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State of Minnesota

HOUSE OF REPRESENTATIVES

NINETY-THIRD SESSION

H. F. No. **2930**

03/16/2023 Authored by Liebling
The bill was read for the first time and referred to the Committee on Rules and Legislative Administration
03/20/2023 Adoption of Report: Re-referred to the Committee on Health Finance and Policy
04/13/2023 Adoption of Report: Amended and re-referred to the Committee on Ways and Means

1.1 A bill for an act

1.2 relating to state government; modifying provisions on health care administration

1.3 and affordability, the Minnesota Department of Health, health-related licensing

1.4 boards, human services background studies, behavioral health, Department of

1.5 Human Services operations and policy, economic assistance, and housing supports;

1.6 requiring reports; making forecast adjustments; appropriating money; amending

1.7 Minnesota Statutes 2022, sections 12A.08, subdivision 3; 13.3805, subdivision 1;

1.8 16A.151, subdivision 2; 62A.045; 62A.30, by adding subdivisions; 62A.673,

1.9 subdivision 2; 62J.17, subdivision 5a; 62J.692, subdivisions 1, 3, 4, 5, 8; 62J.84,

1.10 subdivisions 2, 3, 4, 6, 7, 8, 9, by adding subdivisions; 62Q.01, by adding a

1.11 subdivision; 62Q.021, by adding a subdivision; 62Q.55, subdivision 5; 62Q.556;

1.12 62Q.56, subdivision 2; 62Q.73, subdivisions 1, 7; 62U.04, subdivisions 4, 5, 5a,

1.13 11, by adding subdivisions; 62V.05, subdivision 4a, by adding a subdivision;

1.14 121A.28; 121A.335; 122A.18, subdivision 8; 144.122; 144.1481, subdivision 1;

1.15 144.1501, subdivisions 1, 2, 3, 4, 5; 144.1505; 144.2151; 144.222; 144.226,

1.16 subdivisions 3, 4; 144.382, by adding subdivisions; 144.55, subdivision 3; 144.566;

1.17 144.608, subdivision 1; 144.615, subdivision 7; 144.651, by adding a subdivision;

1.18 144.653, subdivision 5; 144.6535, subdivisions 1, 2, 4; 144.69; 144.7055; 144.7067,

1.19 subdivision 1; 144.9501, subdivisions 9, 17, 26a, 26b, by adding subdivisions;

1.20 144.9505, subdivisions 1, 1g, 1h; 144.9508, subdivision 2; 144A.06, subdivision

1.21 2; 144A.071, subdivision 2; 144A.073, subdivision 3b; 144A.474, subdivisions

1.22 3, 9, 12; 144A.4791, subdivision 10; 144E.001, subdivision 1, by adding a

1.23 subdivision; 144E.101, subdivisions 6, 7; 144E.103, subdivision 1; 144E.35;

1.24 144G.16, subdivision 7; 144G.18; 144G.57, subdivision 8; 145.411, subdivisions

1.25 1, 5; 145.423, subdivision 1; 145.87, subdivision 4; 145.924; 145.925; 145A.131,

1.26 subdivisions 1, 5; 145A.14, by adding a subdivision; 147.02, subdivision 1; 147.03,

1.27 subdivision 1; 147.037, subdivision 1; 147.141; 147A.08; 147A.16; 147B.02,

1.28 subdivisions 4, 7; 148.261, subdivision 1; 148.512, subdivisions 10a, 10b, by

1.29 adding subdivisions; 148.513, by adding a subdivision; 148.515, subdivision 6;

1.30 148.5175; 148.5195, subdivision 3; 148.5196, subdivision 1; 148.5197; 148.5198;

1.31 148B.392, subdivision 2; 148F.11, by adding a subdivision; 150A.08, subdivisions

1.32 1, 5; 150A.091, by adding a subdivision; 150A.13, subdivision 10; 151.01,

1.33 subdivision 27, by adding a subdivision; 151.065, subdivisions 1, 2, 3, 4, 6; 151.37,

1.34 subdivision 12; 151.40, subdivisions 1, 2; 151.555; 151.74, subdivisions 3, 4;

1.35 152.01, subdivision 18; 152.205; 153A.13, subdivisions 3, 4, 5, 6, 7, 9, 10, 11, by

1.36 adding subdivisions; 153A.14, subdivisions 1, 2, 2h, 2i, 2j, 4, 4a, 4b, 4c, 4e, 6, 9,

1.37 11, by adding a subdivision; 153A.15, subdivisions 1, 2, 4; 153A.17; 153A.175;

1.38 153A.18; 153A.20; 245.4661, subdivision 9; 245.4663, subdivisions 1, 4; 245.469,

2.1 subdivision 3; 245.4901, subdivision 4, by adding a subdivision; 245.735,
 2.2 subdivisions 3, 5, 6, by adding subdivisions; 245A.02, subdivisions 5a, 10b;
 2.3 245A.04, subdivisions 1, 7, 7a; 245A.041, by adding a subdivision; 245A.05;
 2.4 245A.055, subdivision 2; 245A.06, subdivisions 1, 2, 4; 245A.07, subdivisions
 2.5 2a, 3; 245A.10, subdivisions 3, 4; 245A.16, subdivision 1, by adding a subdivision;
 2.6 245C.02, subdivisions 6a, 11c, 13e, by adding subdivisions; 245C.03, subdivisions
 2.7 1, 1a, 4, 5, 5a; 245C.031, subdivisions 1, 4; 245C.05, subdivisions 1, 4, by adding
 2.8 a subdivision; 245C.07; 245C.08, subdivision 1; 245C.10, subdivisions 1d, 2, 2a,
 2.9 3, 4, 5, 6, 8, 9, 9a, 10, 11, 12, 13, 14, 15, 16, 17, 20, 21, by adding a subdivision;
 2.10 245C.31, subdivision 1; 245C.32, subdivision 2; 245C.33, subdivision 4; 245G.01,
 2.11 by adding a subdivision; 245G.11, subdivision 10; 245H.01, subdivision 3, by
 2.12 adding a subdivision; 245H.03, subdivisions 2, 3, 4; 245H.06, subdivisions 1, 2;
 2.13 245H.07, subdivisions 1, 2; 245H.13, subdivision 9; 245I.04, subdivisions 14, 16;
 2.14 245I.05, subdivision 3; 245I.08, subdivisions 2, 3, 4; 245I.10, subdivisions 2, 3,
 2.15 5, 6, 7, 8; 245I.11, subdivisions 3, 4; 245I.20, subdivisions 5, 6, 10, 13, 14, 16;
 2.16 254B.02, subdivision 5; 254B.05, subdivisions 1, 1a; 256.01, by adding a
 2.17 subdivision; 256.0471, subdivision 1; 256.478, subdivisions 1, 2, by adding
 2.18 subdivisions; 256.9685, subdivisions 1a, 1b; 256.9686, by adding a subdivision;
 2.19 256.969, subdivisions 2b, 9, 25, by adding a subdivision; 256B.04, subdivisions
 2.20 14, 15; 256B.055, subdivision 17; 256B.056, subdivision 7, by adding a subdivision;
 2.21 256B.0616, subdivisions 3, 4, 5; 256B.0622, subdivisions 7a, 7b, 7c, 8; 256B.0623,
 2.22 subdivision 4; 256B.0624, subdivisions 5, 8; 256B.0625, subdivisions 3a, 5m, 9,
 2.23 13c, 13e, 16, 22, 28b, 30, 31, by adding subdivisions; 256B.0631, subdivisions 1,
 2.24 3; 256B.064; 256B.0757, subdivision 4c; 256B.0941, subdivision 2a, by adding
 2.25 subdivisions; 256B.0946, subdivision 6; 256B.0947, subdivision 7a, by adding a
 2.26 subdivision; 256B.196, subdivision 2; 256B.27, subdivision 3; 256B.434,
 2.27 subdivision 4f; 256B.69, subdivisions 4, 5a, 6d, 28, 36; 256B.692, subdivisions
 2.28 1, 2; 256B.75; 256B.76, subdivisions 1, 2; 256B.764; 256D.01, subdivision 1a;
 2.29 256D.02, by adding a subdivision; 256D.024, subdivision 1; 256D.06, subdivision
 2.30 5; 256D.07; 256I.03, subdivisions 7, 15, by adding a subdivision; 256I.04,
 2.31 subdivisions 1, 2, 3; 256I.06, subdivision 3; 256I.09; 256J.08, subdivision 21;
 2.32 256J.09, subdivision 3; 256J.26, subdivision 1; 256J.95, subdivision 5; 256L.03,
 2.33 subdivisions 1, 5; 256L.04, subdivisions 1c, 7a, 10, by adding a subdivision;
 2.34 256L.07, subdivision 1; 256L.15, subdivision 2; 256P.01, by adding subdivisions;
 2.35 256P.02, subdivisions 1a, 2, by adding subdivisions; 256P.04, by adding a
 2.36 subdivision; 256P.06, subdivision 3, by adding subdivisions; 260C.007, subdivision
 2.37 26d; 260E.09; 270B.14, subdivision 1; 297F.10, subdivision 1; 403.161; 403.162;
 2.38 518A.39, subdivision 2; 524.5-118; 609B.425, subdivision 2; 609B.435, subdivision
 2.39 2; Laws 2017, First Special Session chapter 6, article 5, section 11, as amended;
 2.40 Laws 2021, First Special Session chapter 7, article 6, section 26; article 16, section
 2.41 2, subdivision 32, as amended; Laws 2022, chapter 99, article 1, section 46; article
 2.42 3, section 9; proposing coding for new law in Minnesota Statutes, chapters 62J;
 2.43 62Q; 115; 144; 144E; 145; 148; 245; 245A; 245C; 256; repealing Minnesota
 2.44 Statutes 2022, sections 62J.692, subdivisions 4a, 7, 7a; 62J.84, subdivision 5;
 2.45 62Q.145; 62U.10, subdivisions 6, 7, 8; 137.38, subdivision 1; 144.059, subdivision
 2.46 10; 144.9505, subdivision 3; 145.1621; 145.411, subdivisions 2, 4; 145.412;
 2.47 145.413, subdivisions 2, 3; 145.4131; 145.4132; 145.4133; 145.4134; 145.4135;
 2.48 145.4136; 145.415; 145.416; 145.423, subdivisions 2, 3, 4, 5, 6, 7, 8, 9; 145.4235;
 2.49 145.4241; 145.4242; 145.4243; 145.4244; 145.4245; 145.4246; 145.4247;
 2.50 145.4248; 145.4249; 152.092; 153A.14, subdivision 5; 245A.22; 245C.02,
 2.51 subdivisions 9, 14b; 245C.031, subdivisions 5, 6, 7; 245C.032; 245C.30,
 2.52 subdivision 1a; 245C.301; 256.9685, subdivisions 1c, 1d; 256B.011; 256B.40;
 2.53 256B.69, subdivision 5c; 256I.03, subdivision 6; 261.28; 393.07, subdivision 11;
 2.54 Minnesota Rules, parts 4615.3600; 4640.1500; 4640.1600; 4640.1700; 4640.1800;
 2.55 4640.1900; 4640.2000; 4640.2100; 4640.2200; 4640.2300; 4640.2400; 4640.2500;
 2.56 4640.2600; 4640.2700; 4640.2800; 4640.2900; 4640.3000; 4640.3100; 4640.3200;
 2.57 4640.3300; 4640.3400; 4640.3500; 4640.3600; 4640.3700; 4640.3800; 4640.3900;
 2.58 4640.4000; 4640.4100; 4640.4200; 4640.4300; 4640.6100; 4640.6200; 4640.6300;

3.1 4640.6400; 4645.0300; 4645.0400; 4645.0500; 4645.0600; 4645.0700; 4645.0800;
 3.2 4645.0900; 4645.1000; 4645.1100; 4645.1200; 4645.1300; 4645.1400; 4645.1500;
 3.3 4645.1600; 4645.1700; 4645.1800; 4645.1900; 4645.2000; 4645.2100; 4645.2200;
 3.4 4645.2300; 4645.2400; 4645.2500; 4645.2600; 4645.2700; 4645.2800; 4645.2900;
 3.5 4645.3000; 4645.3100; 4645.3200; 4645.3300; 4645.3400; 4645.3500; 4645.3600;
 3.6 4645.3700; 4645.3800; 4645.3805; 4645.3900; 4645.4000; 4645.4100; 4645.4200;
 3.7 4645.4300; 4645.4400; 4645.4500; 4645.4600; 4645.4700; 4645.4800; 4645.4900;
 3.8 4645.5100; 4645.5200; 4700.1900; 4700.2000; 4700.2100; 4700.2210; 4700.2300,
 3.9 subparts 1, 3, 4, 4a, 5; 4700.2410; 4700.2420; 4700.2500; 5610.0100; 5610.0200;
 3.10 5610.0300; 9505.0235; 9505.0505, subpart 18; 9505.0520, subpart 9b.

3.11 BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MINNESOTA:

3.12 ARTICLE 1

3.13 DEPARTMENT OF HUMAN SERVICES HEALTH CARE

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

3.15 **62A.045 PAYMENTS ON BEHALF OF ENROLLEES IN GOVERNMENT** 3.16 **HEALTH PROGRAMS.**

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

3.26 For the purpose of this section, "health insurer" includes self-insured plans, group health
 3.27 plans (as defined in section 607(1) of the Employee Retirement Income Security Act of
 3.28 1974), service benefit plans, managed care organizations, pharmacy benefit managers, or
 3.29 other parties that are by contract legally responsible to pay a claim for a health-care item
 3.30 or service for an individual receiving benefits under paragraph (b).

3.31 (b) No plan offered by a health insurer issued or renewed to provide coverage to a
 3.32 Minnesota resident shall contain any provision denying or reducing benefits because services
 3.33 are rendered to a person who is eligible for or receiving medical benefits pursuant to title
 3.34 XIX of the Social Security Act (Medicaid) in this or any other state; chapter 256 or 256B;
 3.35 or services pursuant to section 252.27; 256L.01 to 256L.10; 260B.331, subdivision 2;
 3.36 260C.331, subdivision 2; or 393.07, subdivision 1 or 2. No health insurer providing benefits

4.1 under plans covered by this section shall use eligibility for medical programs named in this
4.2 section as an underwriting guideline or reason for nonacceptance of the risk.

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

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

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

4.33 (f) A health insurer must process a clean claim made by a state agency for covered
4.34 expenses paid under state medical programs within 90 business days of the claim's
4.35 submission. A health insurer must process all other claims made by a state agency for

5.1 covered expenses paid under a state medical program within the timeline set forth in Code
5.2 of Federal Regulations, title 42, section 447.45(d)(4).

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

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

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

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

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

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

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

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

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

5.31 (h) "Telehealth" means the delivery of health care services or consultations through the
5.32 use of real time two-way interactive audio and visual communications to provide or support

6.1 health care delivery and facilitate the assessment, diagnosis, consultation, treatment,
6.2 education, and care management of a patient's health care. Telehealth includes the application
6.3 of secure video conferencing, store-and-forward technology, and synchronous interactions
6.4 between a patient located at an originating site and a health care provider located at a distant
6.5 site. Until July 1, ~~2023~~ 2025, telehealth also includes audio-only communication between
6.6 a health care provider and a patient in accordance with subdivision 6, paragraph (b).

6.7 Telehealth does not include communication between health care providers that consists
6.8 solely of a telephone conversation, email, or facsimile transmission. Telehealth does not
6.9 include communication between a health care provider and a patient that consists solely of
6.10 an email or facsimile transmission. Telehealth does not include telemonitoring services as
6.11 defined in paragraph (i).

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

6.17 Sec. 3. Minnesota Statutes 2022, section 256.01, is amended by adding a subdivision to
6.18 read:

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

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

6.30 Subdivision 1. **Qualifying overpayment.** Any overpayment for assistance granted under
6.31 ~~chapter 119B~~, the MFIP program formerly codified under sections 256.031 to 256.0361;
6.32 ~~and~~ the AFDC program formerly codified under sections 256.72 to 256.871; for assistance
6.33 granted under chapters ~~256B for state-funded medical assistance,~~ 119B, 256D, 256I, 256J,

7.1 ~~and 256K, and 256L~~; for assistance granted pursuant to section 256.045, subdivision 10,
7.2 for state-funded medical assistance and state-funded MinnesotaCare under chapters 256B
7.3 and 256L; and for assistance granted under the Supplemental Nutrition Assistance Program
7.4 (SNAP), except agency error claims, become a judgment by operation of law 90 days after
7.5 the notice of overpayment is personally served upon the recipient in a manner that is sufficient
7.6 under rule 4.03(a) of the Rules of Civil Procedure for district courts, or by certified mail,
7.7 return receipt requested. This judgment shall be entitled to full faith and credit in this and
7.8 any other state.

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

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

7.11 Subd. 2b. **Hospital payment rates.** (a) For discharges occurring on or after November
7.12 1, 2014, hospital inpatient services for hospitals located in Minnesota shall be paid according
7.13 to the following:

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

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

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

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

7.22 (b) For the period beginning January 1, 2011, through October 31, 2014, rates shall not
7.23 be rebased, except that a Minnesota long-term hospital shall be rebased effective January
7.24 1, 2011, based on its most recent Medicare cost report ending on or before September 1,
7.25 2008, with the provisions under subdivisions 9 and 23, based on the rates in effect on
7.26 December 31, 2010. For rate setting periods after November 1, 2014, in which the base
7.27 years are updated, a Minnesota long-term hospital's base year shall remain within the same
7.28 period as other hospitals.

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

8.1 2014, shall be calendar year 2012. The rebasing under this paragraph shall be budget neutral,
8.2 ensuring that the total aggregate payments under the rebased system are equal to the total
8.3 aggregate payments that were made for the same number and types of services in the base
8.4 year. Separate budget neutrality calculations shall be determined for payments made to
8.5 critical access hospitals and payments made to hospitals paid under the DRG system. Only
8.6 the rate increases or decreases under subdivision 3a or 3c that applied to the hospitals being
8.7 rebased during the entire base period shall be incorporated into the budget neutrality
8.8 calculation.

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

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

8.19 (1) pediatric services;

8.20 (2) behavioral health services;

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

8.22 (4) transplant services;

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

8.25 (6) outlier admissions;

8.26 (7) low-volume providers; and

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

11.3 (6) geographic location.

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

11.5 Sec. 6. Minnesota Statutes 2022, section 256.969, subdivision 9, is amended to read:

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

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

11.19 (2) for a hospital with a medical assistance inpatient utilization rate above one standard
11.20 deviation above the mean, the adjustment must be determined by multiplying the adjustment
11.21 that would be determined under clause (1) for that hospital by 1.1. The commissioner shall
11.22 report annually on the number of hospitals likely to receive the adjustment authorized by
11.23 this paragraph. The commissioner shall specifically report on the adjustments received by
11.24 public hospitals and public hospital corporations located in cities of the first class.

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

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

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

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

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

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

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

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

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

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

12.29 (f) Any payments or portion of payments made to a hospital under this subdivision that
12.30 are subsequently returned to the commissioner because the payments are found to exceed
12.31 the hospital-specific DSH limit for that hospital shall be redistributed, proportionate to the
12.32 number of fee-for-service discharges, to other DSH-eligible non-children's hospitals that

13.1 have a medical assistance utilization rate that is at least one standard deviation above the
13.2 mean.

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

13.12 Sec. 7. Minnesota Statutes 2022, section 256.969, subdivision 25, is amended to read:

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

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

13.21 (c) For admissions occurring on or after July 1, 2023, long-term hospitals must be paid
13.22 the higher of a per diem amount computed using the methodology described in subdivision
13.23 2b, paragraph (i), or the per diem rate as of July 1, 2021.

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

13.25 Sec. 8. Minnesota Statutes 2022, section 256.969, is amended by adding a subdivision to
13.26 read:

13.27 Subd. 31. **Long-acting reversible contraceptives.** (a) The commissioner must provide
13.28 separate reimbursement to hospitals for long-acting reversible contraceptives provided
13.29 immediately postpartum in the inpatient hospital setting. This payment must be in addition
13.30 to the diagnostic-related group reimbursement for labor and delivery and shall be made
13.31 consistent with section 256B.0625, subdivision 13e, paragraph (e).

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

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

14.4 Sec. 9. Minnesota Statutes 2022, section 256B.04, subdivision 14, is amended to read:

14.5 Subd. 14. **Competitive bidding.** (a) When determined to be effective, economical, and
14.6 feasible, the commissioner may utilize volume purchase through competitive bidding and
14.7 negotiation under the provisions of chapter 16C, to provide items under the medical assistance
14.8 program including but not limited to the following:

14.9 (1) eyeglasses;

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

14.13 (3) hearing aids and supplies;

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

14.15 (i) hospital beds;

14.16 (ii) commodes;

14.17 (iii) glide-about chairs;

14.18 (iv) patient lift apparatus;

14.19 (v) wheelchairs and accessories;

14.20 (vi) oxygen administration equipment;

14.21 (vii) respiratory therapy equipment;

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

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

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

14.28 (6) drugs; and

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

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

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

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

15.7 Sec. 10. Minnesota Statutes 2022, section 256B.055, subdivision 17, is amended to read:

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

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

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

15.19 Sec. 11. Minnesota Statutes 2022, section 256B.0625, subdivision 3a, is amended to read:

15.20 Subd. 3a. ~~Sex reassignment surgery~~ **Gender-affirming services.** ~~Sex reassignment~~
15.21 ~~surgery is not covered.~~ Medical assistance covers gender-affirming services.

15.22 Sec. 12. Minnesota Statutes 2022, section 256B.0625, subdivision 9, is amended to read:

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

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

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

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

15.29 ~~(3) limited exams;~~

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

- 16.1 ~~(5) periapical x-rays;~~
- 16.2 ~~(6) panoramic x-rays, limited to one every five years except (1) when medically necessary~~
16.3 ~~for the diagnosis and follow-up of oral and maxillofacial pathology and trauma or (2) once~~
16.4 ~~every two years for patients who cannot cooperate for intraoral film due to a developmental~~
16.5 ~~disability or medical condition that does not allow for intraoral film placement;~~
- 16.6 ~~(7) prophylaxis, limited to one per year;~~
- 16.7 ~~(8) application of fluoride varnish, limited to one per year;~~
- 16.8 ~~(9) posterior fillings, all at the amalgam rate;~~
- 16.9 ~~(10) anterior fillings;~~
- 16.10 ~~(11) endodontics, limited to root canals on the anterior and premolars only;~~
- 16.11 ~~(12) removable prostheses, each dental arch limited to one every six years;~~
- 16.12 ~~(13) oral surgery, limited to extractions, biopsies, and incision and drainage of abscesses;~~
- 16.13 ~~(14) palliative treatment and sedative fillings for relief of pain;~~
- 16.14 ~~(15) full-mouth debridement, limited to one every five years; and~~
- 16.15 ~~(16) nonsurgical treatment for periodontal disease, including sealing and root planing~~
16.16 ~~once every two years for each quadrant, and routine periodontal maintenance procedures.~~
- 16.17 ~~(c) In addition to the services specified in paragraph (b), medical assistance covers the~~
16.18 ~~following services for adults, if provided in an outpatient hospital setting or freestanding~~
16.19 ~~ambulatory surgical center as part of outpatient dental surgery:~~
- 16.20 ~~(1) periodontics, limited to periodontal sealing and root planing once every two years;~~
- 16.21 ~~(2) general anesthesia; and~~
- 16.22 ~~(3) full-mouth survey once every five years.~~
- 16.23 ~~(d) Medical assistance covers medically necessary dental services for children and~~
16.24 ~~pregnant women. The following guidelines apply:~~
- 16.25 (1) posterior fillings are paid at the amalgam rate;
- 16.26 (2) application of sealants are covered once every five years per permanent molar for
16.27 children only;
- 16.28 (3) application of fluoride varnish is covered once every six months; and
- 16.29 (4) orthodontia is eligible for coverage for children only.

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

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

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

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

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

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

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

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

17.19 Subd. 13c. **Formulary Committee.** The commissioner, after receiving recommendations
 17.20 from professional medical associations and professional pharmacy associations, and consumer
 17.21 groups shall designate a Formulary Committee to carry out duties as described in subdivisions
 17.22 13 to 13g. The Formulary Committee shall be comprised of ~~four~~ at least five licensed
 17.23 physicians actively engaged in the practice of medicine in Minnesota, one of whom ~~must~~
 17.24 ~~be actively engaged in the treatment of persons with mental illness~~ is an actively practicing
 17.25 psychiatrist, one of whom specializes in the diagnosis and treatment of rare diseases, one
 17.26 of whom specializes in pediatrics, and one of whom actively treats persons with disabilities;
 17.27 at least three licensed pharmacists actively engaged in the practice of pharmacy in Minnesota,
 17.28 one of whom practices outside the metropolitan counties listed in section 473.121, subdivision
 17.29 4, one of whom practices in the metropolitan counties listed in section 473.121, subdivision
 17.30 4, and one of whom is a practicing hospital pharmacist; and one at least four consumer
 17.31 ~~representative~~ representatives, all of whom must have a personal or professional connection
 17.32 to medical assistance; and one representative designated by the Minnesota Rare Disease
 17.33 Advisory Council established under section 256.4835; the remainder to be made up of health

18.1 care professionals who are licensed in their field and have recognized knowledge in the
18.2 clinically appropriate prescribing, dispensing, and monitoring of covered outpatient drugs.
18.3 Members of the Formulary Committee shall not be employed by the Department of Human
18.4 Services, but the committee shall be staffed by an employee of the department who shall
18.5 serve as an ex officio, nonvoting member of the committee. The department's medical
18.6 director shall also serve as an ex officio, nonvoting member for the committee. Committee
18.7 members shall serve three-year terms and may be reappointed by the commissioner. The
18.8 Formulary Committee shall meet at least ~~twice~~ once per year. The commissioner may require
18.9 more frequent Formulary Committee meetings as needed. An honorarium of \$100 per
18.10 meeting and reimbursement for mileage shall be paid to each committee member in
18.11 attendance. Notwithstanding section 15.059, subdivision 6, the Formulary Committee expires
18.12 June 30, 2023 does not expire.

18.13 Sec. 14. Minnesota Statutes 2022, section 256B.0625, subdivision 13e, is amended to
18.14 read:

18.15 Subd. 13e. **Payment rates.** (a) The basis for determining the amount of payment shall
18.16 be the lower of the ingredient costs of the drugs plus the professional dispensing fee; or the
18.17 usual and customary price charged to the public. The usual and customary price means the
18.18 lowest price charged by the provider to a patient who pays for the prescription by cash,
18.19 check, or charge account and includes prices the pharmacy charges to a patient enrolled in
18.20 a prescription savings club or prescription discount club administered by the pharmacy or
18.21 pharmacy chain. The amount of payment basis must be reduced to reflect all discount
18.22 amounts applied to the charge by any third-party provider/insurer agreement or contract for
18.23 submitted charges to medical assistance programs. The net submitted charge may not be
18.24 greater than the patient liability for the service. The professional dispensing fee shall be
18.25 \$10.77 for prescriptions filled with legend drugs meeting the definition of "covered outpatient
18.26 drugs" according to United States Code, title 42, section 1396r-8(k)(2). The dispensing fee
18.27 for intravenous solutions that must be compounded by the pharmacist shall be \$10.77 per
18.28 claim. The professional dispensing fee for prescriptions filled with over-the-counter drugs
18.29 meeting the definition of covered outpatient drugs shall be \$10.77 for dispensed quantities
18.30 equal to or greater than the number of units contained in the manufacturer's original package.
18.31 The professional dispensing fee shall be prorated based on the percentage of the package
18.32 dispensed when the pharmacy dispenses a quantity less than the number of units contained
18.33 in the manufacturer's original package. The pharmacy dispensing fee for prescribed
18.34 over-the-counter drugs not meeting the definition of covered outpatient drugs shall be \$3.65
18.35 for quantities equal to or greater than the number of units contained in the manufacturer's

19.1 original package and shall be prorated based on the percentage of the package dispensed
19.2 when the pharmacy dispenses a quantity less than the number of units contained in the
19.3 manufacturer's original package. The National Average Drug Acquisition Cost (NADAC)
19.4 shall be used to determine the ingredient cost of a drug. For drugs for which a NADAC is
19.5 not reported, the commissioner shall estimate the ingredient cost at the wholesale acquisition
19.6 cost minus two percent. The ingredient cost of a drug for a provider participating in the
19.7 federal 340B Drug Pricing Program shall be either the 340B Drug Pricing Program ceiling
19.8 price established by the Health Resources and Services Administration or NADAC,
19.9 whichever is lower. Wholesale acquisition cost is defined as the manufacturer's list price
19.10 for a drug or biological to wholesalers or direct purchasers in the United States, not including
19.11 prompt pay or other discounts, rebates, or reductions in price, for the most recent month for
19.12 which information is available, as reported in wholesale price guides or other publications
19.13 of drug or biological pricing data. The maximum allowable cost of a multisource drug may
19.14 be set by the commissioner and it shall be comparable to the actual acquisition cost of the
19.15 drug product and no higher than the NADAC of the generic product. Establishment of the
19.16 amount of payment for drugs shall not be subject to the requirements of the Administrative
19.17 Procedure Act.

19.18 (b) Pharmacies dispensing prescriptions to residents of long-term care facilities using
19.19 an automated drug distribution system meeting the requirements of section 151.58, or a
19.20 packaging system meeting the packaging standards set forth in Minnesota Rules, part
19.21 6800.2700, that govern the return of unused drugs to the pharmacy for reuse, may employ
19.22 retrospective billing for prescription drugs dispensed to long-term care facility residents. A
19.23 retrospectively billing pharmacy must submit a claim only for the quantity of medication
19.24 used by the enrolled recipient during the defined billing period. A retrospectively billing
19.25 pharmacy must use a billing period not less than one calendar month or 30 days.

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

19.31 (d) If a pharmacy dispenses a multisource drug, the ingredient cost shall be the NADAC
19.32 of the generic product or the maximum allowable cost established by the commissioner
19.33 unless prior authorization for the brand name product has been granted according to the
19.34 criteria established by the Drug Formulary Committee as required by subdivision 13f,

20.1 paragraph (a), and the prescriber has indicated "dispense as written" on the prescription in
20.2 a manner consistent with section 151.21, subdivision 2.

20.3 (e) The basis for determining the amount of payment for drugs administered in an
20.4 outpatient setting shall be the lower of the usual and customary cost submitted by the
20.5 provider, 106 percent of the average sales price as determined by the United States
20.6 Department of Health and Human Services pursuant to title XVIII, section 1847a of the
20.7 federal Social Security Act, the specialty pharmacy rate, or the maximum allowable cost
20.8 set by the commissioner. If average sales price is unavailable, the amount of payment must
20.9 be lower of the usual and customary cost submitted by the provider, the wholesale acquisition
20.10 cost, the specialty pharmacy rate, or the maximum allowable cost set by the commissioner.
20.11 The commissioner shall discount the payment rate for drugs obtained through the federal
20.12 340B Drug Pricing Program by 28.6 percent. The payment for drugs administered in an
20.13 outpatient setting shall be made to the administering facility or practitioner. A retail or
20.14 specialty pharmacy dispensing a drug for administration in an outpatient setting is not
20.15 eligible for direct reimbursement.

