MN HOUSE RESEARCH

Bill Summary

H.F. 4571

First engrossment

Subject Health Finance Bill

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Date April 29, 2024

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Article 1: Department of Human Services Health Care Finance

This article contains provisions related to state health care programs. The article: establishes a state-funded cost-sharing program; requires teaching hospitals to pay a surcharge and provides supplemental payments to hospitals for graduate medical education; provides an alternative payment rate for a children's hospital; increases the MA dispensing fee; changes federal law references related to MA and MinnesotaCare eligibility for DACA recipients; prohibits differential reimbursement of network providers; and requires the commissioner to report to the legislature on alternative health care delivery models and a county-administered medical assistance model.

Section	Description - Article 1: Department of Human Services Health Care Finance
1	**State-funded cost-sharing reductions.** Adds § 62V.12. **Subd. 1. Establishment.** Requires the MNsure board to develop and administer a state-funded cost-sharing reduction program for eligible persons who enroll in a silver level plan through MNsure. Requires the program to be implemented for plan years beginning on or after January 1, 2027. Defines "eligible person" as an individual eligible to receive cost-sharing reductions under federal law. **Subd. 2. Reduction in cost-sharing.** Requires the program to use state funds to reduce enrollee-cost sharing by increasing the actuarial value of a silver level plan from 73 to 87 percent. **Subd. 3. Administration.** Specifies board requirements related to administration of the program.
2	**Alternative care delivery models for medical assistance and MinnesotaCare.** Amends § 256.9631. The amendment to subdivision 1, paragraph (a), requires the commissioner to develop implementation plans for at least three alternative care delivery models, rather than, as required in current law, an implementation plan for a direct payment system. The models must be alternatives to the use of commercial managed care plans and must not shift financial risk to nongovernmental entities. Changes are made throughout this section to reflect the expansion in scope of the implementation plan requirement. The amendment to subdivision 1, paragraph (b), requires one of the alternative models to be a direct payment system. Also requires at least one additional model to include county-based purchasing plans and county-owned HMOs, and allows these entities to deliver care on a single-plan basis if they contract with all providers that

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agree to contract terms, and the commissioner determines that their provider network is adequate to ensure enrollee access and choice.

A new paragraph (c) requires the commissioner to consult with the chairs and ranking minority members of the legislative committees with jurisdiction over health care finance and policy before determining the alternative models for which implementation plans will be developed.

The amendment to subdivision 1, paragraph (d), eliminates certain requirements related to the direct payment system and makes conforming changes.

The amendment to subdivision 2 includes all MA enrollees as eligible individuals for purposes of the alternative models. Under current law related to the direct payment system, only MA enrollees who are families and children and adults without children are eligible. Also defines "Minnesota health care programs" as MA and MinnesotaCare.

The amendment to subdivision 3 applies many of the requirements in current law for the implementation plan for the direct payment system to the implementation plans for the alternative models. Also requires recommendations on care coordination for enrollees who are age 65 or older, blind, or have disabilities, and makes related changes. Eliminates the requirement that the implementation plan assess the feasibility of an MA outpatient prescription drug carve-out from managed care.

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

3 **Teaching hospital surcharge.**

Amends § 256.9657, by adding subd. 2a. (a) Requires teaching hospitals to pay to the MA account a surcharge equal to 0.01 percent of net non-Medicare patient care revenue. Requires the initial surcharge to be paid 60 days after federal approval, and subsequent payments to be made annually as specified by the commissioner.

(b) Provides that the surcharge must be used only to pay the nonfederal share of MA supplemental payments under section 256.969, subdivision 2g, and specifies related requirements.

(c) Defines "teaching hospital" as any Minnesota hospital, except Indian Health Service facilities and regional treatment centers, that reports a teaching hospital designation to the Centers for Medicare and Medicaid Services and is eligible for supplemental payment reimbursement.

States that this section is effective January 1, 2025, or upon federal approval of this section and the supplemental payments for medical education, whichever is later.

Section	Description - Article 1: Department of Human Services Health Care Finance
4	**Hospital payment rates.** Amends § 256.969, subd. 2b. Provides that Medical Education and Research Costs (MERC) payments to hospitals through MA are subject to requirements that apply to MA supplemental medical education payments. States that this section is effective January 1, 2025, or upon federal approval of this section, section 256.969, subdivision 2g, and the teaching hospital surcharge, whichever is later.
5	**Annual supplemental payments; direct and indirect physician graduate medical education.** Amends § 256.969 by adding subd. 2g. (a) Requires the commissioner, for discharges occurring on or after January 1, 2025, to determine and pay annual supplemental payments to eligible hospitals, for direct and indirect physician graduate medical education cost reimbursement. (b) Specifies the information that the commissioner must use to calculate the total cost of direct graduate medical education incurred by each eligible hospital. (c) Allows the commissioner to obtain the information specified in paragraph (b) from a hospital, upon request, or from the hospital's most recently filed CMS-2552-10 form. (d) Specifies the information that the commissioner must use to calculate the total allowable indirect cost of graduate medical education incurred by each eligible hospital. (e) Specifies the method by which the commissioner is to determine each eligible hospital's maximum allowable Medicaid direct graduate medical education supplemental payment. (f) Specifies the method by which the commissioner is to determine each eligible hospital's indirect graduate medical education supplemental payment. (g) States that an eligible hospital's annual supplemental payment is the sum of the amounts calculated under paragraph (e) (direct payment) and paragraph (f) (indirect payment). (h) States that the annual supplemental payments are contingent upon federal approval and must conform with the requirements under federal law. (i) Provides that an eligible hospital is only eligible for payments under section 62J.692 (MERC) for nonphysician graduate medical education training costs not accounted for in the supplemental payment. Prohibits an eligible hospital from

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	accepting MERC reimbursement for physician graduate medical education training costs that are accounted for in the supplemental payment. (j) Defines “children’s hospital” as one designated as such under Medicare. (k) Defines “eligible hospital” as a hospital located in Minnesota that: (1) participates in MA; (2) has received fee-for-service MA payments in the payment year; and (3) either: (i) is eligible to receive graduate medical education payments from Medicare; or (ii) is a children’s hospital. States that this section is effective January 1, 2025, or upon federal approval of this section, the amendment to section 256.969, subdivision 2b, and the teaching hospital surcharge, whichever is later.
6	**Alternate inpatient payment rate for a discharge.** Amends § 256.969, by adding subd. 2h. (a) Provides an alternate inpatient hospital payment rate for a children’s hospital. The alternate rate is retroactive from January 1, 2024, and applies to any rate year in which a discharge of a patient who had resided in the hospital for over 20 years is included in the federally required disproportionate share hospital (DSH) payment audit. The alternate rate is the standard rate, excluding any DSH payment, increased by 99 percent of what the DSH payment would have been had the discharge been excluded. (b) Provides that in any rate year in which the alternate payment rate is effective, no payments shall be made to the hospital under paragraphs 2e and 2f (alternative payment rates in current law) and 9 (DSH payment rates). States that this section is effective upon federal approval.
7	**Payment rates.** Amends § 256B.0625, subd. 13e, as amended. Increases the MA dispensing fee for covered outpatient drugs, certain intravenous solutions, and prescribed over-the-counter drugs that are covered outpatient drugs, from $10.77 to $11.55. States this section is effective July 1, 2024.
8	**Reimbursement of network providers.** Amends § 256B.69, by adding subd. 38. (a) Prohibits a managed care plan that is a staff model health plan company from reimbursing network providers who are employees at a higher rate than network providers who provide services under contract, for services provided to MA and MinnesotaCare enrollees. Exempts value-based purchasing models, total cost of care and risk/gain sharing arrangements, other pay for performance arrangements, and services provided by out-of-network providers from this requirement.

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(b) Provides that any contract between a managed care plan and a network administrator for purposes of delivering services to MA and MinnesotaCare enrollees must require the network administrator to comply with the provider reimbursement requirements in paragraph (a). States that this provision applies whether or not the managed care plan, network administrator, and providers are under the same corporate ownership.

(c) Defines “network provider” and “network administrator.”

9 **County-administered medical assistance model.**

Subd. 1. Model development. (a) Requires the commissioner of human services, in collaboration with the Association of Minnesota Counties and county-based purchasing plans, to develop a county-administered medical assistance (CAMA) model and a detailed implementation plan.

(b) Requires the CAMA model to be designed to:

1) provide a county-owned and administered alternative to the prepaid medical assistance program;
2) facilitate greater integration of health care and social services to address social determinants of health, with the degree of integration varying by county needs and resources;
3) account for differences between counties in the number of MA enrollees and locally available providers; and
4) promote greater accountability for health outcomes, health equity, customer service, community outreach, and cost of care.

Subd. 2. County participation. (a) Requires the model to give each county the option of participating, and to include a process for the commissioner to determine whether and how a county can participate.

(b) States that the model may allow a county-administered managed care organization to deliver care on a single-plan basis, as long as: (1) the managed care organization contracts with all health care providers that agree to contract terms; and (2) the commissioner determines that the organization’s provider network is adequate to ensure access to care and choice of providers.

Subd. 3. Report to legislature. (a) Requires the commissioner to report recommendations and an implementation plan for the CAMA model to the legislature by January 15, 2025. Requires the model and recommendations to address the issues and consider the recommendations made by a mediation panel and provided to the commissioner, that were not contingent on the outcomes of recent litigation between county-based purchasing plans and DHS.

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	(b) Requires the report to identify the clarifications, approvals, and waivers needed from the Centers for Medicare and Medicaid Services, and to include any draft legislation necessary to implement the CAMA model.
10	**Revisor instruction.** Requires the revisor, if a proposed federal rule takes effect, to update two citations to federal law that are in state law. The federal law referenced in these citations would allow Deferred Action for Childhood Arrivals (DACA) recipients to be considered lawfully present, and therefore eligible for MA enrollment as a pregnant woman or child under age 21, or federally funded MinnesotaCare, assuming all other program eligibility requirements are met. Under current federal law, DACA recipients are not eligible for this coverage because they are not considered lawfully present. These changes are made in sections of Minnesota law governing noncitizen eligibility for MA (256B.06, subd. 4, paragraph (d)) and MinnesotaCare (256L.10, subd. 10, paragraph (a)). The 2023 Legislature directed DHS to make federally funded MA and federally funded MinnesotaCare available to DACA recipients in accordance with the finalized federal rule. DACA recipients in MinnesotaCare are currently eligible for MA, funded by the Children's Health Insurance Program, for the period of pregnancy and the postpartum period, state-funded MinnesotaCare, and emergency medical assistance.

Article 2: Department of Human Services Health Care Policy

This article makes policy changes related to the administration of DHS health care programs and behavioral health homes.

Section	Description - Article 2: Department of Human Services Health Care Policy
1	**Qualifying overpayment.** Amends § 256.0471, subd. 1, as amended. Limits the collection of overpayments to recipients of state-funded medical assistance (MA) and state-funded MinnesotaCare, to benefits received during a period of appeal, in which the appeal is not successful. Provides a July 1, 2024, effective date.
2	**Commissioner's duties.** Amends § 256.9657, subd. 8. Eliminates the requirement that the commissioner report annually to the legislature on the provider surcharge program.

Section	Description - Article 2: Department of Human Services Health Care Policy
3	**Income and assets generally.** Amends § 256B.056, subd. 1a. Prohibits state tax credits, rebates, and refunds from being counted as income, for purposes of MA eligibility determinations for persons who are blind, have disabilities, or are age 65 or older. Provides an immediate effective date.
4	**Eligibility determination.** Amends § 256B.056, subd. 10. Allows the commissioner to obtain information from financial institutions to verify assets, for determining MA eligibility for persons who are blind, have disabilities, or are age 65 and older, and for other persons subject to an asset limit. Under current law, this is allowed just to identify unreported assets.
5	**Recuperative care facility rate.** Amends § 256B.0701, subd. 6. Updates a reference to the MA room and board rate, to refer to the Minnesota Supplemental Aid equivalent rate, in a section of law setting the payment rate for the MA recuperative care facility rate.
6	**Behavioral health home services provider requirements.** Amends § 256B.0757, subd. 4a. Removes the requirement that consent be written consent for behavioral health home services. Provides an immediate effective date.
7	**Behavioral health home services delivery standards.** Amends § 256B.0757, subd. 4d. Modifies service delivery standards for behavioral health home services providers related to the required tool providers must use to identify past and current treatment or services. Provides an immediate effective date.
8	**Reimbursement for family planning services.** Amends § 256B.764. Limits the 20 percent rate increase for family planning to those services when provided by an eligible community clinic.
9	**Covered health services.** Amends § 256L.03, subd. 1. Clarifies that MinnesotaCare adult dental services and orthodontic services are covered as they are under MA. (This is done by striking language that exempts these services from the general provision that MinnesotaCare covers services that are reimbursed under MA.)

Section	Description - Article 2: Department of Human Services Health Care Policy
10	**Notice to creditors.** Amends § 524.3-801, as amended. Allows the commissioner to receive electronic notices related to the death of recipients who received assistance for which a claim for recovery can be filed.

Article 3: Health Care

This article contains provisions related to medical debt, the medication repository program, and the emergency and continuing need insulin safety net programs.

Section	Description - Article 3: Health Care
1	**Definitions.** Adds § 62J.805. Defines the following terms for sections on policies for medical debt collection, denial of health care due to outstanding medical debt, and billing for miscoded health care: group practice, health care provider, health plan, hospital, medically necessary, miscode, and payment.
2	**Policy for collection of medical debt.** Adds § 62J.806. Requires a health care provider to make available to the public, the provider's policy on collection of medical debt from patients. Specifies how the policy must be made available, and requires the policy to at least specify the procedures for communicating with patients about medical debt owed and collecting medical debt, referring medical debt to a collection agency or law firm, and identifying medical debt as uncollectable or satisfied and ending collection activities.
3	**Denial of health treatments or services due to outstanding medical debt.** Adds § 62J.807. Prohibits a health care provider from denying medically necessary health treatments or services to a patient or any member of the patient's family or household because of outstanding medical debt owed by the patient or the patient's family or household. As a condition of providing medically necessary health treatments or services to a patient who owes medical debt to the provider, allows a provider to require the patient to enroll in a payment plan.
4	**Billing and payment for miscoded health treatments and services.** Adds § 62J.808. Prohibits health care providers and health plan companies from billing patients, or accepting payment from patients, for miscoded health treatments or services, until after the coding has been reviewed and any miscoding has been corrected.

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Subd. 1. Participation and cooperation required. Requires health care providers to participate in, and cooperate with, processes to identify, review, and correct coding of health treatments and services that were miscoded.

Subd. 2. Notice; billing and payment during review. Requires a health care provider and health plan company who receive notice or determine that a health treatment or service may have been miscoded, to notify the patient that a miscoding review is being conducted and that the patient will not be billed for or be required to submit payments for the treatment or service subject to the review, until the review is complete. During the review, prohibits the provider and health plan company from billing the patient or accepting payment from the patient for any treatment or service being reviewed.

Subd. 3. Billing and payment after completion of review. Allows a health care provider and health plan company to bill the patient for, and accept payment from the patient for, the health treatment or service that was being reviewed only after the review is complete and any miscoded treatments or services have been correctly coded.

5 **Definitions.**

Amends § 144.587, subd. 1. Strikes a definition of revenue recapture for a section establishing requirements for patient screening for eligibility for health coverage or assistance. This definition is being stricken to conform with the amendment to section 270A.03, subd. 2, which prohibits municipal hospitals, hospital districts, and ambulance services from using revenue recapture to recover patient debts.

6 **Prohibited actions.**

Amends § 144.587, subd. 4. In a subdivision prohibiting hospitals from taking certain actions until the hospital determines the patient is ineligible for charity care or denies an application for charity care, strikes a reference to revenue recapture to conform with the amendment to section 270A.03, subd. 2, and strikes a clause prohibiting a hospital from denying health care services to a patient or a member of the patient's household due to outstanding medical debt. Requires a hospital to comply with section 62J.807, which prohibits a health care provider from denying medically necessary health treatments or services to a patient or any member of the patient's family or household because of outstanding medical debt but allows a provider to require such a patient to enroll in a payment plan as a condition of providing care.

7 **Definitions.**

Amends § 151.555, subd. 1. Restructures the statutory format for the definition of "donor."

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8	**Local repository requirements.** Amends § 151.555, subd. 4. Removes the requirement that the central repository provide the Board of Pharmacy with a copy of the withdrawal notice of a local repository.
9	**Individual eligibility and application requirements.** Amends § 151.555, subd. 5. Clarifies eligibility and related requirements for individuals who receive donated drugs or supplies as a new eligible patient, by: ▪ providing that the intake application form submitted by an individual to the local repository may be an electronic or physical form; ▪ allowing medical assistance and MinnesotaCare enrollees to be eligible for the program; and ▪ removing the requirement that the local repository furnish eligible individuals with an identification card.
10	**Standards and procedures for accepting donations of drugs and supplies.** Amends § 151.555, subd. 6. Clarifies requirements for the donation of drugs and medical supplies by: ▪ eliminating the requirement that each donation be accompanied by a medication repository donor form; ▪ requiring the central or local repository to verify and record specified information on the donor form, prior to the first donation from a new donor; ▪ allowing the inventory of donated drugs and supplies to be written or electronic, and allowing the board to waive the inventory requirement if an entity is under common ownership or control, and one of the entities maintains an inventory; and ▪ making other related changes.
11	**Standards and procedures for inspecting and storing donated drugs and supplies.** Amends § 151.555, subd. 7. Removes the requirement that a pharmacist or practitioner who inspects donated drugs or supplies sign an inspection record. Also clarifies that no other record of the destruction of donated drugs and supplies is required, other than that specified in paragraph (f).
12	**Dispensing requirements.** Amends § 151.555, subd. 8. Clarifies that the drug repository recipient form is signed by the recipient before the first drug or supply is dispensed or administered, and that the form may be electronic or physical. Makes other related changes.

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13 **Handling fees.**

Amends § 151.555, subd. 9. Prohibits charging a medical assistance or MinnesotaCare recipient a supply or handling fee.

14 **Forms and record-keeping requirements.**

Amends § 151.555, subd. 11. Allows program participants to use electronic or physical forms that are substantively similar to the forms available on the board's website. Also makes a conforming change.

15 **Liability.**

Amends § 151.555, subd. 12. Clarifies that immunity from civil liability related to facilities and persons taking part in various program activities also applies to persons or entities who facilitate these activities.

16 **Access to urgent need insulin.**

Amends § 151.74, subd. 3. Allows manufacturers to submit to the commissioner of administration a request for reimbursement in an amount not to exceed $35, for each 30-day supply of insulin provided under the urgent-need insulin program, and requires the commissioner to reimburse the manufacturer. States that this section is effective July 1, 2024.

17 **Continuing safety net program; process.**

Amends § 151.74, subd. 6. Allows manufacturers to submit to the commissioner of administration a request for reimbursement in an amount not to exceed $105, for each 90-day supply of insulin provided under the continuing safety net program, and requires the commissioner to reimburse the manufacturer. If the manufacturer provides less than a 90-day supply, allows the manufacturer to submit a request for reimbursement not to exceed $35 for each 30-day supply provided. States that this section is effective July 1, 2024.

18 **Insulin manufacturer registration fee.**

Adds § 151.741.

Subd. 1. Definitions. Defines "board" and "manufacturer."

Subd. 2. Assessment of registration fee. (a) Requires the Board of Pharmacy to assess each insulin manufacturer an annual registration fee of $100,000, except as provided in paragraph (b), and to notify each manufacturer of this requirement by beginning November 1, 2024, and each November 1 thereafter.

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(b) Allows manufacturers with annual sales in the state of $2 million or less in the previous calendar year to request and obtain exemptions from the annual registration fee.

Subd. 3. Payment of registration fee; deposit of fee. (a) Requires manufacturers to pay the registration by March 1, 2025, and by each March 1 thereafter. Also specifies related requirements and allows the board to assess late fees.

(b) Requires the registration fee, and any late fees, to be deposited into the insulin safety net program account.

Subd. 4. Insulin safety net program account. Establishes the insulin safety net program account in the special revenue fund. Appropriates money from the account each fiscal year to the MNsure board to carry out assigned duties related to the insulin program, and to the Board of Pharmacy to cover costs of collecting the registration fee and administering the insulin safety net program.

