Establishes a Minnesota perinatal quality collaborative to improve pregnancy outcomes for pregnant people and newborns, by taking steps to promote evidence-based and evidence-informed care, reviewing data on best practices to prioritize quality improvement initiatives, identifying ways to incorporate antiracism into the delivery of perinatal health care, supporting initiatives that address substance use disorders in pregnant people, providing a forum to discuss quality improvement efforts, reaching providers and institutions to reinforce a continuum of care model, and monitoring interventions and applying systems changes to promote improved perinatal care.

Subd. 3. Eligible organizations. Requires the commissioner to issue a grant to a nonprofit organization to establish a network of organizations to improve outcomes for pregnant persons and infants.

Subd. 4. Grants authorized. Requires the commissioner to award a grant to a nonprofit organization to improve maternal and infant health outcomes, and requires the commissioner to give preference to an organization that can provide these services statewide.

Subd. 5. Minnesota partnership to prevent infant mortality program. Establishes the Minnesota partnership to prevent infant mortality program as a statewide program to improve birth outcomes and eliminate preventable infant mortality. Lists goals for the program.

Subd. 5a. Grants authorized. Requires the commissioner to issue grants 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

Section	Description - Article 3: Department of Health

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. 5b. Technical assistance. Requires the commissioner to provide content expertise, technical expertise, training, and advice on data-driven strategies for the program to prevent infant mortality. Allows the commissioner to award contracts to appropriate entities to provide technical assistance. Lists areas in which technical assistance and training may be provided.

Subd. 6. Developmental and social-emotional screening with follow-up. Requires the commissioner to work with the commissioners of human services and education to identify young children at risk for developmental and behavioral concerns and provide follow-up services to connect families and children with resources and programs.

Subd. 6a. Duties. Lists duties of the commissioner of health related to developmental and social-emotional screening and follow-up: increasing awareness of screening and follow-up services, expanding existing systems to administer screenings, providing screenings for developmental and social-emotional delays, reviewing and sharing results, providing referrals to appropriate services and resources, and establishing performance measures and analyzing and sharing program data.

Subd. 6b. Grants authorized. Requires the commissioner to award grants:

- to community-based organizations, community health boards, and Tribal nations to support follow-up services for children with developmental or social-emotional concerns identified through screening; and
- to community-based organizations to train cultural liaisons to help families navigate the screening and follow-up process.

Subd. 7. Model jail practices for incarcerated parents. Allows the commissioner to make special grants to counties and groups of counties to implement model jails practices to benefit children of incarcerated parents. Also allows the commissioner to make special grants to county governments, Tribal governments, and nonprofit organizations in corresponding geographic areas to build partnerships with county jails to support children of incarcerated parents and their caregivers. Defines model jails practices.

Subd. 7a. Grants authorized; model jail practices. Authorizes grants and allows grant recipients to use grant funds for activities that include the listed activities.

Section	Description - Article 3: Department of Health

Requires grant recipients to report their activities to the commissioner in a format and at a time specified by the commissioner.

Subd. 7b. Technical assistance and oversight; model jail practices. Requires the commissioner to provide content expertise, training, and advice on evidence-based strategies for the model jail practices for incarcerated parents program, and to award contracts to appropriate entities to assist with these activities. Lists areas in which technical assistance and training may be provided.

191 **Help Me Connect resource and referral system for children.**

Requires the commissioner of health to establish the Help Me Connect resource and referral system for children as a resource and referral system for children from prenatal to age eight and their families. Requires the Help Me Connect system to facilitate collaboration across sectors, provide access to local resources for early detection and intervention services, identify and provide access to early childhood and family support navigation specialists, and link children and families to community-based services. Requires the Help Me Connect system to provide community outreach, including providing information on the system and maintaining a resource directory; to maintain a central access point for parents and professionals to obtain information, resources, and services; and to collect data on the current system of support and resources.

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

Provides for implementation of provisions in this article:

- by October 1, 2024, requires each hospital to establish and convene a hospital nurse staffing committee and a hospital nurse workload committee;
- by October 1, 2025, requires each hospital to implement core staffing plans, satisfy the posting requirements for plans, and submit core staffing plans to the commissioner;
- by October 1, 2025, requires the commissioner of health to develop a standard concern for safe staffing form based on the form maintained by the Minnesota Nurses Association and provide an electronic means of submitting the form; and
- by January 1, 2026, requires the commissioner to provide electronic access to uniform nurse staffing reporting format or forms.

193 **Long COVID.**

Establishes a program for the commissioner of health to conduct community needs assessments and epidemiologic investigations to monitor and address the impacts of long COVID. Defines long COVID. Lists purposes of this program. Also requires the

Section	Description - Article 3: Department of Health

commissioner to identify priority actions to support long COVID survivors and their families, implement 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. Requires the commissioner to coordinate with partners to implement priority actions through grants and contracts awarded to organizations that serve communities disproportionately impacted by COVID-19 and long COVID, and lists allowable uses of these grant funds.

194 **Membership terms; Palliative Care Advisory Council.**

Provides that the membership terms for members of the Palliative Care Advisory Council appointed after February 1, 2022, shall be three years. (Because the advisory council is set to sunset on January 1, 2025, under current law, members appointed after February 1, 2022, would serve terms of less than three years before the advisory council expires. This bill removes the sunset, so members appointed after February 1, 2022, are able to serve three-year terms as provided in section 144.059, subd. 3.)

195 **Psychedelic Medicine Task Force.**

Establishes a Psychedelic Medicine Task Force to advise the legislature on legal, medical, and policy issues associated with the legalization of psychedelic medicine. For purposes of this section, defines psychedelic medicine as MDMA, psilocybin, and LSD. Specifies task force membership, and requires members to be designated or appointed by July 15, 2023. Requires the commissioner of health to provide support and meeting space for the task force. Establishes task force duties: surveying existing studies on the efficacy of psychedelic medicine in treating mental health conditions, comparing the efficacy of psychedelic medicine with that of current treatments, and developing a plan that addresses changes to state law needed to legalize psychedelic medicine; state and local regulation of psychedelic medicine; federal law issues; and public education. Requires reports to certain members of the legislature by February 1, 2024, and January 1, 2025.

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

Defines terms for this section: commissioner, nonclaims-based payments, nonpublic data, and primary care services. Requires the commissioner of health to report to the legislature by February 15, 2024, on the volume and distribution of health care spending across payment models used by health plan companies and third-party administrators. Specifies what the report must include, and requires the report to include recommendations on changes needed to gather better data about the use of value-based payments. Lists duties of the commissioner in preparing the report, and requires health plan companies and third-party administrators to comply with data requests from the commissioner within 60 days after the request. Classifies data collected under this section as nonpublic data, and allows summary data prepared

Section	Description - Article 3: Department of Health

under this section to be derived from nonpublic data. Requires the commissioner to establish procedures to protect the integrity and confidentiality of this data.

197 **Return of charitable assets.**

Requires a health system that is a charitable organization and includes M Health Fairview University of Minnesota Medical Center to return to the general fund any charitable assets the health system received from the state, if the health system sells or transfers control to an out-of-state nonprofit entity or to a for-profit entity. This section is effective the day following final enactment and applies to transactions completed on or after that date.

198 **Study and recommendations; nonprofit health maintenance organization conversions and other transactions.**

Requires the commissioner of health to study and make recommendations on the regulation of conversions, mergers, transfers of assets, and other transactions affecting nonprofit and for-profit health maintenance organizations. Lists elements the recommendations must address. In conducting the study, allows the commissioner to use data the commissioner already holds from health maintenance organizations or health carriers, and to collect additional data from health maintenance organizations and related companies. Classifies data collected by the commissioner. Requires the commissioner to seek public comments on the regulation of conversion transactions. Allows the commissioner to use existing enforcement authority if a health maintenance organization fails to comply with a request for information. Requires preliminary findings to be submitted to certain members of certain legislative committees by January 15, 2024, and requires a final report to be submitted to the legislature by June 30, 2024.

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

Requires the commissioner of health, in consultation with an advisory committee, to develop recommendations for a statewide registry of provider order for life-sustaining treatment (POLST) forms to ensure the treatment preferences of patients with advanced, serious illness who are nearing the end of life are honored by health care providers. Lists subjects on which the commissioner must develop recommendations. Requires the commissioner to submit recommendations on establishing the statewide registry to certain members of the legislature by February 1, 2024, and to implement the registry by December 1, 2024.

200 **Vaccines for uninsured and underinsured adults.**

Requires the commissioner of health to administer a program to provide vaccines to uninsured and underinsured adults. Requires the commissioner to determine

Section	Description - Article 3: Department of Health

eligibility and enroll clinics to participate in the program, and requires the commissioner to address racial and ethnic disparities in vaccine coverage rates.

201 **Workplace safety grants; health care entities and human services providers.**

Directs the commissioner of health to award workplace safety grants to health care entities and human services providers.

Subd. 1. Grant program established. Requires the commissioner to award grants to health care entities and human services providers to increase workplace safety in health care settings and human services workplaces.

Subd. 2. Eligible applicants; application. Lists entities eligible for a grant under this section, and requires an entity seeking a grant to submit an application that includes the listed information.

Subd. 3. Grant awards. Requires grants to be awarded on a first-come, first-served basis; requires 40 percent of grant awards to be made to applicants outside the seven-county metro area; and requires awards to be between $5,000 and $100,000.

Subd. 4. Allowable uses of grant funds. Specifies allowable uses of grant funds: procurement and installation of safety equipment, staff training, facility safety improvements, support services and counseling, implementation of an internal incident tracking system, and other prevention and mitigation measures the commissioner determines to be appropriate. Establishes restrictions for the use of certain types of safety equipment and for the use of safety equipment in certain settings. Provides that video, audio, and personally identifiable information collected with safety equipment funded with grant funds must be treated according to federal law, must be subject to applicable rules of evidence and procedure, and must not result in the denial or delay of services provided.

Subd. 5. Report. Requires grant recipients to report to the commissioner on the use of the grant funds, and requires the commissioner to submit a compilation of the reports to certain members of the legislature, the Office of Ombudsman for Long-Term Care, and the Office of Ombudsman for Mental Health and Developmental Disabilities.

Subd. 6. Technical assistance. Requires the commissioner to provide technical assistance to grant applicants during the grant process and to applicants and recipients regarding grant distribution and required reporting.