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

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

21.1 (h) The commissioner shall contract with a vendor to conduct a cost of dispensing survey
21.2 for all pharmacies that are physically located in the state of Minnesota that dispense outpatient
21.3 drugs under medical assistance. The commissioner shall ensure that the vendor has prior
21.4 experience in conducting cost of dispensing surveys. Each pharmacy enrolled with the
21.5 department to dispense outpatient prescription drugs to fee-for-service members must
21.6 respond to the cost of dispensing survey. The commissioner may sanction a pharmacy under
21.7 section 256B.064 for failure to respond. The commissioner shall require the vendor to
21.8 measure a single statewide cost of dispensing for specialty prescription drugs and a single
21.9 statewide cost of dispensing for nonspecialty prescription drugs for all responding pharmacies
21.10 to measure the mean, mean weighted by total prescription volume, mean weighted by
21.11 medical assistance prescription volume, median, median weighted by total prescription
21.12 volume, and median weighted by total medical assistance prescription volume. The
21.13 commissioner shall post a copy of the final cost of dispensing survey report on the
21.14 department's website. The initial survey must be completed no later than January 1, 2021,
21.15 and repeated every three years. The commissioner shall provide a summary of the results
21.16 of each cost of dispensing survey and provide recommendations for any changes to the
21.17 dispensing fee to the chairs and ranking members of the legislative committees with
21.18 jurisdiction over medical assistance pharmacy reimbursement. Notwithstanding section
21.19 256.01, subdivision 42, this paragraph does not expire.

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

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

21.24 Sec. 15. Minnesota Statutes 2022, section 256B.0625, is amended by adding a subdivision
21.25 to read:

21.26 **Subd. 13k. Value-based purchasing arrangements.** (a) The commissioner may enter
21.27 into a value-based purchasing arrangement for the medical assistance or MinnesotaCare
21.28 program by written arrangement with a drug manufacturer based on agreed-upon metrics.
21.29 The commissioner may enter into a contract with a vendor for the purpose of participating
21.30 in a value-based purchasing arrangement. A value-based purchasing arrangement may
21.31 include a rebate, a discount, a price reduction, risk sharing, a reimbursement, a guarantee,
21.32 shared savings payments, withholds, a bonus, or any other thing of value. A value-based
21.33 purchasing arrangement must provide the same amount or more of a value or discount in

22.1 the aggregate as would claiming the mandatory federal drug rebate under the Federal Social
 22.2 Security Act, section 1927.

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

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

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

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

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

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

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

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

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

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

23.1 Sec. 17. Minnesota Statutes 2022, section 256B.0625, subdivision 22, is amended to read:

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

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

23.9 Sec. 18. Minnesota Statutes 2022, section 256B.0625, is amended by adding a subdivision
23.10 to read:

23.11 Subd. 22a. **Residential hospice facility; hospice respite and end-of-life care for**
23.12 **children.** (a) Medical assistance covers hospice respite and end-of-life care if the care is
23.13 for recipients age 21 or under who elect to receive hospice care delivered in a facility that
23.14 is licensed under sections 144A.75 to 144A.755 and that is a residential hospice facility
23.15 under section 144A.75, subdivision 13, paragraph (a). Hospice care services under
23.16 subdivision 22 are not hospice respite or end-of-life care under this subdivision.

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

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

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

24.1 Sec. 19. Minnesota Statutes 2022, section 256B.0625, subdivision 28b, is amended to
24.2 read:

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

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

24.12 Sec. 20. Minnesota Statutes 2022, section 256B.0625, subdivision 30, is amended to read:

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

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

24.30 (c) In order to continue cost-based payment under the medical assistance program
24.31 according to paragraphs (a) and (b), an FQHC or rural health clinic must apply for designation
24.32 as an essential community provider within six months of final adoption of rules by the
24.33 Department of Health according to section 62Q.19, subdivision 7. For those FQHCs and
24.34 rural health clinics that have applied for essential community provider status within the

25.1 six-month time prescribed, medical assistance payments will continue to be made according
25.2 to paragraphs (a) and (b) for the first three years after application. For FQHCs and rural
25.3 health clinics that either do not apply within the time specified above or who have had
25.4 essential community provider status for three years, medical assistance payments for health
25.5 services provided by these entities shall be according to the same rates and conditions
25.6 applicable to the same service provided by health care providers that are not FQHCs or rural
25.7 health clinics.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

26.13 (j) For clinic services provided prior to January 1, 2015, the commissioner shall calculate
26.14 and pay monthly the proposed managed care supplemental payments to clinics, and clinics
26.15 shall conduct a timely review of the payment calculation data in order to finalize all
26.16 supplemental payments in accordance with federal law. Any issues arising from a clinic's
26.17 review must be reported to the commissioner by January 1, 2017. Upon final agreement
26.18 between the commissioner and a clinic on issues identified under this subdivision, and in
26.19 accordance with United States Code, title 42, section 1396a(bb), no supplemental payments
26.20 for managed care plan or county-based purchasing plan claims for services provided prior
26.21 to January 1, 2015, shall be made after June 30, 2017. If the commissioner and clinics are
26.22 unable to resolve issues under this subdivision, the parties shall submit the dispute to the
26.23 arbitration process under section 14.57.

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

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

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

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

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

27.10 (i) general social services and administrative costs;

27.11 (ii) retail pharmacy;

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

27.13 (iv) external lab and x-ray;

27.14 (v) navigation services;

27.15 (vi) health care taxes;

27.16 (vii) advertising, public relations, and marketing;

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

27.18 (ix) contributions and donations;

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

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

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

27.22 (xiii) research and associated administrative costs;

27.23 (xiv) nonpaid workers;

27.24 (xv) lobbying;

27.25 (xvi) scholarships and student aid; and

27.26 (xvii) nonmedical assistance covered services;

27.27 (4) the commissioner shall review the list of nonallowable costs in the years between
27.28 the rebasing process established in clause (5), in consultation with the Minnesota Association

28.1 of Community Health Centers, FQHCs, and rural health clinics. The commissioner shall
28.2 publish the list and any updates in the Minnesota health care programs provider manual;

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

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

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

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

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

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

28.21 (6) the commissioner shall annually inflate the applicable organization encounter rates
28.22 for FQHCs and rural health clinics from the base year payment rate to the effective date by
28.23 using the CMS FQHC Market Basket inflator established under United States Code, title
28.24 42, section 1395m(o), less productivity;

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

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

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

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

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

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

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

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

29.30 (12) the commissioner, when establishing organization encounter rates for new FQHCs
29.31 and rural health clinics, shall consider the patient caseload of existing FQHCs and rural
29.32 health clinics in a 60-mile radius for organizations established outside of the seven-county
29.33 metropolitan area, and in a 30-mile radius for organizations in the seven-county metropolitan

30.1 area. If this information is not available, the commissioner may use Medicare cost reports
30.2 or audited financial statements to establish base rates;

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

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

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

30.18 Sec. 21. Minnesota Statutes 2022, section 256B.0625, subdivision 31, is amended to read:

30.19 Subd. 31. **Medical supplies and equipment.** (a) Medical assistance covers medical
30.20 supplies and equipment. Separate payment outside of the facility's payment rate shall be
30.21 made for wheelchairs and wheelchair accessories for recipients who are residents of
30.22 intermediate care facilities for the developmentally disabled. Reimbursement for wheelchairs
30.23 and wheelchair accessories for ICF/DD recipients shall be subject to the same conditions
30.24 and limitations as coverage for recipients who do not reside in institutions. A wheelchair
30.25 purchased outside of the facility's payment rate is the property of the recipient.

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

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

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

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

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

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

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

31.10 (1) can withstand repeated use;

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

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

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

31.18 (f) Notwithstanding the requirement in paragraph (e) that an electronic tablet must be
31.19 locked to prevent use not as an augmentative communication device, a recipient of waiver
31.20 services may use an electronic tablet for a use not related to communication when the
31.21 recipient has been authorized under the waiver to receive one or more additional applications
31.22 that can be loaded onto the electronic tablet, such that allowing the additional use prevents
31.23 the purchase of a separate electronic tablet with waiver funds.

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

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

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

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

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

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

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

32.7 (j) For the purposes of paragraph (i), "seizure detection device" means a United States
32.8 Food and Drug Administration-approved monitoring device and related service or
32.9 subscription supporting the prescribed use of the device, including technology that provides
32.10 ongoing patient monitoring and alert services that detect seizure activity and transmit
32.11 notification of the seizure activity to a caregiver for appropriate medical response or collects
32.12 data of the seizure activity of the recipient that can be used by a health care provider to
32.13 diagnose or appropriately treat a health care condition that causes the seizure activity. The
32.14 medical assistance reimbursement rate for a subscription supporting the prescribed use of
32.15 a seizure detection device is 60 percent of the rate for monthly remote monitoring under
32.16 the medical assistance telemonitoring benefit.

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

32.20 Sec. 22. Minnesota Statutes 2022, section 256B.0625, is amended by adding a subdivision
32.21 to read:

32.22 Subd. 68. **Tobacco and nicotine cessation.** (a) Medical assistance covers tobacco and
32.23 nicotine cessation services, drugs to treat tobacco and nicotine addiction or dependence,
32.24 and drugs to help individuals discontinue use of tobacco and nicotine products. Medical
32.25 assistance must cover services and drugs as provided in this subdivision consistent with
32.26 evidence-based or evidence-informed best practices.

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

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

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

- 33.1 (3) mental health certified peer specialists under section 256B.0615;
- 33.2 (4) alcohol and drug counselors licensed under chapter 148F;
- 33.3 (5) recovery peers as defined in section 245F.02, subdivision 21;
- 33.4 (6) certified tobacco treatment specialists;
- 33.5 (7) community health workers;
- 33.6 (8) physicians;
- 33.7 (9) physician assistants;
- 33.8 (10) advanced practice registered nurses; or
- 33.9 (11) other licensed or nonlicensed professionals or paraprofessionals with training in
- 33.10 providing tobacco and nicotine cessation education and counseling services.
- 33.11 (c) Medical assistance covers telephone cessation counseling services provided through
- 33.12 a quitline. Notwithstanding section 256B.0625, subdivision 3b, quitline services may be
- 33.13 provided through audio-only communications. The commissioner of human services may
- 33.14 utilize volume purchasing for quitline services consistent with section 256B.04, subdivision
- 33.15 14.
- 33.16 (d) Medical assistance must cover all prescription and over-the-counter pharmacotherapy
- 33.17 drugs approved by the United States Food and Drug Administration for cessation of tobacco
- 33.18 and nicotine use or treatment of tobacco and nicotine dependence, and that are subject to a
- 33.19 Medicaid drug rebate agreement.
- 33.20 (e) Services covered under this subdivision may be provided by telemedicine.
- 33.21 (f) The commissioner must not:
- 33.22 (1) restrict or limit the type, duration, or frequency of tobacco and nicotine cessation
- 33.23 services;
- 33.24 (2) prohibit the simultaneous use of multiple cessation services, including but not limited
- 33.25 to simultaneous use of counseling and drugs;
- 33.26 (3) require counseling before receiving drugs or as a condition of receiving drugs;
- 33.27 (4) limit pharmacotherapy drug dosage amounts for a dosing regimen for treatment of
- 33.28 a medically accepted indication as defined in United States Code, title 14, section
- 33.29 1396r-8(K)(6); limit dosing frequency; or impose duration limits;

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

34.3 (6) require or authorize step therapy; or

34.4 (7) require or utilize prior authorization for any tobacco and nicotine cessation services
34.5 and drugs covered under this subdivision.

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

34.7 Sec. 23. Minnesota Statutes 2022, section 256B.0625, is amended by adding a subdivision
34.8 to read:

34.9 Subd. 69. **Recuperative care services.** (a) Medical assistance covers recuperative care
34.10 services provided in a setting that meets the requirements in paragraph (b) for recipients
34.11 who meet the eligibility requirements in paragraph (c). For purposes of this subdivision,
34.12 "recuperative care" means a model of care that prevents hospitalization or that provides
34.13 postacute medical care and support services for recipients experiencing homelessness who
34.14 are too ill or frail to recover from a physical illness or injury while living in a shelter or are
34.15 otherwise unhoused but who are not sick enough to be hospitalized, or remain hospitalized,
34.16 or to need other levels of care.

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

34.21 (1) 24-hour access to a bed and bathroom;

34.22 (2) access to three meals a day;

34.23 (3) availability to environmental services;

34.24 (4) access to a telephone;

34.25 (5) a secure place to store belongings; and

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

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

34.29 (1) be 21 years of age or older;

34.30 (2) be experiencing homelessness;

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

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

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

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

35.16 (1) basic nursing care, including:

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

35.18 (ii) providing wound care;

35.19 (iii) medication support;

35.20 (iv) patient education;

35.21 (v) immunization review and update; and

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

35.23 (2) care coordination, including:

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

35.25 (ii) development of a care plan;

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

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

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

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

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

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

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

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

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

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

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

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

36.25 Sec. 24. Minnesota Statutes 2022, section 256B.196, subdivision 2, is amended to read:

36.26 Subd. 2. **Commissioner's duties.** (a) For the purposes of this subdivision and subdivision
36.27 3, the commissioner shall determine the fee-for-service outpatient hospital services upper
36.28 payment limit for nonstate government hospitals. The commissioner shall then determine
36.29 the amount of a supplemental payment to Hennepin County Medical Center and Regions
36.30 Hospital for these services that would increase medical assistance spending in this category
36.31 to the aggregate upper payment limit for all nonstate government hospitals in Minnesota.
36.32 In making this determination, the commissioner shall allot the available increases between

37.1 Hennepin County Medical Center and Regions Hospital based on the ratio of medical
37.2 assistance fee-for-service outpatient hospital payments to the two facilities. The commissioner
37.3 shall adjust this allotment as necessary based on federal approvals, the amount of
37.4 intergovernmental transfers received from Hennepin and Ramsey Counties, and other factors,
37.5 in order to maximize the additional total payments. The commissioner shall inform Hennepin
37.6 County and Ramsey County of the periodic intergovernmental transfers necessary to match
37.7 federal Medicaid payments available under this subdivision in order to make supplementary
37.8 medical assistance payments to Hennepin County Medical Center and Regions Hospital
37.9 equal to an amount that when combined with existing medical assistance payments to
37.10 nonstate governmental hospitals would increase total payments to hospitals in this category
37.11 for outpatient services to the aggregate upper payment limit for all hospitals in this category
37.12 in Minnesota. Upon receipt of these periodic transfers, the commissioner shall make
37.13 supplementary payments to Hennepin County Medical Center and Regions Hospital.

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

37.30 (c) Beginning January 1, 2010, Ramsey County may make monthly voluntary
37.31 intergovernmental transfers to the commissioner in amounts not to exceed \$6,000,000 per
37.32 year. The commissioner shall increase the medical assistance capitation payments to any
37.33 licensed health plan under contract with the medical assistance program that agrees to make
37.34 enhanced payments to Regions Hospital. The increase shall be in an amount equal to the
37.35 annual value of the monthly transfers plus federal financial participation, with each health

38.1 plan receiving its pro rata share of the increase based on the pro rata share of medical
38.2 assistance admissions to Regions Hospital by those plans. For the purposes of this paragraph,
38.3 "the base amount" means the total annual value of increased medical assistance capitation
38.4 payments, including the voluntary intergovernmental transfers, under this paragraph in
38.5 calendar year 2017. For managed care contracts beginning on or after January 1, 2018, the
38.6 commissioner shall reduce the total annual value of increased medical assistance capitation
38.7 payments under this paragraph by an amount equal to ten percent of the base amount, and
38.8 by an additional ten percent of the base amount for each subsequent contract year until
38.9 December 31, 2025. Upon the request of the commissioner, health plans shall submit
38.10 individual-level cost data for verification purposes. The commissioner may ratably reduce
38.11 these payments on a pro rata basis in order to satisfy federal requirements for actuarial
38.12 soundness. If payments are reduced, transfers shall be reduced accordingly. Any licensed
38.13 health plan that receives increased medical assistance capitation payments under the
38.14 intergovernmental transfer described in this paragraph shall increase its medical assistance
38.15 payments to Regions Hospital by the same amount as the increased payments received in
38.16 the capitation payment described in this paragraph. This paragraph expires January 1, 2026.

38.17 (d) For the purposes of this subdivision and subdivision 3, the commissioner shall
38.18 determine an upper payment limit for ambulance services affiliated with Hennepin County
38.19 Medical Center and the city of St. Paul, and ambulance services owned and operated by
38.20 another governmental entity that chooses to participate by requesting the commissioner to
38.21 determine an upper payment limit. The upper payment limit shall be based on the average
38.22 commercial rate or be determined using another method acceptable to the Centers for
38.23 Medicare and Medicaid Services. The commissioner shall inform Hennepin County, the
38.24 city of St. Paul, and other participating governmental entities of the periodic
38.25 intergovernmental transfers necessary to match the federal Medicaid payments available
38.26 under this subdivision in order to make supplementary payments to Hennepin County
38.27 Medical Center, the city of St. Paul, and other participating governmental entities equal to
38.28 the difference between the established medical assistance payment for ambulance services
38.29 and the upper payment limit. Upon receipt of these periodic transfers, the commissioner
38.30 shall make supplementary payments to Hennepin County Medical Center, the city of St.
38.31 Paul, and other participating governmental entities. A tribal government that owns and
38.32 operates an ambulance service is not eligible to participate under this subdivision.

38.33 (e) For the purposes of this subdivision and subdivision 3, the commissioner shall
38.34 determine an upper payment limit for physicians, dentists, and other billing professionals
38.35 affiliated with the University of Minnesota and University of Minnesota Physicians. The

39.1 upper payment limit shall be based on the average commercial rate or be determined using
39.2 another method acceptable to the Centers for Medicare and Medicaid Services. The
39.3 commissioner shall inform the University of Minnesota Medical School and University of
39.4 Minnesota School of Dentistry of the periodic intergovernmental transfers necessary to
39.5 match the federal Medicaid payments available under this subdivision in order to make
39.6 supplementary payments to physicians, dentists, and other billing professionals affiliated
39.7 with the University of Minnesota and the University of Minnesota Physicians equal to the
39.8 difference between the established medical assistance payment for physician, dentist, and
39.9 other billing professional services and the upper payment limit. Upon receipt of these periodic
39.10 transfers, the commissioner shall make supplementary payments to physicians, dentists,
39.11 and other billing professionals affiliated with the University of Minnesota and the University
39.12 of Minnesota Physicians.

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

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

39.19 (h) All of the data and funding transactions related to the payments in paragraphs (a) to
39.20 (e) shall be between the commissioner and the governmental entities. The commissioner
39.21 shall not make payments to governmental entities eligible to receive payments described
39.22 in paragraphs (a) to (e) that fail to submit the data needed to compute the payments within
39.23 24 months of the initial request from the commissioner.

39.24 (i) For purposes of this subdivision, billing professionals are limited to physicians, nurse
39.25 practitioners, nurse midwives, clinical nurse specialists, physician assistants,
39.26 anesthesiologists, certified registered nurse anesthetists, dentists, dental hygienists, and
39.27 dental therapists.

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

39.29 Sec. 25. Minnesota Statutes 2022, section 256B.69, subdivision 5a, is amended to read:

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

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

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

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

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

40.33 (2) by January 30 of each year that follows a rate increase for any aspect of services
40.34 under section 256B.0659 or 256B.85, inform the commissioner and the chairs and ranking
40.35 minority members of the legislative committees with jurisdiction over rates determined

41.1 under section 256B.851 of the amount of the rate increase that is paid to each personal care
41.2 assistance provider agency with which the plan has a contract.

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

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

41.23 ~~The withhold described in this paragraph shall continue for each consecutive contract~~
41.24 ~~period until the plan's emergency room utilization rate for state health care program enrollees~~
41.25 ~~is reduced by 25 percent of the plan's emergency room utilization rate for medical assistance~~
41.26 ~~and MinnesotaCare enrollees for calendar year 2009. Hospitals shall cooperate with the~~
41.27 ~~health plans in meeting this performance target and shall accept payment withholds that~~
41.28 ~~may be returned to the hospitals if the performance target is achieved.~~

41.29 ~~(f) Effective for services rendered on or after January 1, 2012, the commissioner shall~~
41.30 ~~include as part of the performance targets described in paragraph (c) a reduction in the plan's~~
41.31 ~~hospitalization admission rate for medical assistance and MinnesotaCare enrollees, as~~
41.32 ~~determined by the commissioner. To earn the return of the withhold each year, the managed~~
41.33 ~~care plan or county-based purchasing plan must achieve a qualifying reduction of no less~~
41.34 ~~than five percent of the plan's hospital admission rate for medical assistance and~~
41.35 ~~MinnesotaCare enrollees, excluding enrollees in programs described in subdivisions 23 and~~

42.1 ~~28, compared to the previous calendar year until the final performance target is reached.~~
42.2 ~~When measuring performance, the commissioner must consider the difference in health risk~~
42.3 ~~in a managed care or county-based purchasing plan's membership in the baseline year~~
42.4 ~~compared to the measurement year, and work with the managed care or county-based~~
42.5 ~~purchasing plan to account for differences that they agree are significant.~~

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

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

42.19 ~~(g) Effective for services rendered on or after January 1, 2012, the commissioner shall~~
42.20 ~~include as part of the performance targets described in paragraph (c) a reduction in the plan's~~
42.21 ~~hospitalization admission rates for subsequent hospitalizations within 30 days of a previous~~
42.22 ~~hospitalization of a patient regardless of the reason, for medical assistance and MinnesotaCare~~
42.23 ~~enrollees, as determined by the commissioner. To earn the return of the withhold each year,~~
42.24 ~~the managed care plan or county-based purchasing plan must achieve a qualifying reduction~~
42.25 ~~of the subsequent hospitalization rate for medical assistance and MinnesotaCare enrollees,~~
42.26 ~~excluding enrollees in programs described in subdivisions 23 and 28, of no less than five~~
42.27 ~~percent compared to the previous calendar year until the final performance target is reached.~~

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

43.1 ~~The withhold described in this paragraph must continue for each consecutive contract~~
43.2 ~~period until the plan's subsequent hospitalization rate for medical assistance and~~
43.3 ~~MinnesotaCare enrollees, excluding enrollees in programs described in subdivisions 23 and~~
43.4 ~~28, is reduced by 25 percent of the plan's subsequent hospitalization rate for calendar year~~
43.5 ~~2011. Hospitals shall cooperate with the plans in meeting this performance target and shall~~
43.6 ~~accept payment withholds that must be returned to the hospitals if the performance target~~
43.7 ~~is achieved.~~

43.8 ~~(h)~~ (e) Effective for services rendered on or after January 1, 2013, through December
43.9 31, 2013, the commissioner shall withhold 4.5 percent of managed care plan payments under
43.10 this section and county-based purchasing plan payments under section 256B.692 for the
43.11 prepaid medical assistance program. The withheld funds must be returned no sooner than
43.12 July 1 and no later than July 31 of the following year. The commissioner may exclude
43.13 special demonstration projects under subdivision 23.

43.14 ~~(i)~~ (f) Effective for services rendered on or after January 1, 2014, the commissioner shall
43.15 withhold three percent of managed care plan payments under this section and county-based
43.16 purchasing plan payments under section 256B.692 for the prepaid medical assistance
43.17 program. The withheld funds must be returned no sooner than July 1 and no later than July
43.18 31 of the following year. The commissioner may exclude special demonstration projects
43.19 under subdivision 23.

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

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

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

43.28 ~~(m)~~ (j) Managed care plans and county-based purchasing plans shall maintain current
43.29 and fully executed agreements for all subcontractors, including bargaining groups, for
43.30 administrative services that are expensed to the state's public health care programs.
43.31 Subcontractor agreements determined to be material, as defined by the commissioner after
43.32 taking into account state contracting and relevant statutory requirements, must be in the
43.33 form of a written instrument or electronic document containing the elements of offer,
43.34 acceptance, consideration, payment terms, scope, duration of the contract, and how the

44.1 subcontractor services relate to state public health care programs. Upon request, the
44.2 commissioner shall have access to all subcontractor documentation under this paragraph.
44.3 Nothing in this paragraph shall allow release of information that is nonpublic data pursuant
44.4 to section 13.02.

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

44.6 Sec. 26. Minnesota Statutes 2022, section 256B.76, subdivision 1, is amended to read:

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

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

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

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

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

44.25 (c) Effective for services rendered on or after July 1, 2009, payment rates for physician
44.26 and professional services shall be reduced by five percent, except that for the period July
44.27 1, 2009, through June 30, 2010, payment rates shall be reduced by 6.5 percent for the medical
44.28 assistance and general assistance medical care programs, over the rates in effect on June
44.29 30, 2009. This reduction and the reductions in paragraph (d) do not apply to office or other
44.30 outpatient visits, preventive medicine visits and family planning visits billed by physicians,
44.31 advanced practice nurses, or physician assistants in a family planning agency or in one of
44.32 the following primary care practices: general practice, general internal medicine, general
44.33 pediatrics, general geriatrics, and family medicine. This reduction and the reductions in

45.1 paragraph (d) do not apply to federally qualified health centers, rural health centers, and
45.2 Indian health services. Effective October 1, 2009, payments made to managed care plans
45.3 and county-based purchasing plans under sections 256B.69, 256B.692, and 256L.12 shall
45.4 reflect the payment reduction described in this paragraph.

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

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

45.18 (f) Effective for services rendered on or after September 1, 2014, payment rates for
45.19 physician and professional services, including physical therapy, occupational therapy, speech
45.20 pathology, and mental health services shall be increased by five percent from the rates in
45.21 effect on August 31, 2014. In calculating this rate increase, the commissioner shall not
45.22 include in the base rate for August 31, 2014, the rate increase provided under section
45.23 256B.76, subdivision 7. This increase does not apply to federally qualified health centers,
45.24 rural health centers, and Indian health services. Payments made to managed care plans and
45.25 county-based purchasing plans shall not be adjusted to reflect payments under this paragraph.

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

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

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

46.7 Sec. 27. Minnesota Statutes 2022, section 256B.76, subdivision 2, is amended to read:

46.8 Subd. 2. **Dental reimbursement.** (a) Effective for services rendered ~~on or after~~ from
46.9 October 1, 1992, to December 31, 2023, the commissioner shall make payments for dental
46.10 services as follows:

46.11 (1) dental services shall be paid at the lower of (i) submitted charges, or (ii) 25 percent
46.12 above the rate in effect on June 30, 1992; and

46.13 (2) dental rates shall be converted from the 50th percentile of 1982 to the 50th percentile
46.14 of 1989, less the percent in aggregate necessary to equal the above increases.

46.15 (b) ~~Beginning~~ From October 1, 1999, to December 31, 2023, the payment for tooth
46.16 sealants and fluoride treatments shall be the lower of (1) submitted charge, or (2) 80 percent
46.17 of median 1997 charges.

46.18 (c) Effective for services rendered ~~on or after~~ from January 1, 2000, to December 31,
46.19 2023, payment rates for dental services shall be increased by three percent over the rates in
46.20 effect on December 31, 1999.

46.21 (d) Effective for services provided ~~on or after~~ from January 1, 2002, to December 31,
46.22 2023, payment for diagnostic examinations and dental x-rays provided to children under
46.23 age 21 shall be the lower of (1) the submitted charge, or (2) 85 percent of median 1999
46.24 charges.

46.25 (e) The increases listed in paragraphs (b) and (c) shall be implemented January 1, 2000,
46.26 for managed care.

46.27 (f) Effective for dental services rendered on or after October 1, 2010, by a state-operated
46.28 dental clinic, payment shall be paid on a reasonable cost basis that is based on the Medicare
46.29 principles of reimbursement. This payment shall be effective for services rendered on or
46.30 after January 1, 2011, to recipients enrolled in managed care plans or county-based
46.31 purchasing plans.

47.1 (g) Beginning in fiscal year 2011, if the payments to state-operated dental clinics in
47.2 paragraph (f), including state and federal shares, are less than \$1,850,000 per fiscal year, a
47.3 supplemental state payment equal to the difference between the total payments in paragraph
47.4 (f) and \$1,850,000 shall be paid from the general fund to state-operated services for the
47.5 operation of the dental clinics.

47.6 ~~(h) Effective for services rendered on or after January 1, 2014, through December 31,~~
47.7 ~~2021, payment rates for dental services shall be increased by five percent from the rates in~~
47.8 ~~effect on December 31, 2013. This increase does not apply to state-operated dental clinics~~
47.9 ~~in paragraph (f), federally qualified health centers, rural health centers, and Indian health~~
47.10 ~~services. Effective January 1, 2014, payments made to managed care plans and county-based~~
47.11 ~~purchasing plans under sections 256B.69, 256B.692, and 256L.12 shall reflect the payment~~
47.12 ~~increase described in this paragraph.~~

47.13 ~~(i) Effective for services provided on or after January 1, 2017, through December 31,~~
47.14 ~~2021, the commissioner shall increase payment rates by 9.65 percent for dental services~~
47.15 ~~provided outside of the seven-county metropolitan area. This increase does not apply to~~
47.16 ~~state-operated dental clinics in paragraph (f), federally qualified health centers, rural health~~
47.17 ~~centers, or Indian health services. Effective January 1, 2017, payments to managed care~~
47.18 ~~plans and county-based purchasing plans under sections 256B.69 and 256B.692 shall reflect~~
47.19 ~~the payment increase described in this paragraph.~~

47.20 ~~(j) Effective for services provided on or after July 1, 2017, through December 31, 2021,~~
47.21 ~~the commissioner shall increase payment rates by 23.8 percent for dental services provided~~
47.22 ~~to enrollees under the age of 21. This rate increase does not apply to state-operated dental~~
47.23 ~~clinics in paragraph (f), federally qualified health centers, rural health centers, or Indian~~
47.24 ~~health centers. This rate increase does not apply to managed care plans and county-based~~
47.25 ~~purchasing plans.~~

47.26 ~~(k)~~ (h) Effective for services provided on or after January 1, 2022, the commissioner
47.27 shall exclude from medical assistance and MinnesotaCare payments for dental services to
47.28 public health and community health clinics the 20 percent increase authorized under Laws
47.29 1989, chapter 327, section 5, subdivision 2, paragraph (b).

47.30 ~~(l)~~ (i) Effective for services provided ~~on or after~~ from January 1, 2022, to December 31,
47.31 2023, the commissioner shall increase payment rates by 98 percent for all dental services.
47.32 This rate increase does not apply to state-operated dental clinics, federally qualified health
47.33 centers, rural health centers, or Indian health services.