Subd. 5. Insulin repayment account; annual transfer from the health care access fund. (a) Establishes the insulin repayment account in the special revenue fund. Appropriates money in the account each fiscal year to the commissioner of administration in an amount sufficient for the commissioner to reimburse manufacturers for insulin dispensed under the insulin safety net program, and to cover costs incurred by the commissioner in providing this reimbursement.

(b) Requires the commissioner of management and budget to transfer from the health care access fund to the insulin repayment account, beginning July 1, 2025, and each July 1 thereafter, an amount sufficient for the commissioner of administration to implement paragraph (a).

Subd. 6. Contingent transfer by commissioner. Provides that if subdivisions 2 and 3 (assessment and payment of registration fee) are held to be invalid by a court, this invalidity does not affect other provisions of the act and the commissioner of management and budget shall transfer from the health care access fund to the insulin safety net program an amount sufficient to implement subdivision 4.

States that this section is effective July 1, 2024.

19 **Claimant agency.**

Amends § 270A.03, subd. 2. Amends the definition of claimant agency for the revenue recapture program administered by the Department of Revenue, to prohibit municipal hospitals, municipal ambulance services, hospital districts, and any ambulance service licensed under chapter 144E from using the revenue recapture

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program to have an individual's tax refund withheld and transferred to apply those funds to debts owed to these entities.

20 **Medical debt credit reporting prohibited.**

Adds § 332.371. Prohibits a consumer reporting agency from making a consumer report concerning medical information, or concerning debt arising from the provision of medical care.

21 **Definitions.**

Adds § 332C.01. For a chapter on collection of medical debt, defines the following terms: collecting party, debtor, medical debt, and person.

22 **Prohibited practices.**

Adds § 332C.02. Prohibits a collecting party from the following:

- Threatening wage garnishment or a legal suit by a particular lawyer, unless the collecting party has retained the lawyer;
- Using sheriffs or other officers to serve legal papers related to collecting a claim, except when performing legally authorized duties;
- Using or threatening to use collection methods that violate Minnesota law;
- Providing legal advice to debtors, or representing that the collecting party is able to provide legal advice to debtors;
- Falsely using the stationery of a lawyer or using forms or instruments that only lawyers are permitted to prepare or which resemble the form and appearance of judicial process;
- Publishing or publicizing debtor lists in one of the listed ways;
- Falsely implying the collecting party is associated with a branch of government;
- Holding itself out as a debt settlement company, debt management company, debt adjustment, or similar entity;
- Violating federal rules when attempting to collect on an account, bill, or debt;
- Communicating with a debtor using an automatic telephone dialing system or artificial or prerecorded voice after the debtor has asked the collecting party to cease these activities;
- Implying medically necessary health treatments or services will be denied because of a medical debt;
- Using a neighbor or third party to ask the debtor to contact the collecting party, with certain exceptions;

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- When attempting to collect a medical debt, failing to provide the debtor with the full name of the collecting party;
- Failing to return overpayments to the debtor;
- Accepting payments without issuing a receipt;
- Attempting to collect any amount not expressly authorized in the agreement creating the medical debt or otherwise permitted by law;
- Falsifying any documents with the intent to deceive;
- Failing to include certain disclosures when contacting a debtor by mail;
- Commencing a legal action to collect a medical debt after the statute of limitations has run;
- Reporting medical debt to a credit reporting agency; or
- Challenging a debtor's claim of exemption to garnishment or levy in bad faith.

23 **Defending medical debt cases.**

Adds § 332C.04. Authorizes a debtor who prevails in a case involving a claim for payment of a medical debt to be awarded costs, including reasonable attorney fees, incurred in defending against the claim for debt payment.

24 **Enforcement.**

Adds § 332C.06. Allows the attorney general to enforce this chapter under section 8.31. Specifies damages a collecting party must pay to a debtor if the collecting party violates this chapter: actual damages, additional damages of up to $1,000 per violation, costs and reasonable attorney fees, and for willful and malicious violations, three times the actual damages and additional damages amounts. Provides for adjustment of the maximum amount of additional damages every even-numbered year based on changes to the Consumer Price Index.

25 **Contracts for medical care.**

Adds subd. 4 to § 334.01. Provides interest for a debt owed to a health care provider for health treatment and services must be at a rate of four percent.

26 **Liability of spouses.**

Amends § 519.05. Strikes language that makes spouses living together jointly and severally liable for necessary medical services provided to either spouse and for necessary household articles and supplies, except provides spouses are jointly and severally liable for claims against estates if a spouse participates in medical assistance.

Section	Description - Article 3: Health Care
27	**Appropriations.** Amends Laws 2020, chapter 73, section 8. Extends, through June 30, 2027, the availability of a prior year appropriation to MNsure for navigator training and compensation related to the insulin safety net program and allows the funding to be used for the insulin safety net program generally.
28	**Repealer; sunset for the long-term safety net insulin program.** Repeals § 151.74, subdivision 16, effective the day following final enactment. The provision repealed provides a December 31, 2024**,** sunset date for the long-term safety net insulin program, and requires the legislature to make a determination on whether this program should continue beyond the sunset date.

Article 4: Health Insurance

This article requires or modifies health plan and medical assistance coverage for certain health treatments and services. It also modifies requirements for utilization review and prior authorization of health care services, requires health maintenance organizations to be domestic nonprofit corporations, authorizes the commissioner of health to oversee certain health maintenance organization transactions, establishes requirements for the inclusion of essential community providers in health plan company provider networks, provides exemptions and accommodations for organizations with religious objections to certain coverage requirements, modifies requirements for MNsure to report to the legislature, and establishes requirements for conversion transactions by nonprofit health coverage entities.

Section	Description - Article 4: Health Insurance
1	**Required coverage.** Amends § 62A.28, subd. 2. Expands an existing private sector health insurance mandate requiring coverage of scalp hair prostheses in cases of hair loss due to alopecia areata, by: ▪ requiring coverage in cases of hair loss suffered as a result of a health condition, or for the treatment of cancer, unless there is a clinical basis for the limitation; and ▪ requiring coverage of all equipment and accessories necessary for regular use of scalp hair prostheses. Limits coverage for scalp hair prostheses to $1,000 per benefit year, and requires scalp hair prostheses to be prescribed by a doctor.

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States that this section is effective January 1, 2025, and applies to policies, plans, certificates, and contracts offered, issued, or renewed on or after that date.

2 **Rapid whole genome sequencing; coverage.**

Adds § 62A.3098. Establishes requirements for health plan coverage of rapid whole genome sequencing.

Subd. 1. Definition. Defines rapid whole genome sequencing or rWGS as an investigation of the entire human genome to identify disease-causing genetic changes, with results provided within 14 days. Provides rapid whole genome sequencing includes patient-only whole genome sequencing and duo and trio whole genome sequencing of the patient and the patient's biological parent or parents.

Subd. 2. Required coverage. Requires a health plan to cover rapid whole genome sequencing testing if the enrollee is age 21 or younger; has a complex or acute illness with an unknown underlying cause not confirmed to have been caused by environmental exposure, toxic ingestion, infection with a normal response to therapy, or trauma; and is receiving inpatient services in an intensive care unit or neonatal or high acuity pediatric unit.

Subd. 3. Coverage criteria. Lists medical necessity criteria on which coverage may be based: the enrollee has symptoms that would require evaluation using multiple genetic tests if rapid whole genome sequencing is not used; rapid whole genome sequencing may help guide the treatment or management of the enrollee's condition; and the enrollee's illness with an unknown underlying cause includes at least one of the listed conditions.

Subd. 4. Cost sharing. Provides coverage under this section is subject to the health plan's cost-sharing requirements that apply to diagnostic testing.

Subd. 5. Payment for services provided. If an enrollee's health plan uses a capitated or bundled payment arrangement to reimburse a provider for inpatient care, requires reimbursement for rapid whole genome sequencing under this section to be paid separately and in addition to other reimbursement paid to the provider, unless the provider and health carrier have negotiated an increased capitated or bundled payment rate that includes the services covered under this section.

Subd. 6. Genetic data. Specifies genetic data generated from the performance of rapid whole genome sequencing must be used for the primary purpose of helping the provider diagnose and treat the enrollee and is protected health information

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under the Health Insurance Portability and Accountability Act (HIPAA) and a protected health record under the Minnesota Health Records Act.

Subd. 7. Reimbursement. Requires the commissioner of commerce to reimburse health carriers for coverage under this section that would not have been provided without the requirements of this section. Annually appropriates to the commissioner of commerce an amount necessary to make defrayal payments, requires health carriers to report to the commissioner the costs attributable to the coverage under this section, and requires the commissioner to evaluate submissions and make payments according to federal rules.

Effective date: This section is effective January 1, 2025, and applies to a health plan offered, issued, or sold on or after that date.

3 **Coverage of service; prior authorization.**

Adds § 62A.59. Prohibits a health carrier from:

- retrospectively denying or limiting coverage of a service for which prior authorization was not required, unless there is evidence the service was provided based on fraud or misinformation; and
- denying or limiting coverage of a service the enrollee already received on the basis of lack of prior authorization, if the service would have been covered if prior authorization had been obtained.

Effective date: This section is effective January 1, 2026, and applies to health plans offered, sold, issued, or renewed on or after that date.

4 **Application of other law.**

Adds § 62C.045. Provides sections 145D.30 to 145D.37 apply to service plan corporations operating under chapter 62C.

5 **Health maintenance organization.**

Amends § 62D.02, subd. 4. Amends the definition of health maintenance organization for chapter 62D (governing regulation of HMOs by the commissioner of health) to provide a health maintenance organization is a nonprofit corporation organized under chapter 317A or a local governmental unit (current law allows a health maintenance organization to be a local governmental unit or a foreign or domestic corporation and does not require it to be nonprofit).

6 **Comprehensive health maintenance services.**

Amends § 62D.02, subd. 7. In the definition of comprehensive health maintenance services for chapter 62D, strikes language providing a health maintenance

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	organization is not required to provide elective, induced abortions, other than those that are medically necessary to prevent the death of the mother. Effective date: This section is effective January 1, 2025, and applies to health plans offered, sold, issued, or renewed on or after that date.
7	**Certificate of authority required.** Amends § 62D.03, subd. 1. Allows a nonprofit corporation, rather than any foreign or domestic corporation as provided in current law, to apply to the commissioner of health for a certificate of authority for a health maintenance organization, and to establish and operate a health maintenance organization.
8	**Authority granted.** Amends § 62D.05, subd. 1. Specifies that a corporation must be a nonprofit corporation in order to operate as a health maintenance organization.
9	**Governing body composition; enrollee advisory body.** Amends § 62D.06, subd. 1. Makes a conforming change to requirements for the governing body of a health maintenance organization organized as a corporation, to require the corporation to be a nonprofit corporation.
10	**Coverage of service.** Amends § 62D.12, subd. 19. Provides this subdivision expires December 31, 2025, for health plans offered, sold, issued, or renewed on or after that date. (This subdivision prohibits a health maintenance organization from denying or limiting coverage already received solely based on lack of prior authorization or second opinion, if the service would have been covered had the prior authorization or second opinion been obtained. This subdivision is being replaced by section 62A.59, subd. 2.)
11	**Unreasonable expenses.** Amends § 62D.19. Adds the purpose of safeguarding a health maintenance organization's underlying nonprofit status to the purposes a health maintenance organization must not incur or pay an unreasonably high amount for a good or service in relation to the value of the good or service.
12	**Rulemaking.** Amends § 62D.20, subd. 1. In a subdivision authorizing the commissioner of health to adopt rules governing health maintenance organizations, strikes language prohibiting the commissioner from adopting rules to require a health maintenance organization to provide elective, induced abortions, other than those that are medically necessary to prevent the death of the mother.

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Effective date: This section is effective January 1, 2025, and applies to health plans offered, sold, issued, or renewed on or after that date.

13 **Other state law.**

Amends § 62D.22, subd. 5. Strikes language providing health maintenance organizations must comply with state law that eliminates elective, induced abortions from health or maternity benefits.

Effective date: This section is effective January 1, 2025, and applies to health plans offered, sold, issued, or renewed on or after that date.

14 **Application of other law.**

Adds subd. 5a to § 62D.22. Provides sections 145D.30 to 145D.37 apply to nonprofit health maintenance organizations operating under chapter 62D.

15 **Oversight of transactions.**

Adds § 62D.221.

Subd. 1. Insurance provisions applicable to health maintenance organizations. Makes health maintenance organizations subject to the following sections that currently apply to insurers, and requires HMOs to comply with those sections: sections 60A.135, 60A.136, 60A.137 (requiring reports of material acquisitions and dispositions of assets and revisions of ceded reinsurance agreements); 60A.16, 60A.161 (mergers and consolidations, insurer domestication and conversion); 60D.17 (filing requirements when acquiring control or merging with a domestic insurer); 60D.18 (requirements for other acquisitions, including preacquisition notification and a waiting period); 60D.20 (standards and management of an insurer within a holding company system). Also requires HMOs to comply with certain requirements in Minnesota Rules, chapter 2720. Also prohibits acquisition of all or substantially all of the assets of an HMO unless the person files with the commissioner of health the information required under section 60D.17 and the acquisition has been approved by the commissioner.

Subd. 2. Conversion transactions. If notice to the commissioner of health is required under subdivision 1, requires an HMO to include with the notice, information on the plan for a conversion benefit entity if the reportable transaction qualifies as a conversion transaction. Allows the commissioner to consider information on the conversion transaction and conversion benefit entity in any actions taken under subdivision 1.

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16 **Health maintenance organization.**

Amends § 62E.02, subd. 3. Makes a conforming change to the definition of health maintenance organization in chapter 62E, to specify it is a nonprofit corporation.

17 **Scope.**

Amends § 62M.01, subd. 3. Provides that effective January 1, 2026, chapter 62M, which governs utilization review of health care, applies to managed care plans and county-based purchasing plans covering medical assistance or MinnesotaCare enrollees, and that the specified sections in chapter 62M apply to services delivered through fee-for-service under chapters 256B and 256L. (Current law provides chapter 62M does not apply to managed care plans and county-based purchasing plans covering medical assistance or MinnesotaCare enrollees.)

18 **Adverse determination.**

Amends § 62M.02, subd. 1a. Amends the definition of adverse determination in chapter 62M to provide adverse determination includes an authorization for a health care service that is less intensive than the health care service specified in the original authorization request.

Effective date: This section is effective the day following final enactment.

19 **Authorization.**

Amends § 62M.02, subd. 5. Amends the definition of authorization in chapter 62M to conform with the application of certain sections in chapter 62M to services delivered through fee-for-service under chapters 256B and 256L, and corrects a term used in this subdivision.

20 **Commissioner.**

Adds subd. 8a to § 62M.02. Effective January 1, 2026, defines commissioner as the commissioner of human services for the sections in chapter 62M that apply to services delivered through fee-for-service under chapters 256B and 256L.

21 **Enrollee.**

Amends § 62M.02, subd. 11. Effective January 1, 2026, amends the definition of enrollee in chapter 62M to conform with the application of certain sections in chapter 62M to services delivered through fee-for-service under chapters 256B and 256L.

22 **Health benefit plan.**

Amends § 62M.02, subd. 12. Effective January 1, 2026, amends the definition of health benefit plan in chapter 62M to conform with the application of certain

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sections in chapter 62M to services delivered through fee-for-service under chapters 256B and 256L.

23 **Utilization review organization.**

Amends § 62M.02, subd. 21. Effective January 1, 2026, amends the definition of utilization review organization in chapter 62M to conform with the application of certain sections in chapter 62M to services delivered through fee-for-service under chapters 256B and 256L.

24 **Responsibility for obtaining authorization.**

Amends § 62M.04, subd. 1. Effective January 1, 2026, requires the commissioner of human services to provide fee-for-service recipients under chapters 256B and 256L with a description of the process for obtaining authorization for health care services (this change is to conform with the application of certain sections in chapter 62M to services delivered through fee-for-service under chapters 256B and 256L). Also corrects a term.

25 **Standard review determination.**

Amends § 62M.05, subd. 3a. Strikes obsolete language from a paragraph establishing timelines for communicating standard review determinations to providers and enrollees.

Effective date: This section is effective the day following final enactment.

26 **Prior authorization of certain services prohibited.**

Amends § 62M.07, subd. 2. Current law prohibits prior authorization from being conducted or required for emergency confinement or an emergency service. This section adds the following to the services for which prior authorization cannot be conducted or required:

- oral buprenorphine to treat a substance use disorder;
- outpatient mental health treatment or outpatient substance use disorder treatment, except for medications not otherwise listed in this subdivision. Prior authorization for medications used for outpatient mental health treatment or outpatient substance use disorder treatment and not otherwise listed in this subdivision must be processed according to the timelines for expedited review and expedited appeals;
- antineoplastic cancer treatment consistent with guidelines of the National Comprehensive Cancer Network, except for medications not otherwise listed in this subdivision. Prior authorization for medications used for antineoplastic cancer treatment and not otherwise listed in this

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subdivision must be processed according to the timelines for expedited review and expedited appeals;

- certain preventive services, immunizations, and screenings;
- pediatric hospice services provided by a licensed hospice provider; and
- treatment provided by a neonatal abstinence program.

Provides clauses (2) to (7) are effective January 1, 2026, and apply to health benefit plans offered, sold, issued, or renewed on or after that date.

27 **Submission of prior authorization requests.**

Amends § 62M.07, subd. 4. Effective January 1, 2027, requires utilization review organizations, health plan companies, and claims administrators to have a prior authorization application programming interface (API) that automates the prior authorization process for health care services, excluding prescription drugs and medications. Specifies requirements the API must meet, and specifies prior authorization requests for prescription drugs and medications must comply with requirements in state law for electronic prescribing.

28 **Treatment of a chronic condition.**

Adds subd. 5 to § 62M.07. Provides an authorization for treatment of a chronic health condition does not expire unless the treatment standard for that chronic condition changes. Defines a chronic condition as a condition that is expected to last for one year or longer and that either requires ongoing medical attention or limits one or more activities of daily living. Provides this subdivision is effective January 1, 2026, and applies to health benefit plans offered, sold, issued, or renewed on or after that date.

29 **Availability of criteria.**

Amends § 62M.10, subd. 7. Effective January 1, 2026, requires the commissioner of human services to post on the department's public website the prior authorization requirements and restrictions that apply to prior authorization determinations for fee-for-service under chapters 256B and 256L (this change is to conform with the application of certain sections in chapter 62M to services delivered through fee-for-service under chapters 256B and 256L).

30 **Notice; new prior authorization requirements or restrictions; change to existing requirement or restriction.**

Amends § 62M.10, subd. 8. Effective January 1, 2026, requires the commissioner of human services to provide written or electronic notice of a new or amended prior authorization requirement or restriction, at least 45 days before the new or amended requirement or restriction takes effect, to health care professionals who are fee-for-service providers under chapters 256B and 256L (this change is to conform with the

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	application of certain sections in chapter 62M to services delivered through fee-for-service under chapters 256B and 256L).
31	**Effect of change in prior authorization clinical criteria.** Amends § 62M.17, subd. 2. Under current law, a utilization review organization's change to coverage of a health care service or to the clinical criteria used for prior authorizations does not apply until the next plan year, for enrollees who received prior authorization for that service using the prior coverage terms or clinical criteria. This general rule does not apply if the utilization review organization changed coverage terms or the clinical criteria when an independent source recommended the change for reasons related to patient harm. A new paragraph (d) specifies the patient harm must be previously unknown and imminent for the exception to apply; paragraph (d) is effective January 1, 2026, and applies to health benefit plans offered, sold, issued, or renewed on or after that date.
32	**Annual report to commissioner of health; prior authorizations.** Adds § 62M.19. By September 1 each year, requires utilization review organizations to report to the commissioner of health, information on prior authorization requests for the previous calendar year. Lists data the reports must include.
33	**Restrictions on enrollee services.** Amends § 62Q.14. Strikes language allowing health plan companies to restrict enrollee choice regarding where the enrollee receives abortion services. Effective date: This section is effective January 1, 2025, and applies to health plans offered, sold, issued, or renewed on or after that date.
34	**Prohibition on use of prior authorization or step therapy protocols.** Amends § 62Q.1841, subd. 2. Prohibits a health plan that covers the treatment of stage four advanced metastatic cancer or associated conditions from requiring prior authorization for an FDA-approved drug to treat stage four advanced metastatic cancer or associated conditions. Effective date: This section is effective January 1, 2025, and applies to health plans offered, sold, issued, or renewed on or after that date.
35	**Health plan company affiliation.** Amends § 62Q.19, subd. 3. Requires a health plan company to offer a contract to all essential community providers located within the area served by the health plan company, and to include all essential community providers that accept a contract in each of the company's provider networks.