202 **Task Force on Pregnancy Health and Substance Use Disorders.**

Establishes a Task Force on Pregnancy Health and Substance Use Disorders to recommend protocols for when health care providers should order toxicology testing

Section	Description - Article 3: Department of Health

for a birthing parent and newborn and protocols for reporting prenatal exposure to a controlled substance to a local welfare agency. Specifies task force membership, and requires appointments to be made by October 1, 2023. Requires the first meeting to occur by October 15, 2023, and provides that task force meetings are subject to the Open Meeting Law. Requires the commissioner of health to provide administrative support and meeting space. Requires the task force to submit a written report to certain members of the legislative committees with jurisdiction over health and human services by December 1, 2024. Provides the task force expires December 1, 2024, or upon submission of the required report, whichever is later.

203 **Revisor instruction.**

Para. (a) directs the revisor of statutes to change “cancer surveillance system” to “cancer reporting system” in statutes and rules.

Para. (b) directs the revisor of statutes to change the headnote for Minnesota Statutes, section 145.423, to read "Recognition of Infant Who Is Born Alive."

Para. (c) directs the revisor to move definitions from section 144.7055 to a definitions section being established, section 144.7051, and to make necessary technical and cross-reference changes.

204 **Repealer.**

Para. (a) repeals the following rules, effective January 1, 2024:

- Minnesota Rules, parts 4640.1500-4640.6400 (hospital licensing and operations rules governing lab and x-ray services; accommodations, furnishings, and equipment for care; food service and food sanitation; physical plant; mental and psychiatric hospitals; and chronic disease hospitals);
- Minnesota Rules, parts 4645.0300-4645.5200 (hospital construction and equipment rules governing design and construction; facility requirements for general hospitals and for specialized units in general hospitals; facility requirements for chronic disease hospitals; structural work, mechanical work, electrical, elevator, and service facilities requirements for all hospitals; and requirements for plans and specifications for all hospitals).

Para. (b) repeals the following statutes:

- 62J.84, subd. 5 (reporting requirements for prices of newly acquired drugs);
- 62U.10, subds. 6, 7, 8 (requiring the commissioner of health to annually report on projected and actual public and private spending for Minnesota residents for specified health indicators and requiring certain transfers based on these reports);

Section	Description - Article 3: Department of Health

- 144.059, subd. 10 (sunset for Palliative Care Advisory Council);
- 144.9505, subd. 3 (requiring the commissioner of health to provide health and safety information on lead abatement and lead hazard reduction to all residential building contractors);
- 145.4235 (positive abortion alternatives grant program); and
- 153A.14, subd. 5 (authorizing the commissioner of health to adopt rules to implement chapter 153A governing hearing aid dispensers).

Para. (c) repeals Minn. Rules, part 4615.3600 (requiring ambulatory facilities to report statistical data on pregnancy terminations to the commissioner of health) effective the day following final enactment.

Para. (d) repeals Minn. Rules, parts 4700.1900-4700.2500 (family planning special project grants application and distribution requirements).

Para (e) repeals the following statutes, effective the day following final enactment:

- 62Q.145 (requirement for health plan company policies on scope of practice for performing abortions);
- 145.1621 (requirements for disposition of aborted or miscarried fetuses);
- 145.411, subds. 2, 4 (definitions of viable and abortion facility)
- 145.412 (requirements for performing abortions, criminal penalty for violations);
- 145.413, subds. 2, 3 (requiring reports to the commissioner of health if a woman who had an abortion dies within a certain period after the abortion, criminal penalty for violations);
- 145.4131-145.4136 (requirements for reporting abortions and abortion complications to the commissioner of health, annual report by the commissioner, enforcement);
- 145.415 (recognition of potentially viable fetus that is live born after attempted abortion as a human person);
- 145.416 (requiring the commissioner of health to license and adopt rules for abortion facilities);
- 145.423, subds. 2-9 (Born Alive Infants Protection Act);
- 145.4241-145.4249 (informed consent and waiting period before the performance of an abortion);
- 256B.011 (statement that Minnesota gives preference to childbirth over abortion);
- 256B.40, 261.28, 393.07, subd. 11 (prohibits state and local funds from being used for abortions that are not eligible for funding under other state law).

Article 4: Medical Education and Research Costs

This article modifies the medical education and research costs (MERC) program to comply with federal rules. It adds a rate factor to medical assistance fee-for-service rates paid to hospitals that qualify for MERC funds, and removes MERC costs from managed care rates. It provides that the commissioner of health must distribute money deposited in the MERC account to eligible training sites that do not qualify for a MERC rate factor, reduces the amount of revenue from cigarette taxes annually deposited in the MERC account, and eliminates grants to the university's medical school.

Section	Description - Article 4: Medical Education and Research Costs
1	**Definitions.** Amends § 62J.692, subd. 1. Amends the definition of clinical medical education program for a section governing the medical education and research costs (MERC) program to specify that training doctor of pharmacy practitioners includes training students and residents and that training dentists includes training dental students and residents.
2	**Application process.** Amends § 62J.692, subd. 3. In a subdivision governing the process for clinical medical education programs to apply for MERC funds, strikes language requiring applications to be submitted by October 1 prior to the year of distribution and listing information that must be included in an application. Instead requires an application to be submitted according to a timeline established by the commissioner of health, and to include information the commissioner deems necessary to determine program eligibility.
3	**Distribution of funds.** Amends § 62J.692, subd. 4. In a subdivision governing distribution of MERC funds by the commissioner of health, strikes language used to determine training site level grants and requiring distribution of funds based on the public program volume factor. Requires money for medical education and research costs distributed under this section to be awarded only to eligible training sites that do not qualify for a medical education and research cost rate factor, and requires distribution of this money according to a formula determined by the commissioner that considers the listed criteria. Allows an accredited sponsoring institution to disqualify a training site, rather than withhold payments, if contract requirements are not met. Allows the commissioner to develop a methodology to determine eligible costs for which MERC funds may be used, and to distribute undistributed money in a subsequent distribution cycle. Strikes para. (g), which allows the commissioner to use up to $150,000 in MERC funds for administrative expenses.

Section	Description - Article 4: Medical Education and Research Costs
4	**Report.** Amends § 62J.692, subd. 5. In para. (a), strikes language requiring a sponsoring institution to return funds received if the sponsoring institution fails to submit the grant verification report by the deadline. Removes language requiring grant verification reports to include information on the number of trainee FTEs, name of each funded program, and amount distributed to each training site. Strikes para. (c), which requires an annual summary report to the legislature on implementation of section 62J.692.
5	**Federal financial participation.** Amends § 62J.692, subd. 8. Directs the commissioner of human services to seek federal financial participation for revenue from cigarette taxes that are credited to the medical education and research costs account. Strikes language requiring the commissioner to use physician clinic rates to maximize federal financial participation.
6	**Clinical dental education innovation grants.** Adds § 144.1913. Requires the commissioner to award clinical dental education innovation grants to teaching institutions and clinical training sites for projects to increase dental access for underserved populations and promote innovative clinical training of dental professionals. Lists criteria for the commissioner to consider in awarding grants. Requires the commissioner to periodically evaluate the priorities in awarding grants to ensure they meet the changing workforce needs of the state. (Similar language is found in section 62J.692, subd. 7a, and that subdivision is being repealed.)
7	**Hospital payment rates.** Amends § 256.969, subd. 2b. For discharges on or after January 1, 2024, modifies payment rates for hospitals, other than critical access hospitals, under the medical assistance program for inpatient services, by adding a rate factor that is specific for each hospital that qualifies for a MERC distribution.
8	**Hospital outpatient reimbursement.** Amends § 256B.75. For services delivered on or after January 1, 2024, adjusts rates paid to critical access hospitals for outpatient, emergency, and ambulatory surgery services to include the amount of any MERC distributions made that were not included in the rate adjustment made by requiring addition of a rate factor under section 256.969, subd. 2b.

Section	Description - Article 4: Medical Education and Research Costs
9	**Tax and use tax on cigarettes.** Amends § 297F.10, subd. 1. Reduces the amount of revenue from cigarette taxes annually credited to the MERC account for distribution, from $3,937,000 to $3,788,000.
10	**Repealer.** Repeals: ▪ section 62J.692, subdivisions 4a (establishes an alternative distribution formula for MERC funds), 7 (requires the commissioner of human services to transfer certain amounts to the named entities for clinical medical education, medical education, and dental innovation grants), and 7a (requires the commissioner to award clinical medical education innovation grants to teaching institutions and clinical training sites); ▪ section 137.38, subdivision 1 (requires the Board of Regents to use funds transferred to it for medical education; the statute requiring the transfer of those funds is being repealed); and ▪ section 256B.69, subdivision 5c (requires the commissioner of human services to transfer an amount of state general fund money used to make capitated payments under the prepaid medical assistance program to the medical education and research fund).

Article 5: Health-Related Licensing Boards

This article modifies statutes governing ambulance services and ambulance service personnel, physicians, physician assistants, acupuncture practitioners, dietitians and nutritionists, marriage and family therapists, individuals and entities regulated by the Board of Pharmacy, alcohol and drug counselors, and individuals regulated by the Board of Dentistry. It also makes conforming changes.

Section	Description - Article 5: Health-Related Licensing Boards
1	**Scope.** Amends § 144E.001, subd. 1. Makes a technical change, to provide the definitions in section 144E.001 apply to chapter 144E.
2	**Medical resource communication center.** Adds subd. 8b to § 144E.001. Defines medical resource communication center for chapter 144E.

Section	Description - Article 5: Health-Related Licensing Boards
3	**Basic life support.** Amends § 144E.101, subd. 6. Requires a basic life support licensee's medical director to authorize basic life support ambulance personnel to administer opiate antagonists (under current law a medical director is permitted, but not required, to authorize personnel to administer opiate antagonists).
4	**Advanced life support.** Amends § 144E.101, subd. 7. Requires an advanced life support ambulance service to provide administration of opiate antagonists.
5	**General requirements.** Amends § 144E.103, subd. 1. Adds opiate antagonists to the required supplies and equipment an ambulance must carry.
6	**Reimbursement to ambulance services for volunteer education costs.** Amends § 144E.35. Increases the maximum amounts that an ambulance service may be reimbursed by the Emergency Medical Services Regulatory Board for costs for volunteer ambulance attendants to complete EMT education courses, from $600 to $900 for an initial education course, and from $275 to $375 for a continuing education course.
7	**Medical resource communication center grants.** Adds § 144E.53. Requires the EMS Regulatory Board to distribute grants on an annual basis to the two medical resource communication centers in operation in Minnesota before January 1, 2000.
8	**United States or Canadian medical school graduates.** Amends § 147.02, subd. 1. In a paragraph requiring applicants for a license to practice medicine to present evidence of completion of one year of clinical medical training, strikes language allowing this training to be graduate training not accredited by a national accrediting organization but approved by the board.
9	**Endorsement; reciprocity.** Amends § 147.03, subd. 1. Makes technical and clarifying changes to a subdivision governing licensure to practice medicine by endorsement or reciprocity, including removing the minimum score of 75 for the Special Purpose Examination of the Federation of State Medical Boards, and adding references to the Comprehensive Osteopathic Medical Licensing Examination to conform with other laws.