48.1 ~~(m)~~ (j) Managed care plans and county-based purchasing plans shall reimburse providers
48.2 at a level that is at least equal to the rate paid under fee-for-service for dental services. If,
48.3 for any coverage year, federal approval is not received for this paragraph, the commissioner
48.4 must adjust the capitation rates paid to managed care plans and county-based purchasing
48.5 plans for that contract year to reflect the removal of this provision. Contracts between
48.6 managed care plans and county-based purchasing plans and providers to whom this paragraph
48.7 applies must allow recovery of payments from those providers if capitation rates are adjusted
48.8 in accordance with this paragraph. Payment recoveries must not exceed an amount equal
48.9 to any increase in rates that results from this provision. If, for any coverage year, federal
48.10 approval is not received for this paragraph, the commissioner shall not implement this
48.11 paragraph for subsequent coverage years.

48.12 (k) Effective for services provided on or after January 1, 2024, payment for dental
48.13 services must be the lower of submitted charges or the percentile of 2018-submitted charges
48.14 from claims paid by the commissioner so that the total aggregate expenditures does not
48.15 exceed the total spend as outlined in the applicable paragraphs (a) to (k). This paragraph
48.16 does not apply to federally qualified health centers, rural health centers, state-operated dental
48.17 clinics, or Indian health centers.

48.18 (l) Beginning January 1, 2028, and every three years thereafter, the commissioner shall
48.19 rebase payment rates for dental services to a percentile of submitted charges for the applicable
48.20 base year using charge data from claims paid by the commissioner so that the total aggregate
48.21 expenditures does not exceed the total spend as outlined in paragraph (k) plus the change
48.22 in the Medicare Economic Index (MEI). In 2028, the change in the MEI must be measured
48.23 from midyear of 2025 and 2027. For each subsequent rebasing, the change in the MEI must
48.24 be measured between the years that are one year after the rebasing years. The base year
48.25 used for each rebasing must be the calendar year that is two years prior to the effective date
48.26 of the rebasing. This paragraph does not apply to federally qualified health centers, rural
48.27 health centers, state-operated dental clinics, or Indian health centers.

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

48.31 Sec. 28. Minnesota Statutes 2022, section 256B.764, is amended to read:

48.32 **256B.764 REIMBURSEMENT FOR FAMILY PLANNING SERVICES.**

48.33 (a) Effective for services rendered on or after July 1, 2007, payment rates for family
48.34 planning services shall be increased by 25 percent over the rates in effect June 30, 2007,

49.1 when these services are provided by a community clinic as defined in section 145.9268,
49.2 subdivision 1.

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

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

49.13 Sec. 29. Minnesota Statutes 2022, section 256L.03, subdivision 1, is amended to read:

49.14 Subdivision 1. **Covered health services.** (a) "Covered health services" means the health
49.15 services reimbursed under chapter 256B, with the exception of special education services,
49.16 home care nursing services, adult dental care services other than services covered under
49.17 section 256B.0625, subdivision 9, orthodontic services, nonemergency medical transportation
49.18 services, personal care assistance and case management services, community first services
49.19 and supports under section 256B.85, behavioral health home services under section
49.20 256B.0757, housing stabilization services under section 256B.051, and nursing home or
49.21 intermediate care facilities services.

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

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

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

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

50.1 Sec. 30. Minnesota Statutes 2022, section 256L.03, subdivision 5, is amended to read:

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

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

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

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

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

50.16 Sec. 31. Laws 2021, First Special Session chapter 7, article 6, section 26, is amended to
50.17 read:

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

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

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

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

51.1 Sec. 32. **REPEALER.**

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

51.3 **ARTICLE 2**

51.4 **HEALTH CARE AFFORDABILITY AND DELIVERY**

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

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

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

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

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

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

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

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

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

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

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

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

51.26 (3) one member representing Indian Tribes;

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

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

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

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

52.4 (8) one member representing rural hospitals;

52.5 (9) one member representing health plans;

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

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

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

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

52.13 (2) health care consumer advocacy;

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

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

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

52.18 or

52.19 (6) addressing health disparities and structural inequities.

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

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

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

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

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

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

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

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

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

53.17 (c) After the initial growth targets are established, the commission shall meet at least
53.18 quarterly to consider summary data presented by the commissioner, draft report findings,
53.19 consider updates to the health care spending growth target program and growth target levels,
53.20 discuss findings with health care providers and payers, and identify additional analyses and
53.21 strategies to limit health care spending growth.

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

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

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

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

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

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

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

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

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

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

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

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

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

54.27 Subd. 11. **Access to information.** (a) The commission or commissioner may request
54.28 that a state agency provide the commission with data as defined in sections 62J.04 and
54.29 295.52 in a usable format as requested by the commission, at no cost to the commission.

54.30 (b) The commission may request from a state agency unique or custom data sets, and
54.31 the agency may charge the commission for providing the data at the same rate the agency

55.1 would charge any other public or private entity. The commission may grant the commissioner
55.2 access to this data.

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

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

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

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

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

55.15 The commission shall:

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

55.17 (2) enhance the transparency of provider organizations;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

56.17 Subd. 2. **Methodologies for growth targets.** (a) The commission shall develop and
56.18 maintain the health care spending growth target program, and report to the legislature and
56.19 the public on progress toward achieving growth targets. The commission shall conduct all
56.20 activities necessary for the successful implementation of the program, in order to limit health
56.21 care spending growth. The commission shall:

56.22 (1) establish a statement of purpose;

56.23 (2) develop a methodology to establish health care spending growth targets and the
56.24 economic indicators to be used in establishing the initial and subsequent target levels;

56.25 (3) establish health care spending growth targets that:

56.26 (i) use a clear and operational definition of total state health care spending;

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

56.30 (iii) apply to all health care providers and all health plan companies in the state's health
56.31 care system; and

57.1 (iv) are measurable on a per capita basis, statewide basis, health plan basis, and health
57.2 care provider basis; and

57.3 (4) establish a methodology for calculating health care cost growth that:

57.4 (i) allows measurement statewide and for each health care provider and health plan
57.5 company, and at the discretion of the commission allows accounting for variability by age
57.6 and sex;

57.7 (ii) takes into consideration the need for variability in targets across public and private
57.8 payers;

57.9 (iii) incorporates health equity considerations; and

57.10 (iv) considers the impact of targets on health care access and disparities.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

58.20 (5) ensure that growth targets:

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

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

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

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

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

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

59.4 (b) The commission shall submit written progress updates about the development and
59.5 implementation of the health care growth target program by February 15, 2024, and February
59.6 15, 2025. The updates must include reporting on commission membership and activities,
59.7 program design decisions, planned timelines for implementation of the program, progress
59.8 of implementation, and comprehensive methodological details underlying program design
59.9 decisions.

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

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

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

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

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

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

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

59.27 (7) an overview of health care entities subject to health care growth targets that have
59.28 implemented or completed a performance improvement plan.

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

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

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

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

60.2 Subd. 2. **Establishment; administration.** (a) The commissioner of health shall appoint
60.3 a 15-member advisory council to provide technical assistance to the commission. Members
60.4 shall be appointed based on their knowledge and demonstrated expertise in one or more of
60.5 the following areas:

60.6 (1) health care spending trends and drivers;

60.7 (2) equitable access to health care services;

60.8 (3) health insurance operation and finance;

60.9 (4) actuarial science;

60.10 (5) the practice of medicine;

60.11 (6) patient perspectives;

60.12 (7) clinical and health services research; and

60.13 (8) the health care marketplace.

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

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

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

60.20 (2) the commissioner of health or a designee;

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

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

60.23 (5) two members who represent nonprofit group purchasers;

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

60.25 (7) two members who represent health care entities;

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

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

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

61.1 Subd. 4. **Terms.** (a) The initial appointments to the council shall be made by September
61.2 30, 2023. The council members shall serve staggered terms of three or four years determined
61.3 by lot by the secretary of state. Following the initial appointments, the council members
61.4 shall serve four-year terms. Members may not serve more than two consecutive terms.

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

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

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

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

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

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

61.16 (i) communities most impacted by health disparities;

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

61.18 (iii) individuals with disabilities;

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

61.20 (v) individuals who reside in rural areas; and

61.21 (vi) individuals with rare diseases.

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

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

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

61.28 Subd. 2. **Performance improvement plans.** (a) The commission shall establish and
61.29 implement procedures to assist health care entities to improve efficiency and reduce cost
61.30 growth by requiring some or all health care entities provided notice under subdivision 1 to

62.1 file and implement a performance improvement plan. The commission shall provide written
62.2 notice of this requirement to health care entities and describe the form and manner in which
62.3 these plans must be prepared and submitted.

62.4 (b) Within 45 days of receiving a notice of the requirement to file a performance
62.5 improvement plan, a health care entity shall:

62.6 (1) file a performance improvement plan as specified in paragraph (d); or

62.7 (2) file a request for a waiver or extension as specified in paragraph (c).

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

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

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

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

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

62.28 (5) any other factors the commission considers relevant.

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

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

63.8 (e) The commission shall approve any performance improvement plan that it determines
63.9 is reasonably likely to address the underlying cause of the entity's cost growth and has a
63.10 reasonable expectation for successful implementation. If the commission determines that
63.11 the performance improvement plan is unacceptable or incomplete, the commission may
63.12 provide consultation on the criteria that have not been met and may allow an additional time
63.13 period of up to 30 calendar days for resubmission. Upon approval of the proposed
63.14 performance improvement plan, the commission shall notify the health care entity to begin
63.15 immediate implementation of the performance improvement plan. Public notice shall be
63.16 provided by the commission on its website, identifying that the health care entity is
63.17 implementing a performance improvement plan. All health care entities implementing an
63.18 approved performance improvement plan shall be subject to additional reporting requirements
63.19 and compliance monitoring, as determined by the commission. The commission may request
63.20 the commissioner to assist in the review of performance improvement plans. The commission
63.21 shall provide assistance to the health care entity in the successful implementation of the
63.22 performance improvement plan.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

65.11 (b) The commissioner shall develop recommendations for pilot projects with the aim of
65.12 ensuring financial viability of rural health care entities in the context of spending growth
65.13 targets. The commissioner shall share findings with the health care affordability commission.

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

65.15 Subd. 11. **Restricted uses of the all-payer claims data.** (a) Notwithstanding subdivision
65.16 4, paragraph (b), and subdivision 5, paragraph (b), the commissioner or the commissioner's
65.17 designee shall only use the data submitted under subdivisions 4 and 5 for the following
65.18 purposes:

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

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

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

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

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

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

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

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

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

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

66.8 (6) to provide technical assistance to the Health Care Affordability Commission to
66.9 implement sections 62J.0411 to 62J.0415.

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

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

66.16 (d) The commissioner or the commissioner's designee may use the data submitted under
66.17 subdivisions 4 and 5 for the purpose described in paragraph (a), clause (3), until July 1,
66.18 2023.

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

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

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

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

66.28 (1) is a resident of Minnesota; and

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

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

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

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

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

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

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

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

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

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

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

67.32 (c) County-based purchasing plans and county-owned health maintenance organizations
67.33 shall be reimbursed at the capitation rate determined under sections 256B.69 and 256B.692,

68.1 unless the county board or boards elect to receive fee-for-service reimbursement under
68.2 subdivision 4, paragraph (b).

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

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

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

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

68.21 Subd. 5. **Termination of managed care contracts.** The commissioner shall terminate
68.22 managed care contracts for eligible individuals under sections 256B.69, 256L.12, and
68.23 256L.121 by December 31, 2026, except that the commissioner may continue to contract
68.24 with county-based purchasing plans and county-owned health maintenance organizations,
68.25 as provided under this section.

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

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

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

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

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

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

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

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

69.11 **Subd. 7. Implementation plan.** (a) The commissioner shall present an implementation
69.12 plan for the direct payment system to the chairs and ranking minority members of the
69.13 legislative committees with jurisdiction over health care policy and finance by January 15,
69.14 2025. The commissioner may contract for technical assistance in developing the
69.15 implementation plan and conducting related studies and analysis.

69.16 (b) The implementation plan must include:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

70.29 Subd. 9. **Disproportionate numbers of low-income patients served.** (a) For admissions
70.30 occurring on or after July 1, 1993, the medical assistance disproportionate population
70.31 adjustment shall comply with federal law and shall be paid to a hospital, excluding regional

71.1 treatment centers and facilities of the federal Indian Health Service, with a medical assistance
71.2 inpatient utilization rate in excess of the arithmetic mean. The adjustment must be determined
71.3 as follows:

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

71.11 (2) for a hospital with a medical assistance inpatient utilization rate above one standard
71.12 deviation above the mean, the adjustment must be determined by multiplying the adjustment
71.13 that would be determined under clause (1) for that hospital by 1.1. The commissioner shall
71.14 report annually on the number of hospitals likely to receive the adjustment authorized by
71.15 this paragraph. The commissioner shall specifically report on the adjustments received by
71.16 public hospitals and public hospital corporations located in cities of the first class.

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

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

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

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

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

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

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

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

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

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

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

72.28 (g) An additional payment adjustment shall be established by the commissioner under
72.29 this subdivision for a hospital that provides high levels of administering high-cost drugs to
72.30 enrollees in fee-for-service medical assistance. The commissioner shall consider factors
72.31 including fee-for-service medical assistance utilization rates and payments made for drugs
72.32 purchased through the 340B drug purchasing program and administered to fee-for-service
72.33 enrollees. If any part of this adjustment exceeds a hospital's hospital-specific disproportionate

73.1 share hospital limit, or if the hospital qualifies for the alternative payment rate described in
 73.2 subdivision 2e, the commissioner shall make a payment to the hospital that equals the
 73.3 nonfederal share of the amount that exceeds the limit. The total nonfederal share of the
 73.4 amount of the payment adjustment under this paragraph shall not exceed \$1,500,000 \$.....

73.5 **EFFECTIVE DATE.** This section is effective January 1, 2026, or the January 1
 73.6 following certification of the modernized pharmacy claims processing system, whichever
 73.7 is later. The commissioner of human services shall notify the revisor of statutes when
 73.8 certification of the modernized pharmacy claims processing system occurs.

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

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

73.13 (b) Notwithstanding any other law to the contrary:

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

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

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

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

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

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

73.23 (3) the child dies; or

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

73.27 ~~(b)~~ (d) For a person eligible for an insurance affordability program as defined in section
 73.28 256B.02, subdivision 19, who reports a change that makes the person eligible for medical
 73.29 assistance, eligibility is available for the month the change was reported and for three months
 73.30 prior to the month the change was reported, if the person was eligible in those prior months.

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

74.5 Sec. 13. Minnesota Statutes 2022, section 256B.0631, subdivision 1, is amended to read:

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

74.9 (1) \$3 per nonpreventive visit, except as provided in paragraph (b). For purposes of this
74.10 subdivision, a visit means an episode of service which is required because of a recipient's
74.11 symptoms, diagnosis, or established illness, and which is delivered in an ambulatory setting
74.12 by a physician or physician assistant, chiropractor, podiatrist, nurse midwife, advanced
74.13 practice nurse, audiologist, optician, or optometrist;

74.14 (2) \$3.50 for nonemergency visits to a hospital-based emergency room, except that this
74.15 co-payment shall be increased to \$20 upon federal approval;

74.16 (3) \$3 per brand-name drug prescription, \$1 per generic drug prescription, and \$1 per
74.17 prescription for a brand-name multisource drug listed in preferred status on the preferred
74.18 drug list, subject to a \$12 per month maximum for prescription drug co-payments. No
74.19 co-payments shall apply to antipsychotic drugs when used for the treatment of mental illness;

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

74.24 (5) total monthly cost-sharing must not exceed five percent of family income. For
74.25 purposes of this paragraph, family income is the total earned and unearned income of the
74.26 individual and the individual's spouse, if the spouse is enrolled in medical assistance and
74.27 also subject to the five percent limit on cost-sharing. This paragraph does not apply to
74.28 premiums charged to individuals described under section 256B.057, subdivision 9.

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

74.31 (c) Notwithstanding paragraph (b), the commissioner, through the contracting process
74.32 under sections 256B.69 and 256B.692, may allow managed care plans and county-based
74.33 purchasing plans to waive the family deductible under paragraph (a), clause (4). The value

75.1 of the family deductible shall not be included in the capitation payment to managed care
75.2 plans and county-based purchasing plans. Managed care plans and county-based purchasing
75.3 plans shall certify annually to the commissioner the dollar value of the family deductible.

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

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

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

75.13 Sec. 14. Minnesota Statutes 2022, section 256B.0631, subdivision 3, is amended to read:

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

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

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

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

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

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

75.26 Sec. 15. Minnesota Statutes 2022, section 256B.69, subdivision 4, is amended to read:

75.27 Subd. 4. **Limitation of choice; opportunity to opt out.** (a) The commissioner shall
75.28 develop criteria to determine when limitation of choice may be implemented in the
75.29 experimental counties, but shall provide all eligible individuals the opportunity to opt out
75.30 of enrollment in managed care under this section. The criteria shall ensure that all eligible

76.1 individuals in the county have continuing access to the full range of medical assistance
76.2 services as specified in subdivision 6.

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

76.5 (1) persons eligible for medical assistance according to section 256B.055, subdivision
76.6 1;

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

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

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

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

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

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

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

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

76.25 (8) persons eligible for medical assistance according to section 256B.057, subdivision
76.26 10;

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

76.30 (10) persons who are absent from the state for more than 30 consecutive days but still
76.31 deemed a resident of Minnesota, identified in accordance with section 256B.056, subdivision
76.32 1, paragraph (b).

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

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

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

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

77.24 (f) An infant born to a woman who is eligible for and receiving medical assistance and
77.25 who is enrolled in the prepaid medical assistance program shall be retroactively enrolled to
77.26 the month of birth in the same managed care plan as the mother once the child is enrolled
77.27 in medical assistance unless the child is determined to be excluded from enrollment in a
77.28 prepaid plan under this section.

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

77.30 Sec. 16. Minnesota Statutes 2022, section 256B.69, subdivision 6d, is amended to read:

77.31 Subd. 6d. **Prescription drugs.** (a) The commissioner ~~may~~ shall exclude or modify
77.32 coverage for outpatient prescription drugs dispensed by a pharmacy to a medical assistance
77.33 or MinnesotaCare enrollee from the prepaid managed care contracts entered into under this

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

78.11 (b) Managed care plans and county-based purchasing plans must reimburse pharmacies
78.12 for drug costs at a level not to exceed the reimbursement rate in section 256B.0625,
78.13 subdivision 13e, paragraphs (a), (d), and (f), excluding the 340B drug program ceiling price
78.14 limit, and must pay a dispensing fee equal to one-half of the fee-for-service dispensing fee
78.15 in section 256B.0625, subdivision 13e, paragraph (a), for outpatient drugs dispensed to
78.16 enrollees. Contracts between managed care plans and county-based purchasing plans and
78.17 providers to which this paragraph applies must allow recovery of payments from those
78.18 providers if capitation rates are adjusted in accordance with this paragraph. Payment
78.19 recoveries must not exceed an amount equal to any increase in rates that results from this
78.20 provision. This paragraph must not be implemented if federal approval is not received for
78.21 this paragraph or if federal approval is withdrawn at any time.

78.22 **EFFECTIVE DATE.** The amendment to paragraph (a) is effective January 1, 2026, or
78.23 the January 1 following certification of the modernized pharmacy claims processing system,
78.24 whichever is later. Paragraph (b) is effective January 1, 2024, or upon federal approval,
78.25 whichever is later. The commissioner of human services shall notify the revisor of statutes
78.26 when federal approval is obtained and when certification of the modernized pharmacy claims
78.27 processing system occurs.

78.28 Sec. 17. Minnesota Statutes 2022, section 256B.69, subdivision 28, is amended to read:

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

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

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

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

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

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

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

79.30 (1) implementation efforts;

79.31 (2) consumer protections; and

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

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

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

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

80.12 Sec. 18. Minnesota Statutes 2022, section 256B.69, subdivision 36, is amended to read:

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

80.16 (b) The enrollee support system must:

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

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

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

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

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

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

81.4 (d) The commissioner may designate enrollment brokers to assist enrollees on selecting
81.5 a managed care organization and providing necessary enrollment information. For purposes
81.6 of this subdivision, "enrollment broker" means an individual or entity that performs choice
81.7 counseling or enrollment activities in accordance with Code of Federal Regulations, part
81.8 42, section 438.810, or both.

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

81.10 Sec. 19. Minnesota Statutes 2022, section 256B.692, subdivision 1, is amended to read:

81.11 Subdivision 1. **In general.** County boards or groups of county boards may elect to
81.12 purchase or provide health care services on behalf of persons eligible for medical assistance
81.13 who would otherwise be required to or may elect to participate in the prepaid medical
81.14 assistance program according to section 256B.69, subject to the opt-out provision of section
81.15 256B.69, subdivision 4, paragraph (a). Counties that elect to purchase or provide health
81.16 care under this section must provide all services included in prepaid managed care programs
81.17 according to section 256B.69, subdivisions 1 to 22. County-based purchasing under this
81.18 section is governed by section 256B.69, unless otherwise provided for under this section.

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

81.20 Sec. 20. Minnesota Statutes 2022, section 256B.75, is amended to read:

81.21 **256B.75 HOSPITAL OUTPATIENT REIMBURSEMENT.**

81.22 (a) For outpatient hospital facility fee payments for services rendered on or after October
81.23 1, 1992, the commissioner of human services shall pay the lower of (1) submitted charge,
81.24 or (2) 32 percent above the rate in effect on June 30, 1992, except for those services for
81.25 which there is a federal maximum allowable payment. Effective for services rendered on
81.26 or after January 1, 2000, payment rates for nonsurgical outpatient hospital facility fees and
81.27 emergency room facility fees shall be increased by eight percent over the rates in effect on
81.28 December 31, 1999, except for those services for which there is a federal maximum allowable
81.29 payment. Services for which there is a federal maximum allowable payment shall be paid
81.30 at the lower of (1) submitted charge, or (2) the federal maximum allowable payment. Total
81.31 aggregate payment for outpatient hospital facility fee services shall not exceed the Medicare
81.32 upper limit. If it is determined that a provision of this section conflicts with existing or

82.1 future requirements of the United States government with respect to federal financial
82.2 participation in medical assistance, the federal requirements prevail. The commissioner
82.3 may, in the aggregate, prospectively reduce payment rates to avoid reduced federal financial
82.4 participation resulting from rates that are in excess of the Medicare upper limitations.

82.5 (b)(1) Notwithstanding paragraph (a), payment for outpatient, emergency, and ambulatory
82.6 surgery hospital facility fee services for critical access hospitals designated under section
82.7 144.1483, clause (9), shall be paid on a cost-based payment system that is based on the
82.8 cost-finding methods and allowable costs of the Medicare program. Effective for services
82.9 provided on or after July 1, 2015, rates established for critical access hospitals under this
82.10 paragraph for the applicable payment year shall be the final payment and shall not be settled
82.11 to actual costs. Effective for services delivered on or after the first day of the hospital's fiscal
82.12 year ending in 2017, the rate for outpatient hospital services shall be computed using
82.13 information from each hospital's Medicare cost report as filed with Medicare for the year
82.14 that is two years before the year that the rate is being computed. Rates shall be computed
82.15 using information from Worksheet C series until the department finalizes the medical
82.16 assistance cost reporting process for critical access hospitals. After the cost reporting process
82.17 is finalized, rates shall be computed using information from Title XIX Worksheet D series.
82.18 The outpatient rate shall be equal to ancillary cost plus outpatient cost, excluding costs
82.19 related to rural health clinics and federally qualified health clinics, divided by ancillary
82.20 charges plus outpatient charges, excluding charges related to rural health clinics and federally
82.21 qualified health clinics.

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

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

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

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

83.9 (f) In addition to the reductions in paragraphs (d) and (e), the total payment for
83.10 fee-for-service services provided on or after July 1, 2008, made to hospitals for outpatient
83.11 hospital facility services before third-party liability and spenddown, is reduced three percent
83.12 from the current statutory rates. Mental health services and facilities defined under section
83.13 256.969, subdivision 16, are excluded from this paragraph.

83.14 **EFFECTIVE DATE.** This section is effective January 1, 2026, or the January 1
83.15 following certification of the modernized pharmacy claims processing system, whichever
83.16 is later. The commissioner of human services shall notify the revisor of statutes when
83.17 certification of the modernized pharmacy claims processing system occurs.

83.18 Sec. 21. Minnesota Statutes 2022, section 256L.04, subdivision 1c, is amended to read:

83.19 Subd. 1c. **General requirements.** To be eligible for MinnesotaCare, a person must meet
83.20 the eligibility requirements of this section. A person eligible for MinnesotaCare ~~shall~~ with
83.21 a family income of less than or equal to 200 percent of the federal poverty guidelines must
83.22 not be considered a qualified individual under section 1312 of the Affordable Care Act, and
83.23 is not eligible for enrollment in a qualified health plan offered through MNsure under chapter
83.24 62V.

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

83.28 Sec. 22. Minnesota Statutes 2022, section 256L.04, subdivision 7a, is amended to read:

83.29 Subd. 7a. **Ineligibility.** Adults whose income is greater than the limits established under
83.30 this section may not enroll in the MinnesotaCare program, except as provided in subdivision
83.31 15.

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

84.4 Sec. 23. Minnesota Statutes 2022, section 256L.04, subdivision 10, is amended to read:

84.5 Subd. 10. **Citizenship requirements.** (a) Eligibility for MinnesotaCare is ~~limited~~
84.6 available to citizens or nationals of the United States ~~and~~; lawfully present noncitizens as
84.7 defined in Code of Federal Regulations, title 8, section 103.12-; and undocumented
84.8 noncitizens ~~are ineligible for MinnesotaCare~~. For purposes of this subdivision, an
84.9 undocumented noncitizen is an individual who resides in the United States without the
84.10 approval or acquiescence of the United States Citizenship and Immigration Services. Families
84.11 with children who are citizens or nationals of the United States must cooperate in obtaining
84.12 satisfactory documentary evidence of citizenship or nationality according to the requirements
84.13 of the federal Deficit Reduction Act of 2005, Public Law 109-171.

84.14 (b) Notwithstanding subdivisions 1 and 7, eligible persons include families and
84.15 individuals who are ~~lawfully present and~~ ineligible for medical assistance by reason of
84.16 immigration status and who have incomes equal to or less than 200 percent of federal poverty
84.17 guidelines, except that these persons may be eligible for emergency medical assistance
84.18 under section 256B.06, subdivision 4.

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

84.20 Sec. 24. Minnesota Statutes 2022, section 256L.04, is amended by adding a subdivision
84.21 to read:

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

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

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

85.1 Sec. 25. Minnesota Statutes 2022, section 256L.07, subdivision 1, is amended to read:

85.2 Subdivision 1. **General requirements.** Individuals enrolled in MinnesotaCare under
 85.3 section 256L.04, subdivision 1, and individuals enrolled in MinnesotaCare under section
 85.4 256L.04, subdivision 7, whose income increases above 200 percent of the federal poverty
 85.5 guidelines, are no longer eligible for the program and ~~shall~~ must be disenrolled by the
 85.6 commissioner, unless the individuals continue MinnesotaCare enrollment through the public
 85.7 option under section 256L.04, subdivision 15. For persons disenrolled under this subdivision,
 85.8 MinnesotaCare coverage terminates the last day of the calendar month in which the
 85.9 commissioner sends advance notice according to Code of Federal Regulations, title 42,
 85.10 section 431.211, that indicates the income of a family or individual exceeds program income
 85.11 limits.

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

85.15 Sec. 26. Minnesota Statutes 2022, section 256L.15, subdivision 2, is amended to read:

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

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

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

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

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

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

85.29	Federal Poverty Guideline	Less than	Individual Premium
85.30	Greater than or Equal to		Amount
85.31	35%	55%	\$4
85.32	55%	80%	\$6
85.33	80%	90%	\$8

86.1	90%	100%	\$10
86.2	100%	110%	\$12
86.3	110%	120%	\$14
86.4	120%	130%	\$15
86.5	130%	140%	\$16
86.6	140%	150%	\$25
86.7	150%	160%	\$37
86.8	160%	170%	\$44
86.9	170%	180%	\$52
86.10	180%	190%	\$61
86.11	190%	200%	\$71
86.12	200%		\$80

86.13 ~~(e)~~ (c) Beginning January 1, 2021 2024, the commissioner shall continue to charge
86.14 premiums in accordance with the simplified premium scale established to comply with the
86.15 American Rescue Plan Act of 2021, in effect from January 1, 2021, through December 31,
86.16 2025, for families and individuals eligible under section 256L.04, subdivisions 1 and 7. The
86.17 commissioner shall adjust the premium scale established under paragraph (d) as needed to
86.18 ensure that premiums do not exceed the amount that an individual would have been required
86.19 to pay if the individual was enrolled in an applicable benchmark plan in accordance with
86.20 the Code of Federal Regulations, title 42, section 600.505 (a)(1).

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

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

86.30 **Sec. 27. TRANSITION TO MINNESOTACARE PUBLIC OPTION.**

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

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

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

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

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

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

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

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

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

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

87.19 **Sec. 28. REQUEST FOR FEDERAL APPROVAL.**

87.20 (a) The commissioner of human services shall seek any federal waivers, approvals, and
87.21 law changes necessary to implement the MinnesotaCare public option, including but not
87.22 limited to those waivers, approvals, and law changes necessary to allow the state to:

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

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

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

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

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

88.5 Sec. 29. **ANALYSIS OF BENEFITS AND COSTS OF UNIVERSAL HEALTH CARE**
88.6 **SYSTEM REFORM MODELS.**

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

88.9 (b) "All necessary care" means the full range of services listed in the proposed Minnesota
88.10 Health Plan legislation, including medical, dental, vision and hearing, mental health, chemical
88.11 dependency treatment, reproductive and sexual health, prescription drugs, medical equipment
88.12 and supplies, long-term care, home care, and coordination of care.

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

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

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

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

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

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

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

89.7 (b) The analysts shall assume that, under the universal health proposal, while gross
89.8 provider payments may be reduced to reflect reduced administrative costs, net provider
89.9 income would remain similar to the current system. However, they shall not assume that
89.10 payment rate negotiations will track current Medicaid, Medicare, or market payment rates
89.11 or a combination of those rates, because provider compensation, after adjusting for reduced
89.12 administrative costs, would not be universally raised or lowered but would be negotiated
89.13 based on market needs, so provider compensation might be raised in an underserved area
89.14 such as mental health but lowered in other areas.

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

89.17 (1) conduct an analysis of the benefits and costs of a legislative proposal for a universal
89.18 health care financing system, based on the legislative proposal known as the Minnesota
89.19 Health Plan (Regular Session 2023, Senate File No. 2740/House File No. 2798) and a similar
89.20 analysis of the current health care financing system to assist the state in comparing the
89.21 proposal to the current system; and

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

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

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

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

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

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

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

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

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

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

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

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

90.30 (iv) shortages or excess capacity of medical facilities, equipment, and personnel, including
90.31 caregivers and staff, under either the current system or the proposal, including capacity of
90.32 clinics, hospitals, and other appropriate care sites versus inappropriate emergency room

91.1 usage. The analysis shall break down capacity by geographic differences such as rural versus
91.2 metro, and disparate access by population group;

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

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

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

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

91.13 (b) The analytic tool must:

91.14 (1) have the capacity to conduct interactive microsimulations;

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

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

91.21 Subd. 5. **Analyses by the commissioner.** The commissioner, in cooperation with the
91.22 commissioners of human services and commerce and the legislature, may use the analytic
91.23 tool to assist in the development, design, and analysis of reform models under consideration
91.24 by the legislature and state agencies, and to supplement the analyses of the Minnesota Health
91.25 Plan, the MinnesotaCare public option, and the direct payment system conducted by the
91.26 contractor or contractors under this section.