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	Effective date: This section is effective January 1, 2025, and applies to health plans offered, issued, or renewed on or after that date.
36	**Contract payment rates; private.** Adds subd. 4a to § 62Q.19. Allows an essential community provider and health plan company to negotiate a payment rate for covered services provided by the essential community provider. Requires the rate to be at least the same rate per unit of service as paid by that health plan company to the essential community provider under the provider contract with the highest number of enrollees from the provider, or, if there is no contract between the health plan company and essential community provider, requires the rate to be at least the same rate per unit of service as is paid to other plan providers for the same or similar services. This subdivision applies to provider contracts for individual, small employer, and large group health plans.
37	**Contract payment rates; public.** Amends § 62Q.19, subd. 5. Specifies that an existing subdivision on contract payment rates between health plan companies and essential community providers applies to provider contracts for health plans offered through the State Employee Group Insurance Program, medical assistance, and MinnesotaCare. (The existing subdivision requires the rate between a health plan company and essential community provider to be at least the same rate per unit of service as is paid to other health plan providers for the same or similar service.)
38	**Definitions.** Amends § 62Q.522, subd. 1. In a section governing coverage of contraceptives, strikes definitions for terms used in subdivisions establishing exceptions to and accommodations for coverage of contraceptives for exempt organizations and eligible organizations with religious objections (the definitions and the subdivisions in which the defined terms are used are being moved to another section). Effective date: This section is effective January 1, 2025, and applies to health plans offered, sold, issued, or renewed on or after that date.
39	**Scope of coverage.** Amends § 62Q.523, subd. 1. Updates a cross-reference to conform with the movement of language establishing exceptions to and accommodations for coverage of contraceptives for exempt organizations and eligible organizations to another section. Effective date: This section is effective January 1, 2025, and applies to health plans offered, sold, issued, or renewed on or after that date.

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40 **Coverage of abortions and abortion-related services.**

Adds § 62Q.524. Establishes requirements for health plan coverage of abortions and abortion-related services.

Subd. 1. Definition. Defines abortion for this section.

Subd. 2. Required coverage; cost-sharing. Requires a health plan to cover abortions and abortion-related services, including preabortion services and follow-up services. Prohibits cost-sharing for coverage of abortions and abortion-related services in an amount that is greater than the cost-sharing that applies to similar services covered under the health plan. Prohibits a health plan from imposing limitations on the coverage of abortions and abortion-related services that are not generally applicable to other coverages under the health plan.

Subd. 3. Exclusion. Provides this section does not apply to managed care organizations or county-based purchasing plans when the plan provides coverage to public health care program enrollees under medical assistance or MinnesotaCare.

Subd. 4. Reimbursement. Requires the commissioner of commerce to reimburse health plan companies for coverage under this section that would not have been provided without the requirements of this section, and annually appropriates to the commissioner an amount needed to make defrayal payments to health plan companies. Requires health carriers to report to the commissioner the costs attributable to the coverage under this section, and requires the commissioner to evaluate submissions for defrayal payments and to make defrayal payments according to federal rules.

Effective date: This section is effective January 1, 2025, and applies to health plans offered, sold, issued, or renewed on or after that date.

41 **Amino acid-based formula coverage.**

Adds § 62Q.525. Requires health plan companies to provide coverage for amino acid-based elemental formula for conditions for which the formula is medically necessary. Specifies conditions for which formula is medically necessary include but are not limited to the listed conditions.

Effective date: This section is effective January 1, 2025, and applies to health plans offered, issued, or sold on or after that date.

42 **Gender-affirming care coverage; medically necessary care.**

Adds § 62Q.585. Establishes requirements for health plan coverage of gender-affirming care.

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Subd. 1. Requirement. Prohibits a health plan that covers physical or mental health services from excluding coverage for medically necessary gender-affirming care, or requiring gender-affirming treatments to meet a definition of medically necessary care that is more restrictive than the definition in subd. 2.

Subd. 2. Minimum definition. Defines medically necessary care as health care services appropriate in type, frequency, level, setting, and duration to the enrollee's diagnosis or condition; diagnostic testing; and preventive services. Requires medically necessary care to be consistent with generally accepted practice parameters and to either help restore or maintain enrollee health or prevent deterioration of the enrollee's condition.

Subd. 3. Definitions. Defines gender-affirming care and health plan for this section.

43 **Coverage for orthotic and prosthetic devices.**

Adds § 62Q.665.

Subd. 1. Definitions. Defines the following terms: accredited facility, orthosis, orthotics, prosthesis, and prosthetics.

Subd. 2. Coverage. (a) Requires a health plan to provide coverage for orthotic and prosthetic devices, supplies, and services, including repair and replacement, at least equal to that provided under Medicare, to the extent consistent with this section.

(b) Prohibits a health plan from subjecting this coverage to separate financial requirements, and requires any cost-sharing to not be more restrictive than that applied to medical and surgical benefits.

(c) Requires any benefit restrictions or financial requirements related to out-of-network coverage to not be more restrictive than those applied to medical and surgical benefits.

(d) Requires a health plan to cover orthoses and prostheses upon an order by a prescriber, and requires coverage to include devices, systems, supplies, accessories, and services that are customized to the covered individual's needs.

(e) Requires a health plan to cover orthoses and prostheses determined by the enrollee's provider to be the most appropriate model that meets the medical needs of the enrollees related to performing physical activities.

(f) Requires coverage of orthoses and prostheses for showering or bathing.

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	Subd. 3. Prior authorization. Allows a health plan to require prior authorization for orthotic and prosthetic devices, supplies, and services in the same manner and to the same extent as is required for any other covered benefit. **Subd. 4. Reimbursement.** Requires the commissioner of commerce to reimburse health plan companies for coverage under this section that would not have been provided without the requirements of this section, and annually appropriates to the commissioner an amount needed to make defrayal payments to health plan companies. Requires health carriers to report to the commissioner the costs attributable to the coverage under this section, and requires the commissioner to evaluate submissions for defrayal payments and to make defrayal payments according to federal rules. States that this section is effective January 1, 2025, and applies to health plans offered, issued, or renewed on or after that date.
44	**Medical necessity and nondiscrimination standards for coverage of prosthetics or orthotics.** Adds § 62Q.666. Sets requirements related to coverage and nondiscrimination standards for prosthetic or orthotic benefits. (a) Requires a health plan company to apply the most recent version of evidence-based treatment and fit criteria, when performing a utilization review. (b) Requires utilization review determinations to be rendered in a nondiscriminatory manner. (c) Prohibits denial of a prosthetic or orthotic benefit for an individual with limb loss or absence, if it would otherwise be covered for a nondisabled person as part of medical or surgical intervention. (d) Requires the evidence of coverage and any benefit denial letters to include language related to enrollee rights pursuant to paragraphs (b) and (c). (e) Requires a health plan to ensure access to medically necessary clinical care and to devices and technology from not less than two in-network prosthetic and orthotic providers located in Minnesota. Specifies requirements related to out-of-network coverage. (f) Specifies requirements related to the replacement of prosthetic and orthotic devices.

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

States that this section is effective January 1, 2025, and applies to health plans offered, issued, or renewed on or after that date.

45 **Religious objections.**

Adds § 62Q.679. Establishes exceptions to and accommodations for coverage of contraceptives, abortions and abortion-related services, and gender-affirming care for organizations with religious objections to covering these services. These exceptions and accommodations exist in current law for coverage of contraceptives and are being modified to include coverage of abortions and abortion-related services and gender-affirming care.

Subd. 1. Definitions. Defines terms for this section: closely held for-profit entity, eligible organization, exempt organization.

Subd. 2. Exemption. Provides an exempt organization is not required to cover contraceptives, abortions and abortion-related services, or gender-affirming care if the exempt organization has religious objections. Requires an exempt organization with a religious objection to the coverage to notify its employees, and if the exempt organization provides partial coverage, requires the notice to specify the services not covered.

Subd. 3. Accommodation for eligible organizations. Allows an eligible organization to not cover some or all benefits for contraceptives, abortions and abortion-related services, or gender-affirming care if the organization has religious objections to covering some or all of the services. Requires notice from an eligible organization to the organization's health plan company if the organization has religious objections to covering the services, lists what the notice must include, and requires a health plan company that receives such a notice to exclude coverage of those benefits from the organization's health plan and provide separate payments for coverage of contraceptives, abortions and abortion-related services, or gender-affirming care. Prohibits the health plan company from imposing cost-sharing, premiums, fees, or other charges on the enrollee for coverage of contraceptives, and prohibits the health plan company from imposing premiums, fees, or other charges on the eligible organization or health plan for coverage of contraceptives, abortions and abortion-related services, or gender-affirming care. Requires health plan companies to annually report to the commissioner of commerce, the number of eligible organizations granted an accommodation under this subdivision.

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	Effective date: This section is effective January 1, 2025, and applies to health plans offered, sold, issued, or renewed on or after that date.
46	**Exception.** Amends § 62Q.73, subd. 2. Effective January 1, 2026, excludes the medical assistance fee-for-service program from a section authorizing independent external reviews of adverse determinations related to health care claims or whether a health care service is medically necessary.
47	**Reports on interagency agreements and intra-agency transfers.** Amends § 62V05, subd. 12. Requires the MNsure board to submit reports to the legislature on interagency agreements and intra-agency transfers annually according to section 15.0395 (the general reporting provisions that apply to state agencies generally). Strikes language in this subdivision that requires the board to report, on a quarterly basis, information similar to that required by section 15.0395. States that the section is effective the day following final enactment.
48	**Reports.** Amends § 62V.08. Changes from January 15 to March 31 the reporting date for an annual MNsure report to the legislature on MNsure performance, responsibilities, budget activities, compliance with data practice laws, and outreach and implementation.
49	**Review of costs.** Amends § 62V.11, subd. 4. Changes from March 15 to March 31 of each year the date by which the MNsure board must submit its annual budget for the next fiscal year, to the Legislative Oversight Committee.
50	**Definitions.** Amends § 145D.01, subd. 1. Provides the definitions in this subdivision apply only to this section and section 145D.02, and not to all of chapter 145D. (This change is to conform with sections being added to this chapter to which other definitions apply.)
51	**Definitions.** Adds § 145D.30. Defines terms for sections governing nonprofit health coverage entity conversion transactions: commissioner, control, conversion benefit entity, conversion transaction, corporation, director, family member, full and fair value, key employee, nonprofit health coverage entity, officer, public benefit assets, and related organization.

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52 **Certain conversion transactions prohibited.**

Adds § 145D.31. Prohibits a nonprofit health coverage entity from entering into a conversion transaction if:

- doing so would result in less than full and fair market value of all public benefit assets remaining dedicated to the public benefit; or
- an individual who has been an executive of the nonprofit health coverage entity or of a related organization, or a family member, has a financial interest in the entity to which public benefit assets are transferred, or in an entity with a business relationship with the entity to which public benefit assets are transferred; or receives financial benefit from the entity to which public benefit assets are transferred, or from an entity with a business relationship with the entity to which public benefit assets are transferred.

53 **Requirements for nonprofit health coverage entity conversion transactions.**

Adds § 145D.32. Establishes requirements for nonprofit health coverage entity conversion transactions, including notice and a waiting period. As part of the transaction, requires the value of the entity's public benefit assets to be transferred to one or more conversion benefit entities.

Subd. 1. Notice. Before entering into a conversion transaction, requires a nonprofit health coverage entity to notify the attorney general and include the listed information in the notice. Also requires the entity to provide the notice to the commissioner of health or commissioner of commerce, as applicable.

Subd. 2. Nonprofit health coverage entity requirements. Before entering into a conversion transaction, requires the nonprofit health coverage entity to ensure:

- the transaction complies with chapters 317A and 501B;
- the transaction does not involve or constitute a breach of charitable trust;
- the entity will receive full and fair value for its public benefit assets;
- the value of the assets to be transferred has not been manipulated in a way to cause the value of the assets to decrease;
- the proceeds of the transaction will be used in a manner that is consistent with the public benefit for which the assets are held by the nonprofit health coverage entity;
- the transaction will not result in a breach of fiduciary duty; and
- the conversion benefit entity receiving the value of the public benefit assets meets the requirements in section 145D.33.

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Subd. 3. Listening sessions and public comment. Allows the attorney general or commissioner to hold public listening sessions and solicit public comments regarding the proposed conversion transaction.

Subd. 4. Waiting period. Prohibits a nonprofit health coverage entity from entering into a conversion transaction until 90 days after the entity provided notice as required under subdivision 1. Allows the attorney general to waive all or part of the waiting period or extend the waiting period for an additional 90 days by notifying the nonprofit health coverage entity. Suspends these time periods while an investigation into the transaction is pending or while a request for additional information is outstanding.

Subd. 5. Transfer of value of assets required. As part of a conversion transaction, requires the nonprofit health coverage entity to transfer the entirety of the full and fair value of its public benefit assets to one or more conversion benefit entities.

Subd. 6. Funds restricted for a particular purpose. Requires a nonprofit health coverage entity to comply with requirements for funds that are restricted for a particular purpose.

54 **Conversion benefit entity requirements.**

Adds § 145D.33. Establishes requirements a conversion benefit entity must meet to be able to have the full and fair value of a nonprofit health coverage entity's public benefit assets transferred to it as part of a conversion transaction.

Subd. 1. Requirements. In order to receive the value of a nonprofit health coverage entity's public benefit assets, requires the conversion benefit entity to be a domestic, nonprofit corporation, nonprofit limited liability company, or wholly owned subsidiary thereof, that is also exempt under section 501(c)(3); have procedures in place to prohibit conflicts of interest; operate to benefit the health of the people of this state; have in place certain procedures related to officers, directors, and key employees; not provide financial benefit to an entity to which the nonprofit health coverage entity transfers public benefit assets or to a related organization; and not have certain individuals as officers, directors, or key employees.

Subd. 2. Review and approval. Requires the commissioner to review and approve a conversion benefit entity before it receives the value of public benefit assets. Lists criteria that must be met for the conversion benefit entity to be approved, and allows the commissioner to hold a public hearing as part of the review of the conversion benefit entity's governance.

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Subd. 3. Community advisory committee. Requires the commissioner to establish a community advisory committee for a conversion benefit entity receiving the value of public benefit assets, and lists duties for the advisory committee.

55 **Enforcement and remedies.**

Adds § 145D.34.

Subd. 1. Investigation. Provides the attorney general has the powers in section 8.31, and that this subdivision does not limit the powers of the attorney general under other law. States an approval by the commissioner for regulatory purposes does not impair or inform the attorney general's authority.

Subd. 2. Enforcement and penalties. Allows the attorney general to bring an action to enjoin or unwind a conversion transaction or seek other equitable relief to protect the public interest, if the nonprofit health coverage entity or conversion transaction violates sections 145D.30 to 145D.33 or the conversion transaction is contrary to the public interest or if the entities involved in the conversion transaction fail to provide timely information to the attorney general or commissioner. Lists factors informing whether a conversion transaction is contrary to the public interest. Establishes civil penalties for an officer, director, or other executive found to have violated sections 145D.30 to 145D.33, and for an entity that is a party to or materially participated in a conversion transaction found to have violated sections 145D.30 to 145D.33. Allows a court to award reasonable attorney fees and costs.

Subd. 3. Commissioner of health; data and research. Requires the commissioner of health to provide the attorney general, upon request, with data and research on market trends, impacts on prices and outcomes, public health and population health considerations, and health care access, to be used to evaluate whether a conversion transaction is contrary to the public interest.

Subd. 4. Failure to take action. Provides failure by the attorney general to take action under this section does not constitute approval of the conversion transaction or waiver, and does not prevent the attorney general from taking action is similar circumstances in the future.

56 **Data practices.**

Adds § 145D.35. Provides section 13.65 (classifying data held by the attorney general's office) applies to data submitted to the attorney general under sections 145D.30 to 145D.33, and section 13.39 (classifying civil investigation data) applies to data held by the commissioner under those sections. Allows the attorney general or

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	commissioner to make confidential or protected nonpublic data accessible to a law enforcement agency if it is determined that access aids the law enforcement process.
57	**Commissioner of health; reports and analysis.** Adds § 145D.36. Allows the commissioner of health to use certain data and information to analyze the aggregate impact of nonprofit health care entity transactions on health care access, quality, and costs, and health care market consolidation. Requires the commissioner of health to issue periodic public reports on the number and type of conversion transactions subject to sections 145D.30 to 145D.33 and the impact of these transactions on health care costs, quality, and competition in Minnesota.
58	**Relation to other law.** Adds § 145D.37. Provides sections 145D.30 to 145D.36 are in addition to and do not affect or limit powers and responsibilities of a health maintenance organization, a service plan corporation, a conversion benefit entity, the attorney general, the commissioner of health, or the commissioner of commerce under existing law. States nothing in sections 145D.30 to 145D.36 authorizes a nonprofit health coverage entity to enter into a conversion transaction not permitted under chapter 317A, 501B, or other law.
59	**Eyeglasses.** Amends § 256B.0625, subd. 12. Strikes language related to MA coverage of dentures and prosthetic and orthotic devices (MA coverage of these devices is specified elsewhere in statute). States that this section is effective January 1, 2025, or upon federal approval, whichever is later.
60	**Abortion services.** Amends § 256B.0625, subd. 16. Requires medical assistance to cover abortions and abortion-related services, including preabortion services and follow-up services, and strikes requirements that abortion services must be medically necessary and delivered in accordance with applicable Minnesota laws. Effective date: This section is effective January 1, 2025, or upon federal approval, whichever is later. The commissioner of human services must notify the revisor of statutes when federal approval is obtained.
61	**Applicability of utilization review provisions.** Adds subd. 25c to § 256B.0625. Effective January 1, 2026, provides statutes on the following apply to the commissioner of human services when delivering services through fee-for-service under chapters 256B and 256L: certain definitions in chapter 62M; standards for the performance of utilization reviews; procedures for standard

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and expedited reviews of utilization review requests; procedures for appeals of adverse determinations; requirements for prior authorizations; use of evidence-based standards; staff qualifications and program requirements for utilization review organizations; review procedures; prohibition on inappropriate incentives; and continuity of care in cases of changes in prior authorization clinical criteria.

62 **Nutritional products.**

Amends § 256B.0625, subd. 32. In a subdivision governing medical assistance coverage of nutritional products, requires medical assistance to cover amino acid-based elemental formulas in the same manner as required under section 62Q.525, which requires coverage for these formulas for conditions for which the formula is medically necessary.

Effective date: This section is effective January 1, 2025.

63 **Orthotic and prosthetic devices.**

Amends § 256B.0625, by adding subd. 72. States that MA covers orthotic and prosthetic devices, supplies, and services, according to section 256B.066. States that this section is effective January 1, 2025, or upon federal approval, whichever is later.

64 **Rapid whole genome sequencing.**

Adds subd. 73 to § 256B.0625. Provides that medical assistance covers rapid whole genome sequencing according to section 62A.3098, subdivisions 1 to 3 and 6.

Effective date: This section is effective January 1, 2025.

65 **Scalp hair prostheses.**

Amends § 256B.0625, by adding subd. 74. Requires MA to cover scalp hair prosthesis for hair loss due to treatment for cancer. Requires MA to meet the requirements that would otherwise apply to a health plan under section 62A.28, except that MA coverage may exceed the annual dollar limit for scalp hair prostheses of $1,000 per benefit year that applies to commercial coverage. States that this section is effective January 1, 2025.

66 **Orthotic and prosthetic devices, supplies, and services.**

Adds § 256B.066. Specifies requirements related to MA coverage for orthotic and prosthetic devices, supplies, and services. Many of the requirements are identical to or similar to those that apply to private sector health plan coverage, as specified in sections 62Q.665 and 62Q.666.

Subd. 1. Definitions. Provides that the definitions in section 62Q.665, subdivision 1, apply to this section.