Section	Description - Article 5: Health-Related Licensing Boards

10 **Requirements.**

Amends § 147.037, subd. 1. Makes clarifying changes to a subdivision establishing licensure requirements to practice medicine for foreign medical school graduates, and lists acceptable osteopathic licensing examinations.

11 **Forms of disciplinary action.**

Amends § 147.141. Makes technical changes to a section governing disciplinary action against physicians.

12 **Forms of disciplinary action.**

Amends § 147A.16. Makes technical changes to a section governing disciplinary action against licensed physician assistants.

13 **Exceptions.**

Amends § 147B.02, subd. 4. Removes language requiring an acupuncture student's formal course of study to be approved by the Acupuncture Advisory Council in order for the student to practice acupuncture without a license. With this change, an acupuncture student may practice without a license if the student is studying in a formal course of study and if the student's practice is supervised.

14 **Licensure requirements.**

Amends § 147B.02, subd. 7. Makes technical and clarifying changes to a subdivision governing requirements for licensure as an acupuncture practitioner, including removing the requirement for a notarized copy of an applicant's National Certification Commission for Acupuncture and Oriental Medicine certification.

15 **Fee.**

Adds § 148.635. Establishes a $20 licensure verification fee for dieticians and nutritionists, and provides that the fee is nonrefundable.

16 **Licensure and application fees.**

Amends § 148B.392, subd. 2. Modifies licensure and application fees collected by the Board of Marriage and Family Therapy to provide fees established by the board cannot exceed the following amounts:

- application fee for the national examination, $150 ($110 in current law);
- application for the LMFT state examination, $150 ($110 in current law);
- annual renewal fee for LMFT license, $225 ($125 in current law);
- late fee for LMFT license renewal, $100 ($50 in current law);
- application fee for LMFT licensure by reciprocity, $300 ($220 in current law);
- fee for initial LAMFT license, $100 ($75 in current law);

Section	Description - Article 5: Health-Related Licensing Boards

- annual renewal fee for LAMFT license, $100 ($75 in current law);
- late fee for LAMFT renewal, $50 ($25 in current law);
- fee for emeritus status, $225 ($125 in current law).

17 **Former students.**

Amends § 148F.11 by adding subd. 2a. Allows a former student to practice alcohol and drug counseling at the site where the student completed their internship for 90 days from the former student's degree conferral date or date of last credit received; requires former student practice to be supervised; specifies that former student practice is paid; specifies that this practice automatically expires after 90 days.

18 **Grounds.**

Amends § 150A.08, subd. 1. Makes a technical change to a subdivision establishing grounds for disciplinary action against dentists, dental hygienists, dental therapists, and dental assistants.

19 **Medical examinations.**

Amends § 150A.08, subd. 5. Makes a technical change to a subdivision authorizing the Board of Dentistry to require a licensee or applicant to submit to a mental or physical examination or assessment in certain circumstances.

20 **Mailing list services.**

Adds subd. 23 to § 150A.091. Requires a licensee of the Board of Dentistry to pay a nonrefundable $5 fee to obtain a mailing address list of licensees.

21 **Failure to report.**

Amends § 150A.13, subd. 10. Strikes an obsolete date in a subdivision authorizing civil penalties against certain persons and entities that fail to comply with requirements to report to the Board of Dentistry.

22 **Practice of pharmacy.**

Amends § 151.01, subd. 27. Modifies authority for pharmacists to administer influenza and COVID-19 vaccines, to allow administration of COVID-19 vaccines authorized by the FDA and to require pharmacists to have a current certificate in CPR in order to administer vaccines. A new para. (b) allows a pharmacist to delegate administration of vaccines to a pharmacy technician or pharmacist intern if the technician or intern satisfies the listed requirements and is supervised by a pharmacist.

Section	Description - Article 5: Health-Related Licensing Boards

23 **Application fees.**

Amends § 151.065, subd. 1. Modifies the following application fees for licensure and registration collected by the Board of Pharmacy:

- pharmacist licensed by examination, $210 ($175 in current law);
- pharmacist licensed by reciprocity, $300 ($275 in current law);
- pharmacy intern, $75 ($50 in current law);
- pharmacy technician, $60 ($50 in current law);
- pharmacy, $300 ($260 in current law);
- drug wholesaler, legend drugs only, $5,300 ($5,260 in current law);
- drug wholesaler, nonlegend drugs, veterinary legend drugs, or both, $5,300 ($5,260 in current law);
- drug wholesaler, legend and nonlegend drugs, $5,300 ($5,260 in current law);
- drug wholesaler, medical gases, $5,300 for the first facility and $300 for each additional ($5,260 and $260 in current law);
- third-party logistics provider, $300 ($260 in current law);
- drug manufacturer, nonopiate legend drugs only, $5,300 ($5,260 in current law);
- drug manufacturer, nonopiate legend and nonlegend drugs, $5,300 ($5,260 in current law);
- drug manufacturer, nonlegend or veterinary legend drugs, $5,300 ($5,260 in current law);
- drug manufacturer, medical gases, $5,300 for the first facility and $300 for each additional ($5,260 and $260 in current law);
- drug manufacturer, also licensed as a pharmacy, $5,300 ($5,260 in current law);
- drug manufacturer of opiate-containing controlled substances, $55,300 ($55,260 in current law);
- controlled substance researcher, $150 ($75 in current law).

24 **Original license fee.**

Amends § 151.065, subd. 2. Changes the pharmacist original licensure fee from $175 to $210.

25 **Annual renewal fees.**

Amends § 151.065, subd. 3. Modifies the following annual licensure and registration renewal fees collected by the Board of Pharmacy:

- pharmacist, $210 ($175 in current law);
- pharmacy technician, $60 ($50 in current law);

Section	Description - Article 5: Health-Related Licensing Boards

- pharmacy, $300 ($260 in current law);
- drug wholesaler, legend drugs only, $5,300 ($5,260 in current law);
- drug wholesaler, legend and nonlegend drugs, $5,300 ($5,260 in current law);
- drug wholesaler, nonlegend drugs, veterinary legend drugs, or both, $5,300 ($5,260 in current law);
- drug wholesaler, medical gases, $5,300 for the first facility and $300 for each additional ($5,260 for the first facility and $260 for each additional in current law);
- third-party logistics provider, $300 ($260 in current law);
- drug manufacturer, nonopiate legend drugs only, $5,300 ($5,260 in current law);
- drug manufacturer, nonopiate legend and nonlegend drugs, $5,300 ($5,260 in current law);
- drug manufacturer, nonlegend, veterinary legend drugs, or both, $5,300 ($5,260 in current law);
- drug manufacturer, medical gases, $5,300 for the first facility and $300 for each additional ($5,260 for the first facility and $260 for each additional in current law);
- drug manufacturer, also licensed as a pharmacy, $5,300 ($5,260 in current law);
- drug manufacturer of opiate-containing controlled substances, $55,300 ($55,260 in current law);
- controlled substance researcher, $150 ($75 in current law);
- pharmacy professional corporation, $150 ($100 in current law).

26 **Miscellaneous fees.**

Amends § 151.065, subd. 4. Modifies the following fees collected by the Board of Pharmacy:

- intern affidavit, $30 ($20 in current law);
- duplicate small license, $30 ($20 in current law).

27 **Reinstatement fees.**

Amends § 151.065, subd. 6. Modifies the fee collected by the Board of Pharmacy for a pharmacy technician to reinstate a registration following a lapse in registration, from $90 to $250.

28 **Medication repository program.**

Amends § 151.555.

Section **Description - Article 5: Health-Related Licensing Boards**

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.

29 **Children's residential facility substance use disorder treatment programs.**

Adds § 245A.245. For alcohol and drug counseling services provided by a former student at a children's residential facility substance use disorder treatment program, requires an alcohol and drug counselor to supervise and be responsible for services provided by the former student and to review and sign assessments, individual treatment plans, progress notes, and treatment plan reviews by the former student. Also requires a former student to receive orientation and training required of permanent staff members.

30 **Former student.**

Adds subd. 13c to § 245G.01. Defines former student for the chapter governing licensure to provide substance use disorder treatment.

31 **Student interns and former students.**

Amends § 245G.11, subd. 10. For alcohol and drug counseling services provided by a former student at a facility licensed to provide substance use disorder treatment, requires an alcohol and drug counselor to supervise and be responsible for services provided by the former student and to review and sign assessments, individual treatment plans, and treatment plan reviews by the former student. Requires former students to receive the orientation and training required for student interns, and adds former students to the requirement that no more than 50 percent of treatment staff may be students or candidates for licensure.

Section	Description - Article 5: Health-Related Licensing Boards
32	**Repealer.** Repeals Minn. Rules, parts 5610.0100, 5610.0200, and 5610.0300 (physician professional corporation rules: requirements for sworn statements to the board; suspension or revocation of license of shareholder, member, director, officer, employee, or agent of a corporation; requiring professional corporations to notify the board of certain events).

Article 6: Background Studies

This article establishes requirements for maltreatment and state licensing checks for guardians and conservators, provides for electronic access to notices and documents through NETStudy 2.0 and an applicant portal, and modifies fees for a range of health and human services background studies.