91.27 Subd. 6. **Report and delivery of analytic tool.** (a) The contractor or contractors, by
91.28 January 15, 2026, shall report findings and recommendations to the commissioner, and to
91.29 the chairs and ranking minority members of the legislative committees with jurisdiction
91.30 over health care and commerce, on the design and implementation of the Minnesota Health
91.31 Plan, the MinnesotaCare public option, and the direct payment system. The findings and
91.32 recommendations must address the feasibility and affordability of the proposals, and the
91.33 projected impact of the proposals on the variables listed in subdivision 4.

92.1 (b) The contractor or contractors shall make the analytic tool available to the
92.2 commissioner by January 15, 2026.

92.3 ARTICLE 3

92.4 DEPARTMENT OF HEALTH

92.5 Section 1. Minnesota Statutes 2022, section 12A.08, subdivision 3, is amended to read:

92.6 Subd. 3. **Implementation.** To implement the requirements of this section, the
92.7 commissioner may cooperate with private health care providers and facilities, Tribal nations,
92.8 and community health boards as defined in section 145A.02; provide grants to assist
92.9 community health boards; and Tribal nations; use volunteer services of individuals qualified
92.10 to provide public health services; and enter into cooperative or mutual aid agreements to
92.11 provide public health services.

92.12 Sec. 2. Minnesota Statutes 2022, section 13.3805, subdivision 1, is amended to read:

92.13 Subdivision 1. **Health data generally.** (a) **Definitions.** As used in this subdivision:

92.14 (1) "Commissioner" means the commissioner of health.

92.15 (2) "Health data" are data on individuals created, collected, received, or maintained by
92.16 the Department of Health, political subdivisions, or statewide systems relating to the
92.17 identification, description, prevention, and control of disease or as part of an epidemiologic
92.18 investigation the commissioner designates as necessary to analyze, describe, or protect the
92.19 public health.

92.20 (b) **Data on individuals.** (1) Health data are private data on individuals. Notwithstanding
92.21 section 13.05, subdivision 9, health data may not be disclosed except as provided in this
92.22 subdivision and section 13.04.

92.23 (2) The commissioner or a community health board as defined in section 145A.02,
92.24 subdivision 5, may disclose health data to the data subject's physician as necessary to locate
92.25 or identify a case, carrier, or suspect case, to establish a diagnosis, to provide treatment, to
92.26 identify persons at risk of illness, or to conduct an epidemiologic investigation.

92.27 (3) With the approval of the commissioner, health data may be disclosed to the extent
92.28 necessary to assist the commissioner to locate or identify a case, carrier, or suspect case, to
92.29 alert persons who may be threatened by illness as evidenced by epidemiologic data, to
92.30 control or prevent the spread of serious disease, or to diminish an imminent threat to the
92.31 public health.

93.1 ~~(e) **Health summary data.** Summary data derived from data collected under section~~
93.2 ~~145.413 may be provided under section 13.05, subdivision 7.~~

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

93.4 Sec. 3. Minnesota Statutes 2022, section 16A.151, subdivision 2, is amended to read:

93.5 Subd. 2. **Exceptions.** (a) If a state official litigates or settles a matter on behalf of specific
93.6 injured persons or entities, this section does not prohibit distribution of money to the specific
93.7 injured persons or entities on whose behalf the litigation or settlement efforts were initiated.
93.8 If money recovered on behalf of injured persons or entities cannot reasonably be distributed
93.9 to those persons or entities because they cannot readily be located or identified or because
93.10 the cost of distributing the money would outweigh the benefit to the persons or entities, the
93.11 money must be paid into the general fund.

93.12 (b) Money recovered on behalf of a fund in the state treasury other than the general fund
93.13 may be deposited in that fund.

93.14 (c) This section does not prohibit a state official from distributing money to a person or
93.15 entity other than the state in litigation or potential litigation in which the state is a defendant
93.16 or potential defendant.

93.17 (d) State agencies may accept funds as directed by a federal court for any restitution or
93.18 monetary penalty under United States Code, title 18, section 3663(a)(3), or United States
93.19 Code, title 18, section 3663A(a)(3). Funds received must be deposited in a special revenue
93.20 account and are appropriated to the commissioner of the agency for the purpose as directed
93.21 by the federal court.

93.22 (e) Tobacco settlement revenues as defined in section 16A.98, subdivision 1, paragraph
93.23 (t), may be deposited as provided in section 16A.98, subdivision 12.

93.24 (f) Any money received by the state resulting from a settlement agreement or an assurance
93.25 of discontinuance entered into by the attorney general of the state, or a court order in litigation
93.26 brought by the attorney general of the state, on behalf of the state or a state agency, related
93.27 to alleged violations of consumer fraud laws in the marketing, sale, or distribution of opioids
93.28 in this state or other alleged illegal actions that contributed to the excessive use of opioids,
93.29 must be deposited in the settlement account established in the opiate epidemic response
93.30 fund under section 256.043, subdivision 1. This paragraph does not apply to attorney fees
93.31 and costs awarded to the state or the Attorney General's Office, to contract attorneys hired
93.32 by the state or Attorney General's Office, or to other state agency attorneys.

94.1 (g) Notwithstanding paragraph (f), if money is received from a settlement agreement or
94.2 an assurance of discontinuance entered into by the attorney general of the state or a court
94.3 order in litigation brought by the attorney general of the state on behalf of the state or a state
94.4 agency against a consulting firm working for an opioid manufacturer or opioid wholesale
94.5 drug distributor, the commissioner shall deposit any money received into the settlement
94.6 account established within the opiate epidemic response fund under section 256.042,
94.7 subdivision 1. Notwithstanding section 256.043, subdivision 3a, paragraph (a), any amount
94.8 deposited into the settlement account in accordance with this paragraph shall be appropriated
94.9 to the commissioner of human services to award as grants as specified by the opiate epidemic
94.10 response advisory council in accordance with section 256.043, subdivision 3a, paragraph
94.11 (d).

94.12 (h) Any money received by the state resulting from a settlement agreement or an assurance
94.13 of discontinuance entered into by the attorney general of the state, or a court order in litigation
94.14 brought by the attorney general of the state on behalf of the state or a state agency related
94.15 to alleged violations of consumer fraud laws in the marketing, sale, or distribution of
94.16 electronic nicotine delivery systems in this state or other alleged illegal actions that
94.17 contributed to the exacerbation of youth nicotine use, must be deposited in the settlement
94.18 account established in the tobacco use prevention account under section 144.398. This
94.19 paragraph does not apply to: (1) attorney fees and costs awarded or paid to the state or the
94.20 Attorney General's Office; (2) contract attorneys hired by the state or Attorney General's
94.21 Office; or (3) other state agency attorneys.

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

94.23 Sec. 4. Minnesota Statutes 2022, section 62J.17, subdivision 5a, is amended to read:

94.24 Subd. 5a. **Retrospective review.** (a) The commissioner shall retrospectively review
94.25 each major spending commitment and ~~notify the provider of the results of the review. The~~
94.26 ~~commissioner shall~~ determine whether the major spending commitment was appropriate.
94.27 In making the determination, the commissioner may consider the following criteria: the
94.28 major spending commitment's impact on the cost, access, and quality of health care; the
94.29 clinical effectiveness and cost-effectiveness of the major spending commitment; and the
94.30 alternatives available to the provider. If the major expenditure is determined not to be
94.31 appropriate, the commissioner shall notify the provider.

94.32 (b) The commissioner may not prevent or prohibit a major spending commitment subject
94.33 to retrospective review. However, if the provider fails the retrospective review, any major

95.1 spending commitments by that provider for the five-year period following the commissioner's
95.2 decision are subject to prospective review under subdivision 6a.

95.3 **Sec. 5. [62J.571] STATEWIDE HEALTH CARE PROVIDER DIRECTORY.**

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

95.6 (b) "Health care provider directory" means an electronic catalog and index that supports
95.7 management of health care provider information, both individual and organizational, in a
95.8 directory structure for public use to find available providers and networks and support state
95.9 agency responsibilities.

95.10 (c) "Health care provider" means a practicing provider that accepts reimbursement from
95.11 a group purchaser.

95.12 (d) "Group purchaser" has the meaning given in section 62J.03, subdivision 6.

95.13 **Subd. 2. Compliance.** The commissioner shall, to the extent practicable, seek the
95.14 cooperation of health care providers and facilities, and may provide any support and
95.15 assistance as available, in obtaining compliance with this section.

95.16 **Subd. 3. Consultation.** The commissioner shall assess the feasibility of the directory in
95.17 consultation with stakeholders, including but not limited to consumers, group purchasers,
95.18 health care providers, community health boards, and state agencies.

95.19 **Sec. 6. [62J.811] PROVIDER BALANCE BILLING REQUIREMENTS.**

95.20 **Subdivision 1. Billing requirements.** (a) Each health care provider and health facility
95.21 shall comply with Consolidated Appropriations Act, 2021, Division BB also known as the
95.22 "No Surprises Act," including any federal regulations adopted under that act.

95.23 (b) For the purposes of this section, "provider" or "facility" means any health care
95.24 provider or facility pursuant to section 62A.63, subdivision 2, or 62J.03, subdivision 8, that
95.25 is subject to relevant provisions of the No Surprises Act.

95.26 **Subd. 3. Civil penalty.** (a) The commissioner, in monitoring and enforcing this section,
95.27 may levy a civil monetary penalty against each health care provider or facility found to be
95.28 in violation of up to \$100 for each violation, but the penalties levied under this subdivision
95.29 may not exceed \$25,000 for identical violations during a calendar year.

95.30 (b) No civil monetary penalty shall be imposed under this section for violations that
95.31 occur prior to January 1, 2024.

96.1 Sec. 7. [62J.826] MEDICAL AND DENTAL PRACTICES; CURRENT STANDARD
96.2 CHARGES; COMPARISON TOOL.

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

96.4 (b) "CDT code" means a code value drawn from the Code on Dental Procedures and
96.5 Nomenclature published by the American Dental Association.

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

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

96.9 (e) "CPT code" means a code value drawn from the Current Procedural Terminology
96.10 published by the American Medical Association.

96.11 (f) "Dental service" means a service charged using a CDT code.

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

96.14 (h) "Diagnostic radiology service" means a service charged using a CPT code within
96.15 the CPT code range of 70010 to 79999 and includes the provision of x-rays, computed
96.16 tomography scans, positron emission tomography scans, magnetic resonance imaging scans,
96.17 and mammographies.

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

96.22 (j) "Medical or dental practice" means a business that:

96.23 (1) earns revenue by providing medical care or dental services to the public;

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

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

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

96.28 (l) "Standard charge" has the meaning given in Code of Federal Regulations, title 45,
96.29 section 180.20.

96.30 Subd. 2. Requirement; current standard charges. The following medical or dental
96.31 practices must make available to the public a list of their current standard charges, as reflected

- 97.1 in the medical or dental practice's chargemaster, for all items and services provided by the
97.2 medical or dental practice:
- 97.3 (1) hospitals;
- 97.4 (2) outpatient surgical centers; and
- 97.5 (3) any other medical or dental practice that has revenue of greater than \$50,000,000
97.6 per year and that derives the majority of its revenue by providing one or more of the following
97.7 services:
- 97.8 (i) diagnostic radiology services;
- 97.9 (ii) diagnostic laboratory testing;
- 97.10 (iii) orthopedic surgical procedures, including joint arthroplasty procedures within the
97.11 CPT code range of 26990 to 27899;
- 97.12 (iv) ophthalmologic surgical procedures, including cataract surgery coded using CPT
97.13 code 66982 or 66984, or refractive correction surgery to improve visual acuity;
- 97.14 (v) anesthesia services commonly provided as an ancillary to services provided at a
97.15 hospital, outpatient surgical center, or medical practice that provides orthopedic surgical
97.16 procedures or ophthalmologic surgical procedures;
- 97.17 (vi) oncology services, including radiation oncology treatments within the CPT code
97.18 range of 77261 to 77799 and drug infusions; or
- 97.19 (vii) dental services.
- 97.20 **Subd. 3. Required file format and content.** (a) A medical or dental practice that is
97.21 subject to this section must make available to the public, and must report to the commissioner,
97.22 current standard charges using the format and data elements specified in the currently
97.23 effective version of the Hospital Price Transparency Sample Format (Tall) (CSV) and related
97.24 data dictionary recommended for hospitals by the Centers for Medicare and Medicaid
97.25 Services (CMS). If CMS modifies or replaces the specifications for this format, the form
97.26 of this file must be modified or replaced to conform with the new CMS specifications by
97.27 the date specified by CMS for compliance with its new specifications. All prices included
97.28 in the file must be expressed as dollar amounts. The data must be in the form of a
97.29 comma-separated-values file that can be directly imported without further editing or
97.30 remediation into a relational database table that has been designed to receive these files.
97.31 The medical or dental practice must make the file available to the public in a manner specified

98.1 by the commissioner and must report the file to the commissioner in a manner and frequency
98.2 specified by the commissioner.

98.3 (b) A medical or dental practice must test its file for compliance with paragraph (a)
98.4 before making the file available to the public and reporting the file to the commissioner.

98.5 (c) A hospital must comply with this section no later than January 1, 2024. A medical
98.6 or dental practice that meets the requirements in subdivision 2, clause (3), or an outpatient
98.7 surgical center must comply with this section no later than January 1, 2025.

98.8 Sec. 8. Minnesota Statutes 2022, section 62J.84, subdivision 2, is amended to read:

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

98.11 (b) "Biosimilar" means a drug that is produced or distributed pursuant to a biologics
98.12 license application approved under United States Code, title 42, section 262(K)(3).

98.13 (c) "Brand name drug" means a drug that is produced or distributed pursuant to:

98.14 (1) ~~an original~~, a new drug application approved under United States Code, title 21,
98.15 section 355(c), except for a generic drug as defined under Code of Federal Regulations,
98.16 title 42, section 447.502; or

98.17 (2) a biologics license application approved under United States Code, title ~~45~~ 42, section
98.18 262(a)(c).

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

98.20 (e) "Generic drug" means a drug that is marketed or distributed pursuant to:

98.21 (1) an abbreviated new drug application approved under United States Code, title 21,
98.22 section 355(j);

98.23 (2) an authorized generic as defined under Code of Federal Regulations, title ~~45~~ 42,
98.24 section 447.502; or

98.25 (3) a drug that entered the market the year before 1962 and was not originally marketed
98.26 under a new drug application.

98.27 (f) "Manufacturer" means a drug manufacturer licensed under section 151.252.

98.28 (g) "New prescription drug" or "new drug" means a prescription drug approved for
98.29 marketing by the United States Food and Drug Administration (FDA) for which no previous
98.30 wholesale acquisition cost has been established for comparison.

99.1 (h) "Patient assistance program" means a program that a manufacturer offers to the public
99.2 in which a consumer may reduce the consumer's out-of-pocket costs for prescription drugs
99.3 by using coupons, discount cards, prepaid gift cards, manufacturer debit cards, or by other
99.4 means.

99.5 (i) "Prescription drug" or "drug" has the meaning provided in section 151.441, subdivision
99.6 8.

99.7 (j) "Price" means the wholesale acquisition cost as defined in United States Code, title
99.8 42, section 1395w-3a(c)(6)(B).

99.9 (k) "30-day supply" means the total daily dosage units of a prescription drug
99.10 recommended by the prescribing label approved by the FDA for 30 days. If the
99.11 FDA-approved prescribing label includes more than one recommended daily dosage, the
99.12 30-day supply is based on the maximum recommended daily dosage on the FDA-approved
99.13 prescribing label.

99.14 (l) "Course of treatment" means the total dosage of a single prescription for a prescription
99.15 drug recommended by the FDA-approved prescribing label. If the FDA-approved prescribing
99.16 label includes more than one recommended dosage for a single course of treatment, the
99.17 course of treatment is the maximum recommended dosage on the FDA-approved prescribing
99.18 label.

99.19 (m) "Drug product family" means a group of one or more prescription drugs that share
99.20 a unique generic drug description or nontrade name and dosage form.

99.21 (n) "National drug code" means the three-segment code maintained by the federal Food
99.22 and Drug Administration that includes a labeler code, a product code, and a package code
99.23 for a drug product and that has been converted to an 11-digit format consisting of five digits
99.24 in the first segment, four digits in the second segment, and two digits in the third segment.
99.25 A three-segment code shall be considered converted to an 11-digit format when, as necessary,
99.26 at least one "0" has been added to the front of each segment containing less than the specified
99.27 number of digits such that each segment contains the specified number of digits.

99.28 (o) "Pharmacy" or "pharmacy provider" means a place of business licensed by the Board
99.29 of Pharmacy under section 151.19 in which prescription drugs are prepared, compounded,
99.30 or dispensed under the supervision of a pharmacist.

99.31 (p) "Pharmacy benefit manager" or "PBM" means an entity licensed to act as a pharmacy
99.32 benefit manager under section 62W.03.

100.1 (q) "Pricing unit" means the smallest dispensable amount of a prescription drug product
100.2 that could be dispensed.

100.3 (r) "Reporting entity" means any manufacturer, pharmacy, pharmacy benefit manager,
100.4 wholesale drug distributor, or any other entity required to submit data under this section.

100.5 (s) "Wholesale drug distributor" or "wholesaler" means an entity that:

100.6 (1) is licensed to act as a wholesale drug distributor under section 151.47; and

100.7 (2) distributes prescription drugs, of which it is not the manufacturer, to persons or
100.8 entities, or both, other than a consumer or patient in the state.

100.9 Sec. 9. Minnesota Statutes 2022, section 62J.84, subdivision 3, is amended to read:

100.10 Subd. 3. **Prescription drug price increases reporting.** (a) Beginning January 1, 2022,
100.11 a drug manufacturer must submit to the commissioner the information described in paragraph
100.12 (b) for each prescription drug for which the price was \$100 or greater for a 30-day supply
100.13 or for a course of treatment lasting less than 30 days and:

100.14 (1) for brand name drugs where there is an increase of ten percent or greater in the price
100.15 over the previous 12-month period or an increase of 16 percent or greater in the price over
100.16 the previous 24-month period; and

100.17 (2) for generic or biosimilar drugs where there is an increase of 50 percent or greater in
100.18 the price over the previous 12-month period.

100.19 (b) For each of the drugs described in paragraph (a), the manufacturer shall submit to
100.20 the commissioner no later than 60 days after the price increase goes into effect, in the form
100.21 and manner prescribed by the commissioner, the following information, if applicable:

100.22 (1) the ~~name~~ description and price of the drug and the net increase, expressed as a
100.23 percentage; with the following listed separately:

100.24 (i) the national drug code;

100.25 (ii) the product name;

100.26 (iii) the dosage form;

100.27 (iv) the strength;

100.28 (v) the package size;

100.29 (2) the factors that contributed to the price increase;

100.30 (3) the name of any generic version of the prescription drug available on the market;

101.1 (4) the introductory price of the prescription drug when it was ~~approved for marketing~~
101.2 ~~by the Food and Drug Administration and the net yearly increase, by calendar year, in the~~
101.3 ~~price of the prescription drug during the previous five years~~ introduced for sale in the United
101.4 States and the price of the drug on the last day of each of the five calendar years preceding
101.5 the price increase;

101.6 (5) the direct costs incurred during the previous 12-month period by the manufacturer
101.7 that are associated with the prescription drug, listed separately:

101.8 (i) to manufacture the prescription drug;

101.9 (ii) to market the prescription drug, including advertising costs; and

101.10 (iii) to distribute the prescription drug;

101.11 (6) the total sales revenue for the prescription drug during the previous 12-month period;

101.12 (7) the manufacturer's net profit attributable to the prescription drug during the previous
101.13 12-month period;

101.14 (8) the total amount of financial assistance the manufacturer has provided through patient
101.15 prescription assistance programs during the previous 12-month period, if applicable;

101.16 (9) any agreement between a manufacturer and another entity contingent upon any delay
101.17 in offering to market a generic version of the prescription drug;

101.18 (10) the patent expiration date of the prescription drug if it is under patent;

101.19 (11) the name and location of the company that manufactured the drug; ~~and~~

101.20 (12) if a brand name prescription drug, the ~~ten highest prices~~ price paid for the
101.21 prescription drug during the previous calendar year in any country other than the ten
101.22 countries, excluding the United States-, that charged the highest single price for the
101.23 prescription drug; and

101.24 (13) if the prescription drug was acquired by the manufacturer during the previous
101.25 12-month period, all of the following information:

101.26 (i) price at acquisition;

101.27 (ii) price in the calendar year prior to acquisition;

101.28 (iii) name of the company from which the drug was acquired;

101.29 (iv) date of acquisition; and

101.30 (v) acquisition price.

102.1 (c) The manufacturer may submit any documentation necessary to support the information
102.2 reported under this subdivision.

102.3 Sec. 10. Minnesota Statutes 2022, section 62J.84, subdivision 4, is amended to read:

102.4 Subd. 4. **New prescription drug price reporting.** (a) Beginning January 1, 2022, no
102.5 later than 60 days after a manufacturer introduces a new prescription drug for sale in the
102.6 United States that is a new brand name drug with a price that is greater than the tier threshold
102.7 established by the Centers for Medicare and Medicaid Services for specialty drugs in the
102.8 Medicare Part D program for a 30-day supply or for a course of treatment lasting fewer than
102.9 30 days or a new generic or biosimilar drug with a price that is greater than the tier threshold
102.10 established by the Centers for Medicare and Medicaid Services for specialty drugs in the
102.11 Medicare Part D program for a 30-day supply or for a course of treatment lasting fewer than
102.12 30 days and is not at least 15 percent lower than the referenced brand name drug when the
102.13 generic or biosimilar drug is launched, the manufacturer must submit to the commissioner,
102.14 in the form and manner prescribed by the commissioner, the following information, if
102.15 applicable:

102.16 (1) the description of the drug, with the following listed separately:

102.17 (i) the national drug code;

102.18 (ii) the product name;

102.19 (iii) the dosage form;

102.20 (iv) the strength;

102.21 (v) the package size;

102.22 ~~(1)~~ (2) the price of the prescription drug;

102.23 ~~(2)~~ (3) whether the Food and Drug Administration granted the new prescription drug a
102.24 breakthrough therapy designation or a priority review;

102.25 ~~(3)~~ (4) the direct costs incurred by the manufacturer that are associated with the
102.26 prescription drug, listed separately:

102.27 (i) to manufacture the prescription drug;

102.28 (ii) to market the prescription drug, including advertising costs; and

102.29 (iii) to distribute the prescription drug; and

102.30 ~~(4)~~ (5) the patent expiration date of the drug if it is under patent.

103.1 (b) The manufacturer may submit documentation necessary to support the information
103.2 reported under this subdivision.

103.3 Sec. 11. Minnesota Statutes 2022, section 62J.84, subdivision 6, is amended to read:

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

103.8 (1) a list of the prescription drugs reported under subdivisions 3, 4, and ~~5~~ 11 to 14 and
103.9 the manufacturers of those prescription drugs; and

103.10 (2) information reported to the commissioner under subdivisions 3, 4, and ~~5~~ 11 to 14.

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

103.14 (c) The commissioner shall not post to the department's website or a private entity
103.15 contracting with the commissioner shall not post any information described in this section
103.16 if the information is not public data under section 13.02, subdivision 8a; or is trade secret
103.17 information under section 13.37, subdivision 1, paragraph (b); or is trade secret information
103.18 pursuant to the Defend Trade Secrets Act of 2016, United States Code, title 18, section
103.19 1836, as amended. If a manufacturer believes information should be withheld from public
103.20 disclosure pursuant to this paragraph, the manufacturer must clearly and specifically identify
103.21 that information and describe the legal basis in writing when the manufacturer submits the
103.22 information under this section. If the commissioner disagrees with the manufacturer's request
103.23 to withhold information from public disclosure, the commissioner shall provide the
103.24 manufacturer written notice that the information will be publicly posted 30 days after the
103.25 date of the notice.

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

103.30 (e) To the extent the information required to be posted under this subdivision is collected
103.31 and made available to the public by another state, by the University of Minnesota, or through
103.32 an online drug pricing reference and analytical tool, the commissioner may reference the
103.33 availability of this drug price data from another source including, within existing

104.1 appropriations, creating the ability of the public to access the data from the source for
104.2 purposes of meeting the reporting requirements of this subdivision.

104.3 Sec. 12. Minnesota Statutes 2022, section 62J.84, subdivision 7, is amended to read:

104.4 Subd. 7. **Consultation.** (a) The commissioner may consult with a private entity or
104.5 consortium that satisfies the standards of section 62U.04, subdivision 6, the University of
104.6 Minnesota, or the commissioner of commerce, as appropriate, in issuing the form and format
104.7 of the information reported under this section; in posting information pursuant to subdivision
104.8 6; and in taking any other action for the purpose of implementing this section.

104.9 (b) The commissioner may consult with representatives of the ~~manufacturers~~ reporting
104.10 entities to establish a standard format for reporting information under this section and may
104.11 use existing reporting methodologies to establish a standard format to minimize
104.12 administrative burdens to the state and ~~manufacturers~~ reporting entities.

104.13 Sec. 13. Minnesota Statutes 2022, section 62J.84, subdivision 8, is amended to read:

104.14 Subd. 8. **Enforcement and penalties.** (a) A ~~manufacturer~~ reporting entity may be subject
104.15 to a civil penalty, as provided in paragraph (b), for:

104.16 (1) failing to register under subdivision 15;

104.17 ~~(+)~~ (2) failing to submit timely reports or notices as required by this section;

104.18 ~~(2)~~ (3) failing to provide information required under this section; or

104.19 ~~(3)~~ (4) providing inaccurate or incomplete information under this section.

104.20 (b) The commissioner shall adopt a schedule of civil penalties, not to exceed \$10,000
104.21 per day of violation, based on the severity of each violation.

104.22 (c) The commissioner shall impose civil penalties under this section as provided in
104.23 section 144.99, subdivision 4.

104.24 (d) The commissioner may remit or mitigate civil penalties under this section upon terms
104.25 and conditions the commissioner considers proper and consistent with public health and
104.26 safety.

104.27 (e) Civil penalties collected under this section shall be deposited in the health care access
104.28 fund.

105.1 Sec. 14. Minnesota Statutes 2022, section 62J.84, subdivision 9, is amended to read:

105.2 Subd. 9. **Legislative report.** (a) No later than May 15, 2022, and by January 15 of each
105.3 year thereafter, the commissioner shall report to the chairs and ranking minority members
105.4 of the legislative committees with jurisdiction over commerce and health and human services
105.5 policy and finance on the implementation of this section, including but not limited to the
105.6 effectiveness in addressing the following goals:

105.7 (1) promoting transparency in pharmaceutical pricing for the state and other payers;

105.8 (2) enhancing the understanding on pharmaceutical spending trends; and

105.9 (3) assisting the state and other payers in the management of pharmaceutical costs.

105.10 (b) The report must include a summary of the information submitted to the commissioner
105.11 under subdivisions 3, 4, and ~~5~~ 11 to 14.

105.12 Sec. 15. Minnesota Statutes 2022, section 62J.84, is amended by adding a subdivision to
105.13 read:

105.14 Subd. 10. **Notice of prescription drugs of substantial public interest.** (a) No later than
105.15 January 31, 2024, and quarterly thereafter, the commissioner shall produce and post on the
105.16 department's website a list of prescription drugs that the department determines to represent
105.17 a substantial public interest and for which the department intends to request data under
105.18 subdivisions 11 to 14, subject to paragraph (c). The department shall base its inclusion of
105.19 prescription drugs on any information the department determines is relevant to providing
105.20 greater consumer awareness of the factors contributing to the cost of prescription drugs in
105.21 the state, and the department shall consider drug product families that include prescription
105.22 drugs:

105.23 (1) that triggered reporting under subdivision 3 or 4 during the previous calendar quarter;

105.24 (2) for which average claims paid amounts exceeded 125 percent of the price as of the
105.25 claim incurred date during the most recent calendar quarter for which claims paid amounts
105.26 are available; or

105.27 (3) that are identified by members of the public during a public comment period process.

105.28 (b) Not sooner than 30 days after publicly posting the list of prescription drugs under
105.29 paragraph (a), the department shall notify, via email, reporting entities registered with the
105.30 department of the requirement to report under subdivisions 11 to 14.

105.31 (c) No more than 500 prescription drugs may be designated as having a substantial public
105.32 interest in any one notice.

106.1 Sec. 16. Minnesota Statutes 2022, section 62J.84, is amended by adding a subdivision to
106.2 read:

106.3 Subd. 11. **Manufacturer prescription drug substantial public interest reporting.** (a)
106.4 Beginning January 1, 2024, a manufacturer must submit to the commissioner the information
106.5 described in paragraph (b) for any prescription drug:

106.6 (1) included in a notification to report issued to the manufacturer by the department
106.7 under subdivision 10;

106.8 (2) which the manufacturer manufactures or repackages;

106.9 (3) for which the manufacturer sets the wholesale acquisition cost; and

106.10 (4) for which the manufacturer has not submitted data under subdivision 3 during the
106.11 120-day period prior to the date of the notification to report.

106.12 (b) For each of the drugs described in paragraph (a), the manufacturer shall submit to
106.13 the commissioner no later than 60 days after the date of the notification to report, in the
106.14 form and manner prescribed by the commissioner, the following information, if applicable:

106.15 (1) a description of the drug with the following listed separately:

106.16 (i) the national drug code;

106.17 (ii) the product name;

106.18 (iii) the dosage form;

106.19 (iv) the strength; and

106.20 (v) the package size;

106.21 (2) the price of the drug product on the later of:

106.22 (i) the day one year prior to the date of the notification to report;

106.23 (ii) the introduced to market date; or

106.24 (iii) the acquisition date;

106.25 (3) the price of the drug product on the date of the notification to report;

106.26 (4) the introductory price of the prescription drug when it was introduced for sale in the
106.27 United States and the price of the drug on the last day of each of the five calendar years
106.28 preceding the date of the notification to report;

106.29 (5) the direct costs incurred during the 12-month period prior to the date of the notification
106.30 to report by the manufacturers that are associated with the prescription drug, listed separately:

- 107.1 (i) to manufacture the prescription drug;
- 107.2 (ii) to market the prescription drug, including advertising costs; and
- 107.3 (iii) to distribute the prescription drug;
- 107.4 (6) the number of units of the prescription drug sold during the 12-month period prior
107.5 to the date of the notification to report;
- 107.6 (7) the total sales revenue for the prescription drug during the 12-month period prior to
107.7 the date of the notification to report;
- 107.8 (8) the total rebate payable amount accrued for the prescription drug during the 12-month
107.9 period prior to the date of the notification to report;
- 107.10 (9) the manufacturer's net profit attributable to the prescription drug during the 12-month
107.11 period prior to the date of the notification to report;
- 107.12 (10) the total amount of financial assistance the manufacturer has provided through
107.13 patient prescription assistance programs during the 12-month period prior to the date of the
107.14 notification to report, if applicable;
- 107.15 (11) any agreement between a manufacturer and another entity contingent upon any
107.16 delay in offering to market a generic version of the prescription drug;
- 107.17 (12) the patent expiration date of the prescription drug if the prescription drug is under
107.18 patent;
- 107.19 (13) the name and location of the company that manufactured the drug;
- 107.20 (14) if the prescription drug is a brand name prescription drug, the ten countries other
107.21 than the United States that paid the highest prices for the prescription drug during the
107.22 previous calendar year and their prices; and
- 107.23 (15) if the prescription drug was acquired by the manufacturer within a 12-month period
107.24 prior to the date of the notification to report, all of the following information:
- 107.25 (i) the price at acquisition;
- 107.26 (ii) the price in the calendar year prior to acquisition;
- 107.27 (iii) the name of the company from which the drug was acquired;
- 107.28 (iv) the date of acquisition; and
- 107.29 (v) the acquisition price.