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Subd. 2. Coverage requirements. (a) Requires MA to cover orthoses and prostheses: (1) upon an order by a prescriber, and requires coverage to include devices, systems, supplies, accessories, and services that are customized to the enrollee's needs; (2) determined by the enrollee's provider to be the most appropriate model that meets the medical needs of the enrollees related to performing physical activities; or (3) for showering or bathing.

(b) Provides that the coverage in paragraph (a) includes the repair and replacement of orthotic and prosthetic devices, supplies, and services.

(c) Prohibits denial of a prosthetic or orthotic benefit for an individual with limb loss or absence, if it would otherwise be covered for a nondisabled person as part of medical or surgical intervention.

(d) Specifies requirements related to the replacement of prosthetic and orthotic devices.

Subd. 3. Restrictions on coverage. (a) Allows prior authorization to be required for orthotic and prosthetic devices, supplies, and services.

(b) Requires the most recent version of evidence-based treatment and fit criteria to be applied when performing a utilization review.

(c) Requires utilization review determinations to be rendered in a nondiscriminatory manner.

(d) Requires the evidence of coverage and any benefit denial letters to include language related to enrollee rights pursuant to paragraphs (b) and (c).

(e) Allows MA to require confirmation from a prescribing health care provider if the prosthetic or custom orthotic device or part being replaced is less than three years old.

Subd. 4. Managed care plan access to care. (a) Requires managed care and county-based purchasing plans to ensure access to medically necessary clinical care and to devices and technology from not less than two in-network prosthetic and orthotic providers located in Minnesota.

(b) Specifies requirements related to out-of-network coverage.

States that this section is effective January 1, 2025, or upon federal approval, whichever is later.

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67 **When required.**

Amends § 317A.811, subd. 1. Adds nonprofit health coverage entities to the nonprofit corporations that must provide notice to the attorney general if they intend to dissolve, merge, consolidate, or convert, or transfer all or substantially all of their assets.

68 **Commissioner of health; analysis and report to the legislature.**

Requires the commissioner of health to use the data submitted by utilization review organizations and other available data to analyze the use of utilization management tools in health care. Lists what the analysis must include, and requires the commissioner to develop recommendations for simplifying prior authorization standards and processes, including recommendations for a prior authorization exemption process for certain providers and group practices. Requires the commissioner to submit the analysis and recommendations to the legislature by December 15, 2026.

69 **Initial reports to commissioner of health; utilization management tools.**

Requires utilization review organizations to submit to the commissioner of health, by September 1, 2025, initial reports on prior authorizations during the previous calendar year.

70 **Transition.**

Provides a health maintenance organization that has a certificate of authority but that is not a nonprofit corporation or a local governmental unit:

- must not offer, sell, issue, or renew health maintenance contracts on or after August 1, 2024;
- may otherwise continue to operate as an HMO until December 31, 2025; and
- must provide notice to HMO enrollees by October 1, 2024, of the date the HMO will cease to operate in Minnesota, and any plans to transition enrollees to another insurer.

Prohibits the commissioner of health from issuing or renewing a certificate of authority to an HMO on or after August 1, 2024, unless the HMO meets the requirements in chapter 62D to operate as an HMO in effect on or after August 1, 2024.

71 **Repealer.**

Repeals:

Section	Description - Article 4: Health Insurance
	▪ § 62A.041, subd. 3 (in a section prohibiting discrimination against unmarried women and minors in covering maternity benefits, repeals a subdivision providing the term maternity benefits does not include elective, induced abortion) ▪ § 62Q.522, subds. 3 and 4 (exceptions to and accommodations for coverage of contraceptives for exempt organizations and eligible organizations with religious objections to the coverage; these exceptions and accommodations are being moved to another section) Effective date: This section is effective January 1, 2025, and applies to health plans offered, sold, issued, or renewed on or after that date.

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This article modifies provisions governing financial examinations of health maintenance organizations, permits for groundwater thermal exchange devices, required reports to the legislature, the health professional education loan forgiveness program, the health professionals clinical training expansion grant program, notice and hearing requirements when a hospital closes or modifies operations, supplemental nursing services agencies, and the 988 telecommunications fee. It also establishes requirements for the licensure of natural organic reduction facilities and authorizes natural organic reduction of dead human bodies.

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1	**Examination authority.** Amends § 62D.14, subd. 1. Changes the timeframe within which the commissioner of health must examine the affairs of health maintenance organizations, from at least every three years to at least every five years.
2	**Permit.** Amends § 103I.621, subd. 1. In a subdivision governing permits for groundwater thermal exchange devices, requires small systems and larger systems to comply with the water-use requirements in chapter 103G, in order to obtain a permit to operate a groundwater thermal exchange device. Allows up to 100 permits to be issued for larger systems, rather than up to ten permits as in current law. Changes the capacity parameters for larger systems from systems with a maximum capacity of 20 to 50 gallons per minute to systems with a maximum capacity of over 20 gallons per minute. Removes specific inspection requirements (systems must still agree to allow inspections by the commissioner as a condition of obtaining a permit). Requires property owners to comply with permit conditions and lists items that may be included as permit conditions, and requires property owners or agents to submit

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	permit applications on forms provided by the commissioner. Specifies a permit under this section is not valid if the project requires but does not have a water-use permit from the commissioner of natural resources. Effective date: This section is effective the day following final enactment.
3	**Water-use requirements apply.** Amends § 103I.621, subd. 2. Provides that water-use permit requirements and penalties under chapter 103G, rather than chapter 103F as in current law, apply to recipients of a permit for a groundwater thermal heat exchange device. Effective date: This section is effective the day following final enactment.
4	**Reports on interagency agreements and intra-agency transfers.** Amends § 144.05, subd. 6. Strikes language establishing requirements for the commissioner of health to provide quarterly reports to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services on specified elements of interagency agreements and intra-agency transfers. Instead requires the commissioner to provide the interagency agreements and intra-agency transfers report according to section 15.0395. With this change, the reports are annual rather than quarterly, the commissioner is no longer required to submit copies of the agreements, and agreements that authorize enterprise central services and transfers required by law are not required to be reported.
5	**Availability.** Amends § 144.1501, subd. 2. For the health professional education loan forgiveness program, strikes language establishing a health professional education loan forgiveness account and authorizing the commissioner to use money from the account for loan forgiveness, and instead authorizes the commissioner to use money appropriated for health professional education loan forgiveness for loan forgiveness according to this section. Specifies appropriations for loan forgiveness under this section do not cancel except for uncommitted appropriations at the end of the biennium, and strikes other references to the account. Also adds physicians to the occupations eligible for loan forgiveness under this program.
6	**Penalty for nonfulfillment.** Amends § 144.1501, subd. 5. Requires repayments received from a participant in the health professional education loan forgiveness program who fails to fulfill the participant's service commitment to be deposited in a dedicated account in the special revenue fund, rather than in the health professional education loan forgiveness account as in current law. Annually appropriates the balance in the dedicated account to the commissioner to provide loan forgiveness.

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7	**Programs.** Amends § 144.1505, subd. 2. Modifies the health professionals clinical training expansion grant program to eliminate the per-year grant limit but maintain the total $300,000 grant limit for a training site. Authorizes the commissioner to provide a one-year, no-cost grant extension.
8	**Notice of closing, curtailing operations, relocating services, or ceasing to offer certain services; hospitals.** Amends § 144.555, subd. 1a. Changes the time frame within which a hospital or hospital campus must notify the commissioner of health and others before it voluntarily closes, curtails operations, relocates services, or stops offering certain services, from 120 days to 182 days. Requires the notice to comply with the requirements in a new subdivision 1d.
9	**Public hearing.** Amends § 144.555, subd. 1b. Changes the time frame within which the commissioner must hold a public hearing on the scheduled cessation, curtailment, or relocation, from 45 days after receiving notice from the hospital to 30 days after receiving notice. Requires the hearing to be held at a location within 30 miles of the hospital or hospital campus and at a location arranged by the hospital or hospital campus, and requires video conferencing technology to be used.
10	**Method of providing notice; content of notice.** Adds subd. 1d to § 144.555. Requires a hospital or hospital campus to provide notice to patients, the public, local units of government, the commissioner of health, and personnel of the affected unit, hospital, or hospital campus of its proposed closure, cessation, or curtailment, by the listed methods. Lists information the notice must include.
11	**Penalty; facilities other than hospitals.** Amends § 144.555, subd. 2. Makes a change to conform with the penalties for hospitals that violate section 144.555 being moved to a new subdivision 3.
12	**Penalties; hospitals.** Adds subd. 3 to § 144.555. Allows the commissioner to issue a correction order if a hospital or hospital campus fails to participate in a public hearing or fails to notify the commissioner (this is current law and is being moved from subdivision 2). Requires the commissioner to impose on the controlling persons of a hospital or hospital campus, a fine of $20,000 for each failure to provide notice to the public, a government entity, or affected personnel of the hospital or hospital campus in the manner required under subdivision 1d, with the total fine amount not to exceed $60,000 for a single scheduled action. Provides the commissioner is not required to

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	issue a correction order before imposing this fine, and provides a person on whom a penalty is imposed has a right to a hearing.
13	**Right of first refusal; sale of hospital or hospital campus.** Adds § 144.556. Before a hospital or hospital campus may be sold or offered for sale, requires the controlling persons to first make a good faith effort to sell or convey the hospital or hospital campus to a local unit of government where the hospital or hospital campus is located at a price which is not above its fair market value. Requires the party to whom the offer is made to accept or decline the offer within 60 days of receipt, and if the party to whom the offer is made fails to respond within 60 days, provides the offer is deemed declined.
14	**Controlling person.** Amends § 144A.70, subd. 3. Modifies the definition of controlling person for sections governing registration of supplemental nursing services agencies.
15	**Person.** Amends § 144A.70, subd. 5. Modifies the definition of person for sections governing registration of supplemental nursing services agencies by removing a reference to firm and adding limited liability company.
16	**Supplemental nursing services agency.** Amends § 144A.70, subd. 6. Modifies the definition of supplemental nursing services agency for sections governing their registration by removing a reference to firm and adding limited liability company to the list of entities that may operate as an SNSA.
17	**Oversight.** Amends § 144A.70, subd. 7. Changes the frequency of surveys of SNSAs by the commissioner from annually to semiannually and allows the commissioner to also perform follow-up surveys.
18	**Application information and fee.** Amends § 144A.71, subd. 2. Modifies the information that must be included on an application for SNSA registration, to require: the names and addresses of the controlling persons of the SNSA; if the owner is a limited liability company, copies of its articles of organization and operating agreement; documentation of medical malpractice insurance; documentation of holding an employee dishonesty bond; documentation of workers' compensation insurance; and documentation that certain information has been filed with the commissioner of revenue (certain of these requirements are being moved from another section). Also specifies the registration fee is nonrefundable.

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19 **Renewal applications.**

Adds subd. 2a to § 144A.71. Requires an applicant for renewal of SNSA registration to complete the form provided by the department at least 60 days before the current registration expires.

20 **Penalties.**

Adds § 144A.715. Provides a violation of sections governing SNSAs that is not corrected by the time of a follow-up survey subjects the entity to a fine, and authorizes a subsequent fine if the violation is not corrected after a subsequent follow-up survey. Requires payment of a fine within 15 business days from receipt of the notice of the fine.

21 **Minimum criteria.**

Amends § 144A.72, subd. 1. Adds to the conditions of registration as an SNSA, that:

- owners and controlling persons of an SNSA must complete a background study and receive a clearance or set aside of a disqualification; and
- the SNSA verifies competency of the individuals it places, with a fine of $3,000 for violating this clause.

Establishes fines for $3,000 if an SNSA restricts the employment opportunities of its employees or requires an employee or facility to pay damages or fees if the facility hires the employee as a permanent employee. Strikes certain conditions related to insurance, an employee dishonesty bond, and filing certain information with the commissioner of revenue; these requirements are moved to another section.

22 **Complaint system.**

Amends § 144A.73. Specifies the commissioner of health, not the Office of Health Facility Complaints, investigates complaints against SNSAs.

23 **988 telecommunications fee.**

Amends § 145.561, subd. 4. Removes the authority of the commissioner of health to recommend to the Public Utilities Commission a fee amount for the monthly 988 telecommunications fee, and instead sets the 988 telecommunications fee at 12 cents per month for each wireline, wireless, or IP-enabled voice service.

Effective date: This section is effective September 1, 2024.

24 **Arrangements for disposition.**

Amends § 149A.02, subd. 3. Effective July 1, 2025, amends the definition of arrangements for disposition to include disposition by natural organic reduction.

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25	**Final disposition.** Amends § 149A.02, subd. 16. Effective July 1, 2025, amends the definition of final disposition to include disposition by means of natural organic reduction.
26	**Inurnment.** Amends § 149A.02, subd. 26a. Effective July 1, 2025, amends the definition of inurnment to include placing naturally reduced remains in a suitable container for placement, burial, or shipment.
27	**Licensee.** Amends § 149A.02, subd. 27. Effective July 1, 2025, amends the definition of licensee to include a person or entity with a license from the commissioner of health to operate a natural organic reduction facility.
28	**Natural organic reduction or naturally reduce.** Adds subd. 30b to § 149A.02. Defines natural organic reduction or naturally reduce as the contained accelerated conversion of a dead human body to soil. This subdivision is effective July 1, 2025.
29	**Natural organic reduction facility.** Adds subd. 30c to § 149A.02 Defines natural organic reduction facility as a structure or space in a building or real property where natural organic reduction occurs. This subdivision is effective July 1, 2025.
30	**Natural organic reduction vessel.** Adds subd. 30d to § 149A.02. Defines natural organic reduction vessel as an enclosed container in which natural organic reduction takes place. This subdivision is effective July 1, 2025.
31	**Naturally reduced remains.** Adds subd. 30e to § 149A.02. Defines naturally reduced remains as the soil remains after the natural organic reduction of a dead human body, and accompanying plant material. This subdivision is effective July 1, 2025.
32	**Naturally reduced remains container.** Adds subd. 30f to § 149A.02. Defines naturally reduced remains container as a container in which naturally reduced remains are placed. This subdivision is effective July 1, 2025.

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33 **Processing.**

Amends § 149A.02, subd. 35. Effective July 1, 2025, amends the definition of processing to include reducing naturally reduced remains by mechanical means to a granulated appearance appropriate for final disposition.

34 **Scattering.**

Amends § 149A.02, subd. 37c. Effective July 1, 2025, amends the definition of scattering to include the authorized dispersal of naturally reduced remains in a defined area of a dedicated cemetery or area where no local prohibition exists.

35 **Duties of commissioner.**

Amends § 149A.03. Amends the duties of the commissioner of health related to mortuary science and the disposition of human bodies, to include enforcing laws and adopting rules on the licensing and operation of natural organic reduction facilities. This amendment is effective July 1, 2025.

36 **License to operate a natural organic reduction facility.**

Adds § 149A.56. Requires a natural organic reduction facility to be licensed by the commissioner of health in order to operate, and establishes requirements for natural organic reduction facilities. This section is effective July 1, 2025.

Subd. 1. License requirement. Prohibits a person from operating a place to perform natural organic reduction of dead human bodies without possessing a license to operate a natural organic reduction facility issued by the commissioner of health.

Subd. 2. Requirements for natural organic reduction facility. Requires a natural organic reduction facility to consist of a building that contains one or more natural organic reduction vessels; a motorized mechanical device to process naturally reduced remains; and a refrigerated holding facility for dead human bodies awaiting natural organic reduction. Allows a facility to contain a display room for funeral goods.

Subd. 3. Application procedure; documentation; initial inspection. Requires an applicant for a license to operate a natural organic reduction facility to apply to the commissioner and specifies what a completed application must include. Upon receipt of the application and fee, requires the commissioner to review and verify information, conduct an initial inspection, grant or deny licensure, and notify the applicant. Requires notice to the applicant to be in writing if the application is denied.

Subd. 4. Nontransferability of license. Provides a license to operate a natural organic reduction facility is not transferable, and that a license is only valid for

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the location listed on the license. Provides a 50 percent or more change in ownership or location automatically terminates the license.

Subd. 5. Display of license. Requires a license to operate a natural organic reduction facility to be conspicuously displayed on the premises at all times.

Subd. 6. Period of licensure. Provides a license to operate a natural organic reduction facility is valid from July 1 to June 30.

Subd. 7. Reporting changes in license information. Requires changes in license information to be reported to the commissioner within 30 days after the change, and provides failure to report the change is grounds for disciplinary action.

Subd. 8. Licensing information. Provides section 13.41 applies to data collected and maintained by the commissioner under this section. (Section 13.41 classifies and provides for access to data held by a state agency related to professional or other types of licenses.)

37 **Renewal of license to operate a natural organic reduction facility.**

Adds § 149A.57. Establishes requirements for renewal of a license for a natural organic reduction facility. This section is effective July 1, 2025.

Subd. 1. Renewal required. Makes natural organic reduction facility licenses expire on June 30, and requires licenses to be renewed to remain valid.

Subd. 2. Renewal procedure and documentation. Requires a licensee who wants to renew a license to submit a completed renewal application by June 30 following the date of licensure, and specifies what a completed renewal application must include. Upon receipt of the completed renewal application, requires the commissioner to review and verify the information, make a determination to renew or not renew the license, and notify the applicant for renewal of the determination. If the determination is to not renew the license, requires the notification to be in writing and allows a hearing to be requested.

Subd. 3. Penalty for late filing. Provides renewal applications received after a license expires will result in assessment of a late fee, and requires the late fee to be paid within 31 days after the license expires for the license to be reissued.

Subd. 4. Lapse of license. Provides a license to operate a natural organic reduction facility lapses if the renewal application and late fee are not submitted to the commissioner within 31 days after the license expires.

Subd. 5. Effect of lapse of license. When a license lapses, provides the person to whom the license was issued is no longer licensed to operate a natural organic

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reduction facility, and requires the commissioner to issue a cease and desist order to prevent the person from operating a natural organic reduction facility.

Subd. 6. Restoration of lapsed license. Allows the commissioner to restore a lapsed license upon receiving and reviewing a completed application, receiving the late filing penalty, and reinspecting the premises, as long as the application is received within one year of the lapse and a cease and desist order has not been violated.

Subd. 7. Reporting changes in license information. Requires changes of license information to be reported to the commissioner within 30 days after the change occurs, and makes failure to report a change a ground for disciplinary action.

Subd. 8. Licensing information. Provides section 13.41 applies to data collected and maintained by the commissioner under this section. (Section 13.41 classifies and provides for access to data held by a state agency related to professional or other types of licenses.)

38 **Natural organic reduction facilities.**

Adds subd. 6a to § 149A.65. Sets the initial and renewal fees to license a natural organic reduction facility at $425, and the late fee charge for license renewal at $100. This subdivision is effective July 1, 2025.

39 **Use of titles.**

Amends § 149A.70, subd. 1. Effective July 1, 2025, provides that only a person with a natural organic reduction facility license may use the title natural organic reduction facility, human composting, or any other title or term implying the person operates a natural organic reduction facility.

40 **Business location.**

Amends § 149A.70, subd. 2. Effective July 1, 2025, prohibits a natural organic reduction facility from doing business at a location that is not licensed as a natural organic reduction facility.

41 **Advertising.**

Amends § 149A.70, subd. 3. Adds certain acts related to performing natural organic reductions to the list of acts that constitute false, misleading, or deceptive advertising and are prohibited under this subdivision. These amendments are effective July 1, 2025.