Section	Description - Article 6: Background Studies
1	**Conservator.** Amends § 245C.02 by adding subd. 7a. Defines “conservator” in DHS background studies chapter.
2	**Guardian.** Amends § 245C.02 by adding subd. 11f. Defines “guardian” in DHS background studies chapter.
3	**NETStudy 2.0.** Amends § 245C.02, subd. 13e. Adds providing electronic access to notices for entities and background study subjects to list of NETStudy 2.0 functions.
4	**Licensed programs.** Amends § 245C.03, subd. 1. Adds to list of entities and individuals for whom the commissioner must conduct background studies, licensed treatment programs for persons with sexual psychopathic personality or sexually dangerous persons.
5	**Guardians and conservators; maltreatment and state licensing agency checks.** Proposes coding for § 245C.033. Establishes requirements for maltreatment and state licensing agency checks for guardians or conservators. **Subd. 1. Maltreatment data.** Outlines requirements for maltreatment data requests when a guardian or conservator has been a perpetrator of substantiated maltreatment of a minor or a vulnerable adult.

Section	Description - Article 6: Background Studies

Subd. 2. State licensing agency data. Requires the commissioner to provide the court with state licensing agency data for licenses directly related to the responsibilities of a guardian or conservator; lists agencies or entities from which data must be provided and specifies the data to be provided.

Subd. 3. Procedure; maltreatment and state licensing agency data. Outlines procedural requirements for guardian and conservator maltreatment and state licensing agency data check requests and for completion of the checks.

Subd. 4. Classification of maltreatment and state licensing agency data; access to information. Specifies that all data obtained by the commissioner for guardian and conservator maltreatment and state licensing agency data checks is private data.

6 **Individual studied.**

Amends § 245C.05, subd. 1. Requires background study subjects and entities to update contact information via NETStudy 2.0.

7 **Electronic transmission.**

Amends § 245C.05, subd. 4. Requires background study subjects to access documents electronically in the applicant portal; allows a study subject to request a variance to this requirement and request paper documentation.

8 **Background studies conducted by Department of Human Services.**

Amends § 245C.08, subd. 1. Adds paragraph (f), stating that background studies for licensed treatment programs for persons with sexual psychopathic personality or sexually dangerous persons must only include a review of certain listed information.

9 **State; national criminal history record check fees.**

Amends § 245C.10, subd. 1d. Allows the commissioner to increase background study fees commensurate with any increase in fees by the state Bureau of Criminal Apprehension. DHS can currently increase fees commensurate with national criminal history record check fees. Strikes language requiring the commissioner to report fee increases to the legislature.

10-28 **Background study fee increases.**

Sections 10 to 28 amend subdivisions of section 245C.10 to raise background study fees by $2, for the following:

- supplemental nursing services agencies;
- occupations regulated by the commissioner of health;
- personal care provider organizations;

Section	Description - Article 6: Background Studies

- temporary personnel agencies, educational programs, and professional services agencies;
- adult foster care and family adult day services;
- unlicensed home and community-based waiver providers;
- children's therapeutic services and supports providers;
- human services licensed programs;
- child care programs;
- community first services and supports organizations;
- providers of housing support;
- child protection workers or social services staff with responsibilities for child protective duties;
- providers of special transportation service;
- children's residential facilities;
- guardians and conservators (*fee adjusted from $110 to $50);
- providers of housing support services;
- early intensive developmental and behavioral intervention providers;
- Professional Educators Licensing Standards Board; and
- Board of School Administrators.

29 **Tribal organizations.**

Amends § 245C.10 by adding subd. 22. Requires the commissioner to recover the cost of background studies initiated by Tribal organizations related to adoption and child foster care. Specifies that fee amounts will be established through interagency agreement and that fees collected will be deposited into the state government special revenue fund, to be appropriated to the commissioner for conducting background studies. Provides a July 1, 2024, effective date.

30 **Use.**

Amends § 245C.32, subd. 2. Allows the commissioner to use the department's background study systems to share background study documentation electronically with entities and individuals who are background study subjects; makes conforming change related to fees.

31 **Maltreatment and state licensing agency checks; criminal history check.**

Amends § 524.5-118. Updates terminology to "maltreatment and state licensing agency checks and criminal history check" for guardians and conservators. Updates required data checks; modifies procedural requirements for guardian and conservator checks. Requires the commissioner to provide the court with maltreatment data within 25 working days of receiving a request.

Section	Description - Article 6: Background Studies
32	**Repealer.** Repeals §§ 245C.02, subd. 14b (definition of public law background study); 245C.031, subds. 5, 6, 7 (guardian and conservator alternative background studies); 245C.032 (public law background studies); and 245C.30, subd. 1a (public law background study variances).

Article 7: Behavioral Health

This article modifies grant program requirements; clarifies and outlines additional certified community behavioral health clinic (CCBHC) requirements, mental health provider qualifications, documentation, service provision requirements, and local agency allocations for substance use disorder treatment; modifies eligible vendors of comprehensive assessments; and establishes start-up and capacity-building grants.

Section	Description - Article 7: Behavioral Health
1	**Grant program established.** Amends § 245.4663, subd. 1. Adds preceptorships and funding training for workers to become supervisors to mental health provider supervision grant program purposes.
2	**Allowable uses of grant funds.** Amends § 245.4663, subd. 4. Adds preceptorships for students and funding training for workers to become supervisors to allowable uses for mental health provider supervision grant program funds.
3	**Data collection and outcome measurement.** Amends § 245.4901, subd. 4. Specifies that school-linked mental health grantees must provide data to the commissioner no more than twice per year; specifies data that must be reported.
4	**Consultation; grant awards.** Amends § 245.4901 by adding subd. 5. For the school-linked behavioral health grant program, requires the commissioner to consult with school districts that have not received grants but wish to collaborate with a community mental health provider. Requires the commissioner to work with culturally specific providers and to consider provider consistency when awarding grants.
5	**Definitions.** Amends § 245.735 by adding subd. 1a. Defines the following terms for sections governing CCBHCs: “alcohol and drug counselor;” “care coordination;” “community

Section	Description - Article 7: Behavioral Health

needs assessment;" "comprehensive evaluation;" "designated collaborating organization;" "functional assessment;" "initial evaluation;" "integrated treatment plan;" "medical director;" "mental health professional;" "mobile crisis services;" and "preliminary screening and risk assessment."

6 **Certified community behavioral health clinics.**

Amends § 245.735, subd. 3. Outlines and modifies CCBHC certification and recertification processes, certification requirements and reviews, and required services. Deletes language that is moved to different subdivisions.

Makes this section effective upon federal approval.

7 **Designated collaborating organizations.**

Amends § 245.735 by adding subd. 3a. Outlines requirements for a CCBHC to contract with a designated collaborating organization to provide specified services.

8 **Exemptions to host county approval.**

Amends § 245.735 by adding subd. 3b. Allows a CCBHC that meets the requirements under section 245.735 to receive the prospective payments for services without a county contract or county approval.

9 **Variances.**

Amends § 245.735 by adding subd. 3c. Allows the commissioner to grant a variance to CCBHC requirements if the variance does not conflict with federal requirements for MA reimbursement. Requires the commissioner to consult with stakeholders before granting variances.

10 **Evidence-based practices.**

Amends § 245.735 by adding subd. 3d. Requires the commissioner to issue a list of required evidence-based practices to be delivered by CCBHCs. Allows the commissioner to issue a list of recommended evidence-based practices and to update the list. Requires the commissioner to provide stakeholders with an opportunity to comment, at least 30 days before issuing the list or any revisions.

11 **Recertification.**

Amends § 245.735 by adding subd. 3e. Requires CCBHCs to apply for recertification every 36 months.

12 **Opportunity to cure.**

Amends § 245.735 by adding subd. 3f. Requires the commissioner to provide a formal written notice outlining a CCBHC certification determination and the process for corrective action required, within 30 calendar days of a site visit. Allows the

Section	Description - Article 7: Behavioral Health
	commissioner to reject an application if all corrective actions are not taken within 60 calendar days. Requires the commissioner to send a final decision on the corrected application within 30 calendar days of the entity's notice to the commissioner of corrective actions taken.
13	**Decertification process.** Amends § 245.735 by adding subd. 3g. Requires the commissioner to establish a decertification process for CCBHCs.
14	**Functional assessment requirements.** Amends § 245.735 by adding subd. 4a. Outlines functional assessment requirements for CCBHCs.
15	**Requirements for comprehensive evaluations.** Amends § 245.735 by adding subd. 4b. Requires a CCBHC to complete a comprehensive evaluation for all new clients within 60 calendar days of the preliminary screening and risk assessment. Outlines requirements for conducting comprehensive evaluations.
16	**Requirements for initial evaluations.** Amends § 245.735 by adding subd. 4c. Requires a CCBHC to complete either an initial evaluation or comprehensive evaluation within ten business days of the preliminary screening and risk assessment. Lists requirements for initial evaluations performed by a CCBHC.
17	**Requirements for integrated treatment plans.** Amends § 245.735 by adding subd. 4d. Requires a CCBHC to complete an integrated treatment plan within 60 calendar days of the preliminary screening and risk assessment. Requires updates to the plan at least every six months, or when the client's circumstances change. Outlines requirements for completing integrated treatment plans.
18	**Information systems support.** Amends § 245.735, subd. 5. Adds data reporting compliance to CCBHC information systems support to be provided.
19	**Section 223 of the Protecting Access to Medicare Act entities.** Amends § 245.735, subd. 6. Requires the commissioner to request federal approval to participate in the federal section 223 demonstration program and, if approved, to continue to participate in the program as long as federal funding is available. Adds paragraphs (b) and (c), requiring the commissioner to follow federal CCBHC payment

Section	Description - Article 7: Behavioral Health
	guidance and outlining additional payment requirements under the federal demonstration program. Makes this section effective upon federal approval.
20	**Addition of CCBHCs to section 223 state demonstration programs.** Amends § 245.735 by adding subd. 7. Requires the commissioner to follow all federal guidance on the addition of CCBHCs to the federal demonstration program, if approved. Requires a CCBHC to meet demonstration certification criteria and prospective payment system guidance, and be certified by the state, prior to participating in the federal demonstration; specifies additional compliance and reporting requirements for CCBHCs participating in the demonstration.
21	**Grievance procedures required.** Amends § 245.735 by adding subd. 8. Requires CCBHCs and designated collaborating organizations to allow all service recipients access to grievance procedures that meet specific minimum requirements.
22	**Mental health rehabilitation worker qualifications.** Amends § 245I.04, subd. 14. Adds requirements for mental health rehabilitation workers to have initial training required under section 245I.05, subd. 3; exempts mental health rehabilitation workers who exclusively staff overnight shifts from certain qualification requirements.
23	**Mental health behavioral aide qualifications.** Amends § 245I.04, subd. 16. Adds requirement for level 1 and level 2 mental health behavioral aides to have initial training under section 245I.05, subd. 3.
24	**Initial training.** Amends § 245I.05, subd. 3. Strikes “clinical trainee” from initial training requirements for direct contact mental health services.
25	**Documentation standards.** Amends § 245I.08, subd. 2. Clarifies client record and personnel file documentation requirements.
26	**Documenting approval.** Amends § 245I.08, subd. 3. Extends time from five to 30 days for a treatment supervisor to document approval of assessments and treatment plans completed by clinical trainees or mental health practitioners.