108.1 (c) The manufacturer may submit any documentation necessary to support the information
108.2 reported under this subdivision.

108.3 Sec. 17. Minnesota Statutes 2022, section 62J.84, is amended by adding a subdivision to
108.4 read:

108.5 **Subd. 12. Pharmacy prescription drug substantial public interest reporting.** (a)
108.6 Beginning January 1, 2024, a pharmacy must submit to the commissioner the information
108.7 described in paragraph (b) for any prescription drug included in a notification to report
108.8 issued to the pharmacy by the department under subdivision 10.

108.9 (b) For each of the drugs described in paragraph (a), the pharmacy shall submit to the
108.10 commissioner no later than 60 days after the date of the notification to report, in the form
108.11 and manner prescribed by the commissioner, the following information, if applicable:

108.12 (1) a description of the drug with the following listed separately:

108.13 (i) the national drug code;

108.14 (ii) the product name;

108.15 (iii) the dosage form;

108.16 (iv) the strength; and

108.17 (v) the package size;

108.18 (2) the number of units of the drug acquired during the 12-month period prior to the date
108.19 of the notification to report;

108.20 (3) the total spent before rebates by the pharmacy to acquire the drug during the 12-month
108.21 period prior to the date of the notification to report;

108.22 (4) the total rebate receivable amount accrued by the pharmacy for the drug during the
108.23 12-month period prior to the date of the notification to report;

108.24 (5) the number of pricing units of the drug dispensed by the pharmacy during the
108.25 12-month period prior to the date of the notification to report;

108.26 (6) the total payment receivable by the pharmacy for dispensing the drug including
108.27 ingredient cost, dispensing fee, and administrative fees during the 12-month period prior
108.28 to the date of the notification to report;

108.29 (7) the total rebate payable amount accrued by the pharmacy for the drug during the
108.30 12-month period prior to the date of the notification to report; and

109.1 (8) the average cash price paid by consumers per pricing unit for prescriptions dispensed
109.2 where no claim was submitted to a health care service plan or health insurer during the
109.3 12-month period prior to the date of the notification to report.

109.4 (c) The pharmacy may submit any documentation necessary to support the information
109.5 reported under this subdivision.

109.6 Sec. 18. Minnesota Statutes 2022, section 62J.84, is amended by adding a subdivision to
109.7 read:

109.8 Subd. 13. **PBM prescription drug substantial public interest reporting.** (a) Beginning
109.9 January 1, 2024, a PBM must submit to the commissioner the information described in
109.10 paragraph (b) for any prescription drug included in a notification to report issued to the
109.11 PBM by the department under subdivision 10.

109.12 (b) For each of the drugs described in paragraph (a), the PBM shall submit to the
109.13 commissioner no later than 60 days after the date of the notification to report, in the form
109.14 and manner prescribed by the commissioner, the following information, if applicable:

109.15 (1) a description of the drug with the following listed separately:

109.16 (i) the national drug code;

109.17 (ii) the product name;

109.18 (iii) the dosage form;

109.19 (iv) the strength; and

109.20 (v) the package size;

109.21 (2) the number of pricing units of the drug product filled for which the PBM administered
109.22 claims during the 12-month period prior to the date of the notification to report;

109.23 (3) the total reimbursement amount accrued and payable to pharmacies for pricing units
109.24 of the drug product filled for which the PBM administered claims during the 12-month
109.25 period prior to the date of the notification to report;

109.26 (4) the total reimbursement or administrative fee amount, or both, accrued and receivable
109.27 from payers for pricing units of the drug product filled for which the PBM administered
109.28 claims during the 12-month period prior to the date of the notification to report;

109.29 (5) the total rebate receivable amount accrued by the PBM for the drug product during
109.30 the 12-month period prior to the date of the notification to report; and

110.1 (6) the total rebate payable amount accrued by the PBM for the drug product during the
110.2 12-month period prior to the date of the notification to report.

110.3 (c) The PBM may submit any documentation necessary to support the information
110.4 reported under this subdivision.

110.5 Sec. 19. Minnesota Statutes 2022, section 62J.84, is amended by adding a subdivision to
110.6 read:

110.7 Subd. 14. **Wholesaler prescription drug substantial public interest reporting.** (a)
110.8 Beginning January 1, 2024, a wholesaler must submit to the commissioner the information
110.9 described in paragraph (b) for any prescription drug included in a notification to report
110.10 issued to the wholesaler by the department under subdivision 10.

110.11 (b) For each of the drugs described in paragraph (a), the wholesaler shall submit to the
110.12 commissioner no later than 60 days after the date of the notification to report, in the form
110.13 and manner prescribed by the commissioner, the following information, if applicable:

110.14 (1) a description of the drug with the following listed separately:

110.15 (i) the national drug code;

110.16 (ii) the product name;

110.17 (iii) the dosage form;

110.18 (iv) the strength; and

110.19 (v) the package size;

110.20 (2) the number of units of the drug product acquired by the wholesale drug distributor
110.21 during the 12-month period prior to the date of the notification to report;

110.22 (3) the total spent before rebates by the wholesale drug distributor to acquire the drug
110.23 product during the 12-month period prior to the date of the notification to report;

110.24 (4) the total rebate receivable amount accrued by the wholesale drug distributor for the
110.25 drug product during the 12-month period prior to the date of the notification to report;

110.26 (5) the number of units of the drug product sold by the wholesale drug distributor during
110.27 the 12-month period prior to the date of the notification to report;

110.28 (6) gross revenue from sales in the United States generated by the wholesale drug
110.29 distributor for this drug product during the 12-month period prior to the date of the
110.30 notification to report; and

111.1 (7) total rebate payable amount accrued by the wholesale drug distributor for the drug
111.2 product during the 12-month period prior to the date of the notification to report.

111.3 (c) The wholesaler may submit any documentation necessary to support the information
111.4 reported under this subdivision.

111.5 Sec. 20. Minnesota Statutes 2022, section 62J.84, is amended by adding a subdivision to
111.6 read:

111.7 Subd. 15. **Registration requirements.** Beginning January 1, 2024, a reporting entity
111.8 subject to this chapter shall register with the department in a form and manner prescribed
111.9 by the commissioner.

111.10 Sec. 21. Minnesota Statutes 2022, section 62J.84, is amended by adding a subdivision to
111.11 read:

111.12 Subd. 16. **Rulemaking.** For the purposes of this section, the commissioner may use the
111.13 expedited rulemaking process under section 14.389.

111.14 Sec. 22. Minnesota Statutes 2022, section 62Q.01, is amended by adding a subdivision to
111.15 read:

111.16 Subd. 6b. **No Surprises Act.** "No Surprises Act" means Division BB of the Consolidated
111.17 Appropriations Act, 2021, which amended Title XXVII of the Public Health Service Act,
111.18 Public Law 116-260, and any amendments to and any federal guidance or regulations issued
111.19 under this act.

111.20 Sec. 23. Minnesota Statutes 2022, section 62Q.021, is amended by adding a subdivision
111.21 to read:

111.22 Subd. 3. **Compliance with 2021 federal law.** Each health plan company, health provider,
111.23 and health facility shall comply with the No Surprises Act, including any federal regulations
111.24 adopted under the act, to the extent that the act imposes requirements that apply in this state
111.25 but are not required under the laws of this state. This subdivision does not require compliance
111.26 with any provision of the No Surprises Act before the effective date provided for that
111.27 provision in the No Surprises Act. The commissioner shall enforce this subdivision.

111.28 Sec. 24. Minnesota Statutes 2022, section 62Q.55, subdivision 5, is amended to read:

111.29 Subd. 5. **Coverage restrictions or limitations.** If emergency services are provided by
111.30 a nonparticipating provider, with or without prior authorization, the health plan company

112.1 shall not impose coverage restrictions or limitations that are more restrictive than apply to
 112.2 emergency services received from a participating provider. Cost-sharing requirements that
 112.3 apply to emergency services received out-of-network must be the same as the cost-sharing
 112.4 requirements that apply to services received in-network and shall count toward the in-network
 112.5 deductible. All coverage and charges for emergency services must comply with the No
 112.6 Surprises Act.

112.7 Sec. 25. Minnesota Statutes 2022, section 62Q.556, is amended to read:

112.8 **62Q.556 UNAUTHORIZED PROVIDER SERVICES CONSUMER**
 112.9 **PROTECTIONS AGAINST BALANCE BILLING.**

112.10 Subdivision 1. ~~Unauthorized provider services~~ **Nonparticipating provider balance**
 112.11 **billing prohibition.** (a) Except as provided in paragraph (e), ~~unauthorized provider services~~
 112.12 ~~or~~ (b), balance billing is prohibited when an enrollee receives services from:

112.13 (1) ~~from~~ a nonparticipating provider at a participating hospital or ambulatory surgical
 112.14 center, ~~when the services are rendered:~~ as described by the No Surprises Act, including any
 112.15 federal regulations adopted under that act;

112.16 ~~(i) due to the unavailability of a participating provider;~~

112.17 ~~(ii) by a nonparticipating provider without the enrollee's knowledge; or~~

112.18 ~~(iii) due to the need for unforeseen services arising at the time the services are being~~
 112.19 ~~rendered; or~~

112.20 (2) ~~from~~ a participating provider that sends a specimen taken from the enrollee in the
 112.21 participating provider's practice setting to a nonparticipating laboratory, pathologist, or other
 112.22 medical testing facility; or

112.23 (3) a nonparticipating provider or facility providing emergency services as defined in
 112.24 section 62Q.55, subdivision 3, and other services as described in the requirements of the
 112.25 No Surprises Act.

112.26 ~~(b) Unauthorized provider services do not include emergency services as defined in~~
 112.27 ~~section 62Q.55, subdivision 3.~~

112.28 ~~(e)~~ (b) The services described in paragraph (a), ~~clause (2)~~ clauses (1), (2), and (3), as
 112.29 defined in the No Surprises Act, and any federal regulations adopted under that act, are not
 112.30 unauthorized provider services subject to balance billing if the enrollee gives advance written
 112.31 provides informed consent to prior to receiving services from the nonparticipating provider
 112.32 acknowledging that the use of a provider, or the services to be rendered, may result in costs

113.1 not covered by the health plan. The informed consent must comply with all requirements
113.2 of the No Surprises Act, including any federal regulations adopted under that act.

113.3 Subd. 2. **Prohibition Cost-sharing requirements and independent dispute**
113.4 **resolution.** (a) An enrollee's financial responsibility for the ~~unauthorized~~ nonparticipating
113.5 provider services described in subdivision 1, paragraph (a), shall be the same cost-sharing
113.6 requirements, including co-payments, deductibles, coinsurance, coverage restrictions, and
113.7 coverage limitations, as those applicable to services received by the enrollee from a
113.8 participating provider. A health plan company must apply any enrollee cost sharing
113.9 requirements, including co-payments, deductibles, and coinsurance, for ~~unauthorized~~
113.10 nonparticipating provider services to the enrollee's annual out-of-pocket limit to the same
113.11 extent payments to a participating provider would be applied.

113.12 (b) A health plan company must attempt to negotiate the reimbursement, less any
113.13 applicable enrollee cost sharing under paragraph (a), for the ~~unauthorized~~ nonparticipating
113.14 provider services with the nonparticipating provider. ~~If a health plan company's and~~
113.15 ~~nonparticipating provider's attempts~~ the attempt to negotiate reimbursement for the health
113.16 ~~care~~ nonparticipating provider services ~~do~~ does not result in a resolution, ~~the health plan~~
113.17 ~~company or provider may elect to refer the matter for binding arbitration, chosen in~~
113.18 ~~accordance with paragraph (c). A nondisclosure agreement must be executed by both parties~~
113.19 ~~prior to engaging an arbitrator in accordance with this section. The cost of arbitration must~~
113.20 ~~be shared equally between the parties.~~ either party may initiate the federal independent
113.21 dispute resolution process pursuant to the No Surprises Act, including any federal regulations
113.22 adopted under that act.

113.23 (c) ~~The commissioner of health, in consultation with the commissioner of the Bureau~~
113.24 ~~of Mediation Services, must develop a list of professionals qualified in arbitration, for the~~
113.25 ~~purpose of resolving disputes between a health plan company and nonparticipating provider~~
113.26 ~~arising from the payment for unauthorized provider services. The commissioner of health~~
113.27 ~~shall publish the list on the Department of Health website, and update the list as appropriate.~~

113.28 (d) ~~The arbitrator must consider relevant information, including the health plan company's~~
113.29 ~~payments to other nonparticipating providers for the same services, the circumstances and~~
113.30 ~~complexity of the particular case, and the usual and customary rate for the service based on~~
113.31 ~~information available in a database in a national, independent, not-for-profit corporation,~~
113.32 ~~and similar fees received by the provider for the same services from other health plans in~~
113.33 ~~which the provider is nonparticipating, in reaching a decision.~~

114.1 Subd. 3. **Annual data reporting.** (a) Beginning April 1, 2024, a health plan company
114.2 must report annually to the commissioner of health:

114.3 (1) the total number of claims and total billed and paid amounts for nonparticipating
114.4 provider services, by service and provider type, submitted to the health plan in the prior
114.5 calendar year; and

114.6 (2) the total number of enrollee complaints received regarding the rights and protections
114.7 established by the No Surprises Act in the prior calendar year.

114.8 (b) The commissioners of commerce and health shall develop the form and manner for
114.9 health plan companies to comply with paragraph (a).

114.10 Subd. 4. **Enforcement.** (a) Any provider or facility, including a health care provider or
114.11 facility pursuant to section 62A.63, subdivision 2, or 62J.03, subdivision 8, that is subject
114.12 to the relevant provisions of the No Surprises Act is subject to the requirements of this
114.13 section and section 62J.811.

114.14 (b) The commissioner of commerce or health shall enforce this section.

114.15 (c) If a health-related licensing board has cause to believe that a provider has violated
114.16 this section, it may further investigate and enforce the provisions of this section pursuant
114.17 to chapter 214.

114.18 Sec. 26. Minnesota Statutes 2022, section 62Q.56, subdivision 2, is amended to read:

114.19 **Subd. 2. Change in health plans.** (a) If an enrollee is subject to a change in health plans,
114.20 the enrollee's new health plan company must provide, upon request, authorization to receive
114.21 services that are otherwise covered under the terms of the new health plan through the
114.22 enrollee's current provider:

114.23 (1) for up to 120 days if the enrollee is engaged in a current course of treatment for one
114.24 or more of the following conditions:

114.25 (i) an acute condition;

114.26 (ii) a life-threatening mental or physical illness;

114.27 (iii) pregnancy ~~beyond the first trimester of pregnancy;~~

114.28 (iv) a physical or mental disability defined as an inability to engage in one or more major
114.29 life activities, provided that the disability has lasted or can be expected to last for at least
114.30 one year, or can be expected to result in death; or

114.31 (v) a disabling or chronic condition that is in an acute phase; or

115.1 (2) for the rest of the enrollee's life if a physician certifies that the enrollee has an expected
115.2 lifetime of 180 days or less.

115.3 For all requests for authorization under this paragraph, the health plan company must grant
115.4 the request for authorization unless the enrollee does not meet the criteria provided in this
115.5 paragraph.

115.6 (b) The health plan company shall prepare a written plan that provides a process for
115.7 coverage determinations regarding continuity of care of up to 120 days for new enrollees
115.8 who request continuity of care with their former provider, if the new enrollee:

115.9 (1) is receiving culturally appropriate services and the health plan company does not
115.10 have a provider in its preferred provider network with special expertise in the delivery of
115.11 those culturally appropriate services within the time and distance requirements of section
115.12 62D.124, subdivision 1; or

115.13 (2) does not speak English and the health plan company does not have a provider in its
115.14 preferred provider network who can communicate with the enrollee, either directly or through
115.15 an interpreter, within the time and distance requirements of section 62D.124, subdivision
115.16 1.

115.17 The written plan must explain the criteria that will be used to determine whether a need for
115.18 continuity of care exists and how it will be provided.

115.19 (c) This subdivision applies only to group coverage and continuation and conversion
115.20 coverage, and applies only to changes in health plans made by the employer.

115.21 Sec. 27. Minnesota Statutes 2022, section 62Q.73, subdivision 1, is amended to read:

115.22 Subdivision 1. **Definition.** For purposes of this section, "adverse determination" means:

115.23 (1) for individual health plans, a complaint decision relating to a health care service or
115.24 claim that is partially or wholly adverse to the complainant;

115.25 (2) an individual health plan that is grandfathered plan coverage may instead apply the
115.26 definition of adverse determination for group coverage in clause (3);

115.27 (3) for group health plans, a complaint decision relating to a health care service or claim
115.28 that has been appealed in accordance with section 62Q.70 and the appeal decision is partially
115.29 or wholly adverse to the complainant;

115.30 (4) any adverse determination, as defined in section 62M.02, subdivision 1a, that has
115.31 been appealed in accordance with section 62M.06 and the appeal did not reverse the adverse
115.32 determination;

116.1 (5) a decision relating to a health care service made by a health plan company licensed
116.2 under chapter 60A that denies the service on the basis that the service was not medically
116.3 necessary; ~~or~~

116.4 (6) the enrollee has met the requirements of subdivision 6, paragraph (e); or

116.5 (7) a decision relating to a health plan's coverage of nonparticipating provider services
116.6 as described in and subject to section 62Q.556, subdivision 1, paragraph (a).

116.7 An adverse determination does not include complaints relating to fraudulent marketing
116.8 practices or agent misrepresentation.

116.9 Sec. 28. Minnesota Statutes 2022, section 62Q.73, subdivision 7, is amended to read:

116.10 Subd. 7. **Standards of review.** (a) For an external review of any issue in an adverse
116.11 determination that does not require a medical necessity determination, the external review
116.12 must be based on whether the adverse determination was in compliance with the enrollee's
116.13 health benefit plan or section 62Q.556, subdivision 1, paragraph (a).

116.14 (b) For an external review of any issue in an adverse determination by a health plan
116.15 company licensed under chapter 62D that requires a medical necessity determination, the
116.16 external review must determine whether the adverse determination was consistent with the
116.17 definition of medically necessary care in Minnesota Rules, part 4685.0100, subpart 9b.

116.18 (c) For an external review of any issue in an adverse determination by a health plan
116.19 company, other than a health plan company licensed under chapter 62D, that requires a
116.20 medical necessity determination, the external review must determine whether the adverse
116.21 determination was consistent with the definition of medically necessary care in section
116.22 62Q.53, subdivision 2.

116.23 (d) For an external review of an adverse determination involving experimental or
116.24 investigational treatment, the external review entity must base its decision on all documents
116.25 submitted by the health plan company and enrollee, including:

116.26 (1) medical records;

116.27 (2) the recommendation of the attending physician, advanced practice registered nurse,
116.28 physician assistant, or health care professional;

116.29 (3) consulting reports from health care professionals;

116.30 (4) the terms of coverage;

116.31 (5) federal Food and Drug Administration approval; and

117.1 (6) medical or scientific evidence or evidence-based standards.

117.2 Sec. 29. Minnesota Statutes 2022, section 62U.04, subdivision 4, is amended to read:

117.3 Subd. 4. **Encounter data.** (a) All health plan companies, dental plan companies, and
117.4 third-party administrators shall submit encounter data on a monthly basis to a private entity
117.5 designated by the commissioner of health. The data shall be submitted in a form and manner
117.6 specified by the commissioner subject to the following requirements:

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

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

117.13 (3) the data must include enrollee race and ethnicity, to the extent available; and

117.14 ~~(3)~~ (4) except for the identifier data described in clause clauses (2) and (3), the data must
117.15 not include information that is not included in a health care claim, dental care claim, or
117.16 equivalent encounter information transaction that is required under section 62J.536.

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

117.23 (c) Data on providers collected under this subdivision are private data on individuals or
117.24 nonpublic data, as defined in section 13.02. ~~Notwithstanding the definition of summary data~~
117.25 ~~in section 13.02, subdivision 19, summary data prepared under this subdivision may be~~
117.26 ~~derived from nonpublic data.~~ Notwithstanding the data classifications in this paragraph,
117.27 data on providers collected under this subdivision may be released or published as authorized
117.28 in subdivision 11. The commissioner or the commissioner's designee shall establish
117.29 procedures and safeguards to protect the integrity and confidentiality of any data that it
117.30 maintains.

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

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

118.7 EFFECTIVE DATE. Paragraph (a), clause (3), is effective retroactively from January
118.8 1, 2023, and applies to claims incurred on or after that date.

118.9 Sec. 30. Minnesota Statutes 2022, section 62U.04, subdivision 5, is amended to read:

118.10 Subd. 5. **Pricing data.** (a) All health plan companies, dental plan companies, and
118.11 third-party administrators shall submit, on a monthly basis, data on their contracted prices
118.12 with health care providers and dental care providers to a private entity designated by the
118.13 commissioner of health for the purposes of performing the analyses required under this
118.14 subdivision. Data on contracted prices submitted under this paragraph must include data on
118.15 supplemental contractual value-based payments paid to health care providers. The data shall
118.16 be submitted in the form and manner specified by the commissioner of health.

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

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

118.30 Sec. 31. Minnesota Statutes 2022, section 62U.04, subdivision 5a, is amended to read:

118.31 Subd. 5a. **Self-insurers.** (a) The commissioner shall not require a self-insurer governed
118.32 by the federal Employee Retirement Income Security Act of 1974 (ERISA) to comply with
118.33 this section.

119.1 (b) A third-party administrator must annually notify the self-insurers whose health plans
119.2 are administered by the third-party administrator that the self-insurer may elect to have the
119.3 third-party administrator submit encounter data and data on contracted prices under
119.4 subdivisions 4 and 5 from the self-insurer's health plan for the upcoming plan year. This
119.5 notice must be provided in a form and manner specified by the commissioner. After receiving
119.6 responses from self-insurers, a third-party administrator must, in a form and manner specified
119.7 by the commissioner, report to the commissioner:

119.8 (1) the self-insurers that elected to have the third-party administrator submit encounter
119.9 data and data on contracted prices from the self-insurer's health plan for the upcoming plan
119.10 year;

119.11 (2) the self-insurers that declined to have the third-party administrator submit encounter
119.12 data and data on contracted prices from the self-insurer's health plan for the upcoming plan
119.13 year; and

119.14 (3) data deemed necessary by the commissioner to identify and track the status of
119.15 reporting of data from self-insured health plans.

119.16 Sec. 32. Minnesota Statutes 2022, section 62U.04, is amended by adding a subdivision to
119.17 read:

119.18 Subd. 5b. **Nonclaims-based payments.** (a) Beginning January 1, 2025, all health plan
119.19 companies and third-party administrators shall submit to a private entity designated by the
119.20 commissioner of health all nonclaims-based payments made to health care providers. The
119.21 data shall be submitted in a form, manner, and frequency specified by the commissioner.
119.22 Nonclaims-based payments are payments to health care providers designed to pay for value
119.23 of health care services over volume of health care services and include alternative payment
119.24 models or incentives, payments for infrastructure expenditures or investments, and payments
119.25 for workforce expenditures or investments. Nonclaims-based payments submitted under
119.26 this subdivision must, to the extent possible, be attributed to a health care provider in the
119.27 same manner in which claims-based data are attributed to a health care provider and, where
119.28 appropriate, must be combined with data collected under subdivisions 4 and 5 in analyses
119.29 of health care spending.

119.30 (b) Data collected under this subdivision are nonpublic data as defined in section 13.02.
119.31 Notwithstanding the definition of summary data in section 13.02, subdivision 19, summary
119.32 data prepared under this subdivision may be derived from nonpublic data. The commissioner
119.33 shall establish procedures and safeguards to protect the integrity and confidentiality of any
119.34 data maintained by the commissioner.

120.1 (c) The commissioner shall consult with health plan companies, hospitals, health care
120.2 providers, and the commissioner of human services in developing the data reported under
120.3 this subdivision and standardized reporting forms.

120.4 Sec. 33. Minnesota Statutes 2022, section 62U.04, subdivision 11, is amended to read:

120.5 Subd. 11. **Restricted uses of the all-payer claims data.** (a) Notwithstanding subdivision
120.6 4, paragraph (b), and subdivision 5, paragraph (b), the commissioner or the commissioner's
120.7 designee shall only use the data submitted under subdivisions 4 ~~and~~, 5, 5a, and 5b for the
120.8 ~~following~~ purposes authorized in this subdivision and in subdivision 13:

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

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

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

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

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

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

120.21 (ii) not identify individual patients, ~~payers, or providers~~ but that may identify the
120.22 rendering or billing hospital, clinic, or medical practice so long as no individual health
120.23 professionals are identified and the commissioner finds the data to be accurate, valid, and
120.24 suitable for publication for such use;

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

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

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

121.1 (6) to conduct analyses of the impact of health care transactions on health care costs,
121.2 market consolidation, and quality under section 144.593, subdivision 6.

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

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

121.12 ~~(d) The commissioner or the commissioner's designee may use the data submitted under~~
121.13 ~~subdivisions 4 and 5 for the purpose described in paragraph (a), clause (3), until July 1,~~
121.14 ~~2023.~~

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

121.18 Sec. 34. Minnesota Statutes 2022, section 62U.04, is amended by adding a subdivision to
121.19 read:

121.20 Subd. 13. **Expanded access to and use of the all-payer claims data.** (a) The
121.21 commissioner or the commissioner's designee shall make the data submitted under
121.22 subdivisions 4, 5, 5a, and 5b available to individuals and organizations engaged in research
121.23 on, or efforts to effect transformation in, health care outcomes, access, quality, disparities,
121.24 or spending, provided the use of the data serves a public benefit. Data made available under
121.25 this subdivision may not be used to:

121.26 (1) create an unfair market advantage for any participant in the health care market in
121.27 Minnesota, including health plan companies, payers, and providers;

121.28 (2) reidentify or attempt to reidentify an individual in the data; or

121.29 (3) publicly report contract details between a health plan company and provider and
121.30 derived from the data.

121.31 (b) To implement paragraph (a), the commissioner shall:

122.1 (1) establish detailed requirements for data access; a process for data users to apply to
122.2 access and use the data; legally enforceable data use agreements to which data users must
122.3 consent; a clear and robust oversight process for data access and use, including a data
122.4 management plan, that ensures compliance with state and federal data privacy laws;
122.5 agreements for state agencies and the University of Minnesota to ensure proper and efficient
122.6 use and security of data; and technical assistance for users of the data and for stakeholders;

122.7 (2) develop a fee schedule to support the cost of expanded access to and use of the data,
122.8 provided the fees charged under the schedule do not create a barrier to access or use for
122.9 those most affected by disparities; and

122.10 (3) create a research advisory group to advise the commissioner on applications for data
122.11 use under this subdivision, including an examination of the rigor of the research approach,
122.12 the technical capabilities of the proposed user, and the ability of the proposed user to
122.13 successfully safeguard the data.

122.14 **Sec. 35. [115.7411] ADVISORY COUNCIL ON WATER SUPPLY SYSTEMS AND**
122.15 **WASTEWATER TREATMENT FACILITIES.**

122.16 Subdivision 1. **Purpose; membership.** The Advisory Council on Water Supply Systems
122.17 and Wastewater Treatment Facilities shall advise the commissioners of health and the
122.18 Pollution Control Agency regarding classification of water supply systems and wastewater
122.19 treatment facilities, qualifications and competency evaluation of water supply system
122.20 operators and wastewater treatment facility operators, and additional laws, rules, and
122.21 procedures that may be desirable for regulating the operation of water supply systems and
122.22 of wastewater treatment facilities. The advisory council is composed of 11 voting members,
122.23 of whom:

122.24 (1) one member must be from the Department of Health, Division of Environmental
122.25 Health, appointed by the commissioner of health;

122.26 (2) one member must be from the Pollution Control Agency appointed by the
122.27 commissioner of the Pollution Control Agency;

122.28 (3) three members must be certified water supply system operators, appointed by the
122.29 commissioner of health, one of whom must represent a nonmunicipal community or
122.30 nontransient noncommunity water supply system;

122.31 (4) three members must be certified wastewater treatment facility operators, appointed
122.32 by the commissioner of the Pollution Control Agency;

123.1 (5) one member must be a representative from an organization representing municipalities,
123.2 appointed by the commissioner of health with the concurrence of the commissioner of the
123.3 Pollution Control Agency; and

123.4 (6) two members must be members of the public who are not associated with water
123.5 supply systems or wastewater treatment facilities. One must be appointed by the
123.6 commissioner of health and the other by the commissioner of the Pollution Control Agency.
123.7 Consideration should be given to one of these members being a representative of academia
123.8 knowledgeable in water or wastewater matters.

123.9 Subd. 2. **Geographic representation.** At least one of the water supply system operators
123.10 and at least one of the wastewater treatment facility operators must be from outside the
123.11 seven-county metropolitan area and one wastewater treatment facility operator must be
123.12 from the Metropolitan Council.

123.13 Subd. 3. **Terms; compensation.** The terms of the appointed members and the
123.14 compensation and removal of all members are governed by section 15.059.

123.15 Subd. 4. **Officers.** When new members are appointed to the council, a chair must be
123.16 elected at the next council meeting. The Department of Health representative shall serve as
123.17 secretary of the council.

123.18 Sec. 36. Minnesota Statutes 2022, section 121A.335, is amended to read:

123.19 **121A.335 LEAD IN SCHOOL DRINKING WATER.**

123.20 Subdivision 1. **Model plan.** The commissioners of health and education shall jointly
123.21 develop a model plan to require school districts to accurately and efficiently test for the
123.22 presence of lead in water in public school buildings serving students in kindergarten through
123.23 grade 12. To the extent possible, the commissioners shall base the plan on the standards
123.24 established by the United States Environmental Protection Agency. The plan may be based
123.25 on the technical guidance in the Department of Health's document, "Reducing Lead in
123.26 Drinking Water: A Technical Guidance for Minnesota's School and Child Care Facilities."
123.27 The plan must include recommendations for remediation efforts when testing reveals the
123.28 presence of lead above five parts per billion.