42 **Reimbursement prohibited.**

Amends § 149A.70, subd. 5. Effective July 1, 2025, prohibits a licensee, student, or intern from offering, asking for, or accepting a fee or other reimbursement for

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	recommending or causing a body to be disposed of by a specific natural organic reduction facility.
43	**Preventive requirements.** Amends § 149A.71, subd. 2. Adds naturally reduced remains containers to the list of funeral goods for which funeral providers must have a separate price list. Requires a funeral provider's general price list to have separate prices for each natural organic reduction, each shroud, and any natural organic reduction facility charges, and to have either the price range for shrouds and naturally reduced remains containers offered by the funeral establishment or the prices of individual containers offered by the funeral establishment. These amendments are effective July 1, 2025.
44	**Casket, alternative container, alkaline hydrolysis container, naturally reduced remains container, and cremation container sales; records; required disclosures.** Amends § 149A.71, subd. 4. Effective July 1, 2025, requires a funeral provider who sells or offers for sale a naturally reduced remains container to maintain a record of each sale, and requires the record to contain the listed information.
45	**Casket for alkaline hydrolysis, natural organic reduction, or cremation provisions; deceptive acts or practices.** Amends § 149A.72, subd. 3. Effective July 1, 2025, provides it is a deceptive act or practice for a funeral provider to represent that a casket is required under state or federal law for natural organic reductions.
46	**Deceptive acts or practices.** Amends § 149A.72, subd. 9. Effective July 1, 2025, provides it is a deceptive act or practice for a funeral provider to represent that natural organic reduction facilities require the purchase of any funeral goods or services or burial site goods or services when such a purchase is not required by natural organic reduction facilities.
47	**Casket for alkaline hydrolysis, natural organic reduction, or cremation provisions; deceptive acts or practices.** Amends § 149A.73, subd. 1. Effective July 1, 2025, provides it is a deceptive act or practice for a funeral provider to require a casket to be purchased for natural organic reduction.
48	**Services provided without prior approval; deceptive acts or practices.** Amends § 149A.74, subd. 1. Effective July 1, 2025, requires a funeral provider, in seeking permission to embalm a body, to disclose that no embalming fee will be charged if the family selects disposition by natural organic reduction.

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49 **Disposition permit.**

Amends § 149A.93, subd. 3. Effective July 1, 2025, adds natural organic reduction to the types of disposition for which a disposition permit is required.

50 **Generally.**

Amends § 149A.94, subd. 1. Adds natural organic reduction to the types of disposition that must be performed within a reasonable time after death. If natural organic reduction will not be initiated within 72 hours after death or release of the body, requires the body to be embalmed, refrigerated, or packed in dry ice. These amendments are effective July 1, 2025.

51 **Permit required.**

Amends § 149A.94, subd. 3. Adds alkaline hydrolysis and, effective July 1, 2025, natural organic reduction to the types of disposition of a dead human body for which a disposition permit is required.

52 **Alkaline hydrolysis, cremation, or natural organic reduction.**

Amends § 149A.94, subd. 4. Effective July 1, 2025, provides that inurnment of naturally reduced remains and release to an appropriate party is considered final disposition, and no further permits or authorizations are required for transportation, interment, or placement.

53 **Natural organic reduction facilities and natural organic reduction.**

Adds § 149A.955. Establishes requirements for the performance of natural organic reductions. This section is effective July 1, 2025.

Subd. 1. License required. Provides a dead human body may undergo natural organic reduction only at a licensed natural organic reduction facility.

Subd. 2. General requirements. Requires a building used as a natural organic reduction facility to comply with building codes, zoning laws, and environmental standards and have a natural organic reduction system approved by the commissioner, a motorized mechanical device for processing naturally reduced remains, and a refrigerated holding facility accessible only by authorized personnel.

Subd. 3. Aerobic reduction vessel. Requires the natural organic reduction vessel to be a contained reduction vessel designed to promote aerobic reduction and minimize odors.

Subd. 4. Unlicensed personnel. Allows a natural organic reduction facility to employ unlicensed personnel, requires the facility to provide unlicensed

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personnel with proper training, and makes the facility liable for compliance with this chapter and occupational health and safety laws.

Subd. 5. Authorization to naturally reduce. Prohibits a natural organic reduction facility from naturally reducing a dead human body or identifiable body part without written authorization to do so, and specifies what the written authorization must include.

Subd. 6. Limitation of liability. Refers to limitation of liability language that applies to crematories to make a natural organic reduction facility immune from civil liability or criminal prosecution for actions it takes, if acting in good faith, with reasonable reliance on an authorization to naturally reduce, according to an authorization to naturally reduce, and in an otherwise lawful manner.

Subd. 7. Acceptance of delivery of body. Provides a dead human body shall not be accepted for final disposition unless a licensed mortician is present; the body is wrapped in an impermeable, leak-resistant container; the body is accompanied by a disposition permit; and the body is accompanied by a natural organic reduction authorization. Lists circumstances in which a natural organic reduction facility must not accept delivery of a dead human body. Requires a body to be transferred to a new container or returned to the contracting funeral establishment if the current container is leaking. If the body is delivered in a container not suitable to be placed in a natural organic reduction vessel, requires the body to be transferred to the vessel by a licensed mortician.

Subd. 8. Bodies awaiting natural organic reduction. Requires a body to be placed in a natural organic reduction vessel to begin natural organic reduction within 24 hours after the facility accepts the body.

Subd. 9. Handling of dead human bodies. Requires facility employees handling containers holding dead human bodies to use universal precautions and use reasonable precautions to minimize the risk of transmitting a communicable disease from the body. Prohibits a body from being removed from the container in which it is delivered to the facility without authorization from the person who controls disposition, and requires removal to be performed by a licensed mortician. Provides the remains are considered a dead human body until after processing and curing are complete.

Subd. 10. Identification of the body. Requires a natural organic reduction facility to maintain identification procedures to identify dead human bodies from the time the facility accepts delivery of the body until the naturally reduced remains are released to an authorized party.

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Subd. 11. Natural organic reduction vessel for human remains. Requires a natural organic reduction facility to naturally reduce only dead human bodies or human remains in a natural organic reduction vessel.

Subd. 12. Natural organic reduction procedures; privacy. Requires final disposition of dead human bodies by natural organic reduction to be performed in privacy, and only allows authorized personnel to be in the natural organic reduction area unless there is written authorization from the person who controls final disposition that others may be present. Provides this does not prohibit a laying-in ceremony.

Subd. 13. Natural organic reduction procedures; commingling of bodies prohibited. Except with express permission of the person with the right to control final disposition of the body, prohibits a natural organic reduction facility from commingling multiple bodies in the same natural organic reduction vessel. Provides incidental residue remaining in the vessel does not violate this subdivision.

Subd. 14. Natural organic reduction procedures; removal from natural organic reduction vessel. Requires reasonable efforts to be made to remove all recoverable remains from a natural organic reduction vessel when the process is complete. Requires materials that cannot be naturally reduced to be separated from the naturally reduced remains and disposed of by the facility.

Subd. 15. Natural organic reduction procedures; processing naturally reduced remains. Requires remaining intact remains to be reduced to a granulated appearance and the granulated remains and rest of the remains to be returned to the natural organic reduction vessel for final reduction.

Subd. 16. Natural organic reduction procedures; commingling of naturally reduced remains prohibited. Except with express permission of the person with the right to control final disposition of the body, prohibits a natural organic reduction facility from commingling naturally reduced remains of more than one body at a time in the mechanical processor. Provides incidental residue remaining in the processor does not violate this subdivision.

Subd. 17. Natural organic reduction procedures; testing naturally reduced remains. Requires material in a natural organic reduction vessel to maintain a temperature of 131 degrees for at least 72 hours, and establishes testing requirements for naturally reduced remains. Requires a natural organic reduction facility to annually report to the commissioner of health on the facility's activities during the previous calendar year.

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Subd. 18. Natural organic reduction procedures; use of more than one naturally reduced remains container. If naturally reduced remains are placed in two or more containers, requires all containers to contain duplicate identification tags or labels, and requires paperwork to indicate the number and disposition of each container.

Subd. 19. Natural organic reduction procedures; disposition of accumulated residue. Requires residue in the natural organic reduction vessel, mechanical processor, and other equipment to be disposed of by any lawful manner deemed appropriate.

Subd. 20. Natural organic reduction procedures; release of naturally reduced remains. After natural organic reduction, requires the remains to be released according to instructions on the authorization for natural organic reduction. Establishes requirements when the remains are to be shipped, and when there is a dispute over the release or disposition of the remains.

Subd. 21. Unclaimed naturally reduced remains. Establishes procedures for the facility to follow if the naturally reduced remains are unclaimed.

Subd. 22. Required records. Requires a natural organic reduction facility to maintain a record of each natural organic reduction performed, and lists what the record must contain.

Subd. 23. Retention of records. Requires records on natural organic reductions to be maintained for three years after release of the remains, after which they may be placed in storage or reduced to another format for ten years after release of the remains. After ten years, the records may be destroyed.

54 **Request for information; evaluation of statewide health care needs and capacity and projections of future health care needs.**

By November 1, 2024, requires the commissioner of health to publish a request for information to assist with a future comprehensive evaluation of current health care needs and capacity in the state and projections of future health care needs. Establishes requirements for the RFI, and requires the commissioner, by February 1, 2025, to report to the chairs and ranking minority members of certain legislative committees regarding conducting the comprehensive evaluation.

55 **Repealer.**

Repeals § 144.0528, subd. 5 (this subdivision authorizes the commissioner of health, in fiscal year 2026 and subsequent fiscal years, to spend up to 25% of the appropriation for the comprehensive drug overdose and morbidity program to

Section	Description - Article 5: Department of Health Finance
	promote, administer, and evaluate the program and provide technical assistance to grantees).

Article 6: Department of Health Policy

This article establishes or modifies provisions governing registration and reporting by 340B covered entities, public comments regarding certain rules, certain reports by the commissioner of health, the director of the Antimicrobial Stewardship Collaborative, certain fees collected by the commissioner of health, nursing facility case mix reimbursement classifications, the secondary and postsecondary summer health care intern program, the international medical graduates assistance program, health records, thrombectomy-capable stroke center designations, the hospital construction moratorium, publication of information by hospitals that are nonprofits and are tax-exempt, dispute resolution regarding deficiencies issued to nursing facilities, home care providers, assisted living facilities, and supervision of temporary tattoo and body piercing technicians.

Section	Description - Article 6: Department of Health Policy
1	**340B covered entity report.** Adds § 62J.461. **Subd. 1. Definitions.** Defines the following terms: 340B covered entity, 340B Drug Pricing Program, 340B entity type, 340B ID, contract pharmacy, and pricing unit. (These terms are not defined in the current 340B reporting provision.) **Subd. 2. Current registration.** Beginning April 1, 2024, requires each 340B covered entity to maintain a current registration with the commissioner. Requires the registration to include: (1) the name of the covered entity; (2) the 340B ID of the entity; (3) the serving address of the entity; and (4) the 340B entity type. (Current law requires the covered entity to report information but does not require registration; the reporting of the information in clauses (1) and (3) is required under current law, clause (2) is a new requirement, and clause (4) modifies current language.) **Subd. 3. Reporting by covered entities to the commissioner.** (a) Requires each 340B covered entity to report to the commissioner, by April 1, 2024, and by each April 1 thereafter, the following payment and cost information related to participation in the 340B program: (1) the aggregated acquisition cost for 340B drugs obtained (required under current law); (2) the aggregated payment amount received for 340B drugs dispensed or administered to patient (reporting for drugs dispensed is required under current law); (3) the number of pricing units dispensed or administered under clause (2) (a new provision); and (4) the

Section	Description - Article 6: Department of Health Policy

aggregated payments made to: (i) contract pharmacies; (ii) other entities for program management; and (iii) for all other administrative expenses (items (ii) and (iii) are not referenced in current law). Also incorporates current law requirements related to reporting the information in clauses (2) and (3) by payer type.

(b) Incorporates the current law requirement that hospitals report specified information for the 50 most frequently dispensed or administered drugs (current law requires this reporting only for drugs that are dispensed).

(c) Incorporates the current law provision classifying the data submitted as nonpublic data.

Subd. 4. Enforcement and exceptions. Adds language on enforcement that is not included in current law. Paragraph (a) provides that any entity that fails to provide data in the form and manner specified by the commissioner is subject to a fine, to be paid to the commissioner, of up to $500 for each day the data are past due. States that any fine levied is subject to contested case and judicial review provisions. Paragraph (b) allows the commissioner to grant an extension or exemption for an entity, upon a showing of good cause.

Subd. 5. Reports to the legislature. Incorporates the current law requirement that the commissioner report aggregate data submitted by covered entities annually to the legislature, beginning November 15, 2024, and each November 15 thereafter. Adds a new provision that requires the following information to be included in the report for 340B entities whose net 340B revenue constitutes a significant share of all net 340B revenue across 340B covered entities in the state: (1) the information submitted in subdivision 2 as part of the registration; and (2) the 340B net revenue for each entity, calculated as specified. For all other entities, requires the data reported to be aggregated to the entity type or groupings in a way that prevents identification of an individual entity and an entity’s specific data reported.

2 **Opportunity for comment.**

Amends § 62J.61, subd. 5. Requires the commissioner of health to maintain an email address for comments from interested parties about the rulemaking procedures used to implement the Health Care Administration Simplification Act, rather than seeking comments by holding meetings as required under current law. Strikes language requiring the commissioner to issue a report every year to the Minnesota Health Data Institute and the Minnesota Administrative Uniformity Committee. Allows the commissioner to seek additional input and provide additional opportunities for input.

Section	Description - Article 6: Department of Health Policy

3 **Expiration of report mandates.**

Amends § 144.05, subd. 7. Amends a section providing for the expiration of required reports from the commissioner of health to the legislature, to specify that the annual report from the commissioner to certain members of the legislature listing reports set to expire during the following calendar year does not expire.

Effective date: This section is effective retroactively from January 1, 2024.

4 **Establishment.**

Amends § 144.0526, subd. 1. Requires the commissioner to hire a director for the Minnesota One Health Antimicrobial Stewardship Collaborative, rather than appointing that individual as provided under current law.

5 **Interpreter services quality initiative.**

Amends § 144.058. Provides that all fees collected by the commissioner to list a spoken language health care interpreter on the spoken language health care interpreter roster, are nonrefundable.

6 **Definitions.**

Amends § 144.0724, subd. 2. In a subdivision defining terms for a section on nursing facility resident case mix reimbursement classifications, strikes a paragraph defining resource utilization groups or RUG, modifies the definition of case mix index to mean the weighted factors assigned to the classifications determined by the assessment, and strikes a reference to a statute on medical assistance payment for nursing facility services.

7 **Resident case mix reimbursement classifications.**

Amends § 144.0724, subd. 3a. Strikes language requiring the commissioner of health to establish nursing facility case mix reimbursement classifications according to the RUG-IV resource utilization groups. Requires case mix reimbursement classifications to be based on assessments completed according to a specific manual, and requires the optional state assessment to be completed according to another specific manual. Strikes a date.

8 **Resident assessment schedule.**

Amends § 144.0724, subd. 4. In a subdivision governing assessments used to determine nursing facility resident case mix reimbursement classifications, replaces “RUG classification” with “reimbursement classification” and strikes language requiring a significant change in status assessment when all speech, occupational, and physical therapies have ended and isolation for an infectious disease has ended. Requires the optional state assessment to accompany OBRA assessments, and specifies the optional state assessment is also required to determine reimbursement

Section	Description - Article 6: Department of Health Policy
	when all speech, occupational, and physical therapies have ended and isolation for an infectious disease has ended.
9	**Penalties for late or nonsubmission.** Amends § 144.0724, subd. 6. In a subdivision specifying consequences for a facility's failure to complete or submit an assessment, specifies the consequences apply when the facility fails to complete or submit the assessment when the assessment is due, and strikes language specifying the consequences apply if the assessment is not completed or submitted within seven days of the time requirements listed in a resident assessment manual. Modifies a term used, from "RUG-IV classification" to "case mix reimbursement classification."
10	**Notice of resident case mix reimbursement classification.** Amends § 144.0724, subd. 7. Modifies terms: from "modifying assessment" to "modified assessment" and from "case mix classification" to "case mix reimbursement classification."
11	**Request for reconsideration of resident classifications.** Amends § 144.0724, subd. 8. In a subdivision governing requests for reconsideration of resident case mix reimbursement classifications, classifies data collected as part of the reconsideration process as private data on individuals and nonpublic data. Notwithstanding these classifications, allows the commissioner to share the data with the Centers for Medicare and Medicaid Services (CMS) and the commissioner of human services as needed for reimbursement. Makes other technical changes.
12	**Audit authority.** Amends § 144.0724, subd. 9. In a subdivision governing audits by the commissioner of health of the accuracy of resident assessments, adds a manual the commissioner must use when conducting audits. Replaces a reference to "RUG-IV classifications" with "case mix reimbursement classifications" and makes other technical changes.
13	**Nursing facility level of care.** Amends § 144.0724, subd. 11. Updates a cross-reference to conform with an amendment to section 144.0724, subdivision 4, and refer to both the federally required assessment and the state assessment.
14	**Summer internships.** Amends § 144.1464, subd. 1. Adds assisted living facilities to the health care facilities that may be awarded grants for the secondary and postsecondary summer health care intern program.

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15 **Criteria.**

Amends § 144.1464, subd. 2. Adds assisted living facilities to the health care facilities that may be awarded grants to employ pupils in the secondary and postsecondary summer health care intern program. Also removes an obsolete date.

16 **Grants.**

Amends § 144.1464, subd. 3. Adds assisted living facilities to the health care facilities that may be awarded grants to employ pupils in the secondary and postsecondary summer health care intern program.

17 **Definitions.**

Amends § 144.1911, subd. 2. For purposes of the international medical graduates assistance program, amends the definition of immigrant international medical graduate to include a graduate who has entered the U.S. on a temporary status based on urgent humanitarian or significant public benefits reasons (current law in part requires the graduate to permanently reside in the U.S.).

18 **Cost.**

Amends § 144.292, subd. 6. Clarifies an existing prohibition on charging fees to certain patients for copies of medical records, to specify a provider must not charge a per-page fee, retrieval fee, or any other fee for copies of medical records needed to appeal a denial of Social Security disability income or Social Security disability benefits when the patient is receiving public assistance, represented by an attorney on behalf of a civil legal services program, or represented by a volunteer attorney based on indigency. Specifies documentation the patient or representative must provide to verify the patient is eligible to obtain medical records without charge.

19 **Construction.**

Adds § 144.2925. Provides that sections 144.291 to 144.298 (the Minnesota Health Records Act) must be construed to protect the privacy of patient health records in a more stringent manner than the federal HIPAA security and privacy rules. Defines “more stringent” by reference to the definition of that term in federal rules.

This section is effective the day following final enactment.

20 **Patient consent to release of records.**

Amends § 144.293, subd. 2. Modifies a subdivision authorizing the release of patient health records in certain circumstances, to specify a provider or a person who receives health records from a provider and does not have patient consent to the release, may not release a patient’s health records without specific authorization in Minnesota law. (Currently this subdivision provides in part that a patient’s health

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records may not be released without specific authorization in law, and authorization in law has been interpreted to mean authorization in state or federal law.)

This section is effective the day following final enactment and applies to health records released on or after that date.

21 **Duration of consent.**

Amends § 144.293, subd. 4. Specifies the duration of a consent to the release of health records is governed by Minnesota law, for consents for which Minnesota law specifies a duration.

This section is effective the day following final enactment and applies to health records released on or after that date.

22 **Documentation of release.**

Amends § 144.293, subd. 9. Amends a subdivision establishing requirements for documenting provider releases of health records without patient consent to conform with the amendment to section 144.293, subd. 2.

This section is effective the day following final enactment and applies to health records released on or after that date.

23 **Warranties regarding consents, requests, and disclosures.**

Amends § 144.293, subd. 10. Amends a subdivision establishing requirements for requesting a patient's consent to the release of health records to conform with the amendment to section 144.293, subd. 2.

This section is effective the day following final enactment and applies to health records released on or after that date.

24 **Thrombectomy-capable stroke center.**

Adds subd. 2a to § 144.493. States a hospital meets the criteria for a thrombectomy-capable stroke center if the hospital:

- is certified as a thrombectomy-capable stroke center by the Joint Commission (a hospital accreditation organization) or another nationally recognized accreditation organization; or
- is a primary stroke center that has attained a level of stroke care distinction by offering mechanical endovascular therapies and has been certified by a department-approved certifying body that is a nationally recognized, guidelines-based organization.

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25 **Designation.**

Amends § 144.494, subd. 2. Allows a hospital that voluntarily meets the criteria for a thrombectomy-capable stroke center to apply to the commissioner of health for that designation. If the commissioner approves the application, provides the hospital shall be designated as such for a three-year period.

26 **Restricted construction or modification.**

Amends § 144.551, subd. 1. Adds an exception to the moratorium on hospital construction projects that increase bed capacity, relocate or redistribute beds, or establish a new hospital, to allow a project involving the relocation of up to 26 long-term acute care hospital beds from Regency Hospital in Golden Valley to dedicated space on the campus of Regions Hospital in St. Paul to operate as long-term acute care hospital beds, provided the commissioner of health finds the project is in the public interest after conducting a public interest review. (A public interest review was completed on April 5, 2024, and the project was determined to be in the public interest.)