Section	Description - Article 7: Behavioral Health
27	**Progress notes.** Amends § 245I.08, subd. 4. Removes requirement to list the service modality within the documentation of the scope of a service in progress notes.
28	**Generally.** Amends § 245I.10, subd. 2. Modifies diagnostic assessment requirements by allowing an update to a client's diagnostic assessment rather than only a new assessment, removing the annual requirement based on client need, and adding that a client can request an update or new assessment. Simplifies written update requirements.
29	**Continuity of services.** Amends § 245I.10, subd. 3. Extends expiration of subdivision extending validity of diagnostic assessments completed before July 1, 2022, from July 1, 2023, to October 17, 2023.
30	**Brief diagnostic assessment; required elements.** Amends § 245I.10, subd. 5. Removes language so that a brief diagnostic assessment may be used for a client who is under six years old.
31	**Standard diagnostic assessment; required elements.** Amends § 245I.10, subd. 6. Removes specified assessment instruments for child clients, and allows information from other providers or prior assessments to be used in a diagnostic assessment if the information source is documented.
32	**Individual treatment plan.** Amends § 245I.10, subd. 7. Makes clarifying change.
33	**Individual treatment plan; required elements.** Amends § 245I.10, subd. 8. Makes clarifying changes for when a licensed provider receives a diagnostic assessment from a different provider.
34	**Storing and accounting for medications.** Amends § 245I.11, subd. 3. Modifies requirements so that only specific Schedule II drugs must be separately locked by a license holder; removes requirement for documentation procedures on each shift.
35	**Medication orders.** Amends § 245I.11, subd. 4. Removes requirement for a license holder to obtain psychotropic medication prescription renewals for each client every 90 days and annually for other prescription renewals.

Section	Description - Article 7: Behavioral Health
36	**Treatment supervision specified.** Amends § 245I.20, subd. 5. Strikes paragraph (b), containing treatment supervision case review requirements for mental health professionals supervising mental health practitioners and clinical trainees.
37	**Additional policy and procedure requirements.** Amends § 245I.20, subd. 6. Adds paragraph (d), requiring psychiatry billed as evaluation and management services to be documented in accordance with current procedural terminology published by the American Medical Association.
38	**Local agency allocation.** Amends § 254B.02, subd. 5. Modifies administrative adjustment payments to local agencies to allocations for supporting individuals with substance use disorders; modifies cap on payments so that payments must not be less than 133 percent of the local agency payment for the 2009 fiscal year. Provides an immediate effective date.
39	**Licensure required.** Amends § 254B.05, subd. 1. Adds paragraph specifying that hospitals, federally qualified health centers, and rural clinics are eligible vendors of a comprehensive assessment, completed by an alcohol and drug counselor who is individually enrolled with the commissioner. Makes this section effective upon federal approval.
40	**Room and board provider requirements.** Amends § 254B.05, subd. 1a. Adds programs providing children's residential mental health services, except for child protection or voluntary foster care for treatment placements, to list of vendors eligible for room and board payments from the behavioral health fund.
41	**Purpose.** Amends § 256.478, subd. 1. Modifies transition to community initiative terminology to include children; adds access to services supporting short- and long-term needs for developmental growth and individualized treatment.
42	**Eligibility.** Amends § 256.478, subd. 2. Modifies transition to community initiative terminology to include children; modifies eligibility criteria to include a demonstration that current services are not able to meet community-based treatment or service needs.

Section	Description - Article 7: Behavioral Health
	Expands list of residential or hospital-level care settings; adds criteria for needs beyond current service designs. Makes section effective July 1, 2023.
43	**Eligibility.** Amends § 256B.0616, subd. 3. Makes the provision of family peer support services mandatory, if medically necessary, rather than optional, for recipients eligible for the services under medical assistance. Makes section effective January 1, 2024, or upon federal approval, whichever is later.
44	**Peer support specialist program providers.** Amends § 256B.0616, subd. 4. Adds requirement for the commissioner to develop a process to certify family and youth peer support specialist programs and training support.
45	**Certified family and youth peer specialist training and certification.** Amends § 256B.0616, subd. 5. Allows the commissioner to approve, rather than only to develop, a training and certification process for family and youth peer specialists. Adds requirements for youth peer specialist candidates. Allows training to be delivered by the commissioner or by organizations approved by the commissioner. Makes section effective January 1, 2024, or upon federal approval, whichever is later.
46	**Assertive community treatment team staff requirements and roles.** Amends § 256B.0622, subd. 7a. Removes requirement for an assertive community treatment team leader mental health professional who is unlicensed but eligible for licensure and otherwise qualified to obtain licensure within 24 months. Removes requirement for team leader to provide treatment supervision. Allows the team leader to delegate overall treatment supervision duties to another qualified licensed professional at any time.
47	**Assertive community treatment program size and opportunities.** Amends § 256B.0622, subd. 7b. Removes requirement for a minimum of 8-hour shift coverage for assertive community treatment team staff.
48	**Assertive community treatment program organization and communication requirements.** Amends § 256B.0622, subd. 7c. Removes minimum weekly client services for assertive community treatment teams; requires services at a frequency that meets client needs.

Section	Description - Article 7: Behavioral Health
49	**Medical assistance payment for assertive community treatment and intensive residential treatment services.** Amends § 256B.0622, subd. 8. Allows assertive community treatment, intensive residential treatment services, and residential crisis services providers to include in their prospective cost-based rate-setting methodology a line item reflecting estimated additional staffing compensation costs, subject to review by the commissioner. Allows intensive residential treatment services and residential crisis services providers to include in their prospective cost-based rate-setting methodology a line item reflecting estimated new capital costs, subject to review by the commissioner.
50	**Provider entity standards.** Amends § 256B.0623, subd. 4. Removes adult rehabilitative mental health services requirement for noncounty providers to obtain additional certification from each county in which services would be provided. Modifies state-level recertification requirement to every three years, instead of at least every three years.
51	**Behavioral health home services staff qualifications.** Amends § 256B.0757, subd. 4c. Modifies behavioral health home services integration specialist language to allow a licensed practical nurse to serve in the role.
52	**Sleeping hours.** Amends § 256B.0941, subd. 2a. For psychiatric residential treatment facilities, requires at least one staff member present during sleeping hours to be trained and certified to provide emergency medical response; requires a registered nurse to be available on call and available within 60 minutes during sleeping hours.
53	**Crisis assessment and intervention staff qualifications.** Amends § 256B.0624, subd. 5. Adds that at least 6 hours of the required ongoing training for crisis assessment and intervention staff must be specific to working with families and providing crisis stabilization services to children; lists topics that must be included in such training.
54	**Crisis stabilization staff qualifications.** Amends § 256B.0624, subd. 8. Adds that at least 6 hours of the required ongoing training for mental health crisis stabilization staff must be specific to working with families and providing crisis stabilization services to children; lists topics that must be included in such training.

Section	Description - Article 7: Behavioral Health

55 **Certified community behavioral health clinic services.**

Amends § 256B.0625, subd. 5m. Modifies rebasing for CCBHC rates from every three years to every two years; specifies that if the commissioner has not reentered the CCBHC federal demonstration program by July 1, 2023, CCBHCs will be paid the daily bundled rate under this section. Adds paragraph (g), specifying that medically necessary peer services provided by a CCBHC are covered under MA.

Makes this section effective July 1, 2023, or upon federal approval, whichever is later.

56 **Shared site.**

Amends § 256B.0941 by adding subd. 2b. Allows for services related to but distinctly separate from psychiatric residential treatment services to be delivered in the same facility. Specifies that shared site staff must only provide services within the program with which they are officially affiliated.

57 **Start-up and capacity-building grants.**

Amends § 256B.0941 by adding subd. 5. Specifies the allowable uses for start-up grants to prospective psychiatric residential treatment facility sites; specifies that start-up and capacity-building grants to prospective and current psychiatric residential treatment facilities may be used to support providers who treat and accept individuals with complex support needs.

Makes this section effective July 1, 2023.

58 **Young adult continuity of care.**

Amends § 256B.0947 by adding subd. 10. Allows a client to continue to receive services from the client's children's intensive behavioral health services or youth ACT providers until the client is 27 years old.

59 **Managed care contracts.**

Amends § 256B.69, subd. 5a. Adds paragraph (n), directing the commissioner, effective January 1, 2024, to require in a contract that all managed care use timely 12-month claim filing timelines and use remittance advice and prior authorizations timelines consistent with those used under medical assistance fee-for-service for mental health and substance use disorder treatment services. Prohibits a managed care plan under this section from taking back funds paid to a mental health and substance use disorder treatment provider after six months.

60 **Qualified residential treatment program.**

Amends § 260C.007, subd. 26d. Specifies that qualified residential treatment program aftercare support may include mental health certified family and youth peer specialists.

Section	Description - Article 7: Behavioral Health
61	**Local agency substance use disorder allocation.** Directs the commissioner to evaluate the ongoing need for local agency substance use disorder allocations. Specifies what the evaluation must include; allows the commissioner to contract with a vendor to support the evaluation. Provides an immediate effective date.
62	**Rate increase for mental health adult day treatment.** Directs the commissioner to increase the adult day treatment reimbursement rates by 50 percent over the June 30, 2023, rates. Makes this section effective January 1, 2024, or upon federal approval, whichever is later.
63	**Room and board costs in children's residential facilities.** Requires the commissioner to update the behavioral health fund room and board rate schedule to include specified children's residential facility services; requires rates to be commensurate with current room and board rates for adolescent SUD treatment programs. Makes this section effective July 1, 2023.
64	**Direction to the commissioner; early intervention and prevention services.** Directs the commissioner to make the International Classification of Diseases, Tenth Revision V and Z codes available to MA and MinnesotaCare enrolled professionals to provide early intervention and prevention services, under the supervision of a mental health professional, for up to six months.