123.29 Subd. 2. **School plans.** (a) By July 1, 2018, the board of each school district or charter
123.30 school must adopt the commissioners' model plan or develop and adopt an alternative plan
123.31 to accurately and efficiently test for the presence of lead in water in school buildings serving
123.32 prekindergarten students and students in kindergarten through grade 12.

124.1 (b) By July 1, 2024, a school district or charter school must revise its plan to include its
124.2 policies and procedures for ensuring consistent water quality throughout the district's or
124.3 charter school's facilities. The plan must document the routine water management strategies
124.4 and procedures used in each building or facility to maintain water quality and reduce exposure
124.5 to lead. A district or charter school must base the plan on the United States Environmental
124.6 Protection Agency's "Ensuring Drinking Water Quality in Schools During and After Extended
124.7 Closures" fact sheet and the United States Environmental Protection Agency's "3Ts Toolkit
124.8 for Reducing Lead in Drinking Water in Schools and Child Care Facilities" manual. A
124.9 district or charter school's plan must be publicly available upon request.

124.10 **Subd. 3. Frequency of testing.** (a) The plan under subdivision 2 must include a testing
124.11 schedule for every building serving prekindergarten through grade 12 students. The schedule
124.12 must require that each building be tested at least once every five years. A school district or
124.13 charter school must begin testing school buildings by July 1, 2018, and complete testing of
124.14 all buildings that serve students within five years.

124.15 (b) A school district or charter school that finds lead at a specific location providing
124.16 cooking or drinking water within a facility must formulate, make publicly available, and
124.17 implement a plan that is consistent with established guidelines and recommendations to
124.18 ensure that student exposure to lead is ~~minimized~~ reduced to at or below five parts per billion
124.19 as verified by a retest. This includes, when a school district or charter school finds the
124.20 presence of lead ~~at a level where action should be taken as set by the guidance~~ above five
124.21 parts per billion in any water source fixture that can provide cooking or drinking water,
124.22 immediately shutting off the water ~~source~~ fixture or making it unavailable until the hazard
124.23 has been ~~minimized~~ remediated as verified by a retest.

124.24 (c) A school district or charter school must test for the presence of lead after completing
124.25 remediation activities required under this section to confirm that the water contains lead at
124.26 a level at or below five parts per billion.

124.27 **Subd. 4. Ten-year facilities plan.** A school district may include lead testing and
124.28 remediation as a part of its ten-year facilities plan under section 123B.595.

124.29 **Subd. 5. Reporting.** ~~(a) A school district or charter school that has tested its buildings~~
124.30 ~~for the presence of lead shall make the results of the testing available to the public for review~~
124.31 ~~and must notify parents of the availability of the information. School districts and charter~~
124.32 ~~schools must follow the actions outlined in guidance from the commissioners of health and~~
124.33 ~~education.~~ must send parents an annual notice that includes the district's or charter school's
124.34 annual testing and remediation plan, information about how to find test results, and a

125.1 description of remediation efforts on the district website. The district or charter school must
125.2 update the lead testing and remediation information on its website at least annually. In
125.3 addition to the annual notice, the district or charter school must include in an official school
125.4 handbook or official school policy guide information on how parents may find the test
125.5 results and a description of remediation efforts on the district or charter school website and
125.6 how often this information is updated.

125.7 (b) If a test conducted under subdivision 3, paragraph (a), reveals the presence of lead
125.8 above a level where action should be taken as set by the guidance five parts per billion, the
125.9 school district or charter school must, within 30 days of receiving the test result, either
125.10 remediate the presence of lead to at or below the level set in guidance five parts per billion,
125.11 verified by retest, or directly notify parents of the test result. ~~The school district or charter~~
125.12 ~~school must make the water source unavailable until the hazard has been minimized.~~

125.13 (c) Starting July 1, 2024, school districts and charter schools must report their test results
125.14 and remediation activities to the commissioner of health in the form and manner determined
125.15 by the commissioner in consultation with school districts and charter schools, by July 1 of
125.16 each year. The commissioner of health must post and annually update the test results and
125.17 remediation efforts on the department website by school site.

125.18 (d) A district or charter school must maintain a record of lead testing results and
125.19 remediation activities for at least 15 years.

125.20 Subd. 6. **Public water systems.** (a) A district or charter school is not financially
125.21 responsible for remediation of documented elevated lead levels in drinking water caused
125.22 by the presence of lead infrastructure owned by a public water supply utility providing water
125.23 to the school facility, such as lead service lines, meters, galvanized service lines downstream
125.24 of lead, or lead connectors. The district or charter school must communicate with the public
125.25 water system regarding its documented significant contribution to lead contamination in
125.26 school drinking water and request from the public water system a plan for reducing the lead
125.27 contamination.

125.28 (b) If the infrastructure is jointly owned by a district or charter school and a public water
125.29 supply utility, the district or charter school must attempt to coordinate any needed
125.30 replacements of lead service lines with the public water supply utility.

125.31 (c) A district or charter school may defer its remediation activities under this section
125.32 until after the elevated lead level in the public water system's infrastructure is remediated
125.33 and postremediation testing does not detect an elevated lead level in the drinking water that
125.34 passes through that infrastructure. A district or charter school may also defer its remediation

126.1 activities if the public water supply exceeds the federal Safe Drinking Water Act lead action
126.2 level or is in violation of the Safe Drinking Water Act Lead and Copper Rule.

126.3 Subd. 7. **Commissioner recommendations.** By January 1, 2026, and every five years
126.4 thereafter, the commissioner of health must report to the legislative committees having
126.5 jurisdiction over health and kindergarten through grade 12 education any recommended
126.6 changes to this section. The recommendations must be based on currently available scientific
126.7 evidence regarding the effects of lead in drinking water.

126.8 Sec. 37. **[144.0526] MINNESOTA ONE HEALTH ANTIMICROBIAL**
126.9 **STEWARDSHIP COLLABORATIVE.**

126.10 Subdivision 1. **Establishment.** The commissioner of health shall establish the Minnesota
126.11 One Health Antimicrobial Stewardship Collaborative. The commissioner shall appoint a
126.12 director to execute operations, conduct health education, and provide technical assistance.

126.13 Subd. 2. **Commissioner's duties.** The commissioner of health shall oversee a program
126.14 to:

126.15 (1) maintain the position of director of One Health Antimicrobial Stewardship to lead
126.16 state antimicrobial stewardship initiatives across human, animal, and environmental health;

126.17 (2) communicate to professionals and the public the interconnectedness of human, animal,
126.18 and environmental health, especially related to preserving the efficacy of antibiotic
126.19 medications, which are a shared resource;

126.20 (3) leverage new and existing partnerships. The commissioner of health shall consult
126.21 and collaborate with organizations and agencies in fields including but not limited to health
126.22 care, veterinary medicine, animal agriculture, academic institutions, and industry and
126.23 community organizations to inform strategies for education, practice improvement, and
126.24 research in all settings where antimicrobial products are used;

126.25 (4) ensure that veterinary settings have education and strategies needed to practice
126.26 appropriate antibiotic prescribing, implement clinical antimicrobial stewardship programs,
126.27 and prevent transmission of antimicrobial-resistant microbes; and

126.28 (5) support collaborative research and programmatic initiatives to improve the
126.29 understanding of the impact of antimicrobial use and resistance in the natural environment.

127.1 Sec. 38. [144.0528] COMPREHENSIVE DRUG OVERDOSE AND MORBIDITY
127.2 PREVENTION ACT.

127.3 Subdivision 1. Definition. For the purpose of this section, "drug overdose and morbidity"
127.4 means health problems that people experience after inhaling, ingesting, or injecting medicines
127.5 in quantities that exceed prescription status; medicines taken that are prescribed to a different
127.6 person; medicines that have been adulterated or adjusted by contaminants intentionally or
127.7 unintentionally; or nonprescription drugs in amounts that result in morbidity or mortality.

127.8 Subd. 2. Establishment. The commissioner of health shall establish a comprehensive
127.9 drug overdose and morbidity program to conduct comprehensive drug overdose and morbidity
127.10 prevention activities, epidemiologic investigations and surveillance, and evaluation to
127.11 monitor, address, and prevent drug overdoses statewide through integrated strategies that
127.12 include the following:

127.13 (1) advance access to evidence-based nonnarcotic pain management services;

127.14 (2) implement culturally specific interventions and prevention programs with population
127.15 and community groups in greatest need, including those who are pregnant and their infants;

127.16 (3) enhance overdose prevention and supportive services for people experiencing
127.17 homelessness. This strategy includes funding for emergency and short-term housing subsidies
127.18 through the homeless overdose prevention hub and expanding support for syringe services
127.19 programs serving people experiencing homelessness statewide;

127.20 (4) equip employers to promote health and well-being of employees by addressing
127.21 substance misuse and drug overdose;

127.22 (5) improve outbreak detection and identification of substances involved in overdoses
127.23 through the expansion of the Minnesota Drug Overdose and Substance Use Surveillance
127.24 Activity (MNDOSA);

127.25 (6) implement Tackling Overdose With Networks (TOWN) community prevention
127.26 programs;

127.27 (7) identify, address, and respond to drug overdose and morbidity in those who are
127.28 pregnant or have just given birth through multitiered approaches that may:

127.29 (i) promote medication-assisted treatment options;

127.30 (ii) support programs that provide services in accord with evidence-based care models
127.31 for mental health and substance abuse disorder;

128.1 (iii) collaborate with interdisciplinary and professional organizations that focus on quality
128.2 improvement initiatives related to substance use disorder; and

128.3 (iv) implement substance use disorder-related recommendations from the maternal
128.4 mortality review committee, as appropriate; and

128.5 (8) design a system to assess, address, and prevent the impacts of drug overdose and
128.6 morbidity on those who are pregnant, their infants, and children. Specifically, the
128.7 commissioner of health may:

128.8 (i) inform health care providers and the public of the prevalence, risks, conditions, and
128.9 treatments associated with substance use disorders involving or affecting pregnancies,
128.10 infants, and children; and

128.11 (ii) identify communities, families, infants, and children affected by substance use
128.12 disorder in order to recommend focused interventions, prevention, and services.

128.13 Subd. 3. **Partnerships.** The commissioner of health may consult with sovereign Tribal
128.14 nations, the Minnesota Departments of Human Services, Corrections, Public Safety, and
128.15 Education, local public health agencies, care providers and insurers, community organizations
128.16 that focus on substance abuse risks and recovery, individuals affected by substance use
128.17 disorders, and any other individuals, entities, and organizations as necessary to carry out
128.18 the goals of this section.

128.19 Subd. 4. **Grants authorized.** (a) The commissioner of health may award grants, as
128.20 funding allows, to entities and organizations focused on addressing and preventing the
128.21 negative impacts of drug overdose and morbidity. Examples of activities the commissioner
128.22 may consider for these grant awards include:

128.23 (1) developing, implementing, or promoting drug overdose and morbidity prevention
128.24 programs and activities;

128.25 (2) community outreach and other efforts addressing the root causes of drug overdose
128.26 and morbidity;

128.27 (3) identifying risk and protective factors relating to drug overdose and morbidity that
128.28 contribute to identification, development, or improvement of prevention strategies and
128.29 community outreach;

128.30 (4) developing or providing trauma-informed drug overdose and morbidity prevention
128.31 and services;

129.1 (5) developing or providing culturally and linguistically appropriate drug overdose and
129.2 morbidity prevention and services, and programs that target and serve historically underserved
129.3 communities;

129.4 (6) working collaboratively with educational institutions, including school districts, to
129.5 implement drug overdose and morbidity prevention strategies for students, teachers, and
129.6 administrators;

129.7 (7) working collaboratively with sovereign Tribal nations, care providers, nonprofit
129.8 organizations, for-profit organizations, government entities, community-based organizations,
129.9 and other entities to implement substance misuse and drug overdose prevention strategies
129.10 within their communities; and

129.11 (8) creating or implementing quality improvement initiatives to improve drug overdose
129.12 and morbidity treatment and outcomes.

129.13 (b) Any organization or government entity receiving grant money under this section
129.14 must collect and make available to the commissioner of health aggregate data related to the
129.15 activity funded by the program under this section. The commissioner of health shall use the
129.16 information and data from the program evaluation to inform the administration of existing
129.17 Department of Health programming and the development of Department of Health policies,
129.18 programs, and procedures.

129.19 Subd. 5. **Promotion; administration.** In fiscal years 2026 and beyond, the commissioner
129.20 may spend up to 25 percent of the total funding appropriated to the comprehensive drug
129.21 overdose and morbidity program in each fiscal year to promote, administer, support, and
129.22 evaluate the programs authorized under this section and to provide technical assistance to
129.23 program grantees.

129.24 Subd. 6. **External contributions.** The commissioner may accept contributions from
129.25 governmental and nongovernmental sources and may apply for grants to supplement state
129.26 appropriations for the programs authorized under this section. Contributions and grants
129.27 received from the sources identified in this subdivision to advance the purpose of this section
129.28 are appropriated to the commissioner for the comprehensive drug overdose and morbidity
129.29 program.

129.30 Subd. 7. **Program evaluation.** Beginning February 28, 2024, the commissioner of health
129.31 shall report every even-numbered year to the legislative committees with jurisdiction over
129.32 health detailing the expenditures of funds authorized under this section. The commissioner
129.33 shall use the data to evaluate the effectiveness of the program. The commissioner must
129.34 include in the report:

- 130.1 (1) the number of organizations receiving grant money under this section;
130.2 (2) the number of individuals served by the grant programs;
130.3 (3) a description and analysis of the practices implemented by program grantees; and
130.4 (4) best practices recommendations to prevent drug overdose and morbidity, including
130.5 culturally relevant best practices and recommendations focused on historically underserved
130.6 communities.

130.7 Subd. 8. **Measurement.** Notwithstanding any law to the contrary, the commissioner of
130.8 health shall assess and evaluate grants and contracts awarded using available data sources,
130.9 including but not limited to the Minnesota All Payer Claims Database (MN APCD), the
130.10 Minnesota Behavioral Risk Factor Surveillance System (BRFSS), the Minnesota Student
130.11 Survey, vital records, hospitalization data, syndromic surveillance, and the Minnesota
130.12 Electronic Health Record Consortium.

130.13 Sec. 39. **[144.0752] CULTURAL COMMUNICATIONS.**

130.14 Subdivision 1. **Establishment.** The commissioner of health shall establish:

130.15 (1) a cultural communications program that advances culturally and linguistically
130.16 appropriate communication services for communities most impacted by health disparities
130.17 which includes limited English proficient (LEP) populations, African American populations,
130.18 LGBTQ+ populations, and people with disabilities; and

130.19 (2) a position that works with department leadership and division to ensure that the
130.20 department follows the National Standards for Culturally and Linguistically Appropriate
130.21 Services (CLAS) Standards.

130.22 Subd. 2. **Commissioner's duties.** The commissioner of health shall oversee a program
130.23 to:

130.24 (1) align the department services, policies, procedures, and governance with the National
130.25 CLAS Standards, establish culturally and linguistically appropriate goals, policies, and
130.26 management accountability, and apply them throughout the organization's planning and
130.27 operations;

130.28 (2) ensure the department services respond to the cultural and linguistic diversity of
130.29 Minnesotans and that the department partners with the community to design, implement,
130.30 and evaluate policies, practices, and services that are aligned with the national cultural and
130.31 linguistic appropriateness standard; and

131.1 (3) ensure the department leadership, workforce, and partners embed culturally and
131.2 linguistically appropriate policies and practices into leadership and public health program
131.3 planning, intervention, evaluation, and dissemination.

131.4 Subd. 3. **Eligible contractors.** The commissioner may enter into contracts to implement
131.5 this section. Organizations eligible to receive contract funding under this section include:

131.6 (1) master contractors that are selected through the state to provide language and
131.7 communication services; and

131.8 (2) organizations that are able to provide services for languages that master contractors
131.9 are unable to cover.

131.10 **Sec. 40. [144.0754] OFFICE OF AFRICAN AMERICAN HEALTH; DUTIES.**

131.11 Subdivision 1. **Establishment.** The commissioner shall establish the Office of African
131.12 American Health to address the unique public health needs of African American Minnesotans
131.13 and work to develop solutions and systems to address identified health disparities of African
131.14 American Minnesotans arising from a context of cumulative and historical discrimination
131.15 and disadvantages in multiple systems, including but not limited to housing, education,
131.16 employment, gun violence, incarceration, environmental factors, and health care
131.17 discrimination.

131.18 Subd. 2. **Duties of the office.** The office shall:

131.19 (1) convene the African American Health State Advisory Council (AAHSAC) under
131.20 section 144.0755 to advise the commissioner on issues and to develop specific, targeted
131.21 policy solutions to improve the health of African American Minnesotans, with a focus on
131.22 United States-born African Americans;

131.23 (2) based upon input from and collaboration with the AAHSAC, health indicators, and
131.24 identified disparities, conduct analysis and develop policy and program recommendations
131.25 and solutions targeted at improving African American health outcomes;

131.26 (3) coordinate and conduct community engagement across multiple systems, sectors,
131.27 and communities to address racial disparities in labor force participation, educational
131.28 achievement, and involvement with the criminal justice system that impact African American
131.29 health and well-being;

131.30 (4) conduct data analysis and research to support policy goals and solutions;

131.31 (5) award and administer African American health special emphasis grants to health and
131.32 community-based organizations to plan and develop programs targeted at improving African

132.1 American health outcomes, based upon needs identified by the council, health indicators,
132.2 and identified disparities and addressing historical trauma and systems of United States-born
132.3 African American Minnesotans; and

132.4 (6) develop and administer Department of Health immersion experiences for students
132.5 in secondary education and community colleges to improve diversity of the public health
132.6 workforce and introduce career pathways that contribute to reducing health disparities.

132.7 Sec. 41. [144.0755] AFRICAN AMERICAN HEALTH STATE ADVISORY
132.8 COUNCIL.

132.9 Subdivision 1. Establishment; purpose. The commissioner of health shall establish
132.10 and administer the African American Health State Advisory Council to advise the
132.11 commissioner on implementing specific strategies to reduce health inequities and disparities
132.12 that particularly affect African Americans in Minnesota.

132.13 Subd. 2. Members. (a) The council shall include no fewer than 12 or more than 20
132.14 members from any of the following groups:

132.15 (1) representatives of community-based organizations serving or advocating for African
132.16 American citizens;

132.17 (2) at-large community leaders or elders, as nominated by other council members;

132.18 (3) African American individuals who provide and receive health care services;

132.19 (4) African American secondary or college students;

132.20 (5) health or human service professionals serving African American communities or
132.21 clients;

132.22 (6) representatives with research or academic expertise in racial equity; and

132.23 (7) other members that the commissioner deems appropriate to facilitate the goals and
132.24 duties of the council.

132.25 (b) The commissioner shall make recommendations for council membership and, after
132.26 considering recommendations from the council, shall appoint a chair or chairs of the council.
132.27 Council members shall be appointed by the governor.

132.28 Subd. 3. Terms. A term shall be for two years and appointees may be reappointed to
132.29 serve two additional terms. The commissioner shall recommend appointments to replace
132.30 members vacating their positions in a timely manner, no more than three months after the
132.31 council reviews panel recommendations.

133.1 Subd. 4. **Duties of commissioner.** The commissioner or commissioner's designee shall:

133.2 (1) maintain and actively engage with the council established in this section;

133.3 (2) based on recommendations of the council, review identified department or other
133.4 related policies or practices that maintain health inequities and disparities that particularly
133.5 affect African Americans in Minnesota;

133.6 (3) in partnership with the council, recommend or implement action plans and resources
133.7 necessary to address identified disparities and advance African American health equity;

133.8 (4) support interagency collaboration to advance African American health equity; and

133.9 (5) support member participation in the council, including participation in educational
133.10 and community engagement events across Minnesota that specifically address African
133.11 American health equity.

133.12 Subd. 5. **Duties of council.** The council shall:

133.13 (1) identify health disparities found in African American communities and contributing
133.14 factors;

133.15 (2) recommend to the commissioner for review any statutes, rules, or administrative
133.16 policies or practices that would address African American health disparities;

133.17 (3) recommend policies and strategies to the commissioner of health to address disparities
133.18 specifically affecting African American health;

133.19 (4) form work groups of council members who are persons who provide and receive
133.20 services and representatives of advocacy groups;

133.21 (5) provide the work groups with clear guidelines, standardized parameters, and tasks
133.22 for the work groups to accomplish; and

133.23 (6) annually submit to the commissioner a report that summarizes the activities of the
133.24 council, identifies disparities specially affecting the health of African American Minnesotans,
133.25 and makes recommendations to address identified disparities.

133.26 Subd. 6. **Duties of council members.** The members of the council shall:

133.27 (1) attend scheduled meetings with no more than three absences per year, participate in
133.28 scheduled meetings, and prepare for meetings by reviewing meeting notes;

133.29 (2) maintain open communication channels with respective constituencies;

133.30 (3) identify and communicate issues and risks that may impact the timely completion
133.31 of tasks;

134.1 (4) participate in any activities the council or commissioner deems appropriate and
134.2 necessary to facilitate the goals and duties of the council; and

134.3 (5) participate in work groups to carry out council duties.

134.4 Subd. 7. **Staffing; office space; equipment.** The commissioner shall provide the advisory
134.5 council with staff support, office space, and access to office equipment and services.

134.6 Subd. 8. **Reimbursement.** Compensation and reimbursement for travel and expenses
134.7 incurred for council activities are governed by section 15.059, subdivision 3.

134.8 Sec. 42. **[144.0756] AFRICAN AMERICAN HEALTH SPECIAL EMPHASIS GRANT**
134.9 **PROGRAM.**

134.10 Subdivision 1. **Establishment.** The commissioner of health shall establish the African
134.11 American health special emphasis grant program administered by the Office of African
134.12 American Health. The purposes of the program are to:

134.13 (1) identify disparities impacting African American health arising from cumulative and
134.14 historical discrimination and disadvantages in multiple systems, including but not limited
134.15 to housing, education, employment, gun violence, incarceration, environmental factors, and
134.16 health care discrimination; and

134.17 (2) develop community-based solutions that incorporate a multisector approach to
134.18 addressing identified disparities impacting African American health.

134.19 Subd. 2. **Requests for proposals; accountability; data collection.** As directed by the
134.20 commissioner of health, the Office of African American Health shall:

134.21 (1) develop a request for proposals for an African American health special emphasis
134.22 grant program in consultation with community stakeholders;

134.23 (2) provide outreach, technical assistance, and program development guidance to potential
134.24 qualifying organizations or entities;

134.25 (3) review responses to requests for proposals in consultation with community
134.26 stakeholders and award grants under this section;

134.27 (4) establish a transparent and objective accountability process in consultation with
134.28 community stakeholders, focused on outcomes that grantees agree to achieve;

134.29 (5) provide grantees with access to summary and other public data to assist grantees in
134.30 establishing and implementing effective community-led solutions; and

134.31 (6) collect and maintain data on outcomes reported by grantees.

135.1 Subd. 3. **Eligible grantees.** Organizations eligible to receive grant funding under this
135.2 section include nonprofit organizations or entities that work with African American
135.3 communities or are focused on addressing disparities impacting the health of African
135.4 American communities.

135.5 Subd. 4. **Strategic consideration and priority of proposals; grant awards.** In
135.6 developing the requests for proposals and awarding the grants, the commissioner and the
135.7 Office of African American Health shall consider building upon the existing capacity of
135.8 communities and on developing capacity where it is lacking. Proposals shall focus on
135.9 addressing health equity issues specific to United States-born African American communities;
135.10 addressing the health impact of historical trauma; and reducing health disparities experienced
135.11 by United States-born African American communities; and incorporating a multisector
135.12 approach to addressing identified disparities.

135.13 Subd. 5. **Report.** Grantees must report grant program outcomes to the commissioner on
135.14 the forms and according to timelines established by the commissioner.

135.15 **Sec. 43. [144.0757] OFFICE OF AMERICAN INDIAN HEALTH.**

135.16 Subdivision 1. **Duties.** The Office of American Indian Health is established to address
135.17 unique public health needs of American Indian Tribal communities in Minnesota, and shall:

135.18 (1) coordinate with Minnesota's Tribal Nations and urban American Indian
135.19 community-based organizations to identify underlying causes of health disparities, address
135.20 unique health needs of Minnesota's Tribal communities, and develop public health approaches
135.21 to achieve health equity;

135.22 (2) strengthen capacity of American Indian and community-based organizations and
135.23 Tribal Nations to address identified health disparities and needs;

135.24 (3) administer state and federal grant funding opportunities targeted to improve the
135.25 health of American Indians;

135.26 (4) provide overall leadership for targeted development of holistic health and wellness
135.27 strategies to improve health and to support Tribal and urban American Indian public health
135.28 leadership and self-sufficiency;

135.29 (5) provide technical assistance to Tribal and American Indian urban community leaders
135.30 to develop culturally appropriate activities to address public health emergencies;

135.31 (6) develop and administer the department immersion experiences for American Indian
135.32 students in secondary education and community colleges to improve diversity of the public

136.1 health workforce and introduce career pathways that contribute to reducing health disparities;
136.2 and

136.3 (7) identify and promote workforce development strategies for Department of Health
136.4 staff to work with the American Indian population and Tribal Nations more effectively in
136.5 Minnesota.

136.6 Subd. 2. **Grants and contracts.** To carry out these duties, the office may contract with
136.7 or provide grants to qualifying entities.

136.8 Sec. 44. **[144.0758] AMERICAN INDIAN HEALTH SPECIAL EMPHASIS GRANTS.**

136.9 Subdivision 1. **Establishment.** The commissioner of health shall establish the American
136.10 Indian health special emphasis grant program. The purposes of the program are to:

136.11 (1) plan and develop programs targeted to address continuing and persistent health
136.12 disparities of Minnesota's American Indian population and improve American Indian health
136.13 outcomes based upon needs identified by health indicators and identified disparities;

136.14 (2) identify disparities in American Indian health arising from cumulative and historical
136.15 discrimination; and

136.16 (3) plan and develop community-based solutions with a multisector approach to
136.17 addressing identified disparities in American Indian health.

136.18 Subd. 2. **Commissioner's duties.** The commissioner of health shall:

136.19 (1) develop a request for proposals for an American Indian health special emphasis grant
136.20 program in consultation with Minnesota's Tribal Nations and urban American Indian
136.21 community-based organizations based upon needs identified by the community, health
136.22 indicators, and identified disparities;

136.23 (2) provide outreach, technical assistance, and program development guidance to potential
136.24 qualifying organizations or entities;

136.25 (3) review responses to requests for proposals in consultation with community
136.26 stakeholders and award grants under this section;

136.27 (4) establish a transparent and objective accountability process in consultation with
136.28 community stakeholders focused on outcomes that grantees agree to achieve;

136.29 (5) provide grantees with access to data to assist grantees in establishing and
136.30 implementing effective community-led solutions; and

136.31 (6) collect and maintain data on outcomes reported by grantees.

137.1 Subd. 3. **Eligible grantees.** Organizations eligible to receive grant funding under this
137.2 section are Minnesota's Tribal Nations and urban American Indian community-based
137.3 organizations.

137.4 Subd. 4. **Strategic consideration and priority of proposals; grant awards.** In
137.5 developing the proposals and awarding the grants, the commissioner shall consider building
137.6 upon the existing capacity of Minnesota's Tribal Nations and urban American Indian
137.7 community-based organizations and on developing capacity where it is lacking. Proposals
137.8 may focus on addressing health equity issues specific to Tribal and urban American Indian
137.9 communities; addressing the health impact of historical trauma; reducing health disparities
137.10 experienced by American Indian communities; and incorporating a multisector approach
137.11 to addressing identified disparities.

137.12 Subd. 5. **Report.** Grantees must report grant program outcomes to the commissioner on
137.13 the forms and according to the timelines established by the commissioner.

137.14 Sec. 45. Minnesota Statutes 2022, section 144.122, is amended to read:

137.15 **144.122 LICENSE, PERMIT, AND SURVEY FEES.**

137.16 (a) The state commissioner of health, by rule, may prescribe procedures and fees for
137.17 filing with the commissioner as prescribed by statute and for the issuance of original and
137.18 renewal permits, licenses, registrations, and certifications issued under authority of the
137.19 commissioner. The expiration dates of the various licenses, permits, registrations, and
137.20 certifications as prescribed by the rules shall be plainly marked thereon. Fees may include
137.21 application and examination fees and a penalty fee for renewal applications submitted after
137.22 the expiration date of the previously issued permit, license, registration, and certification.
137.23 The commissioner may also prescribe, by rule, reduced fees for permits, licenses,
137.24 registrations, and certifications when the application therefor is submitted during the last
137.25 three months of the permit, license, registration, or certification period. Fees proposed to
137.26 be prescribed in the rules shall be first approved by the Department of Management and
137.27 Budget. All fees proposed to be prescribed in rules shall be reasonable. The fees shall be
137.28 in an amount so that the total fees collected by the commissioner will, where practical,
137.29 approximate the cost to the commissioner in administering the program. All fees collected
137.30 shall be deposited in the state treasury and credited to the state government special revenue
137.31 fund unless otherwise specifically appropriated by law for specific purposes.

137.32 (b) The commissioner may charge a fee for voluntary certification of medical laboratories
137.33 and environmental laboratories, and for environmental and medical laboratory services
137.34 provided by the department, without complying with paragraph (a) or chapter 14. Fees

138.1 charged for environment and medical laboratory services provided by the department must
 138.2 be approximately equal to the costs of providing the services.

138.3 (c) The commissioner may develop a schedule of fees for diagnostic evaluations
 138.4 conducted at clinics held by the services for children with disabilities program. All receipts
 138.5 generated by the program are annually appropriated to the commissioner for use in the
 138.6 maternal and child health program.

138.7 (d) The commissioner shall set license fees for hospitals and nursing homes that are not
 138.8 boarding care homes at the following levels:

138.9	Joint Commission on Accreditation of	\$7,655 plus \$16 per bed
138.10	Healthcare Organizations (JCAHO) and	
138.11	American Osteopathic Association (AOA)	
138.12	hospitals	
138.13	Non-JCAHO and non-AOA hospitals	\$5,280 plus \$250 per bed
138.14	Nursing home	\$183 plus \$91 per bed until June 30, 2018.
138.15		\$183 plus \$100 per bed between July 1, 2018,
138.16		and June 30, 2020. \$183 plus \$105 per bed
138.17		beginning July 1, 2020.

138.18 The commissioner shall set license fees for outpatient surgical centers, boarding care
 138.19 homes, supervised living facilities, assisted living facilities, and assisted living facilities
 138.20 with dementia care at the following levels:

138.21	Outpatient surgical centers	\$3,712
138.22	Boarding care homes	\$183 plus \$91 per bed
138.23	Supervised living facilities	\$183 plus \$91 per bed.
138.24	Assisted living facilities with dementia care	\$3,000 plus \$100 per resident.
138.25	Assisted living facilities	\$2,000 plus \$75 per resident.