27 **Chapter 16C waiver.**

Adds subd. 10 to § 144.605. Amends a section authorizing the commissioner of health to designate trauma hospitals that meet certain requirements, to allow the commissioner to waive provisions in chapter 16C, governing state procurement and contracting, when approving contracts for independent clinical teams.

28 **Community health needs assessment; community health improvement services; implementation.**

Adds § 144.6985.

Subd. 1. Community health needs assessment. Requires a nonprofit hospital that is tax-exempt under section 501(c)(3) of the Internal Revenue Code to make available to the public and submit to the commissioner of health its current community health needs assessment by January 15, 2026, and to make available and submit subsequent assessments within 15 calendar days after submitting the subsequent assessment to the Internal Revenue Service.

Subd. 2. Description of community. Requires a nonprofit hospital subject to subdivision 1 to make available to the public and submit to the commissioner of health a description of the community served by the hospital, and requires the description to include the listed information. Provides a hospital does not need to separately provide this information if it is included in the hospital's community health needs assessment made available and submitted under subdivision 1.

Subd. 3. Addendum; community health improvement services. Para. (a) requires a nonprofit hospital subject to subdivision 1, other than a hospital

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identified in para. (b), to annually submit to the commissioner an addendum that details information about hospital activities identified as community health improvement services with a cost of $5,000 or more. Specifies information the addendum must include for each activity.

Para. (b) requires a hospital that is subject to subdivision 1 and that is a critical access hospital, a sole community hospital, or a rural emergency hospital to annually submit to the commissioner an addendum detailing information on the ten highest-cost activities of the hospital identified as community health improvement services. Specifies information the addendum must include for each activity.

Subd. 4. Community benefit implementation strategy. Requires a nonprofit hospital subject to subdivision 1 to make available to the public, within one year after completing each community health needs assessment, a community benefit implementation strategy. Requires the strategy to be developed in consultation with certain entities, and lists information the strategy must include.

Subd. 5. Information made available to the public. Specifies a hospital required to make information available to the public under this section may do so by posting it on the hospital's website in a consolidated location and with clear labeling.

Effective date: This section is effective January 1, 2026.

29 **Duty to analyze reports; communicate findings.**

Amends § 144.7067, subd. 2. Provides the mandate for the commissioner of health to publish an annual report on adverse event reports, correction action plans, root cause analyses, and recommendations, does not expire.

Effective date: This section is effective retroactively from January 1, 2023.

30 **Informal dispute resolution.**

Amends § 144A.10, subd. 15. Modifies the timeframe within which the commissioner must respond to a certified nursing facility request for informal dispute resolution after being cited for deficiencies in a survey by the commissioner, from within 30 days of the exit date of the facility's survey to within ten calendar days of the facility's receipt of the notice of deficiencies.

Effective date: This section is effective August 1, 2024.

31 **Independent informal dispute resolution.**

Amends § 144A.10, subd. 16. Limits the situations in which certified nursing facilities may request an independent informal dispute resolution process after being cited for

Section	Description - Article 6: Department of Health Policy
	deficiencies in a survey by the commissioner, to when a facility is assessed a civil money penalty under federal rules. Requires the request to be made within ten calendar days of receiving notice the civil money penalty will be imposed. Allows the facility and commissioner to be represented by an attorney, and provides independent informal dispute resolution may not be requested for a deficiency that is the subject of informal dispute resolution. Requires independent informal dispute resolution to be conducted by an administrative law judge, rather than by an arbitrator. Specifies timelines for scheduling the proceeding, submitting arguments and evidence, and submitting a recommendation to CMS. Requires the proceeding to be informal. Provides the administrative law judge's findings and recommendations are not binding on the commissioner. Effective date: This section is effective October 1, 2024, or upon federal approval, whichever is later, and applies to appeals of deficiencies issued on or after that date.
32	**Statement of rights.** Amends § 144A.44, subd. 1. Amends the home care bill of rights, to strike a reference to receiving home care services in an assisted living facility, a requirement for 30 days' notice of terminating services for a client residing in an assisted living facility, and language providing a right to place an electronic monitoring device in a client's or resident's space. Strikes other language to conform with assisted living facility licensure. With the licensure of assisted living facilities, this bill of rights does not apply to assisted living facility residents (a separate bill of rights in chapter 144G applies to assisted living facility residents).
33	**Licensure under other law.** Adds subd. 1a to § 144A.471. Provides a home care licensee must not provide sleeping accommodations as part of its home care services, and provides a home care licensee that provides sleeping accommodations and assisted living services must be licensed as an assisted living facility.
34	**Home care surveyor training.** Amends § 144A.474, subd. 13. Amends the topics on which home care surveyors must receive training to no longer require training on the laws governing housing with services establishments, since this facility type no longer exists.
35	**Termination of service plan.** Amends § 144A.4791, subd. 10. Strikes obsolete language that requires a written notice of termination of a service plan from a home care provider to include a statement that a notice of termination of home care services does not constitute notice of termination of housing.

Section	Description - Article 6: Department of Health Policy

36 **Stroke transport protocols.**

Amends § 144E.16, subd. 7. Adds thrombectomy-capable stroke centers to the types of stroke centers for which regional emergency medical services programs and ambulance services must develop transport standards for acute stroke patients, as part of their stroke transport protocols.

37 **Licensed health professional.**

Amends § 144G.08, subd. 29. Amends the definition of licensed health professional for the assisted living facility statutes.

38 **Protected title; restriction on use.**

Adds subd. 5 to § 144G.10. Effective January 1, 2026, prohibits the use of the phrase "assisted living" to advertise, market, or otherwise describe any housing, service, package, or program provided in the state, unless the person or entity is licensed as an assisted living facility. Effective January 1, 2026, prohibits a licensee for a new assisted living facility from including the term "home care" or "nursing home" in the facility's name.

39 **Requirements for notice and transfer.**

Amends § 144G.16, subd. 6. Requires a licensee with a provisional assisted living facility license whose license is denied, when the denial is upheld by the reconsideration process, to submit a closure plan within ten calendar days of receiving the reconsideration decision.

40 **Supervisors.**

Amends § 146B.03, subd. 7a. Requires tattoo technicians and body piercing technicians to have held a regular license from the commissioner of health or be licensed by reciprocity, in order to supervise a temporary tattoo technician or temporary body piercing technician.

41 **Licensing fees.**

Amends § 146B.10, subd. 1. Specifies the fees for tattoo technician licensure, body piercing technician licensure, and licensure of body art establishments are due with the application for licensure. Strikes a paragraph setting a fee to reissue a provisional establishment license that relocates prior to inspection.

42 **Deposit.**

Amends § 146B.10. Provides that all fees for licensure of tattoo technicians, body piercing technicians, and body art establishments are nonrefundable.

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43 **Fees.**

Amends § 149A.65. Specifies the fees in this section for mortuary science licensure, license renewal, and licensure by endorsement; renewal of a funeral director license; funeral establishment licensure; crematory licensure; and alkaline hydrolysis facility licensure are due with the application for licensure or license renewal. Provides all fees under this section are nonrefundable.

44 **Facility average case mix index.**

Amends § 256R.02, subd. 20. Amends a definition of facility average case mix index in chapter 256R (nursing facility rates) to remove a reference to the resource utilization group (RUG) classification system (this change is being made to conform with amendments to section 144.0724).

45 **Revisor instruction.**

Directs the revisor of statutes to change "employee" to "staff" in the listed assisted living facility statutes.

46 **Repealer.**

Repeals:

- § 144.497 (requiring the commissioner of health to assess and report on the quality of care provided in the state for ST elevation myocardial infarction response and treatment)
- § 256R.02, subd. 46 (defining resource utilization groups or RUG for chapter 256R, nursing facility rates)
- § 62J.312, subd. 6 (reporting requirements for 340B covered entities)

Article 7: Emergency Medical Services

This article eliminates the Emergency Medical Services Regulatory Board effective January 1, 2025, and replaces it with an Office of Emergency Medical Services headed by a director to regulate the provision of emergency medical services in the state. It also modifies requirements for ambulance staffing and qualifications, training, and education program requirements for ambulance service personnel and emergency medical responders.

Section	Description - Article 7: Emergency Medical Services

1 **Agency head salaries.**

Amends § 15A.0815, subd. 2. Adds the director of the Office of Emergency Medical Services to the list of agency heads whose salaries must be determined by the Compensation Council.

Effective date: This section is effective January 1, 2025.

2 **Additional unclassified positions.**

Amends § 43A.08, subd. 1a. Adds the Office of Emergency Medical Services to the list of state departments and agencies authorized to designate unclassified positions.

Effective date: This section is effective January 1, 2025.

3 **Establishment.**

Amends § 62J.49, subd. 1. Amends a subdivision requiring the establishment of a financial data collection system for ambulance services to conform with the transfer of duties and authority from the Emergency Medical Services Regulatory Board to the Office of Emergency Medical Services and its director.

Effective date: This section is effective January 1, 2025.

4 **Ambulance service personnel.**

Amends § 144E.001, subd. 3a. In the definition of ambulance service personnel, amends the qualification requirements for registered nurses and physician assistants who may provide emergency care for an ambulance service. Instead of being required to pass a paramedic practical skills test approved by the board, requires registered nurses and physician assistants to have been approved by the ambulance service medical director to provide emergency care for the ambulance service. Also allows registered nurses certified as a certified flight registered nurse or certified emergency nurse to provide emergency care for the ambulance service.

5 **Director.**

Adds subd. 16 to § 144E.001. Defines director for chapter 144E as the director of the Office of Emergency Medical Services.

Effective date: This section is effective January 1, 2025.

6 **Office.**

Adds subd. 17 to § 144E.001. Defines office for chapter 144E as the Office of Emergency Medical Services.

Effective date: This section is effective January 1, 2025.

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7 **Office of Emergency Medical Services.**

Adds § 144E.011. Establishes the Office of Emergency Medical Services with a director appointed by the governor, and establishes duties for the director.

Subd. 1. Establishment. Establishes the Office of Emergency Medical Services with the powers and duties established in law.

Subd. 2. Director. Requires the governor to appoint a director for the office with the advice and consent of the senate, and requires the director to direct the activities of the office.

Subd. 3. Powers and duties. Lists powers and duties for the director: administering and enforcing chapter 144E and adopting rules to implement chapter 144E; licensing ambulance services and regulating their operation; establishing and modifying primary service areas; designating ambulance services to provide services in a primary service area and removing designations; registering medical response units and regulating their operation; certifying and registering individuals for the listed occupations; approving education programs and administering qualifications for instructors; administering grant programs; annually reporting to the legislature; investigating complaints and imposing disciplinary action; and performing other duties related to the provision of emergency medical services in the state.

Subd. 4. Employees. Allows the director to employ personnel in the classified services and unclassified personnel.

Subd. 5. Work plan. Requires the director to prepare a work plan to guide the work of the office, and to update the plan every two years.

Effective date: This section is effective January 1, 2025.

8 **Medical Services Division.**

Adds § 144E.015. Creates a Medical Services Division in the Office of Emergency Medical Services, under the direction of a deputy director of medical services appointed by the director. Specifies the deputy director must be a physician licensed under chapter 147. Requires the deputy director to enforce and coordinate laws, rules, and policies assigned by the director, including clinical aspects of prehospital medical care and education programs for emergency medical service personnel.

Effective date: This section is effective January 1, 2025.

9 **Ambulance Services Division.**

Adds § 144E.016. Creates an Ambulance Services Division in the Office of Emergency Medical Services, under the direction of a deputy director of ambulance services

Section	Description - Article 7: Emergency Medical Services

appointed by the director. Requires the deputy director to enforce and coordinate laws, rules, and policies assigned by the director, including operating standards and licensing of ambulance services, registration and operation of medical response units, establishing and modifying primary service areas, coordination of ambulance services, and administration of grants.

Effective date: This section is effective January 1, 2025.

10 **Emergency Medical Service Providers Division.**

Adds § 144E.017. Creates an Emergency Medical Service Providers Division in the Office of Emergency Medical Services, under the direction of a deputy director of emergency medical service providers appointed by the director. Requires the deputy director to enforce and coordinate laws, rules, and policies assigned by the director, including certification and registration of emergency medical service providers; overseeing worker safety, well-being, and working conditions; implementing education programs; and administration of grants.

Effective date: This section is effective January 1, 2025.

11 **Emergency Medical Services Advisory Council.**

Adds § 144E.03. Establishes the Emergency Medical Services Advisory Council and specifies its duties.

Subd. 1. Establishment; members. Establishes the Emergency Medical Services Advisory Council consisting of one EMT, one paramedic, one medical director of a licensed ambulance service, one firefighter serving as an emergency medical responder (EMR), one flight nurse, one hospital administrator, one social worker, one member of a federally recognized Tribal Nation in Minnesota, three public members, one member with experience working as an employee organization representative, two members representing local government, two members of the legislature, and the commissioner of health and commissioner of public safety as ex officio members.

Subd. 2. Legislative members. Provides for appointment of legislative members to the advisory council and provides for compensation and reimbursement for expenses.

Subd. 3. Terms, compensation, removal, vacancies, and expiration. Provides terms (except for initial appointees), compensation, removal of members, and vacancies are governed by section 15.059 (advisory councils and committees). Provides this advisory council does not expire.

Subd. 4. Officers; meetings. Requires the advisory council to elect a chair and vice-chair, and allows it to elect other officers as necessary. Requires the advisory

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council to meet quarterly or at the call of the chair and to comply with the Open Meeting Law.

Subd. 5. Duties. Requires the advisory council to make recommendations to the director and deputy director of ambulance services on the regulation of ambulance services and medical response units, the operation of the emergency medical services system in the state, and other topics directed by the director.

Effective date: This section is effective January 1, 2025.

12 **Emergency Medical Services Physician Advisory Council.**

Adds § 144E.035. Establishes an Emergency Medical Services Physician Advisory Council and specifies duties.

Subd. 1. Establishment; membership. Establishes the Emergency Medical Services Physician Advisory Council consisting of ten physicians who meet the qualifications in statute for medical directors and the medical director member of the Emergency Medical Services Advisory Council.

Subd. 2. Terms, compensation, removal, vacancies, and expiration. Provides terms (except for initial appointees), compensation, removal of members, and vacancies are governed by section 15.059. Provides the advisory council does not expire.

Subd. 3. Officers; meetings. Requires the advisory council to elect a chair and vice-chair, and allows it to elect other officers as necessary. Requires the advisory council to meet twice a year or at the call of the chair and to comply with the Open Meeting Law.

Subd. 4. Duties. Requires the advisory council to review and make recommendations to the director and deputy director of medical services on clinical aspects of prehospital care and to serve as subject matter aspects of evolving topics in clinical medicine.

Effective date: This section is effective January 1, 2025.

13 **Labor and Emergency Medical Service Providers Advisory Council.**

Adds § 144E.04. Establishes a Labor and Emergency Medical Service Providers Advisory Council and specifies duties.

Subd. 1. Establishment; membership. Establishes the Labor and Emergency Medical Service Providers Advisory Council consisting of eight emergency medical service providers of any type, one emergency medical technician instructor, two members with experience working as an employee organization representative,

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one emergency medical service provider based in a fire department, and one emergency medical service provider not based in a fire department.

Subd. 2. Terms, compensation, removal, vacancies, and expiration. Provides terms (except for initial appointees), compensation, removal of members, and vacancies are governed by section 15.059. Provides the advisory council does not expire.

Subd. 3. Officers; meetings. Requires the advisory council to elect a chair and vice-chair, and allows it to elect other officers as necessary. Requires the advisory council to meet quarterly or at the call of the chair and to comply with the Open Meeting Law.

Subd. 4. Duties. Requires the advisory council to review and make recommendations to the director and deputy director of emergency medical service providers on laws, rules, and policies assigned to the Emergency Medical Service Providers Division and other topics assigned by the director.

Effective date: This section is effective January 1, 2025.

14 **Basic life support.**

Amends § 144E.101, subd. 6. Specifies a basic life support ambulance must be staffed by at least two individuals who are certified as an EMT, are a registered nurse who meets the qualification requirements to staff an ambulance, or are a physician assistant who meets the qualification requirements to staff an ambulance (current law requires a basic life support ambulance to be staffed by at least two EMTs). Also modifies alternative staffing for basic life support ambulances to conform with this change. Removes language limiting this alternative staffing to ambulance services operating in certain rural areas, allowing any basic life support ambulance to be staffed in compliance with the alternative staffing. Adds a reference to basic life support ambulance staffing that may be authorized by a variance from the board. For a registered nurse staffing a basic life support ambulance as a driver, requires the registered nurse to have successfully completed a certified emergency vehicle operators program.

15 **Variance; staffing of basic life-support ambulance.**

Adds subd. 6a to § 144E.101. Upon application from an ambulance service that includes evidence demonstrating hardship, allows the EMS Regulatory Board to grant a variance and permit a basic life support ambulance to be staffed with: (1) one individual who is an EMT, a registered nurse who meets the qualification requirements to staff an ambulance, or a physician assistant who meets the qualification requirements to staff an ambulance; and (2) one individual to drive the ambulance who holds a valid driver’s license, has attended an emergency vehicle

Section	Description - Article 7: Emergency Medical Services
	driving course, completed a CPR course, and registered with the board. Allows the board to prohibit an individual from driving an ambulance, or place conditions on an individual's ability to drive an ambulance, under this subdivision for acts that are grounds for disciplinary action.
16	**Advanced life support.** Amends § 144E.101, subd. 7. Modifies the qualification requirements for registered nurses and physician assistants authorized to staff an advanced life support ambulance, to require registered nurses and physician assistants to have been approved by the ambulance service's medical director, instead of passing a paramedic practical skills test approved by the board. Also specifies a registered nurse may staff an advanced life support ambulance if the registered nurse is certified as a certified flight registered nurse or certified emergency nurse. Removes language limiting authority to seek a variance for alternative staffing of advanced life support ambulances to ambulance services operating in certain rural areas, allowing any advanced life support ambulance to seek a variance and, if approved, be staffed in compliance with the alternative staffing. For a registered nurse staffing an advanced life support ambulance as a driver, requires the registered nurse to have successfully completed a certified emergency vehicle operators program.
17	**Local government's powers.** Amends § 144E.16, subd. 5. Transfers duties and authority from the EMS Regulatory Board to the director of the Office of Emergency Medical Services. Effective date: This section is effective January 1, 2025.
18	**Temporary suspension.** Amends § 144E.19, subd. 3. Transfers duties and authority from the EMS Regulatory Board to the director of the Office of Emergency Medical Services and makes a conforming change. Effective date: This section is effective January 1, 2025.
19	**Renewal.** Amends § 144E.27, subd. 3. For the board to renew a registration or renew a lapsed registration of an emergency medical responder, requires the EMR to complete a CPR course approved by the ambulance service's medical director and specifies the CPR course may be part of a board-approved refresher course. Extends the time within which the board may renew a lapsed registration, from 12 months after the registration expires to 48 months after the registration expires.

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20 **Denial, suspension, revocation.**

Amends § 144E.27, subd. 5. Transfers duties and authority from the EMS Regulatory Board to the director of the Office of Emergency Medical Services and establishes grounds for disciplinary action related to emergency medical responder participation in a health professionals services program or diversion program (a similar ground for disciplinary action in section 214.355 currently applies to ambulance service personnel and emergency medical responders; this bill removes ambulance service personnel and EMRs from section 214.355).

Effective date: This section is effective January 1, 2025.

21 **Denial, suspension, revocation; emergency medical responders and drivers.**

Amends § 144E.27, subd. 5. Specifies this subdivision, listing grounds for disciplinary action and providing a process for imposing discipline, applies to emergency medical responders and to individuals seeking registration or registered as a driver of a basic life support ambulance.

22 **Temporary suspension; emergency medical responders and drivers.**

Amends § 144E.27, subd. 6. Specifies this subdivision, which allows the board to temporarily suspend a registration, applies to emergency medical responders and to individuals registered as a driver of a basic life support ambulance.

23 **Reciprocity.**

Amends § 144E.28, subd. 3. Corrects a term referring to the credential an EMT receives from the National Registry of Emergency Medical Technicians, from registration to certification.