Article 8: Department of Human Services Policy

This article contains Department of Human Services policy and technical provisions related to mental health services, grant programs, medical assistance room and board, general assistance, supportive housing, and economic assistance programs.

Section	Description - Article 8: Department of Human Services Policy
1	**Services and programs.** Amends § 245.4661, subd. 9. Removes intensive community rehabilitative mental health services from list of services eligible for adult mental health grants.

Section	Description - Article 8: Department of Human Services Policy
2	**Mental health crisis services.** Amends § 245.469, subd. 3. Adds reference to crisis response services section. Provides an immediate effective date.
3	**Cultural and ethnic minority infrastructure grant program.** Proposes coding for § 245.4907. Codifies the cultural and ethnic minority infrastructure grant program (CEMIG). Requires the commissioner of human services to establish a cultural and ethnic minority infrastructure grant program, to ensure that behavioral health supports and services are culturally specific and culturally responsive. Outlines grant applicant eligibility and allowable grant activities; adds allowable grant activities for children's residential facility interpreter services and case-specific consultation; requires the commissioner to assist grantees with meeting third-party credentialing requirements; requires grantees to obtain all available third-party reimbursement sources; and specifies that grantees must serve individuals from cultural and ethnic minority communities regardless of health coverage or ability to pay for services. Requires grantees to provide regular data to the commissioner, to evaluate grant program effectiveness; lists evaluation criteria. Provides an immediate effective date.
4	**Mental health certified peer specialist grant program.** Proposes coding for § 245.4906. Codifies the mental health certified peer specialist grant program, to provide funding for mental health certified peer specialist training. Provides information on mental health certified peer specialist services and qualifications. Specifies eligible grant activities and outcome evaluation requirements. Provides an immediate effective date.
5	**Mental health certified family peer specialist grant program.** Proposes coding for § 245.4907. Codifies the mental health certified family peer specialist grant program, to provide funding for mental health certified family peer specialist training. Provides information on mental health certified family peer specialist services and qualifications. Specifies eligible grant activities and outcome evaluation requirements. Provides an immediate effective date.

Section	Description - Article 8: Department of Human Services Policy
6	**Projects for assistance in transition from homelessness program.** Proposes coding for § 245.991. Establishes the projects for assistance in transition from homelessness program, to prevent or end homelessness for people with serious mental illness or co-occurring substance use disorder, and meet the commissioner's housing mission statement goals. Lists eligible grant activities, program eligibility requirements, and outcome evaluation requirements; specifies that the commissioner must comply with all federal aid or grant requirements. Provides an immediate effective date.
7	**Housing with support for adults with serious mental illness program.** Proposes coding for § 245.992. Establishes the housing with support for adults with serious mental illness program, to prevent or end homelessness for people with serious mental illness, increase availability of housing with support, and meet the commissioner's housing mission statement goals. Lists eligible grant activities, program eligibility requirements, and outcome evaluation requirements. Provides an immediate effective date.
8	**Authorized uses of grant funds.** Amends § 256.478, by adding subd. 3. Lists allowable uses of transition to community initiative grant funds. Provides an immediate effective date.
9	**Outcomes.** Amends § 256.478, by adding subd. 4. Lists program outcomes for the transition to community initiative. Provides an immediate effective date.
10	**Medical assistance room and board rate.** Amends § 256B.056, by adding subd. 5d. Defines "medical assistance room and board rate" in the chapter of statutes governing medical assistance. This language is moved from section 256I.03, subdivision 6.
11	**Medical assistance payment for assertive community treatment and intensive residential treatment services.** Amends § 256B.0622, subd. 8. Makes technical change related to medical assistance room and board rate.

Section	Description - Article 8: Department of Human Services Policy
12	**Excluded services.** Amends § 256B.0946, subd. 6. Makes technical change related to medical assistance room and board rate.
13	**Noncovered services.** Amends § 256B.0947, subd. 7a. Makes technical change related to medical assistance room and board rate.
14	**Date of application.** Amends § 256D.02, by adding subd. 20. Defines “date of application” in the chapter of statutes governing general assistance.
15	**Time of payment of assistance.** Amends § 256D.07. Removes certain general assistance application requirements and requires applications to be submitted according to the chapter of statutes governing economic assistance program eligibility and verification. Modifies the timeline for which the first month’s grant must cover.
16	**Supportive housing.** Amends § 256I.03, subd. 15. Modifies the definition of “supportive housing” in the chapter of statutes governing housing support to specify supportive housing does not include licensed assisted living facilities.
17	**Date of application.** Amends § 256I.03, by adding subd. 16. Defines “date of application” in the chapter of statutes governing housing support.
18	**Date of eligibility.** Amends § 256I.04, subd. 2. Modifies the date of eligibility for housing assistance to conform to changes in application requirements under the chapter of statutes governing economic assistance eligibility and verification.
19	**Filing of application.** Amends § 256I.06, subd. 3. Modifies application requirements for housing support to conform to changes related to applications in the chapter of statutes governing economic assistance eligibility and verification.
20	**Community living infrastructure.** Amends § 256I.09. Allows the commissioner to award community living infrastructure grants to multi-Tribal collaboratives.

Section	Description - Article 8: Department of Human Services Policy
21	**Date of application.** Amends § 256J.08, subd. 21. Modifies the definition of "date of application" in the chapter of statutes governing MFIP to conform to changes related to application requirements in the chapter of statutes governing economic assistance eligibility and verification.
22	**Submitting application form.** Amends § 256J.09, subd. 3. Makes conforming changes to MFIP application requirements to align with changes in the chapter of statutes governing economic assistance eligibility and verification.
23	**Submitting application form.** Amends § 256J.95, subd. 5. Makes conforming changes to DWP application requirements to align with changes in the chapter of statutes governing economic assistance eligibility and verification.
24	**Date of application.** Amends § 256P.01, by adding subd. 2b. Defines "date of application" in the chapter of statutes governing economic assistance eligibility and verification.
25	**Application submission.** Amends § 256P.04, by adding subd. 1a. Lays out application requirements for programs governed by the economic assistance eligibility and verification chapter of statutes.
26	**Revisor instruction.** Instructs the revisor of statutes to: (1) renumber the subdivisions in the statutes containing definitions for the general assistance and housing support programs so that the definitions are in alphabetical order; and (2) correct any cross-references that change as a result of the renumbering.
27	**Repealer.** Repeals Minn. Stat. § 256I.03, subd. 6 (medical assistance room and board rate). This language was moved to § 256B.056, subd. 5d.

Article 9: Department of Human Services Operations Policy

This article makes technical, clarifying, and policy changes to provisions governing licensing and background studies conducted by the Department of Human Services and to medical assistance program integrity and review procedures.

Section	Description - Article 9: Department of Human Services Operations Policy
1	**Background study required.** Amends § 62V.05, subd. 4a. Modifies MNsure navigator background study requirements related to the board's duties to evaluate disqualification notifications from the Department of Human Services; makes clarifying changes.
2	**Background studies.** Amends § 122A.18, subd. 8. Makes clarifying changes related to background studies for educator and administrator licenses.
3	**Controlling individual.** Amends § 245A.02, subd. 5a. Expands the definition of "controlling individual" for purposes of DHS licensing to include the president and treasurer of the board of directors of a nonprofit corporation.
4	**Owner.** Amends § 245A.02, subd. 10b. Modifies the definition of "owner" for purposes of DHS licensing. Provides that the "owner of an employee stock ownership plan" means the president and treasurer of the entity and provides that a nonprofit corporation issued a licensed under the chapter is designated as an owner.
5	**Application for licensure.** Amends § 245A.04, subd. 1. Paragraph (a) corrects a statutory cross-reference. Paragraphs (f), (g), and (h) provide that specified applicants for licenses under the chapter must provide an e-mail address that will be made public. Provides an immediate effective date.
6	**Grant of license; license extension.** Amends § 245A.04, subd. 7. Paragraph (a) adds "public e-mail address of the program" to the list of information that must be stated on a license issued under the chapter. Paragraph (b) makes technical changes. Paragraph (d) provides that the commissioner cannot issue or reissue a license if an applicant, license holder, or controlling individual fails to submit specified information related to the Child and Adult Care Food Program. Provides an immediate effective date.
7	**First date of direct contact; documentation requirements.** Amends § 245A.041 by adding subd. 6. Requires that license holders document the first date that a background study subject has direct contact with a person served by the license holder's program and either maintain documentation of the first contact in personnel files or provide the documentation to the commissioner upon request. Exempts family child care, family foster care for children, and family adult day services from the requirement. Provides a January 1, 2024, effective date.

Section	Description - Article 9: Department of Human Services Operations Policy

8 **Immediate suspension expedited hearing.**

Amends § 245A.07, subd. 2a. Modifies the commissioner's process for determining licensing sanctions after a final order affirming an immediate suspension.

9 **License suspension, revocation, or fine.**

Amends § 245A.07, subd. 3. Allows the commissioner to suspend a license if persons served by a program are at imminent risk of harm while investigations or judicial proceedings that are necessary for determining a final licensing sanction are ongoing.

10 **Application fee for initial license or certification.**

Amends § 245A.10, subd. 3. Makes technical conforming changes. Provides an immediate effective date.

11 **License or certification fee for certain programs.**

Amends § 245A.10, subd. 4. Makes technical conforming changes. Provides an immediate effective date.

12 **Delegation of authority to agencies.**

Amends § 245A.16, subd. 1. Removes language related to family child care background studies performed by county or private agencies; removes obsolete language about background study requirements. Provides an immediate effective date.

13 **Prone restraint prohibition.**

Creates § 245A.211.

Subd. 1. Applicability. Applies the section to all programs licensed or certified under the specified chapters of statute.

Subd. 2. Definitions. Defines "mechanical restraint," "prone restraint," and "restraint."

Subd. 3. Prone restraint prohibition. Prohibits a license or certification holder from using a prone restraint on any person receiving services in a program, except in the specified circumstances.

Subd. 4. Contraindicated physical restraints. Prohibits a license or certification holder from implementing a restraint on a person receiving services in a program in a way that is contraindicated for any of the person's known medical or psychological conditions. Requires that a license or certification holder assess and document a determination of any medical or psychological conditions for which restraints are contraindicated prior to using restraints on a person.