138.26 Fees collected under this paragraph are nonrefundable. The fees are nonrefundable even if
 138.27 received before July 1, 2017, for licenses or registrations being issued effective July 1, 2017,
 138.28 or later.

138.29 (e) Unless prohibited by federal law, the commissioner of health shall charge applicants
 138.30 the following fees to cover the cost of any initial certification surveys required to determine
 138.31 a provider's eligibility to participate in the Medicare or Medicaid program:

138.32	Prospective payment surveys for hospitals	\$	900
138.33	Swing bed surveys for nursing homes	\$	1,200
138.34	Psychiatric hospitals	\$	1,400
138.35	Rural health facilities	\$	1,100
138.36	Portable x-ray providers	\$	500

139.1	Home health agencies		\$	1,800
139.2	Outpatient therapy agencies		\$	800
139.3	End stage renal dialysis providers		\$	2,100
139.4	Independent therapists		\$	800
139.5	Comprehensive rehabilitation outpatient facilities		\$	1,200
139.6	Hospice providers		\$	1,700
139.7	Ambulatory surgical providers		\$	1,800
139.8	Hospitals		\$	4,200
139.9	Other provider categories or additional	Actual surveyor costs: average		
139.10	resurveys required to complete initial	surveyor cost x number of hours for		
139.11	certification	the survey process.		

139.12 These fees shall be submitted at the time of the application for federal certification and
 139.13 shall not be refunded. All fees collected after the date that the imposition of fees is not
 139.14 prohibited by federal law shall be deposited in the state treasury and credited to the state
 139.15 government special revenue fund.

139.16 (f) Notwithstanding section 16A.1283, the commissioner may adjust the fees assessed
 139.17 on assisted living facilities and assisted living facilities with dementia care under paragraph
 139.18 (d), in a revenue-neutral manner in accordance with the requirements of this paragraph:

139.19 (1) a facility seeking to renew a license shall pay a renewal fee in an amount that is up
 139.20 to ten percent lower than the applicable fee in paragraph (d) if residents who receive home
 139.21 and community-based waiver services under chapter 256S and section 256B.49 comprise
 139.22 more than 50 percent of the facility's capacity in the calendar year prior to the year in which
 139.23 the renewal application is submitted; and

139.24 (2) a facility seeking to renew a license shall pay a renewal fee in an amount that is up
 139.25 to ten percent higher than the applicable fee in paragraph (d) if residents who receive home
 139.26 and community-based waiver services under chapter 256S and section 256B.49 comprise
 139.27 less than 50 percent of the facility's capacity during the calendar year prior to the year in
 139.28 which the renewal application is submitted.

139.29 The commissioner may annually adjust the percentages in clauses (1) and (2), to ensure this
 139.30 paragraph is implemented in a revenue-neutral manner. The commissioner shall develop a
 139.31 method for determining capacity thresholds in this paragraph in consultation with the
 139.32 commissioner of human services and must coordinate the administration of this paragraph
 139.33 with the commissioner of human services for purposes of verification.

139.34 (g) The commissioner shall charge hospitals an annual licensing base fee of \$1,826 per
 139.35 hospital, plus an additional \$23 per licensed bed or bassinets fee. Revenue shall be deposited

140.1 to the state government special revenue fund and credited toward trauma hospital designations
140.2 under sections 144.605 and 144.6071.

140.3 Sec. 46. Minnesota Statutes 2022, section 144.1481, subdivision 1, is amended to read:

140.4 Subdivision 1. **Establishment; membership.** The commissioner of health shall establish
140.5 a ~~16-member~~ Rural Health Advisory Committee. The committee shall consist of the following
140.6 22 members, all of whom must reside outside the seven-county metropolitan area, as defined
140.7 in section 473.121, subdivision 2:

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

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

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

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

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

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

140.18 (7) a dentist licensed under chapter 150A;

140.19 (8) an allied dental personnel as defined in Minnesota Rules, part 3100.0100, subpart
140.20 5;

140.21 ~~(8) a midlevel practitioner;~~

140.22 (9) an advanced practice professional;

140.23 ~~(9)~~ (10) a registered nurse or licensed practical nurse;

140.24 ~~(10)~~ (11) a licensed health care professional from an occupation not otherwise represented
140.25 on the committee;

140.26 ~~(11)~~ (12) a representative of an institution of higher education located outside the
140.27 seven-county metropolitan area that provides training for rural health care providers; ~~and~~

140.28 (13) a member of a Tribal Nation;

140.29 (14) a representative of a local public health agency or community health board;

141.1 (15) a health professional or advocate with experience working with people with mental
141.2 illness;

141.3 (16) a representative of a community organization that works with individuals
141.4 experiencing health disparities;

141.5 (17) an individual with expertise in economic development, or an employer working
141.6 outside the seven-county metropolitan area;

141.7 ~~(12) three~~ (18) two consumers, at least one of whom must be ~~an advocate for persons~~
141.8 ~~who are mentally ill or developmentally disabled.~~ from a community experiencing health
141.9 disparities; and

141.10 (19) one consumer who is an advocate for persons who are developmentally disabled.

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

141.17 Sec. 47. Minnesota Statutes 2022, section 144.1501, subdivision 1, is amended to read:

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

141.20 (b) "Advanced dental therapist" means an individual who is licensed as a dental therapist
141.21 under section 150A.06, and who is certified as an advanced dental therapist under section
141.22 150A.106.

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

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

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

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

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

142.4 (h) "Hospital nurse" means an individual who is licensed as a registered nurse and who
142.5 is providing direct patient care in a nonprofit hospital setting.

142.6 (i) "Mental health professional" means an individual providing clinical services in the
142.7 treatment of mental illness who is qualified in at least one of the ways specified in section
142.8 245.462, subdivision 18.

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

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

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

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

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

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

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

142.22 ~~(q)~~ (q) "Physician assistant" means a person licensed under chapter 147A.

142.23 (r) "PSLF program" means the federal Public Service Loan Forgiveness program
142.24 established under Code of Federal Regulations, title 34, section 685.219.

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

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

143.1 ~~(s)~~ (u) "Underserved urban community" means a Minnesota urban area or population
143.2 included in the list of designated primary medical care health professional shortage areas
143.3 (HPSAs), medically underserved areas (MUAs), or medically underserved populations
143.4 (MUPs) maintained and updated by the United States Department of Health and Human
143.5 Services.

143.6 Sec. 48. Minnesota Statutes 2022, section 144.1501, subdivision 2, is amended to read:

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

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

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

143.16 (3) for nurses who agree to practice in a Minnesota nursing home; in an intermediate
143.17 care facility for persons with developmental disability; in a hospital if the hospital owns
143.18 and operates a Minnesota nursing home and a minimum of 50 percent of the hours worked
143.19 by the nurse is in the nursing home; ~~a housing with services establishment as defined in~~
143.20 ~~section 144D.01, subdivision 4~~ in an assisted living facility as defined in section 144G.08,
143.21 subdivision 7; or for a home care provider as defined in section 144A.43, subdivision 4; or
143.22 agree to teach at least 12 credit hours, or 720 hours per year in the nursing field in a
143.23 postsecondary program at the undergraduate level or the equivalent at the graduate level;

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

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

143.32 (6) for dentists agreeing to deliver at least 25 percent of the dentist's yearly patient
143.33 encounters to state public program enrollees or patients receiving sliding fee schedule

144.1 discounts through a formal sliding fee schedule meeting the standards established by the
144.2 United States Department of Health and Human Services under Code of Federal Regulations,
144.3 title 42, section ~~51, chapter 303.~~ 51c.303; and

144.4 (7) for nurses who are enrolled in the PSLF program, employed as a hospital nurse by
144.5 a nonprofit hospital that is an eligible employer under the PSLF program, and providing
144.6 direct care to patients at the nonprofit hospital.

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

144.11 Sec. 49. Minnesota Statutes 2022, section 144.1501, subdivision 3, is amended to read:

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

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

144.20 (2) submit an application to the commissioner of health. Nurses applying under
144.21 subdivision 2, paragraph (a), clause (7), must also include proof that the applicant is enrolled
144.22 in the PSLF program and confirmation that the applicant is employed as a hospital nurse.

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

144.26 (1) a nurse, who must agree to serve a minimum two-year full-time service obligation
144.27 according to subdivision 2, which shall begin no later than March 31 following completion
144.28 of required training;

144.29 (2) a nurse selected under subdivision 2, paragraph (a), clause (7), who must agree to
144.30 continue as a hospital nurse for the repayment period of the participant's eligible loan under
144.31 the PSLF program; and

145.1 (3) a nurse who agrees to teach according to subdivision 2, paragraph (a), clause (3),
145.2 who must sign a contract to agree to teach for a minimum of two years.

145.3 Sec. 50. Minnesota Statutes 2022, section 144.1501, subdivision 4, is amended to read:

145.4 Subd. 4. **Loan forgiveness.** (a) The commissioner of health may select applicants each
145.5 year for participation in the loan forgiveness program, within the limits of available funding.
145.6 In considering applications, the commissioner shall give preference to applicants who
145.7 document diverse cultural competencies. The commissioner shall distribute available funds
145.8 for loan forgiveness proportionally among the eligible professions according to the vacancy
145.9 rate for each profession in the required geographic area, facility type, teaching area, patient
145.10 group, or specialty type specified in subdivision 2, except for hospital nurses. The
145.11 commissioner shall allocate funds for physician loan forgiveness so that 75 percent of the
145.12 funds available are used for rural physician loan forgiveness and 25 percent of the funds
145.13 available are used for underserved urban communities and pediatric psychiatry loan
145.14 forgiveness. If the commissioner does not receive enough qualified applicants each year to
145.15 use the entire allocation of funds for any eligible profession, the remaining funds may be
145.16 allocated proportionally among the other eligible professions according to the vacancy rate
145.17 for each profession in the required geographic area, patient group, or facility type specified
145.18 in subdivision 2. Applicants are responsible for securing their own qualified educational
145.19 loans. The commissioner shall select participants based on their suitability for practice
145.20 serving the required geographic area or facility type specified in subdivision 2, as indicated
145.21 by experience or training. The commissioner shall give preference to applicants closest to
145.22 completing their training. Except as specified in paragraphs (b) and (c), for each year that
145.23 a participant meets the service obligation required under subdivision 3, up to a maximum
145.24 of four years, the commissioner shall make annual disbursements directly to the participant
145.25 equivalent to 15 percent of the average educational debt for indebted graduates in their
145.26 profession in the year closest to the applicant's selection for which information is available,
145.27 not to exceed the balance of the participant's qualifying educational loans. Before receiving
145.28 loan repayment disbursements and as requested, the participant must complete and return
145.29 to the commissioner a confirmation of practice form provided by the commissioner verifying
145.30 that the participant is practicing as required under subdivisions 2 and 3. The participant
145.31 must provide the commissioner with verification that the full amount of loan repayment
145.32 disbursement received by the participant has been applied toward the designated loans.
145.33 After each disbursement, verification must be received by the commissioner and approved
145.34 before the next loan repayment disbursement is made. Participants who move their practice

146.1 remain eligible for loan repayment as long as they practice as required under subdivision
146.2 2.

146.3 (b) For hospital nurses, the commissioner of health shall select applicants each year for
146.4 participation in the hospital nursing education loan forgiveness program, within limits of
146.5 available funding for hospital nurses. Applicants are responsible for applying for and
146.6 maintaining eligibility for the PSLF program. For each year that a participant meets the
146.7 eligibility requirements described in subdivision 3, the commissioner shall make an annual
146.8 disbursement directly to the participant in an amount equal to the minimum loan payments
146.9 required to be paid by the participant under the participant's repayment plan established for
146.10 the participant under the PSLF program for the previous loan year. Before receiving the
146.11 annual loan repayment disbursement, the participant must complete and return to the
146.12 commissioner a confirmation of practice form provided by the commissioner, verifying that
146.13 the participant continues to meet the eligibility requirements under subdivision 3. The
146.14 participant must provide the commissioner with verification that the full amount of loan
146.15 repayment disbursement received by the participant has been applied toward the loan for
146.16 which forgiveness is sought under the PSLF program.

146.17 (c) For each year that a participant who is a nurse and who has agreed to teach according
146.18 to subdivision 2 meets the teaching obligation required in subdivision 3, the commissioner
146.19 shall make annual disbursements directly to the participant equivalent to 15 percent of the
146.20 average annual educational debt for indebted graduates in the nursing profession in the year
146.21 closest to the participant's selection for which information is available, not to exceed the
146.22 balance of the participant's qualifying educational loans.

146.23 Sec. 51. Minnesota Statutes 2022, section 144.1501, subdivision 5, is amended to read:

146.24 Subd. 5. **Penalty for nonfulfillment.** If a participant does not fulfill the required
146.25 minimum commitment of service according to subdivision 3, or for hospital nurses, if the
146.26 secretary of education determines that the participant does not meet eligibility requirements
146.27 for the PSLF, the commissioner of health shall collect from the participant the total amount
146.28 paid to the participant under the loan forgiveness program plus interest at a rate established
146.29 according to section 270C.40. The commissioner shall deposit the money collected in the
146.30 health care access fund to be credited to the health professional education loan forgiveness
146.31 program account established in subdivision 2. The commissioner shall allow waivers of all
146.32 or part of the money owed the commissioner as a result of a nonfulfillment penalty if
146.33 emergency circumstances prevented fulfillment of the minimum service commitment, or

147.1 for hospital nurses, if the PSLF program is discontinued before the participant's service
147.2 commitment is fulfilled.

147.3 Sec. 52. [144.1504] EMPLOYEE RECRUITMENT EDUCATION LOAN
147.4 FORGIVENESS PROGRAM.

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

147.7 (b) "Advanced practice registered nurse" has the meaning given in section 148.171,
147.8 subdivision 3.

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

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

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

147.17 (f) "Physician assistant" means a person licensed under chapter 147A.

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

147.21 Subd. 2. Creation of account. (a) A health professional employee education loan
147.22 forgiveness program account is established. The commissioner of health shall use money
147.23 from the account to make grants to eligible providers for a loan forgiveness recruitment and
147.24 retention program. Nominations for loan forgiveness through a grant shall be available to
147.25 employees who are advanced practice registered nurses, physicians, or physician assistants
147.26 who agree to practice in designated rural areas that are included in a health profession's
147.27 shortage area, where the provider rate per 10,000 population is less than ten and the vacancy
147.28 rate has reached a level determined by the commissioner.

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

148.1 Subd. 3. **Eligibility.** (a) Eligible providers must provide services in designated rural
148.2 areas that are included in a health profession's shortage area where the provider rate per
148.3 10,000 population is less than ten and the vacancy rate has reached a level determined by
148.4 the commissioner for advanced practice registered nurses, physicians, or physician assistants.

148.5 (b) Employees, as described in subdivision 2, paragraph (a), selected to receive loan
148.6 forgiveness must agree to work a minimum average of 30 hours per week for a minimum
148.7 of five years for a qualifying provider organization to maintain eligibility for loan forgiveness
148.8 under this section.

148.9 Subd. 4. **Request for proposals.** The commissioner shall publish request for proposals
148.10 that specify qualifying provider eligibility requirements; criteria for a qualifying employee
148.11 loan forgiveness recruitment program; provider selection criteria; documentation required
148.12 for program participation; maximum number of loan forgiveness slots available per eligible
148.13 provider; and methods of evaluation. The commissioner must publish additional requests
148.14 for proposals each year in which funding is available for this purpose.

148.15 Subd. 5. **Application requirements.** (a) Eligible providers seeking loan forgiveness for
148.16 employees shall submit an application to the commissioner. Applications from eligible
148.17 providers must contain a complete description of the employee loan forgiveness program
148.18 being proposed by the applicant, the process for determining which employees are eligible
148.19 for loan forgiveness, and any special circumstances related to the provider that make it
148.20 difficult to recruit and retain qualified employees. Eligible providers must submit the names
148.21 of their employees to be considered for loan forgiveness.

148.22 (b) An employee whose name has been submitted to the commissioner and who wishes
148.23 to apply for loan forgiveness must submit an application to the commissioner that must
148.24 include employee practice site information and verification of employee qualified educational
148.25 loan debt. The employee is responsible for securing the employee's qualified educational
148.26 loans.

148.27 Subd. 6. **Selection process.** The commissioner shall determine a maximum number of
148.28 loan forgiveness slots available per eligible provider and shall make selections based on the
148.29 information provided in the grant application, including the demonstrated need for an
148.30 applicant provider to enhance the retention of its workforce, the proposed employee loan
148.31 forgiveness selection process, and other criteria as determined by the commissioner.

148.32 Subd. 7. **Reporting requirements.** (a) Participating providers whose employees receive
148.33 loan forgiveness shall submit a report to the commissioner on a schedule determined by the
148.34 commissioner and on a form supplied by the commissioner. The report must include the

149.1 number of employees receiving loan forgiveness and, for each employee receiving loan
149.2 forgiveness, the employee's name, current position, and average number of hours worked
149.3 per week. During the loan forgiveness period, the commissioner may require and collect
149.4 from participating providers and employees receiving loan forgiveness other information
149.5 necessary to evaluate the program and ensure ongoing eligibility.

149.6 (b) Before receiving loan repayment disbursements, the employee must complete and
149.7 return to the commissioner a confirmation of practice form provided by the commissioner
149.8 verifying that the employee is practicing as required in subdivision 3. The employee must
149.9 provide the commissioner with verification that the full amount of loan repayment
149.10 disbursement received by the employee has been applied toward the designated loans. After
149.11 each disbursement, verification must be received by the commissioner and approved before
149.12 the next loan repayment disbursement is made. Employees who move to a different eligible
149.13 provider remain eligible for loan repayment as long as they practice as required in subdivision
149.14 3.

149.15 Subd. 8. **Penalty for nonfulfillment.** If an employee does not fulfill the required
149.16 minimum service commitment in subdivision 3, the commissioner shall collect from the
149.17 employee the total amount paid to the employee under the loan forgiveness program, plus
149.18 interest at a rate established according to section 270C.40. The commissioner shall deposit
149.19 the money collected in an account in the special revenue fund and money in that account
149.20 is annually appropriated to the commissioner for purposes of this section. The commissioner
149.21 may allow waivers of all or part of the money owed to the commissioner as a result of a
149.22 nonfulfillment penalty if emergency circumstances prevented fulfillment of the minimum
149.23 service commitment.

149.24 Subd. 9. **Rules.** The commissioner may adopt rules to implement this section.

149.25 Sec. 53. Minnesota Statutes 2022, section 144.1505, is amended to read:

149.26 **144.1505 HEALTH PROFESSIONALS CLINICAL TRAINING EXPANSION**
149.27 **AND RURAL AND UNDERSERVED CLINICAL ROTATIONS GRANT PROGRAM**
149.28 **PROGRAMS.**

149.29 Subdivision 1. **Definitions.** For purposes of this section, the following definitions apply:

149.30 (1) "eligible advanced practice registered nurse program" means a program that is located
149.31 in Minnesota and is currently accredited as a master's, doctoral, or postgraduate level
149.32 advanced practice registered nurse program by the Commission on Collegiate Nursing

150.1 Education or by the Accreditation Commission for Education in Nursing, or is a candidate
150.2 for accreditation;

150.3 (2) "eligible dental therapy program" means a dental therapy education program or
150.4 advanced dental therapy education program that is located in Minnesota and is either:

150.5 (i) approved by the Board of Dentistry; or

150.6 (ii) currently accredited by the Commission on Dental Accreditation;

150.7 (3) "eligible mental health professional program" means a program that is located in
150.8 Minnesota and is listed as a mental health professional program by the appropriate accrediting
150.9 body for clinical social work, psychology, marriage and family therapy, or licensed
150.10 professional clinical counseling, or is a candidate for accreditation;

150.11 (4) "eligible pharmacy program" means a program that is located in Minnesota and is
150.12 currently accredited as a doctor of pharmacy program by the Accreditation Council on
150.13 Pharmacy Education;

150.14 (5) "eligible physician assistant program" means a program that is located in Minnesota
150.15 and is currently accredited as a physician assistant program by the Accreditation Review
150.16 Commission on Education for the Physician Assistant, or is a candidate for accreditation;

150.17 (6) "mental health professional" means an individual providing clinical services in the
150.18 treatment of mental illness who meets one of the qualifications under section 245.462,
150.19 subdivision 18; ~~and~~

150.20 (7) "eligible physician training program" means a physician residency training program
150.21 located in Minnesota and that is currently accredited by the accrediting body or has presented
150.22 a credible plan as a candidate for accreditation;

150.23 (8) "eligible dental program" means a dental education program or a dental residency
150.24 training program located in Minnesota and that is currently accredited by the accrediting
150.25 body or has presented a credible plan as a candidate for accreditation; and

150.26 ~~(7)~~ (9) "project" means a project to establish or expand clinical training for physician
150.27 assistants, advanced practice registered nurses, pharmacists, dental therapists, advanced
150.28 dental therapists, or mental health professionals in Minnesota.

150.29 Subd. 2. ~~Program Programs.~~ (a) For advanced practice provider clinical training
150.30 expansion grants, the commissioner of health shall award health professional training site
150.31 grants to eligible physician assistant, advanced practice registered nurse, pharmacy, dental
150.32 therapy, and mental health professional programs to plan and implement expanded clinical

151.1 training. A planning grant shall not exceed \$75,000, and a training grant shall not exceed
 151.2 \$150,000 for the first year, \$100,000 for the second year, and \$50,000 for the third year per
 151.3 program.

151.4 (b) For health professional rural and underserved clinical rotations grants, the
 151.5 commissioner of health shall award health professional training site grants to eligible
 151.6 physician, physician assistant, advanced practice registered nurse, pharmacy, dentistry,
 151.7 dental therapy, and mental health professional programs to augment existing clinical training
 151.8 programs to add rural and underserved rotations or clinical training experiences, such as
 151.9 credential or certificate rural tracks or other specialized training. For physician and dentist
 151.10 training, the expanded training must include rotations in primary care settings such as
 151.11 community clinics, hospitals, health maintenance organizations, or practices in rural
 151.12 communities.

151.13 ~~(b)~~ (c) Funds may be used for:

151.14 (1) establishing or expanding rotations and clinical training for ~~physician assistants,~~
 151.15 ~~advanced practice registered nurses, pharmacists, dental therapists, advanced dental therapists,~~
 151.16 ~~and mental health professionals in Minnesota;~~

151.17 (2) recruitment, training, and retention of students and faculty;

151.18 (3) connecting students with appropriate clinical training sites, internships, practicums,
 151.19 or externship activities;

151.20 (4) travel and lodging for students;

151.21 (5) faculty, student, and preceptor salaries, incentives, or other financial support;

151.22 (6) development and implementation of cultural competency training;

151.23 (7) evaluations;

151.24 (8) training site improvements, fees, equipment, and supplies required to establish,
 151.25 maintain, or expand a ~~physician assistant, advanced practice registered nurse, pharmacy,~~
 151.26 ~~dental therapy, or mental health professional~~ training program; and

151.27 (9) supporting clinical education in which trainees are part of a primary care team model.

151.28 Subd. 3. **Applications.** Eligible physician assistant, advanced practice registered nurse,
 151.29 pharmacy, dental therapy, and mental health professional programs and physician and dental
 151.30 programs seeking a grant shall apply to the commissioner. Applications must include a
 151.31 description of the number of additional students who will be trained using grant funds;
 151.32 attestation that funding will be used to support an increase in the number of clinical training

152.1 slots; a description of the problem that the proposed project will address; a description of
152.2 the project, including all costs associated with the project, sources of funds for the project,
152.3 detailed uses of all funds for the project, and the results expected; and a plan to maintain or
152.4 operate any component included in the project after the grant period. The applicant must
152.5 describe achievable objectives, a timetable, and roles and capabilities of responsible
152.6 individuals in the organization. Applicants applying under subdivision 2, paragraph (b),
152.7 must include information about length of training and training site settings, geographic
152.8 location of rural sites, and rural populations expected to be served.

152.9 **Subd. 4. Consideration of applications.** The commissioner shall review each application
152.10 to determine whether or not the application is complete and whether the program and the
152.11 project are eligible for a grant. In evaluating applications, the commissioner shall score each
152.12 application based on factors including, but not limited to, the applicant's clarity and
152.13 thoroughness in describing the project and the problems to be addressed, the extent to which
152.14 the applicant has demonstrated that the applicant has made adequate provisions to ensure
152.15 proper and efficient operation of the training program once the grant project is completed,
152.16 the extent to which the proposed project is consistent with the goal of increasing access to
152.17 primary care and mental health services for rural and underserved urban communities, the
152.18 extent to which the proposed project incorporates team-based primary care, and project
152.19 costs and use of funds.

152.20 **Subd. 5. Program oversight.** The commissioner shall determine the amount of a grant
152.21 to be given to an eligible program based on the relative score of each eligible program's
152.22 application, including rural locations as applicable under subdivision 2, paragraph (b), other
152.23 relevant factors discussed during the review, and the funds available to the commissioner.
152.24 Appropriations made to the program do not cancel and are available until expended. During
152.25 the grant period, the commissioner may require and collect from programs receiving grants
152.26 any information necessary to evaluate the program.

152.27 **Sec. 54. [144.1507] PRIMARY CARE RESIDENCY TRAINING GRANT**
152.28 **PROGRAM.**

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

152.31 (b) "Eligible program" means a program that meets the following criteria:

152.32 (1) is located in Minnesota;

153.1 (2) trains medical residents in the specialties of family medicine, general internal
153.2 medicine, general pediatrics, psychiatry, geriatrics, or general surgery in rural residency
153.3 training programs or in community-based ambulatory care centers that primarily serve the
153.4 underserved; and

153.5 (3) is accredited by the Accreditation Council for Graduate Medical Education or presents
153.6 a credible plan to obtain accreditation.

153.7 (c) "Rural residency training program" means a residency program that provides an
153.8 initial year of training in an accredited residency program in Minnesota. The subsequent
153.9 years of the residency program are based in rural communities, utilizing local clinics and
153.10 community hospitals, with specialty rotations in nearby regional medical centers.

153.11 (d) "Community-based ambulatory care centers" means federally qualified health centers,
153.12 community mental health centers, rural health clinics, health centers operated by the Indian
153.13 Health Service, an Indian Tribe or Tribal organization, or an urban American Indian
153.14 organization or an entity receiving funds under Title X of the Public Health Service Act.

153.15 (e) "Eligible project" means a project to establish and maintain a rural residency training
153.16 program.

153.17 **Subd. 2. Rural residency training program.** (a) The commissioner of health shall
153.18 award rural residency training program grants to eligible programs to plan, implement, and
153.19 sustain rural residency training programs. A rural residency training program grant shall
153.20 not exceed \$250,000 per year for up to three years for planning and development, and
153.21 \$225,000 per resident per year for each year thereafter to sustain the program.

153.22 (b) Funds may be spent to cover the costs of:

153.23 (1) planning related to establishing accredited rural residency training programs;

153.24 (2) obtaining accreditation by the Accreditation Council for Graduate Medical Education
153.25 or another national body that accredits rural residency training programs;

153.26 (3) establishing new rural residency training programs;

153.27 (4) recruitment, training, and retention of new residents and faculty related to the new
153.28 rural residency training program;

153.29 (5) travel and lodging for new residents;

153.30 (6) faculty, new resident, and preceptor salaries related to new rural residency training
153.31 programs;

154.1 (7) training site improvements, fees, equipment, and supplies required for new rural
154.2 residency training programs; and

154.3 (8) supporting clinical education in which trainees are part of a primary care team model.

154.4 **Subd. 3. Applications for rural residency training program grants.** Eligible programs
154.5 seeking a grant shall apply to the commissioner. Applications must include the number of
154.6 new primary care rural residency training program slots planned, under development or
154.7 under contract; a description of the training program, including location of the established
154.8 residency program and rural training sites; a description of the project, including all costs
154.9 associated with the project; all sources of funds for the project; detailed uses of all funds
154.10 for the project; the results expected; proof of eligibility for federal graduate medical education
154.11 funding, if applicable; and a plan to seek the funding. The applicant must describe achievable
154.12 objectives, a timetable, and the roles and capabilities of responsible individuals in the
154.13 organization.

154.14 **Subd. 4. Consideration of grant applications.** The commissioner shall review each
154.15 application to determine if the residency program application is complete, if the proposed
154.16 rural residency program and residency slots are eligible for a grant, and if the program is
154.17 eligible for federal graduate medical education funding, and when the funding is available.
154.18 If eligible programs are not eligible for federal graduate medical education funding, the
154.19 commissioner may award continuation funding to the eligible program beyond the initial
154.20 grant period. The commissioner shall award grants to support training programs in family
154.21 medicine, general internal medicine, general pediatrics, psychiatry, geriatrics, general
154.22 surgery, and other primary care focus areas.

154.23 **Subd. 5. Program oversight.** During the grant period, the commissioner may require
154.24 and collect from grantees any information necessary to evaluate the program. Notwithstanding
154.25 section 16A.28, subdivision 6, encumbrances for grants under this section issued by June
154.26 30 of each year may be certified for a period of up to three years beyond the year in which
154.27 the funds were originally appropriated.

154.28 **Sec. 55. [144.1508] CLINICAL HEALTH CARE TRAINING.**

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

154.31 (b) "Accredited clinical training" means the clinical training provided by a medical
154.32 education program that is accredited through an organization recognized by the Department
154.33 of Education, the Centers for Medicare and Medicaid Services, or another national body

155.1 that reviews the accrediting organizations for multiple disciplines and whose standards for
155.2 recognizing accrediting organizations are reviewed and approved by the commissioner of
155.3 health.

155.4 (c) "Clinical medical education program" means the accredited clinical training of
155.5 physicians, medical students, residents, doctors of pharmacy practitioners, doctors of
155.6 chiropractic, dentists, advanced practice nurses, clinical nurse specialists, certified registered
155.7 nurse anesthetists, nurse practitioners, certified nurse midwives, physician assistants, dental
155.8 therapists and advanced dental therapists, psychologists, clinical social workers, community
155.9 paramedics, community health workers, and other medical professions as determined by
155.10 the commissioner.

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

155.12 (e) "Eligible entity" means an organization that is located in Minnesota, provides a
155.13 clinical medical education experience, and hosts students, residents, or other trainee types
155.14 as determined by the commissioner, and is from an accredited Minnesota teaching program
155.15 and institution.

155.16 (f) "Eligible trainee FTEs" means the number of trainees, as measured by full-time
155.17 equivalent counts, that are training in Minnesota at an entity with either currently active
155.18 medical assistance enrollment status and a National Provider Identification (NPI) number
155.19 or documentation that they provide sliding fee services. Training may occur in an inpatient
155.20 or ambulatory patient care setting or alternative setting as determined by the commissioner.
155.21 Training that occurs in nursing facility settings is not eligible for funding under this section.

155.22 (g) "Teaching institution" means a hospital, medical center, clinic, or other organization
155.23 that conducts a clinical medical education program in Minnesota that is accountable to the
155.24 accrediting body.