24 **Denial, suspension, revocation.**

Amends § 144E.28, subd. 5. Transfers duties and authority from the EMS Regulatory Board to the director of the Office of Emergency Medical Services and establishes grounds for disciplinary action related to participation by ambulance service personnel in a health professionals services program or diversion program (a similar ground for disciplinary action in section 214.355 currently applies to ambulance service personnel and emergency medical responders; this bill removes ambulance service personnel and EMRs from section 214.355).

Effective date: This section is effective January 1, 2025.

25 **Temporary suspension.**

Amends § 144E.28, subd. 6. Transfers duties and authority from the EMS Regulatory Board to the director of the Office of Emergency Medical Services and makes a conforming change.

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Effective date: This section is effective January 1, 2025.

26 **Reinstatement.**

Amends § 144E.28, subd. 8. In a subdivision governing reinstatement of a lapsed EMT, AEMT, paramedic, or community paramedic certification, requires community paramedics to complete training equivalent to the continuing education required for community paramedics in order to have a certification reinstated. Also allows the board, between July 1, 2024, and December 31, 2025, to reinstate an EMT, AEMT, paramedic, or community paramedic certification if the certification lapsed more than four years ago but less than ten years ago, and if the listed requirements are met. (Under current law an individual must complete the initial certification process if more than four years passed since the individual's certification expired.)

27 **Approval required.**

Amends § 144E.285, subd. 1. Requires education programs for EMRs to be approved by the board (this requirement is currently in section 144E.27, subdivision 1a, and that subdivision is being repealed in this bill). Modifies the information that must be included in an application to the board for approval of an EMR, EMT, AEMT, or paramedic education program and eliminates certain criteria an education program must meet to be approved by the board (some of these requirements apply only to certain education programs and are being moved to subsequent subdivisions).

28 **EMR education program requirements.**

Adds subd. 1a to § 144E.285. States the National EMS Education Standards specify the minimum knowledge and skills required for EMRs. Requires an EMR education program to meet the education program requirements in subdivision 1, para. (b), that apply to all education programs, and allows a medical director of an EMR group to establish additional knowledge and skill requirements for EMRs.

29 **EMT education program requirements.**

Adds subd. 1b to § 144E.285. In addition to the requirements in subdivision 1, para. (b), that apply to all education programs, requires an education program applying for approval to teach EMTs to include in the application, the names and addresses of clinical sites; to maintain a written agreement with at least one clinical training site of a type recognized by the National EMS Education Standards; and to maintain a minimum average yearly pass rate set by the board.

30 **AEMT and paramedic education program requirements.**

Amends § 144E.285, subd. 2. In addition to the requirements in subdivision 1, para. (b), that apply to all education programs, requires an education program applying for approval to teach AEMTs and paramedics to include in the application, the names and addresses of clinical training sites, and to maintain a written agreement with a

Section	Description - Article 7: Emergency Medical Services
	licensed hospital or licensed ambulance service designating a clinical training site. Strikes a paragraph exempting from this subdivision, a paramedic education program operated by an advanced life support ambulance service that received approval from the commissioner of health before 1991 to operate the paramedic education program.
31	**Reapproval.** Amends § 144E.285, subd. 4. Changes the timeline within which an education program must apply for reapproval, from within three months before the expiration date of its approval to within 30 days before the expiration date of its approval. Requires an education program seeking reapproval to be subject to a site visit by the board, comply with the applicable education program requirements, and, for AEMT and paramedic education programs, maintain accreditation with the Commission of Accreditation of Allied Health Education Programs (CAAHEP).
32	**Temporary suspension.** Amends § 144E.285, subd. 6. Transfers duties and authority from the EMS Regulatory Board to the director of the Office of Emergency Medical Services and makes a conforming change. Effective date: This section is effective January 1, 2025.
33	**Diversion program.** Amends § 144E.287. Authorizes the director to conduct a health professionals services program or contract for a diversion program, rather than requiring participation in the health professionals services program for health-related licensing boards under chapter 214. Effective date: This section is effective January 1, 2025.
34	**Immunity.** Amends § 144E.305, subd. 3. Makes changes to conform with the transfer of duties and authority from the EMS Regulatory Board to the Office of Emergency Medical Services. Effective date: This section is effective January 1, 2025.
35	**Access to reporting system data.** Amends § 152.126, subd. 6. Amends a subdivision governing access to data in the prescription monitoring program to authorize personnel of the Office of Emergency Medical Services, rather than personnel of the board, to access data to investigate

Section	Description - Article 7: Emergency Medical Services
	complaints received by the office. Also removes a reference to personnel licensed by the board participating in the health professionals services program. Effective date: This section is effective January 1, 2025.
36	**Council of Health Boards.** Amends § 214.025. Removes a representative of the Emergency Medical Services Regulatory Board from the membership of the Council of Health Boards, but allows a representative of the Office of Emergency Medical Services to be a member when the council is reviewing legislative proposals on the regulation of health occupations. Effective date: This section is effective January 1, 2025.
37	**Performance of executive directors.** Amends § 214.04, subd. 2a. Removes language permitting the governor to request that the Emergency Medical Services Regulatory Board review the performance of its executive director, to conform with the elimination of the board. Effective date: This section is effective January 1, 2025.
38	**Program required.** Amends § 214.29. Removes a requirement that the Emergency Medical Services Regulatory Board either participate in the health professionals services program for personnel regulated by health-related licensing boards or contract for a diversion program. Effective date: This section is effective January 1, 2025.
39	**Authority.** Amends § 214.31. Strikes language permitting the Emergency Medical Services Regulatory Board to participate in the health professionals services program for personnel regulated by health-related licensing boards. Effective date: This section is effective January 1, 2025.
40	**Grounds for disciplinary action.** Amends § 214.355. Amends a section governing grounds for disciplinary action for violations related to health professionals services program participation, to conform with the Emergency Medical Services Regulatory Board no longer participating in the health professionals services program for personnel regulated by health-related licensing boards. Effective date: This section is effective January 1, 2025.

Section	Description - Article 7: Emergency Medical Services

41 **Initial members and first meeting; Emergency Medical Services Advisory Council.**

Requires initial appointments to the Emergency Medical Services Advisory Council to be made by January 1, 2025, and specifies the terms of initial appointees. Requires the medical director appointee to convene the first meeting of the advisory council by February 1, 2025.

42 **Initial members and first meeting; Emergency Medical Services Physician Advisory Council.**

Requires initial appointments to the Emergency Medical Services Physician Advisory Council to be made by January 1, 2025, and specifies the terms of initial appointees. Requires the medical director appointee to convene the first meeting of the advisory council by February 1, 2025.

43 **Initial members and first meeting; Labor and Emergency Medical Service Providers Advisory Council.**

Requires initial appointments to the Labor and Emergency Medical Service Providers Advisory Council to be made by January 1, 2025, and specifies the terms of initial appointees. Requires the EMT instructor appointee to convene the first meeting by February 1, 2025.

44 **Transition.**

Requires the governor to appoint a director-designee to the office by October 1, 2024, and makes the designee the governor's appointee as director effective January 1, 2025. Effective January 1, 2025, transfers the responsibilities to regulate emergency medical services in the state from the Emergency Medical Services Regulatory Board to the Office of Emergency Medical Services and its director. Provides a statute on transfers of power among agencies applies to this transfer of responsibilities. Allows the commissioner of administration, with approval of the governor, to issue any needed reorganization orders. Provides a law that allows transfers of responsibilities to be made only to an agency that has been in existence for at least one year does not apply to this transfer.

45 **Revisor instruction.**

Instructs the revisor of statutes to modify terms in Minnesota Statutes consistent with the transfer of duties and authority from the Emergency Medical Services Regulatory Board to the Office of Emergency Medical Services and its director.

46 **Repealer.**

Para. (a) repeals the following sections:

- 144E.001, subd. 5 (definition of board in chapter 144E);
- 144E.01 (establishing the Emergency Medical Services Regulatory Board);

Section	Description - Article 7: Emergency Medical Services

- 144E.123, subd. 5 (obsolete subdivision on a working group in 2011 and 2012);
- 144E.50, subd. 3 (defining board)

Para. (b) repeals § 144E.27, subds. 1 (requiring an education program instructor to be an EMR, EMT, AEMT, paramedic, physician, physician assistant, or registered nurse) and 1a (requiring education programs for EMRs to be approved by the board and listing requirements for EMR education programs).

Effective date: Para. (a) is effective January 1, 2025.

Article 8: Pharmacy Practice

This article: prohibits health plans and MA from requiring prior authorization or step therapy for drugs to prevent HIV, unless certain conditions are met; allows pharmacists to prescribe, dispense, and administer drugs to prevent HIV; and allows pharmacists to order, conduct, and interpret laboratory tests related to the prevention of HIV. The article also: allows pharmacists to order certain laboratory tests and to collect specimens; expands the authority of pharmacists to initiate, order, and administer influenza and COVID vaccines; and sets criteria for MA reimbursement of these services.

Section	Description - Article 8: Pharmacy Practice
1	**Coverage for preventive services and items.** Amends § 62Q.46, subd. 1. Prohibits health plans from requiring prior authorization or step therapy for preexposure prophylaxis, except that this may be required if the Food and Drug Administration has approved one or more therapeutic equivalents, and at least one therapeutically equivalent version is covered without prior authorization or step therapy. Provides a January 1, 2026, effective date.
2	**Practitioner.** Amends § 151.01, subd. 23. Includes in the definition of “practitioner” a pharmacist authorized to prescribe drugs to prevent HIV under section 151.37, subd. 17. Provides a January 1, 2026, effective date.
3	**Practice of pharmacy.** Amends § 151.01, subd. 27. The amendment to clause (3) modifies the practice of pharmacy to allow a pharmacist to order laboratory tests as part of monitoring drug

Section	Description - Article 8: Pharmacy Practice

therapies and participating in clinical interpretations. Also authorizes a pharmacist to collect specimens, interpret results, notify patients of results, and refer patients to other health care providers for follow-up care and to initiate, modify, or discontinue drug therapy pursuant to a protocol or collaborative practice agreement. Allows a pharmacy technician or intern to perform these tests if working under the direct supervision of a pharmacist.

The amendment to clause (6) expands pharmacists' authority to administer, initiate, and order influenza or SARS-CoV-2 vaccines authorized or approved by the FDA to all individuals ages three and older and all other FDA-approved vaccines to patients six and older, according to the federal Advisory Committee on Immunization Practices recommendations. Allows a pharmacist to delegate vaccine administration authority to a pharmacy technician or intern if the pharmacy technician or intern meets listed requirements for training, assessment of immunization status, reporting, and supervision.

If a patient is under 18 years old, requires the pharmacist, pharmacy technician, or intern to inform the patient and any accompanying adult caregiver of the importance of a well-child visit with a primary care provider or pediatrician. Provides supervision, certification, and training requirements for pharmacy technicians administering vaccinations.

New clauses (14) and (15) include the following in the definition of the practice of pharmacy:

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

Provides a January 1, 2026, effective date.

4 **Drugs for preventing the acquisition of HIV.**

Amends § 151.37, by adding subd. 17.

(a) States that a pharmacist is authorized to prescribe and administer drugs to prevent HIV in accordance with this subdivision.

(b) Requires the Board of Pharmacy, by January 1, 2025, to develop a standardized protocol for a pharmacist to follow in prescribing drugs under paragraph (a). Allows the board to consult with specified groups in developing the protocol.

Section	Description - Article 8: Pharmacy Practice

(c) Before a pharmacist is authorized to prescribe a drug under paragraph (a), requires the pharmacist to successfully complete a training program specifically developed for prescribing drugs to prevent HIV, offered by a college of pharmacy, an accredited continuing education provider, or a program approved by the board. Requires the pharmacist to complete continuing education requirements as specified by the board, in order to maintain authorization to prescribe.

(d) Before prescribing a drug under paragraph (a), requires the pharmacist to follow the appropriate standardized protocol. If appropriate, allows the pharmacist to dispense a drug described in paragraph (a).

(e) Before dispensing a drug under paragraph (a) that is prescribed by the pharmacist, requires the pharmacist to provide counseling and specified information to the patient.

(f) Prohibits a pharmacist from delegating prescribing authority provided under this subdivision. Allows a pharmacist intern to prepare the prescription, but requires a pharmacist authorized to prescribe under this subdivision to review, approve, and sign the prescription, before the prescription is processed or dispensed.

(g) States that nothing in the subdivision prohibits a pharmacist from participating in the initiation, management, modification, and discontinuation of drug therapy according to a protocol authorized in this section and section 151.01, subd. 27 (authorization for participation in drug therapy under the definition of the practice of pharmacy).

Provides a January 1, 2026, effective date.

5 **Prior authorization.**

Amends § 256B.0625, subd. 13f. Prohibits MA from applying prior authorization and step therapy to any class of drugs approved by the Food and Drug Administration for preexposure prophylaxis of HIV/AIDS, except under the condition specified in section 62Q.46, subdivision 1, paragraph (e).

Provides a January 1, 2026, effective date.

6 **Vaccines and laboratory tests provided by pharmacists.**

Amends § 256B.0625 by adding subd. 13l. Requires medical assistance to cover vaccines initiated, ordered, or administered by a licensed pharmacist according to specified requirements, and laboratory tests ordered and performed by a licensed pharmacist according to specified requirements, at no less than the rate for which the same services are covered when provided by any other licensed practitioner.

Section	Description - Article 8: Pharmacy Practice
	Makes this section effective January 1, 2025, or upon federal approval, whichever is later.

Article 9: Mental Health

This article contains provisions related to child and adult mental health grants; mental health uniform service standards and staffing requirements for a range of mental health services; assertive community treatment (ACT) eligibility, staffing, and programming; adult rehabilitative mental health services; certified community behavioral health clinics; child and family psychoeducation services; children's therapeutic services and supports; and intensive nonresidential rehabilitative treatment team requirements. The article requires expedited rulemaking related to children's residential facilities, directs the commissioner to develop recommendations related to mental health services, and makes technical changes.

Section	Description - Article 9: Mental Health
1	**Community support services program.** Amends § 245.462, subd. 6. Specifies that a program that meets the standards for Clubhouse International model programs meets the requirements for community support services.
2	**Eligible providers.** Amends § 245.4663, subd. 2. Modifies the criteria a mental health provider must meet to be eligible for a mental health provider supervision grant by including providers providing services to people in a city or township that is not within the seven-county metropolitan area and is not the city of Duluth, Mankato, Moorhead, Rochester, or St. Cloud.
3	**Establishment and authority.** Amends § 245.4889, subd. 1. In children's mental health grants respite care services, modifies terminology from "out-of-home placement" to "residential treatment or hospitalization;" expands eligibility for respite care services; requires counties to work to provide access to regular respite care.
4	**Functional assessment.** Amends § 245I.02, subd. 17. Modifies the definition of "functional assessment" in the chapter of statutes governing the Mental Health Uniform Service Standards Act by removing requirements to use specified functional assessment instruments.

Section	Description - Article 9: Mental Health
5	**Level of care assessment.** Amends § 245I.02, subd. 19. Modifies the definition of "level of care assessment" in the chapter of statutes governing the Mental Health Uniform Service Standards Act by removing requirements to use specified level of care assessment instruments.
6	**Clinical trainee qualifications.** Amends § 245I.04, subd. 6. Expands the list of qualifications for clinical trainee staff to include a person who has completed an accredited graduate program of study to prepare the staff person for independent licensure as a mental health professional and has completed a practicum or internship and has not yet taken or received the results from the required test or is waiting for the final licensure decision.
7	**Functional assessment; required elements.** Amends § 245I.10, subd. 9. Removes a narrative summary from the list of elements included in a functional assessment for an adult client and modifies the timeline for updating the client's functional assessment from every 180 days to every 365 days. Allows a license holder to use any available, validated assessment tool when completing the required elements of a functional assessment.
8	**Generally.** Amends § 245I.11, subd. 1. For children's day treatment services license holders, defines "observed self-administration."
9	**Medication administration in children's day treatment settings.** Amends § 245I.11 by adding subd. 6. Requires children's day treatment services license holders to maintain policies and procedures related to medication storage and observe self-administration of medication. Requires programs allowing self-administration to maintain documentation from a licensed prescriber regarding the safety of medications held by clients.
10	**Minimum staffing standards.** Amends § 245I.20, subd. 4. Removes requirement that the two required mental health professionals employed by a mental health clinic specialize in different mental health disciplines.
11	**Weekly meetings.** Amends § 245I.23, subd. 14. Adds paragraph (d) outlining requirements for a treatment team member working only one shift during a week who cannot participate in a weekly team meeting. Adds paragraph (e) allowing remote weekly team meetings under specified circumstances, and for a limited time, unless the license holder requests a variance.

Section	Description - Article 9: Mental Health
12	**Mental health services provider certification.** Creates § 256B.0617. Requires the commissioner of human services to: (1) establish an initial provider entity application and certification process and recertification process to determine whether a provider entity has administrative and clinical infrastructures that meet the requirements to be certified. Lists the mental health services to which the certification process applies; (2) recertify a provider entity every three years; (3) establish a process to decertify a provider entity; and (4) provide certain information to provider entities for the certification, recertification, and decertification processes. Makes this section effective July 1, 2024, and requires the commissioner to implement all requirements in this section by September 1, 2024.
13	**Eligibility for assertive community treatment.** Amends § 256B.0622, subd. 2a. Expands the list of high-intensity services needed that make a person eligible for assertive community treatment.
14	**Provider certification and contract requirements for assertive community treatment.** Amends § 256B.0622, subd. 3a. Removes a requirement that an assertive community treatment provider have a contract with the host county to provide services.
15	**Assertive community treatment team staff requirements and roles.** Amends § 256B.0622, subd. 7a. Modifies assertive community treatment team staff requirements and role of the team leader.
16	**Assertive community treatment program scores.** Amends § 256B.0622, subd. 7b. Removes language related to assertive community treatment team caseload limits, staff-to-client ratios, and other requirements related to team size. Requires each assertive community treatment team to demonstrate that the team attained a passing score according to the most recently issued Tool for Measurement of Assertive Community Treatment.
17	**Assertive community treatment assessment and individual treatment plan.** Amends § 256B.0622, subd. 7d. Makes the timing of updates to the ACT client's diagnostic assessment consistent with requirements in the Mental Health Uniform Service Standards Act.

Section	Description - Article 9: Mental Health
18	**Medical assistance payment for assertive community treatment and intensive residential treatment services.** Amends § 256B.0622, subd. 8. Makes technical correction to inflation adjustment forecast provision.
19	**Qualifications of provider staff.** Amends § 256B.0623, subd. 5. Expands the list of individuals qualified to provide adult rehabilitative mental health services to include licensed occupational therapists. Makes section effective upon federal approval.
20	**Certified community behavioral health clinic services.** Amends § 256B.0625, subd. 5m. Modifies certified community behavioral health clinic rate rebasing requirements and timelines.
21	**Mental health case management.** Amends § 256B.0625, subd. 20. Allows mental health case management providers to receive payment for providing contact via secure electronic message, if preferred by the adult client.
22	**Child and family psychoeducation services.** Amends § 256B.0671, subd. 5. Expands family psychoeducation services medical assistance benefit. Modifies terminology to "child and family psychoeducation services" and expands allowable providers and services, to include individual, family, or group skills development or training. Outlines service components.
23	**Excluded services.** Amends § 256B.0943, subd. 12. For children's therapeutic services and supports, allows treatment by multiple providers within the same agency at the same clock time if one service is provided to the child and the other service is provided to the family or treatment team without the child present.
24	**Standards for intensive nonresidential rehabilitative providers.** Amends § 256B.0947, subd. 5. Modifies the list of professionals who must make up the clinically qualified core team for intensive nonresidential rehabilitative mental health services to include a co-occurring disorder specialist.
25	**Medical assistance payment and rate setting.** Amends § 256B.0947, subd. 7. Makes technical correction to inflation adjustment forecast provision.

Section	Description - Article 9: Mental Health

26 **Direction to commissioner of human services; children's residential facility rulemaking.**

Requires the commissioner to use expedited rulemaking to make specified amendments to rules governing children's residential facilities. Makes this section effective the day following final enactment.