Section	Description - Article 9: Department of Human Services Operations Policy
14	**Child care background study subject.** Amends § 245C.02, subd. 6a. Clarifies that a child care contractor is a background study subject if the contractor is providing services for hire in the program. Provides that newly defined terms do not apply for child care background study subjects.
15	**Entity.** Amends § 245C.02, subd. 11c. Adds license holder to the definition of "entity" for background study purposes.
16	**Employee.** Amends § 245C.02 by adding subd. 11f. Adds definition of "employee" for background study purposes.
17	**Volunteer.** Amends § 245C.02 by adding subd. 22. Adds definition of "volunteer" for background study purposes.
18	**Licensed program.** Amends § 245C.03, subd. 1. Strikes "contractor" term and strikes "independent living assistance for youth" from list of licensed programs. Provides an immediate effective date.
19	**Procedure.** Amends § 245C.03, subd. 1a. Adds reference to Bureau of Criminal Apprehension consent and self-disclosure.
20	**Personnel pool agencies; temporary personnel agencies; educational programs; professional services agencies.** Amends § 245C.03, subd. 4. Adds paragraph requiring personnel pool agencies, temporary personnel agencies, and professional services to employ the individuals providing direct care services; requires those individuals to be affiliated in NETStudy 2.0 and subject to oversight and direct supervision by the entity.
21	**Other state agencies.** Amends § 245C.03, subd. 5. Strikes "contractors."
22	**Facilities serving children or adults licensed or regulated by the Department of Health.** Amends § 245C.03, subd. 5a. Makes clarifying change; states that the Department of Human Services is not liable for conducting background studies that have been submitted or not removed from the roster.

Section	Description - Article 9: Department of Human Services Operations Policy
23	**Alternative background studies.** Amends § 245C.031, subd. 1. Adds reference to Bureau of Criminal Apprehension consent and self-disclosure.
24	**Applicants, licensees, and other occupations regulated by the commissioner of health.** Amends § 245C.031, subd. 4. Adds criminal history disclosure form to alternative background study requirements.
25	**Individual studied.** Amends § 245C.05, subd. 1. Provides that background study subjects who do not have a driver's license or state identification card may submit an acceptable form of identification as determined by the commissioner. Requires background study subjects to submit a criminal history disclosure form.
26	**Study submitted.** Amends § 245C.05 by adding subd. 8. Specifies that an entity with which the background study subject is seeking affiliation must initiate the NETStudy 2.0 background study.
27	**Study subject affiliated with multiple facilities.** Amends § 245C.07. Makes clarifying change; adds temporary personnel agencies.
28	**Temporary personnel agencies, personnel pool agencies, educational programs, and professional services agencies.** Amends § 245C.10, subd. 4. Adds personnel pool agencies to the list of agencies from which the commissioner of human services must recover the costs of background studies initiated by the agency.
29	**Board determines disciplinary or corrective action.** Amends § 245C.31, subd. 1. Removes paragraph that exempts individuals submitting a study for child foster care, adult foster care, or family child care licensure, from the requirement that the commissioner notify a health-related licensing board of a finding of substantiated maltreatment.
30	**Information commissioner reviews.** Amends § 245C.33, subd. 4. Removes language requiring the submission of the dates of adoption-related background studies and the names of the agencies that conducted the studies.

Section	Description - Article 9: Department of Human Services Operations Policy

31 **Behavior guidance.**

Amends § 245H.13, subd. 9. Prohibits certified, license-exempt child care centers from using prone restraints, as prohibited by section 245A.211, on children.

32 **Application procedures.**

Amends § 245I.20, subd. 10. For mental health provider certification, adds language allowing the commissioner to require the applicant or certification holder to provide an e-mail address for the certification holder that will be made public.

33 **Administrative reconsideration.**

Amends § 256.9685, subd. 1a. Provides that the commissioner must receive a request for reconsideration of a decision that inpatient hospital services are not medically necessary within 45 calendar days after the date of the notice of the decision was mailed. Specifies that a request for reconsideration must be reviewed by an independent medical review agent who shall make a recommendation to the commissioner. Provides that the commissioner's decision on reconsideration is final and not subject to appeal.

34 **Appeal of reconsideration.**

Amends § 256.9685, subd. 1b. Removes language regarding appeals of reconsideration decisions for inpatient hospital services determined to be medically unnecessary; specifies that the commissioner's decision is appealable only by petition for writ of certiorari under chapter 606.

35 **Medical review agent.**

Amends § 256.9685 by adding subd. 7a. Adds definition of "medical review agent" and specifies requirements.

36 **Utilization review.**

Amends § 256B.04, subd. 15. Makes clarifying change.

37 **Sanctions; monetary recovery.**

Amends § 256B.064. Makes clarifying changes; expands individuals against whom the commissioner may impose sanctions, to include any individual or entity that receives medical assistance payments or provides goods or services for which medical assistance payment is made; specifies meaning of "goods or services." In subdivision 2, allows the commissioner to issue fines in place of or in addition to full monetary recovery of the value of the claims submitted under subdivision 1c.

38 **Access to medical records.**

Amends § 256B.27, subd. 3. Specifies that the commissioner's access to medical records for fraud investigations must be in the manner and within the time

Section	Description - Article 9: Department of Human Services Operations Policy
	prescribed by the commissioner. Specifies admissibility of records for evidentiary purposes.
39	**Procedure; state licensing agency data.** Amends § 524.5-118, subd. 2a. Removes Department of Education from list of agencies for which the commissioner of human services must provide a court with specified licensing agency data for guardianship and conservatorship purposes.
40	**Revisor instruction.** Instructs the revisor to reorganize section 245C.02 as necessary.
41	**Repealer.** Repeals §§ 245A.22 (independent living assistance for youth); 245C.02, subdivision 9 (definition of “contractor”); 245C.301 (child care; notification of set-aside or variance); and 256.9685, subdivisions 1c and 1d (inpatient hospital services judicial review; transmittal of record). Repeals Minnesota Rules, parts 9505.0505, subpart 18 (definition of “medical review agent”); and 9505.0520, subpart 9b (reconsideration; physician advisers appointed by medical review agent). Provides an immediate effective date.

Article 10: Economic Assistance

This article makes changes to general assistance (GA), housing support, and MFIP related to increasing the GA standard of assistance, modifying drug testing requirements for GA, MSA, MFIP, and SNAP applicants and recipients, and creating income exclusions for census income and lived experience engagement income.

Section	Description - Article 10: Economic Assistance
1	**Standards.** Amends § 256D.01, subd. 1a. Increases the GA standard of assistance for single adults by making the standard equal to the cash portion of the MFIP transitional standard for a single adult. Provides an October 1, 2024, effective date.
2	**Person convicted of drug offenses.** Amends § 256D.024, subd. 1. Modifies requirements related to drug testing of individuals receiving GA benefits who have been convicted of a drug offense.

Section	Description - Article 10: Economic Assistance
	Requires counties to provide information about substance use disorder treatment programs to a person who tests positive for an illegal controlled substance. Provides an August 1, 2023, effective date.
3	**Eligibility requirements.** Amends § 256D.06, subd. 5. Increases the amount of time a GA recipient has to apply for federal disability benefits. Provides a January 1, 2024, effective date.
4	**Person convicted of drug offenses.** Amends § 256J.26, subd. 1. Modifies requirements related to drug testing of individuals receiving MFIP and SNAP benefits who have been convicted of a drug offense. Requires counties to provide information about substance use disorder treatment programs to a person who tests positive for an illegal controlled substance. Provides an August 1, 2023, effective date.
5	**Census income.** Amends § 256P.01, by adding subd. 2b. Defines “census income” in the chapter of statues governing economic assistance program eligibility verification.
6	**Lived-experience engagement.** Amends § 256P.01, by adding subd. 5a. Defines “lived-experience engagement” in the chapter of statutes governing economic assistance program eligibility and verification.
7	**Exemption.** Amends § 256P.02, subd. 1a. Exempts census income from the CCAP asset limit.
8	**Personal property limitations.** Amends § 256P.02, subd. 2. Excludes certain cash from personal property limitations under the chapter of statutes governing economic assistance program eligibility and verification.
9	**Health and human services recipient engagement income.** Amends § 256P.02, by adding subd. 4. Excludes income received from lived-experience engagement when determining the equity value of personal property for economic assistance programs.

Section	Description - Article 10: Economic Assistance
10	**Census income.** Amends § 256P.02, by adding subd. 5. Excludes census income when determining the equity value of personal property.
11	**Income inclusions.** Amends § 256P.06, subd. 3. Removes Tribal per capita payments from the list of unearned income that must be included when determining the income of an assistance unit under the chapter of statutes governing economic assistance program eligibility and verification.
12	**Recipient engagement income.** Amends § 256P.06, by adding subd. 4. Excludes income received from lived-experience engagement from being counted as income for purposes of determining or redetermining eligibility or benefits under the chapter of statutes governing economic assistance program eligibility and verification. Provides an August 1, 2024, effective date.
13	**Census income.** Amends § 256P.06, by adding subd. 5. Excludes census income from income calculations for purposes of determining or redetermining economic assistance eligibility or benefits.
14	**Benefit eligibility.** Amends § 609B.425, subd. 2. Modifies requirements related to drug testing of individuals receiving GA and MSA benefits who have been convicted of a drug offense. Requires counties to provide information about substance use disorder treatment programs to a person who tests positive for an illegal controlled substance. Provides an August 1, 2023, effective date.
15	**Drug offenders; random testing; sanctions.** Amends § 609B.435, subd. 2. Modifies requirements related to drug testing of individuals applying for MFIP benefits who have been convicted of a drug offense. Requires counties to provide information about substance use disorder treatment programs to a person who tests positive for an illegal controlled substance. Provides an August 1, 2023, effective date.

Article 11: Housing Supports

This article makes changes to housing support eligibility, modifies countable income under the housing support program, and requires the commissioner to seek federal approval to adjust housing stabilization services rates for inflation.

Section	Description - Article 11: Housing Supports
1	**Countable income.** Amends § 256I.03, subd. 7. Modifies the definition of "countable income" under the chapter of statutes governing housing support to reduce the amount of countable income for SSI recipients living in certain supportive housing settings from 100 percent of the SSI benefit limit to 30 percent of SSI benefits received. Also sets countable income for SSI recipients who do not live in certain supportive housing settings at the SSI limit in effect at the time the recipient is receiving housing support, less the personal needs allowance. Sets countable income for recipients of unearned income other than SSI who live in certain supportive housing settings at 30 percent of total income after applicable exclusions and disregards. Specifies the MA personal needs allowance does not apply to SSI and unearned income recipients who live in the specified supportive housing settings. Provides an October 1, 2024, effective date.
2	**Individual eligibility requirements.** Amends § 256I.04, subd. 1. Modifies housing support eligibility requirements by expanding eligibility to individuals who have a certified disability or disabling condition and lack a fixed, adequate, nighttime residence upon discharge from a correctional facility. Allows individuals who meet this criteria to be eligible for up to three months. Specifies individuals who meet the disabling condition criteria will not have any countable income for the duration of eligibility. Provides a November 1, 2024, effective date.
3	**Moratorium on development of housing support beds.** Amends § 256I.04, subd. 3. Modifies the housing support bed moratorium exception for the metro demo project by adding additional counties to the exception.
4	**Housing stabilization services inflationary adjustment.** Requires the commissioner of human services to: (1) seek federal approval to apply biennial inflationary updates to housing stabilization services rates based on the CPI; and (2) update rates using the most recently available data from the CPI beginning January 1, 2024.

Section	Description - Article 11: Housing Supports
	Makes this section effective January 1, 2024, or upon federal approval, whichever is later. Requires the commissioner of human services to notify the revisor of statutes when federal approval is obtained.

Article 12: Licensing

This articles establishes a licensing and provider hub for programs licensed or certified by the Department of Human Services, identifies various licensing and certification activities that are to be carried out through the hub once it is completed, and directs the commissioner of revenue to disclose information to the commissioner of human services to verify the income and tax identification of specified applicants for licenses or certifications and for license or certification holders.

Section	Description - Article 12: Licensing
1	**Application for licensure.** Amends § 245A.04, subd. 1. Provides that applicants and license holders must use the licensing hub as directed by the commissioner once the hub is implemented. Makes the section effective immediately.
2	**Notification required.** Amends § 245A.04, subd. 7a. Directs license holders to make required notifications to the commissioner through the hub once the hub is implemented. Makes the section effective immediately.
3	**Denial of application.** Amends § 245A.05. Allows the commissioner to provide notice of a denied license to an applicant through the hub. Makes the section effective immediately.
4	**Reconsideration of closure.** Amends § 245A.055, subd. 2. Adds the use of the hub to the process by which a provider may request reconsideration of a closed license. Makes the section effective immediately.
5	**Contents of correction orders and conditional licenses.** Amends § 245A.06, subd. 1. Allows the commissioner to issue a correction order and an order of conditional license through the hub. Makes the section effective immediately.

Section	Description - Article 12: Licensing
6	**Reconsideration of correction orders.** Amends § 245A.06, subd. 2. Adds the use of the hub to the process by which a provider may request reconsideration of correction orders. Makes the section effective immediately.
7	**Notice of conditional license; reconsideration of conditional license.** Amends § 245A.06, subd. 4. Adds the use of the hub to the process by which a license holder must be notified about a conditional license and may request a reconsideration of a conditional license. Makes the section effective immediately.
8	**License suspension, revocation, or fine.** Amends § 245A.07, subd. 3. Adds the use of the hub to the process by which a commissioner must notify a license holder that a license has been suspended or revoked or that a fine must be paid. Makes the section effective immediately.
9	**Licensing and reporting hub.** Adds a subdivision to § 245A.16. Directs county staff who perform licensing functions to use the hub once it is implemented. Makes the section effective immediately.
10	**Center operator or program operator.** Amends § 245H.01, subd. 3. Prohibits a certified, license-exempt child care center from having more than one designated center operator or program operator.
11	**Authorized agent.** Adds a subdivision to § 245H.01. Defines “authorized agent” for purposes of certified, license-exempt child care centers.
12	**Application submission.** Amends § 245H.03, subd. 2. Provides that an applicant for certification of a license-exempt child care center must use the hub once it is implemented. Makes the section effective immediately.
13	**Incomplete applications.** Amends § 245H.03, subdivision 3. Does not make changes.
14	**Reconsideration of certification denial.** Amends § 245.03, subd. 4. Adds the use of the hub to the process by which an applicant for certification of a license-exempt child care center may request reconsideration of a denial. Makes the section effective immediately.

Section	Description - Article 12: Licensing
15	**Correction order requirements.** Amends § 245H.06, subd. 1. Allows the commissioner to issue a correction order to an applicant or certification holder through the hub (for purposes of certified, license-exempt child care centers). Makes the section effective immediately.
16	**Reconsideration request.** Amends § 245H.06, subd. 2. Adds the use of the hub to the process by which an applicant or certification holder may request reconsideration of the commissioner's correction order (for purposes of certified, license-exempt child care centers). Makes the section effective immediately.
17	**Generally.** Amends § 245H.07, subd. 1. Allows the commissioner to issue a decertification order to a certification holder through the hub (for purposes of certified, license-exempt child care centers). Makes the section effective immediately.
18	**Reconsideration of decertification.** Amends § 245H.07, subd. 2. Adds the use of the hub to the process by which a certification holder may request reconsideration of decertification (for purposes of certified, license-exempt child care centers). Makes the section effective immediately.
19	**Application procedures.** Amends § 245I.20, subd. 10. Requires applicants for certification of a mental health clinic to use the hub in a manner prescribed by the commissioner once the hub is implemented. Makes the section effective immediately.
20	**Correction orders.** Amends § 245I.20, subd. 13. Adds the use of the hub to the process by which the commissioner may issue a correction order to an applicant or certification holder (for purposes of certified mental health clinics). Makes the section effective immediately.
21	**Decertification.** Amends § 245I.20, subd. 14. Adds the use of the hub to the decertification process for certified mental health clinics. Makes the section effective immediately.
22	**Notifications required and noncompliance.** Amends § 245I.20, subd. 16. Requires certified mental health clinics to enter and update required information in the hub once the hub is implemented. Makes the section effective immediately.

Section	Description - Article 12: Licensing
23	**Reporting requirements.** Amends § 260E.09. Allows, once the hub is implemented, an individual who has a hub account and is required to report suspected maltreatment as a licensed program under section 260E.06, subdivision 1, to submit a written report in the hub instead of making an oral report. Makes the section effective immediately.
24	**Disclosure to commissioner of human services.** Amends § 270B.14, subd. 1. Directs the commissioner of revenue to disclose information to the commissioner of human services to verify the income and tax identification of specified applicants for licenses or certifications and for license or certification holders.

Article 13: Miscellaneous

This article contains provisions related to the coverage of additional diagnostic services or testing after a mammogram, syringe services providers, cost-sharing for prescription drugs and medical supplies to treat chronic disease, and identification requirements for the urgent-need and continuing need insulin programs.

Section	Description - Article 13: Miscellaneous
1	**Mammogram; diagnostic services and testing.** Amends § 62A.30, by adding subd. 5. 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-payments, coinsurance, or deductibles. **Effective date.** This section is effective January 1, 2024.
2	**Application.** Amends § 62A.30, by adding subd. 6. Clarifies that section 1 applies after an enrollee has met their deductible if section 1 would make the enrollee's health savings account or catastrophic health plan ineligible for tax benefits. **Effective date.** This section is effective January 1, 2024.
3	**Cost-sharing for prescription drugs and related medical supplies to treat chronic disease.** Adds § 62Q.481.

Section	Description - Article 13: Miscellaneous

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 regardless of the amount or type of medication and to no more than $50 per month in total for all related medical supplies. States that the cost-sharing limit for related medical supplies does not increase with the number of chronic diseases for which an enrollee is treated. 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 or catastrophic health plan ineligibility, then this section shall apply to the drug or related medical supply only after the deductible has been met.

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, 2024, and applies to health plans offered, issued, and renewed on or after that date.

4 **Law enforcement records.**

Amends § 121A.28. Strikes reference to § 152.092 (possession of drug paraphernalia crime), which is being repealed, from section requiring a law enforcement agency to provide notice to schools of drug incidents involving students.

5 **Syringe services provider.**

Amends § 151.01 by adding subd. 43. Adds definition of “syringe services provider.”

6 **Generally.**

Amends § 151.40, subd. 1. Modifies list of persons who may possess, control, manufacture, sell, furnish, dispense, or otherwise dispose of hypodermic syringes or needles. Removes “possess” and “control” from list of unlawful acts.

Adds syringe services providers and their employees and agents, and participants receiving services from a syringe services provider to list of exceptions.

Makes this section effective August 1, 2023.

7 **Sales of clean needles and syringes.**

Amends § 151.40, subd. 2. Removes limit of ten or fewer for sales of unused hypodermic needles or syringes without a prescription or direction of a practitioner.

Section	Description - Article 13: Miscellaneous
8	**Access to urgent-need insulin.** Amends § 151.74, subd. 3. Allows an individual tax identification number to be used as identification indicating Minnesota residency, for purposes of eligibility for the urgent need insulin program.
9	**Continuing safety net program; general.** Amends § 151.74, subd. 4. Allows an individual tax identification number to be used as identification indicating Minnesota residency, for purposes of eligibility for the continuing need insulin program.
10	**Drug paraphernalia.** Amends § 152.01, subd. 18. Modifies definition of "drug paraphernalia" by removing equipment, products, or materials used for testing the strength, effectiveness, or purity of a controlled substance. Removes limitation on possessing hypodermic syringes or needles or any instrument or implement which can be adapted for subcutaneous injections. Makes this section effective August 1, 2023.
11	**Local regulations.** Amends § 152.205. Removes reference to § 152.092, which is being repealed.
12	**Cost-sharing.** Amends § 256L.03, subd. 5. Requires cost-sharing under MinnesotaCare for prescription drugs and related medical supplies to treat chronic disease to comply with § 62Q.481. Provides a January 1, 2024, effective date.
13	**Cost-sharing.** Amends § 256L.03, subd. 5. Prohibits the application under MinnesotaCare of co-payments, coinsurance, and deductibles for diagnostic services and testing required after a mammogram. **Effective date.** This section is effective January 1, 2024.
14	**Repealer.** Repeals § 152.092 (possession of drug paraphernalia crime).

Article 14: Forecast Adjustments

This article adjusts fiscal year 2023 appropriations to the commissioner of human services for the forecasted programs listed in this article and administered by the Department of Human Services, to conform with the February 2023 forecast.

Article 15: Appropriations

This article appropriates money from the specified funds in fiscal years 2024 and 2025 to the commissioner of human services, commissioner of health, health-related licensing boards, Emergency Medical Services Regulatory Board, MNsure, and Rare Disease Advisory Council, for the specified purposes.