27 **Direction to commissioner; medical assistance children's residential mental health crisis stabilization.**

Requires the commissioner of human services to consult with others to develop a covered benefit under MA to provide residential mental health crisis stabilization for children. Lists the items that must be included in the benefit. Requires the commissioner to: (1) make recommendations for providers to be reimbursed for room and board when developing the new benefit; (2) consult with or contract with rate-setting experts to develop a prospective data-based rate methodology for the children's residential mental health crisis stabilization benefit; and (3) submit to the legislature a report detailing specified information for the children's residential mental health crisis stabilization benefit.

Provides a July 1, 2024, effective date.

28 **Direction to commissioner of human services; mental health procedure codes.**

Requires the commissioner, in consultation with experts and external partners, to develop recommendations on simplifying mental health procedure codes and the feasibility of converting mental health procedure codes to the current procedural terminology (CPT) code structure. Requires a report to the legislature on the recommendations. Makes this section effective July 1, 2024.

29 **Direction to commissioner of human services; respite care access.**

Requires the commissioner of human services to develop proposals by December 31, 2025, to increase access to licensed respite foster care homes that take into consideration the new federal rule related to licensing and approval standards for relative or kinship foster family homes.

30 **Mental health services formula-based allocation.**

Requires the commissioner of human services to consult with the commissioner of management and budget, counties, Tribes, mental health providers, and advocacy organizations to develop recommendations for moving from the children's and adult mental health grant funding structure to a formula-based allocation structure for mental health service. Requires the recommendations to consider formula-based allocations for grants for respite care, school-linked behavioral health, mobile crisis teams, and first episode of psychosis programs.

Section	Description - Article 9: Mental Health
31	**Revisor instruction.** Instructs the revisor of statutes, in consultation with nonpartisan legislative staff and the commissioner of human services, to: (1) prepare legislation for the 2025 legislative session to recodify the statutes governing assertive community treatment and intensive residential treatment services to move those provisions into separate sections of statute; and (2) correct any cross-references made necessary by this recodification.
32	**Repealer.** Repeals Minnesota Rules, part 2960.0620, subpart 3 (monitoring for tardive dyskinesia).

Article 10: Department of Human Services Office of Inspector General

This article contains provisions from the Department of Human Services Office of Inspector General policy bill. The article makes technical fixes and policy changes to licensing requirements and processes, modifies provisions related to background study procedures and requirements, and modifies withdrawal management, substance use disorder treatment, and opioid treatment program licensing provisions. The article also includes conforming changes made necessary by the recodification of statutes for the Department of Children, Youth, and Families.

Section	Description - Article 10: Department of Human Services Office of Inspector General
1	**Licensing data.** Amends § 13.46, as amended by Laws 2024, chapter 80, article 8, section 4. Provides that the email addresses of license holders, certification holders, and former licensees are considered public data, except for the email addresses for family child foster care providers. Makes the section effective January 1, 2025.
2	**Exclusion from licensure.** Amends § 245A.03, subdivision 2, as amended by Laws 2024, chapter 80, article 2, section 35 and Laws 2024, chapter 85, section 52. Provides that assisted living facilities licensed by the commissioner of health under chapter 144G are exempt from DHS licensing requirements.

Section	Description - Article 10: Department of Human Services Office of Inspector General
3	**Notification to commissioner of changes in key staff positions; children's residential facilities and detoxification programs.** Adds a subdivision to § 245A.04. Directs a license holder of a children's residential facility or a detoxification program to notify the DHS commissioner within five business days of a change or vacancy in specified staff positions. Makes this section effective January 1, 2025.
4	**Change in ownership.** Amends § 245A.043, subd. 2. Modifies requirements governing what is considered a change of ownership and when a program must submit a new license application to the DHS commissioner. Makes the section effective January 1, 2025.
5	**Standard change of ownership process.** Amends § 245A.043, subd. 3. Makes changes to the standard change of ownership process for DHS license holders. Makes the section effective January 1, 2025.
6	**Emergency change in ownership process.** Adds a subdivision to § 245A.043. Establishes a process by which a license holder may submit a request to the DHS commissioner for an emergency change in ownership. Makes the section effective January 1, 2025.
7	**Temporary transitional license.** Amends § 245A.043, subd. 4. Strikes language providing a temporary change in ownership license. Allows the DHS commissioner to issue a temporary transitional license for specified licenses when the party requesting the license already holds an active license to provide home and community-based services under chapter 245D. Makes the section effective January 1, 2025.
8	**Failure to comply.** Adds a subdivision to § 245A.043. Allows the DHS commissioner to impose a licensing sanction on an applicant or license holder who does not comply with requirements governing license application after change of ownership. Makes the section effective January 1, 2025.
9	**Sanctions; appeals; license.** Amends § 245A.07, subd. 1. Allows the DHS commissioner to impose terms that a license holder must follow if the commissioner issues the license holder a temporary provisional license while pending a final order on an appeal of a suspension or revocation of a license. Makes the section effective January 1, 2025.

Section	Description - Article 10: Department of Human Services Office of Inspector General
10	**Appeal of multiple sanctions.** Amends § 245A.07, subd. 6. Provides for the use of the provider licensing and reporting hub when a license holder appeals more than one licensing action or sanction.
11	**Adult foster care and community residential setting; variance for alternate overnight supervision.** Amends § 245A.11, subd. 7. Allows the DHS commissioner to grant a variance to statute or rules that requires that a caregiver is present in a community residential setting during normal sleeping hours to allow for alternative methods of overnight supervision. Makes the section effective immediately.
12	**Delegation of authority to agencies.** Amends § 245A.16, subdivision 1, as amended by Laws 2024, chapter 80, article 2, section 65. Provides that only the DHS commissioner may issue specified variances that apply to community residential settings. Makes the section effective immediately.
13	**Contraindicated physical restraints.** Amends § 245A.211, subd. 4. Clarifies language governing the process by which a license or certification holder may use restraints on a person. Makes the section effective immediately.
14	**Emergency overdose treatment.** Amends § 245A.242, subd. 2. Modifies requirements for substance use and mental health programs that are required to maintain a supply of emergency overdose medication by allowing staff and adult clients to carry the medication on them and store it in an unlocked location and providing that staff who administer the medications only need to be trained on administering that medication if it is the only medicine they deliver. Makes the section effective immediately.
15	**Door to attached garage.** Amends § 245A.52, subd. 2. Modifies requirements governing doors to attached garages in licensed family child care homes.
16	**NETStudy 2.0.** Amends § 245C.02, subd. 13c. Specifies that information obtained from public web-based data or any other source that is not direct correspondence from DHS does not constitute notice of disqualification.

Section	Description - Article 10: Department of Human Services Office of Inspector General
17	**Procedure; maltreatment and state licensing agency data.** Amends § 245C.033, subd. 3. Differentiates between procedures for requests for maltreatment and state licensing agency data paid directly by a guardian or conservator and procedures for requests paid by the court on the in forma pauperis (fee waived due to inability to pay) status of the guardian or conservator.
18	**Emergency waiver to temporarily modify background study requirements.** Proposes coding for § 245C.041. Adds section to allow for the commissioner to temporarily waive or modify background study requirements in the event of an emergency identified by the commissioner. Lists provisions the commissioner cannot modify or waive, and what an emergency may include. Specifies requirements for entities when an emergency ends. Provides an immediate effective date.
19	**Fingerprints and photographs.** Amends § 245C.05, subd. 5. Establishes fingerprint submission requirements for Head Start program background studies.
20	**Background studies conducted by Department of Human Services.** Amends § 245C.08, subd. 1. Clarifies that juvenile court records are reviewed for all background studies conducted under chapter 245C.
21	**Juvenile court records.** Amends § 245C.08, subd. 4. Clarifies that juvenile court records are reviewed for all background study subjects under chapter 245C. Removes language specific to family child care background study review of juvenile court records.
22	**Guardians and conservators.** Amends § 245C.10, subd. 15. Requires the court to pay fees for a guardian and conservator maltreatment and state licensing agency check for an applicant granted in forma pauperis status.
23	**Applicants, licensees, or other occupations regulated by commissioner of health.** Amends § 245C.10, subd. 18. Specifies that background study fees must not exceed $44 per study for individuals regulated by the commissioner of health.
24	**Basis for disqualification.** Amends § 245C.14 by adding subd. 5. Specifies that information obtained from public web-based data or any other source that is not direct correspondence from DHS does not constitute notice of disqualification.

Section	Description - Article 10: Department of Human Services Office of Inspector General

25 **Risk of harm; set aside.**

Amends § 245C.22, subd. 4. Requires the commissioner, for an individual seeking a child foster care license who is a relative of the child, to consider the importance of maintaining the child's relative relationships as a significant factor in determining whether to set aside a background study disqualification.

26 **Permanent bar to set aside a disqualification.**

Amends § 245C.24, subd. 2. Prohibits the commissioner from granting a set aside or variance for a disqualification connected with a foster residence setting or children's residential facility, if the individual was disqualified under the licensed family foster setting permanent disqualifications.

27 **Five-year bar to set aside or variance disqualification; children's residential facilities, foster residence settings.**

Amends § 245C.24, subd. 5. Adds variance language and broadens bar to set aside or granting a variance to include foster residence settings.

28 **Five-year bar to set aside disqualification; family foster setting.**

Amends § 245C.24, subd. 6. Allows for a set aside or variance connected with a foster family setting license if the individual is under 18 years old at the time of the background study.

29 **Child foster care variances.**

Amends § 245C.30 by adding subd. 1b. Requires the commissioner, for an individual seeking a child foster care license who is a relative of the child, to consider the importance of maintaining the child's relative relationships as a significant factor in determining whether to grant a variance background study disqualification.

30 **Protective procedures plan.**

Amends § 245F.09, subd. 2. In withdrawal management licensing statutes, adds that contraindicated holds are not allowed. Provides an immediate effective date.

31 **Notification to commissioner of changes in key staff positions.**

Amends § 245F.14 by adding subd. 8. Requires a withdrawal management program license holder to notify the commissioner of human services, on a form approved by the commissioner, within five days of a change or vacancy in a key staff position. Lists key positions. Makes this section effective January 1, 2025.

32 **Personnel files.**

Amends § 245F.17. Removes the requirement that a withdrawal management program license holder maintain documentation of a statement of freedom from

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substance use problems in a personnel file for each staff member. Provides an immediate effective date.

33 **Location of service provision.**

Amends § 245G.07, subd. 4. Modifies permissible locations for a licensed substance use disorder treatment provider to provide treatment. Allows services to be provided: (1) at one of the licensee's licensed locations; (2) at a client's residence, for nonresidential services; (3) via telehealth under specified circumstances; and (4) upon written approval, satellite locations at a school, jail, or nursing home, or other approved suitable locations, for nonresidential services.

Requires the license holder to provide the commissioner access to all files, documentation, staff, and any other information the commissioner requires at the main licensed location. Exempts listed locations from program abuse prevention plan requirements. Makes this section effective January 1, 2025.

34 **Administration of medication and assistance with self-medication.**

Amends § 245G.08, subd. 5. Removes naloxone training language; modifies terminology from "naloxone" to "opiate antagonist." Provides an immediate effective date.

35 **Control of drugs.**

Amends § 245G.08, subd. 6. Removes naloxone destruction language; modifies terminology from "naloxone" to "opiate antagonist." Provides an immediate effective date.

36 **Notification to commissioner of changes in key staff positions.**

Amends § 245G.10 by adding subd. 6. Requires a substance use disorder program license holder to notify the commissioner of human services, on a form approved by the commissioner, within five days of a change or vacancy in a key staff position. Lists key positions. Makes this section effective January 1, 2025.

37 **Definitions.**

Amends § 245G.22, subd. 2. Modifies the definitions of "practitioner" by removing variance language and "unsupervised use" by adding "take-home doses" in the section of statutes governing opioid treatment programs. Provides an immediate effective date.

38 **Criteria for unsupervised use.**

Amends § 245G.22, subd. 6. Modifies requirements for unsupervised use of medication used for the treatment of opioid use disorder, to allow for individualized take-home doses as ordered for days the client's clinic is closed, on one weekend day

Section	Description - Article 10: Department of Human Services Office of Inspector General
	and state and federal holidays. Removes the list of criteria a practitioner must review and document for allowed take-home doses and instead requires review and documentation of federally required criteria. Provides an immediate effective date.
39	**Restrictions for unsupervised use of methadone hydrochloride.** Amends § 245G.22, subd. 7. Modifies unsupervised use of methadone to allow unsupervised use if a client meets statutory criteria and can safely manage unsupervised doses, as assessed, determined, and documented by a practitioner. Cites federal regulations for the limitation on the number of allowed take-home doses a client can receive. Provides an immediate effective date.
40	**Policies and procedures.** Amends § 245G.22, subd. 17. Makes conforming changes. Provides an immediate effective date.
41	**Administrative disqualification of child care providers caring for children receiving child care assistance.** Amends § 256.046, subd. 3. Provides that when the DHS commissioner initiates an administrative disqualification for a child care provider receiving child care assistance, the commissioner must send written notice using a signature-verified confirmed delivery method. Makes the section effective August 1, 2024.
42	**Notice.** Amends § 256B.064, subd. 4. Provides that when the DHS commissioner serves notice to an individual or entity about monetary recovery or sanctions under medical assistance, the commissioner must do so using a signature-verified confirmed delivery method.
43	**Request for reconsideration.** Amends § 260E.33, subdivision 2, as amended by Laws 2024, chapter 80, article 8, section 44. Requires an individual or facility to use the provider licensing and reporting hub to request reconsideration of a maltreatment determination, once the hub is implemented. Requires the request to be received by the commissioner within 15 calendar days of the individual's receipt of the notice of determination.
44	**Change in ownership.** Amends Laws 2024, chapter 80, article 2, section 6, subdivision 2. Makes conforming changes in section governing entities licensed by the Department of Children, Youth, and Families. Makes this section effective January 1, 2025.

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45	**Standard change in ownership process.** Amends Laws 2024, chapter 80, article 2, section 6, subdivision 3. Makes conforming changes in section governing entities licensed by the Department of Children, Youth, and Families. Makes this section effective January 1, 2025.
46	**Emergency change in ownership process.** Amends Laws 2024, chapter 80, article 2, section 6, by adding subd. 3a. Makes conforming change to add the emergency change in ownership process to statutes governing entities licensed by the Department of Children, Youth, and Families. Makes this section effective January 1, 2025.
47	**Failure to comply.** Amends Laws 2024, chapter 80, article 2, section 6, by adding subd. 5. Makes conforming changes in section governing entities licensed by the Department of Children, Youth, and Families. Makes this section effective January 1, 2025.
48	**Sanctions; appeal; license.** Amends Laws 2024, chapter 80, article 2, section 10, subdivision 1. Makes conforming changes in section governing entities licensed by the Department of Children, Youth, and Families. Makes this section effective January 1, 2025.
49	**Appeal of multiple sanctions.** Amends Laws 2024, chapter 80, article 2, section 10, subdivision 6. Makes conforming changes in section governing entities licensed by the Department of Children, Youth, and Families. Makes this section effective January 1, 2025.
50	**Repealer.** (a) Repeals Minn. Stat., section 245.125 (background study; Head Start programs). (b) Repeals Minn. Stat., section 245C.08, subdivision 2 (pre-NETStudy 2.0 background studies conducted by a county agency for family child care). (c) Repeals Minn. Rules, part 9502.0425, subpart 5 (occupancy separations). (d) Repeals Laws 2024, chapter 80, article 2, section 6, subdivision 4 (license application after change of ownership; conforming change).

Article 11: Substance Use Disorder Treatment Licensing

This article modifies alcohol and drug counselor and treatment coordination provider qualifications in the chapter governing substance use disorder treatment licensing.

Section	Description - Article 11: Substance Use Disorder Treatment Licensing
1	**Alcohol and drug counselor qualifications.** Amends § 245G.11, subdivision 5. Adds the following qualifications for individuals who are exempt from alcohol and drug counselor licensure to meet, to provide substance use disorder treatment services, until December 31, 2026: ▪ Qualification as a mental health professional and completion of relevant substance use disorder training. ▪ Qualification as a mental health clinical trainee, practicing under the supervision of a mental health professional who is qualified under this section. ▪ Licensure as a registered nurse and completion of relevant substance use disorder training.
2	**Treatment coordination provider qualifications.** Amends § 245G.11, subd. 7. Modifies treatment coordination provider qualifications to reduce the number of training hours and required supervised practice experience hours, and adding mental health practitioners as eligible providers. Makes this section effective upon federal approval.

Article 12: Miscellaneous

This article contains provisions related to alcohol and drug counselor licensing educational requirements, the projects in transition from homelessness program, general assistance, and the housing support program. It also contains provisions prohibiting the approval of specified flavored cannabis and hemp-derived consumer products and the labeling of such products as flavored.

Section	Description - Article 12: Miscellaneous
1	**Education requirements for licensure.** Amends § 148F.025, subd. 2. Specifies that an applicant for alcohol and drug counselor licensure may have a bachelor's degree or a master's degree.
2	**Establishment.** Amends § 245.991, subd. 1. Expands the projects for assistance in transition from homelessness program to include people with substance use disorder.
3	**Client eligibility.** Amends § 254B.04, subd. 1a. Specifies that MinnesotaCare enrollees are eligible for behavioral health fund for intensive residential treatment services or residential crisis

Section	Description - Article 12: Miscellaneous
	stabilization services room and board. Makes this section effective January 1, 2025, or upon federal approval, whichever is later.
4	**Standards.** Amends § 256D.01, subd. 1a. Corrects an error in the effective date of the general assistance standard of assistance increase. Provides an immediate effective date.
5	**Required services.** Amends § 256I.04, subd. 2f. Clarifies a provision related to eligibility for housing support payment.
6	**Supplementary service rates.** Amends § 256I.05, subd. 1a. Aligns housing support cost-neutral transfer program standards by consolidating language in section 256I.05, subdivision 11.
7	**Cost-neutral transfers from the housing support fund.** Amends § 256I.05, subd. 11. Aligns housing support cost-neutral transfer program standards by consolidating language in this subdivision. Makes technical changes.
8	**Approval of cannabis flower, products, and cannabinoids.** Amends § 342.06. Prohibits the Office of Cannabis Management from approving any cannabis flower, cannabis product, or hemp-derived consumer product that is intended to be inhaled as smoke, aerosol, or vapor from the product and that: ▪ contains artificial, synthetic, or natural flavoring; ▪ describes or depicts flavor that implies the product contains flavors other than the taste or smell of cannabis; ▪ imparts a taste or smell, other than the taste or smell of cannabis, distinguishable before or during consumption of the product; or ▪ imparts a cooling, burning, numbing, or other sensation distinguishable to impart a flavor other than cannabis before or during consumption of the product. Allows the office to approve cannabis flower, cannabis products, or hemp-derived consumer products intended to be inhaled and that impart a flavor or smell if the additives are terpenes extracted from hemp plants or cannabis plants and are in concentrations that do not exceed those naturally occurring in the source hemp plants or cannabis plants.

Section	Description - Article 12: Miscellaneous
9	**Content of label; products intended to be inhaled as smoke, aerosol, or vapor.** Adds subd. 7 to § 342.63. Prohibits the label on cannabis flower, cannabis products, or hemp-derived consumer products intended to be inhaled from including a descriptor of flavor that implies the product contains flavors other than cannabis, except allows a cannabis plant or hemp plant strain name that includes a descriptor of flavor to be listed on the label in six point font or smaller and in black or white type.
10	**Revisor instruction.** Instructs the revisor of statutes to renumber Minn. Stat. § 256D.21 (continuation of benefits; former Minneapolis employees), as Minn. Stat. § 261.004.
11	**Repealer.** Repeals Minn. Stat. § 256D.19, subds. 1 and 2 (abolition of township system of poor relief); 256D.20, subds. 1 to 4 (transfer of town employees); and 256D.23, subds. 1 to 3 (temporary county assistance program). Provides an immediate effective date.

Article 13: Human Services Forecast Adjustments

This article adjusts appropriations to the commissioner of human services for fiscal years 2024 and 2025 for forecasted programs administered by the Department of Human Services, to conform with the February 2024 forecast.

Article 14: Appropriations

This article appropriates money to the commissioner of human services, commissioner of health, Board of Pharmacy, and Board of Directors of MNsure. It also authorizes a transfer from the premium security plan account and transfers from the health care access fund and amends certain appropriations and riders from Laws 2023, chapters 22 and 70.

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