155.25 (h) "Trainee" means a student, resident, fellow, or other postgraduate involved in a
155.26 clinical medical education program from an accredited Minnesota teaching program and
155.27 institution.

155.28 Subd. 2. **Application process.** (a) An eligible entity hosting clinical trainees from a
155.29 clinical medical education program and teaching institution is eligible for funds under
155.30 subdivision 3, if the entity:

155.31 (1) is funded in part by sliding fee scale services or enrolled in the Minnesota health
155.32 care program;

156.1 (2) faces increased financial pressure as a result of competition with nonteaching patient
156.2 care entities; and

156.3 (3) emphasizes primary care or specialties that are in undersupply in rural or underserved
156.4 areas of Minnesota.

156.5 (b) An entity hosting a clinical medical education program for advanced practice nursing
156.6 is eligible for funds under subdivision 3, if the program meets the eligibility requirements
156.7 in paragraph (a), clauses (1) to (3), and is sponsored by the University of Minnesota
156.8 Academic Health Center, the Mayo Foundation, or an institution that is part of the Minnesota
156.9 State Colleges and Universities system or members of the Minnesota Private College Council.

156.10 (c) An application must be submitted to the commissioner by an eligible entity through
156.11 the teaching institution and contain the following information:

156.12 (1) the official name and address and the site addresses of the clinical medical education
156.13 programs where eligible trainees are hosted;

156.14 (2) the name, title, and business address of those persons responsible for administering
156.15 the funds;

156.16 (3) for each applicant, the type and specialty orientation of trainees in the program; the
156.17 name, entity address, medical assistance provider number, and national provider identification
156.18 number of each training site used in the program, as appropriate; the federal tax identification
156.19 number of each training site, where available; the total number of eligible trainee FTEs at
156.20 each site; and

156.21 (4) other supporting information the commissioner deems necessary.

156.22 (d) An applicant that does not provide information requested by the commissioner shall
156.23 not be eligible for funds for the current funding cycle.

156.24 Subd. 3. **Distribution of funds.** (a) The commissioner may distribute funds for clinical
156.25 training in areas of Minnesota and for the professions listed in subdivision 1, paragraph (c),
156.26 determined by the commissioner as a high need area and profession shortage area. The
156.27 commissioner shall annually distribute medical education funds to qualifying applicants
156.28 under this section based on the costs to train, service level needs, and profession or training
156.29 site shortages. Use of funds is limited to related clinical training costs for eligible programs.

156.30 (b) To ensure the quality of clinical training, eligible entities must demonstrate that they
156.31 hold contracts in good standing with eligible educational institutions that specify the terms,
156.32 expectations, and outcomes of the clinical training conducted at sites. Funds shall be
156.33 distributed in an administrative process determined by the commissioner to be efficient.

157.1 Subd. 4. Report. (a) Teaching institutions receiving funds under this section must sign
157.2 and submit a medical education grant verification report (GVR) to verify funding was
157.3 distributed as specified in the GVR. If the teaching institution fails to submit the GVR by
157.4 the stated deadline, the teaching institution is required to return the full amount of funds
157.5 received to the commissioner within 30 days of receiving notice from the commissioner.
157.6 The commissioner shall distribute returned funds to the appropriate training sites in
157.7 accordance with the commissioner's approval letter.

157.8 (b) Teaching institutions receiving funds under this section must provide any other
157.9 information the commissioner deems appropriate to evaluate the effectiveness of the use of
157.10 funds for medical education.

157.11 Sec. 56. Minnesota Statutes 2022, section 144.2151, is amended to read:

157.12 **144.2151 FETAL DEATH RECORD AND CERTIFICATE OF BIRTH**
157.13 **RESULTING IN STILLBIRTH.**

157.14 Subdivision 1. **Filing Registration.** A fetal death record of birth for each birth resulting
157.15 in a stillbirth in this state, on or after August 1, 2005, must be established for which a each
157.16 fetal death report is required reported and registered under section 144.222, subdivision 1;
157.17 shall be filed with the state registrar within five days after the birth if the parent or parents
157.18 of the stillbirth request to have a record of birth resulting in stillbirth prepared.

157.19 Subd. 2. **Information to parents.** The party responsible for filing a fetal death report
157.20 under section 144.222, subdivision 1, shall advise the parent or parents of a stillbirth:

157.21 (1) that they may request preparation of a record of birth resulting in stillbirth;

157.22 (2) that preparation of the record is optional; and

157.23 (3) how to obtain a certified copy of the record if one is requested and prepared.

157.24 (1) that the parent or parents may choose to provide a full name or provide only a last
157.25 name for the record;

157.26 (2) that the parent or parents may request a certificate of birth resulting in stillbirth after
157.27 the fetal death record is established;

157.28 (3) that the parent who gave birth may request an informational copy of the fetal death
157.29 record; and

157.30 (4) that the parent or parents named on the fetal death record and the party responsible
157.31 for reporting the fetal death may correct or amend the record to protect the integrity and
157.32 accuracy of vital records.

158.1 Subd. 3. **Preparation Responsibilities of the state registrar.** ~~(a) Within five days after~~
158.2 ~~delivery of a stillbirth, the parent or parents of the stillbirth may prepare and file the record~~
158.3 ~~with the state registrar if the parent or parents of the stillbirth, after being advised as provided~~
158.4 ~~in subdivision 2, request to have a record of birth resulting in stillbirth prepared.~~

158.5 ~~(b) If the parent or parents of the stillbirth do not choose to provide a full name for the~~
158.6 ~~stillbirth, the parent or parents may choose to file only a last name.~~

158.7 ~~(c) Either parent of the stillbirth or, if neither parent is available, another person with~~
158.8 ~~knowledge of the facts of the stillbirth shall attest to the accuracy of the personal data entered~~
158.9 ~~on the record in time to permit the filing of the record within five days after delivery.~~

158.10 The state registrar shall:

158.11 (1) prescribe the process to:

158.12 (i) register a fetal death;

158.13 (ii) request the certificate of birth resulting in stillbirth; and

158.14 (iii) request the informational copy of a fetal death record;

158.15 (2) prescribe a standardized format for the certificate of birth resulting in stillbirth, which
158.16 shall integrate security features and be as similar as possible to a birth certificate;

158.17 (3) issue a certificate of birth resulting in stillbirth or a statement of no vital record found
158.18 to the parent or parents named on the fetal death record upon the parent's proper completion
158.19 of an attestation provided by the commissioner and payment of the required fee;

158.20 (4) correct or amend the fetal death record upon a request from the parent who gave
158.21 birth, parents, or the person who registered the fetal death or filed the report; and

158.22 (5) refuse to amend or correct the fetal death record when an applicant does not submit
158.23 the minimum documentation required to amend the record or when the state registrar has
158.24 cause to question the validity or completeness of the applicant's statements or any
158.25 documentary evidence and the deficiencies are not corrected. The state registrar shall advise
158.26 the applicant of the reason for this action and shall further advise the applicant of the right
158.27 of appeal to a court with competent jurisdiction over the Department of Health.

158.28 Subd. 4. **Retroactive application Delayed registration.** ~~Notwithstanding subdivisions~~
158.29 ~~1 to 3, If a birth that fetal death occurred in this state at any time resulted in a stillbirth for~~
158.30 ~~which a fetal death report was required under section 144.222, subdivision 1, but a record~~
158.31 ~~of birth resulting in stillbirth was not prepared under subdivision 3, a parent of the stillbirth~~
158.32 ~~may submit to the state registrar, on or after August 1, 2005, a written request for preparation~~

159.1 ~~of a record of birth resulting in stillbirth and evidence of the facts of the stillbirth in the~~
 159.2 ~~form and manner specified by the state registrar. The state registrar shall prepare and file~~
 159.3 ~~the record of birth resulting in stillbirth within 30 days after receiving satisfactory evidence~~
 159.4 ~~of the facts of the stillbirth.~~ fetal death was not registered and a record was not established,
 159.5 a person responsible for registering the fetal death, the medical examiner or coroner with
 159.6 jurisdiction, or a parent may submit to the state registrar a written request to register the
 159.7 fetal death and submit the evidence to support the request.

159.8 ~~Subd. 5. Responsibilities of state registrar.~~ The state registrar shall:

159.9 ~~(1) prescribe the form of and information to be included on a record of birth resulting~~
 159.10 ~~in stillbirth, which shall be as similar as possible to the form of and information included~~
 159.11 ~~on a record of birth;~~

159.12 ~~(2) prescribe the form of and information to be provided by the parent of a stillbirth~~
 159.13 ~~requesting a record of birth resulting in stillbirth under subdivisions 3 and 4 and make this~~
 159.14 ~~form available on the Department of Health's website;~~

159.15 ~~(3) issue a certified copy of a record of birth resulting in stillbirth to a parent of the~~
 159.16 ~~stillbirth that is the subject of the record if:~~

159.17 ~~(i) a record of birth resulting in stillbirth has been prepared and filed under subdivision~~
 159.18 ~~3 or 4; and~~

159.19 ~~(ii) the parent requesting a certified copy of the record submits the request in writing;~~
 159.20 ~~and~~

159.21 ~~(4) create and implement a process for entering, preparing, and handling stillbirth records~~
 159.22 ~~identical or as close as possible to the processes for birth and fetal death records when~~
 159.23 ~~feasible, but no later than the date on which the next reprogramming of the Department of~~
 159.24 ~~Health's database for vital records is completed.~~

159.25 Sec. 57. Minnesota Statutes 2022, section 144.222, is amended to read:

159.26 **144.222 FETAL DEATH REPORTS OF FETAL OR INFANT DEATH AND**
 159.27 **REGISTRATION.**

159.28 Subdivision 1. **Fetal death report required.** A fetal death report must be filed registered
 159.29 or reported within five days of the death of a fetus for whom 20 or more weeks of gestation
 159.30 have elapsed, except for abortions defined under section 145.4241. A fetal death report ~~must~~
 159.31 ~~be prepared~~ must be registered or reported in a format prescribed by the state registrar and
 159.32 filed in accordance with Minnesota Rules, parts 4601.0100 to 4601.2600 by:

160.1 (1) a person in charge of an institution or that person's authorized designee if a fetus is
160.2 delivered in the institution or en route to the institution;

160.3 (2) a physician, certified nurse midwife, or other licensed medical personnel in attendance
160.4 at or immediately after the delivery if a fetus is delivered outside an institution; or

160.5 (3) a parent or other person in charge of the disposition of the remains if a fetal death
160.6 occurred without medical attendance at or immediately after the delivery.

160.7 ~~Subd. 2. Sudden infant death. Each infant death which is diagnosed as sudden infant~~
160.8 ~~death syndrome shall be reported within five days to the state registrar.~~

160.9 Sec. 58. Minnesota Statutes 2022, section 144.222, subdivision 1, is amended to read:

160.10 Subdivision 1. **Fetal death report required.** A fetal death report must be filed within
160.11 five days of the death of a fetus for whom 20 or more weeks of gestation have elapsed,
160.12 except for abortions defined under section ~~145.4241~~ 145.411, subdivision 5. A fetal death
160.13 report must be prepared in a format prescribed by the state registrar and filed in accordance
160.14 with Minnesota Rules, parts 4601.0100 to 4601.2600 by:

160.15 (1) a person in charge of an institution or that person's authorized designee if a fetus is
160.16 delivered in the institution or en route to the institution;

160.17 (2) a physician, certified nurse midwife, or other licensed medical personnel in attendance
160.18 at or immediately after the delivery if a fetus is delivered outside an institution; or

160.19 (3) a parent or other person in charge of the disposition of the remains if a fetal death
160.20 occurred without medical attendance at or immediately after the delivery.

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

160.22 Sec. 59. Minnesota Statutes 2022, section 144.226, subdivision 3, is amended to read:

160.23 Subd. 3. **Birth record surcharge.** (a) In addition to any fee prescribed under subdivision
160.24 1, there shall be a nonrefundable surcharge of \$3 for each certified birth or stillbirth record
160.25 and for a certification that the vital record cannot be found. The state registrar or local
160.26 issuance office shall forward this amount to the commissioner of management and budget
160.27 each month following the collection of the surcharge for deposit into the account for the
160.28 children's trust fund for the prevention of child abuse established under section 256E.22.
160.29 This surcharge shall not be charged under those circumstances in which no fee for a certified
160.30 birth or stillbirth record is permitted under subdivision 1, paragraph (b). Upon certification

161.1 by the commissioner of management and budget that the assets in that fund exceed
161.2 \$20,000,000, this surcharge shall be discontinued.

161.3 (b) In addition to any fee prescribed under subdivision 1, there shall be a nonrefundable
161.4 surcharge of \$10 for each certified birth record. The state registrar or local issuance office
161.5 shall forward this amount to the commissioner of management and budget each month
161.6 following the collection of the surcharge for deposit in the general fund.

161.7 Sec. 60. Minnesota Statutes 2022, section 144.226, subdivision 4, is amended to read:

161.8 Subd. 4. **Vital records surcharge.** In addition to any fee prescribed under subdivision
161.9 1, there is a nonrefundable surcharge of \$4 for each certified and noncertified birth, stillbirth,
161.10 or death record, and for a certification that the record cannot be found. The local issuance
161.11 office or state registrar shall forward this amount to the commissioner of management and
161.12 budget each month following the collection of the surcharge to be deposited into the state
161.13 government special revenue fund.

161.14 Sec. 61. **[144.3431] NONRESIDENTIAL MENTAL HEALTH SERVICES.**

161.15 A minor who is age 16 or older may give effective consent for nonresidential mental
161.16 health services, and the consent of no other person is required. For purposes of this section,
161.17 "nonresidential mental health services" means outpatient services as defined in section
161.18 245.4871, subdivision 29, provided to a minor who is not residing in a hospital, inpatient
161.19 unit, or licensed residential treatment facility or program.

161.20 Sec. 62. Minnesota Statutes 2022, section 144.382, is amended by adding a subdivision
161.21 to read:

161.22 Subd. 2a. **Connector.** "Connector" means gooseneck, pigtail, and other service line
161.23 connectors. A connector is typically a short section of piping not exceeding two feet that
161.24 can be bent and used for connections between rigid service piping.

161.25 Sec. 63. Minnesota Statutes 2022, section 144.382, is amended by adding a subdivision
161.26 to read:

161.27 Subd. 3a. **Galvanized requiring replacement.** "Galvanized requiring replacement"
161.28 means a galvanized service line that is or was at any time connected to a lead service line
161.29 or lead status unknown service line, or is currently or was previously affixed to a lead
161.30 connector. The majority of galvanized service lines fall under this category.

162.1 Sec. 64. Minnesota Statutes 2022, section 144.382, is amended by adding a subdivision
162.2 to read:

162.3 Subd. 3b. **Galvanized service line.** "Galvanized service line" means a service line made
162.4 of iron or piping that has been dipped in zinc to prevent corrosion and rusting.

162.5 Sec. 65. Minnesota Statutes 2022, section 144.382, is amended by adding a subdivision
162.6 to read:

162.7 Subd. 3c. **Lead connector.** "Lead connector" means a connector made of lead.

162.8 Sec. 66. Minnesota Statutes 2022, section 144.382, is amended by adding a subdivision
162.9 to read:

162.10 Subd. 3d. **Lead service line.** "Lead service line" means a portion of pipe that is made
162.11 of lead, which connects the water main to the building inlet. A lead service line may be
162.12 owned by the water system, by the property owner, or both.

162.13 Sec. 67. Minnesota Statutes 2022, section 144.382, is amended by adding a subdivision
162.14 to read:

162.15 Subd. 3e. **Lead status unknown service line or unknown service line.** "Lead status
162.16 unknown service line" or "unknown service line" means a service line that has not been
162.17 demonstrated to meet or does not meet the definition of lead free in section 1417 of the Safe
162.18 Drinking Water Act.

162.19 Sec. 68. Minnesota Statutes 2022, section 144.382, is amended by adding a subdivision
162.20 to read:

162.21 Subd. 3f. **Nonlead service line.** "Nonlead service line" means a service line determined
162.22 through an evidence-based record, method, or technique not to be a lead service line or
162.23 galvanized service line requiring replacement. Most nonlead service lines are made of copper
162.24 or plastic.

162.25 Sec. 69. Minnesota Statutes 2022, section 144.382, is amended by adding a subdivision
162.26 to read:

162.27 Subd. 4a. **Service line.** "Service line" means a portion of pipe that connects the water
162.28 main to the building inlet. A service line may be owned by the water system, by the property
162.29 owner, or both. A service line may be made of many materials, such as lead, copper,
162.30 galvanized steel, or plastic.

163.1 **Sec. 70. [144.3853] CLASSIFICATION OF SERVICE LINES.**

163.2 **Subdivision 1. Classification of lead status of service line.** (a) A water system may
163.3 classify the actual material of a service line, such as copper or plastic, as an alternative to
163.4 classifying the service line as a nonlead service line, for the purpose of the lead service line
163.5 inventory.

163.6 (b) It is not necessary to physically verify the material composition, such as copper or
163.7 plastic, of a service line for its lead status to be identified. For example, if records demonstrate
163.8 the service line was installed after a municipal, state, or federal ban on the installation of
163.9 lead service lines, the service line may be classified as a nonlead service line.

163.10 **Subd. 2. Lead connector.** For the purposes of the lead service line inventory and lead
163.11 service line replacement plan, if a service line has a lead connector, the service line shall
163.12 be classified as a lead service line or a galvanized service line requiring replacement.

163.13 **Subd. 3. Galvanized service line.** A galvanized service line may only be classified as
163.14 a nonlead service line if there is documentation verifying it was never connected to a lead
163.15 service line or lead connector. Rarely will a galvanized service line be considered a nonlead
163.16 service line.

163.17 **Sec. 71. [144.398] TOBACCO USE PREVENTION ACCOUNT; ESTABLISHMENT**
163.18 **AND USES.**

163.19 **Subdivision 1. Definitions.** (a) As used in this section, the terms in this subdivision have
163.20 the meanings given.

163.21 (b) "Electronic delivery device" has the meaning given in section 609.685, subdivision
163.22 1, paragraph (c).

163.23 (c) "Nicotine delivery product" has the meaning given in section 609.6855, subdivision
163.24 1, paragraph (c).

163.25 (d) "Tobacco" has the meaning given in section 609.685, subdivision 1, paragraph (a).

163.26 (e) "Tobacco-related devices" has the meaning given in section 609.685, subdivision 1,
163.27 paragraph (b).

163.28 **Subd. 2. Account created.** A tobacco use prevention account is created in the special
163.29 revenue fund. Pursuant to section 16A.151, subdivision 2, paragraph (h), the commissioner
163.30 of management and budget shall deposit into the account any money received by the state
163.31 resulting from a settlement agreement or an assurance of discontinuance entered into by the
163.32 attorney general of the state, or a court order in litigation brought by the attorney general

164.1 of the state on behalf of the state or a state agency related to alleged violations of consumer
164.2 fraud laws in the marketing, sale, or distribution of electronic nicotine delivery systems in
164.3 this state or other alleged illegal actions that contributed to the exacerbation of youth nicotine
164.4 use.

164.5 Subd. 3. Appropriations from tobacco use prevention account. (a) Each fiscal year,
164.6 the amount of money in the tobacco use prevention account is appropriated to the
164.7 commissioner of health for:

164.8 (1) tobacco and electronic delivery device use prevention and cessation projects consistent
164.9 with the duties specified in section 144.392;

164.10 (2) a public information program under section 144.393;

164.11 (3) the development of health promotion and health education materials about tobacco
164.12 and electronic delivery device use prevention and cessation;

164.13 (4) tobacco and electronic delivery device use prevention activities under section 144.396;
164.14 and

164.15 (5) statewide tobacco cessation services under section 144.397.

164.16 (b) In activities funded under this subdivision, the commissioner of health must:

164.17 (1) prioritize preventing persons under the age of 21 from using commercial tobacco,
164.18 electronic delivery devices, tobacco-related devices, and nicotine delivery products;

164.19 (2) promote racial and health equity; and

164.20 (3) use strategies that are evidence-based or based on promising practices.

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

164.22 Sec. 72. Minnesota Statutes 2022, section 144.55, subdivision 3, is amended to read:

164.23 Subd. 3. **Standards for licensure.** (a) Notwithstanding the provisions of section 144.56,
164.24 for the purpose of hospital licensure, the commissioner of health shall use as minimum
164.25 standards the hospital certification regulations promulgated pursuant to title XVIII of the
164.26 Social Security Act, United States Code, title 42, section 1395, et seq. The commissioner
164.27 may use as minimum standards changes in the federal hospital certification regulations
164.28 promulgated after May 7, 1981, if the commissioner finds that such changes are reasonably
164.29 necessary to protect public health and safety. ~~The commissioner shall also promulgate in~~
164.30 ~~rules additional minimum standards for new construction.~~

165.1 (b) Hospitals must meet the applicable provisions of the 2022 edition of the Facility
165.2 Guidelines Institute *Guidelines for Design and Construction of Hospitals*. This minimum
165.3 design standard must be met for all new licenses, new construction, change of use, or change
165.4 of occupancy for which plan review packages are received on or after January 1, 2024.

165.5 (c) If the commissioner decides to update the edition of the guidelines specified in
165.6 paragraph (b) for purposes of this subdivision, the commissioner must notify the chairs and
165.7 ranking minority members of the legislative committees with jurisdiction over health care
165.8 and public safety of the planned update by January 15 of the year in which the new edition
165.9 will become effective. Following notice from the commissioner, the new edition shall
165.10 become effective for hospitals beginning August 1 of that year, unless otherwise provided
165.11 in law. The commissioner shall, by publication in the State Register, specify a date by which
165.12 hospitals must comply with the updated edition. The date by which hospitals must comply
165.13 shall not be sooner than 12 months after publication of the commissioner's notice in the
165.14 State Register and shall apply only to plan review packages received on or after that date.

165.15 (d) Hospitals shall be in compliance with all applicable state and local governing laws,
165.16 regulations, standards, ordinances, and codes for fire safety, building, and zoning
165.17 requirements.

165.18 ~~(b)~~ (e) Each hospital and outpatient surgical center shall establish policies and procedures
165.19 to prevent the transmission of human immunodeficiency virus and hepatitis B virus to
165.20 patients and within the health care setting. The policies and procedures shall be developed
165.21 in conformance with the most recent recommendations issued by the United States
165.22 Department of Health and Human Services, Public Health Service, Centers for Disease
165.23 Control. The commissioner of health shall evaluate a hospital's compliance with the policies
165.24 and procedures according to subdivision 4.

165.25 ~~(e)~~ (f) An outpatient surgical center must establish and maintain a comprehensive
165.26 tuberculosis infection control program according to the most current tuberculosis infection
165.27 control guidelines issued by the United States Centers for Disease Control and Prevention
165.28 (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality
165.29 Weekly Report (MMWR). This program must include a tuberculosis infection control plan
165.30 that covers all paid and unpaid employees, contractors, students, and volunteers. The
165.31 Department of Health shall provide technical assistance regarding implementation of the
165.32 guidelines.

165.33 ~~(d)~~ (g) Written compliance with this subdivision must be maintained by the outpatient
165.34 surgical center.

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

166.2 Sec. 73. Minnesota Statutes 2022, section 144.566, is amended to read:

166.3 **144.566 VIOLENCE AGAINST HEALTH CARE WORKERS.**

166.4 Subdivision 1. **Definitions.** (a) The following definitions apply to this section and have
166.5 the meanings given.

166.6 (b) "Act of violence" means an act by a patient or visitor against a health care worker
166.7 that includes kicking, scratching, urinating, sexually harassing, or any act defined in sections
166.8 609.221 to 609.2241.

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

166.10 (d) "Health care worker" means any person, whether licensed or unlicensed, employed
166.11 by, volunteering in, or under contract with a hospital, who has direct contact with a patient
166.12 of the hospital for purposes of either medical care or emergency response to situations
166.13 potentially involving violence.

166.14 (e) "Hospital" means any facility licensed as a hospital under section 144.55.

166.15 (f) "Incident response" means the actions taken by hospital administration and health
166.16 care workers during and following an act of violence.

166.17 (g) "Interfere" means to prevent, impede, discourage, or delay a health care worker's
166.18 ability to report acts of violence, including by retaliating or threatening to retaliate against
166.19 a health care worker.

166.20 (h) "Preparedness" means the actions taken by hospital administration and health care
166.21 workers to prevent a single act of violence or acts of violence generally.

166.22 (i) "Retaliate" means to discharge, discipline, threaten, otherwise discriminate against,
166.23 or penalize a health care worker regarding the health care worker's compensation, terms,
166.24 conditions, location, or privileges of employment.

166.25 (j) "Workplace violence hazards" means locations and situations where violent incidents
166.26 are more likely to occur, including, as applicable, but not limited to locations isolated from
166.27 other health care workers; health care workers working alone; health care workers working
166.28 in remote locations; health care workers working late night or early morning hours; locations
166.29 where an assailant could prevent entry of responders or other health care workers into a
166.30 work area; locations with poor illumination; locations with poor visibility; lack of physical
166.31 barriers between health care workers and persons at risk of committing workplace violence;
166.32 lack of effective escape routes; obstacles and impediments to accessing alarm systems;

167.1 locations within the facility where alarm systems are not operational; entryways where
167.2 unauthorized entrance may occur, such as doors designated for staff entrance or emergency
167.3 exits; presence, in the areas where patient contact activities are performed, of furnishings
167.4 or objects that could be used as weapons; and locations where high-value items, currency,
167.5 or pharmaceuticals are stored.

167.6 Subd. 2. ~~Hospital duties~~ **Action plans and action plan reviews required.** (a) All
167.7 hospitals must design and implement preparedness and incident response action plans to
167.8 acts of violence by January 15, 2016, and review and update the plan at least annually
167.9 thereafter. The plan must be in writing; specific to the workplace violence hazards and
167.10 corrective measures for the units, services, or operations of the hospital; and available to
167.11 health care workers at all times.

167.12 Subd. 3. **Action plan committees.** (b) A hospital shall designate a committee of
167.13 representatives of health care workers employed by the hospital, including nonmanagerial
167.14 health care workers, nonclinical staff, administrators, patient safety experts, and other
167.15 appropriate personnel to develop preparedness and incident response action plans to acts
167.16 of violence. The hospital shall, in consultation with the designated committee, implement
167.17 the plans under ~~paragraph (a)~~ subdivision 2. Nothing in this ~~paragraph~~ subdivision shall
167.18 require the establishment of a separate committee solely for the purpose required by this
167.19 subdivision.

167.20 Subd. 4. **Required elements of action plans; generally.** The preparedness and incident
167.21 response action plans to acts of violence must include:

167.22 (1) effective procedures to obtain the active involvement of health care workers and
167.23 their representatives in developing, implementing, and reviewing the plan, including their
167.24 participation in identifying, evaluating, and correcting workplace violence hazards, designing
167.25 and implementing training, and reporting and investigating incidents of workplace violence;

167.26 (2) names or job titles of the persons responsible for implementing the plan; and

167.27 (3) effective procedures to ensure that supervisory and nonsupervisory health care
167.28 workers comply with the plan.

167.29 Subd. 5. **Required elements of action plans; evaluation of risk factors.** (a) The
167.30 preparedness and incident response action plans to acts of violence must include assessment
167.31 procedures to identify and evaluate workplace violence hazards for each facility, unit,
167.32 service, or operation, including community-based risk factors and areas surrounding the
167.33 facility, such as employee parking areas and other outdoor areas. Procedures shall specify
167.34 the frequency with which such environmental assessments will take place.

168.1 (b) The preparedness and incident response action plans to acts of violence must include
168.2 assessment tools, environmental checklists, or other effective means to identify workplace
168.3 violence hazards.

168.4 Subd. 6. Required elements of action plans; review of workplace violence
168.5 incidents. The preparedness and incident response action plans to acts of violence must
168.6 include procedures for reviewing all workplace violence incidents that occurred in the
168.7 facility, unit, service, or operation within the previous year, whether or not an injury occurred.

168.8 Subd. 7. Required elements of action plans; reporting workplace violence. The
168.9 preparedness and incident response action plans to acts of violence must include:

168.10 (1) effective procedures for health care workers to document information regarding
168.11 conditions that may increase the potential for workplace violence incidents and communicate
168.12 that information without fear of reprisal to other health care workers, shifts, or units;

168.13 (2) effective procedures for health care workers to report a violent incident, threat, or
168.14 other workplace violence concern without fear of reprisal;

168.15 (3) effective procedures for the hospital to accept and respond to reports of workplace
168.16 violence and to prohibit retaliation against a health care worker who makes such a report;

168.17 (4) a policy statement stating the hospital will not prevent a health care worker from
168.18 reporting workplace violence or take punitive or retaliatory action against a health care
168.19 worker for doing so;

168.20 (5) effective procedures for investigating health care worker concerns regarding workplace
168.21 violence or workplace violence hazards;

168.22 (6) procedures for informing health care workers of the results of the investigation arising
168.23 from a report of workplace violence or from a concern about a workplace violence hazard
168.24 and of any corrective actions taken;

168.25 (7) effective procedures for obtaining assistance from the appropriate law enforcement
168.26 agency or social service agency during all work shifts. The procedure may establish a central
168.27 coordination procedure; and

168.28 (8) a policy statement stating the hospital will not prevent a health care worker from
168.29 seeking assistance and intervention from local emergency services or law enforcement when
168.30 a violent incident occurs or take punitive or retaliatory action against a health care worker
168.31 for doing so.

169.1 Subd. 8. Required elements of action plans; coordination with other employers. The
169.2 preparedness and incident response action plans to acts of violence must include methods
169.3 the hospital will use to coordinate implementation of the plan with other employers whose
169.4 employees work in the same health care facility, unit, service, or operation and to ensure
169.5 that those employers and their employees understand their respective roles as provided in
169.6 the plan. These methods must ensure that all employees working in the facility, unit, service,
169.7 or operation are provided the training required by subdivision 11 and that workplace violence
169.8 incidents involving any employee are reported, investigated, and recorded.

169.9 Subd. 9. Required elements of action plans; white supremacist affiliation and support
169.10 prohibited. (a) The preparedness and incident response action plans to acts of violence
169.11 must include a policy statement stating that security personnel employed by the hospital or
169.12 assigned to the hospital by a contractor are prohibited from affiliating with, supporting, or
169.13 advocating for white supremacist groups, causes, or ideologies or participating in, or actively
169.14 promoting, an international or domestic extremist group that the Federal Bureau of
169.15 Investigation has determined supports or encourages illegal, violent conduct.

169.16 (b) For purposes of this subdivision, white supremacist groups, causes, or ideologies
169.17 include organizations and associations and ideologies that promote white supremacy and
169.18 the idea that white people are superior to Black, Indigenous, and people of color (BIPOC);
169.19 promote religious and racial bigotry; seek to exacerbate racial and ethnic tensions between
169.20 BIPOC and non-BIPOC; or engage in patently hateful and inflammatory speech, intimidation,
169.21 and violence against BIPOC as means of promoting white supremacy.

169.22 Subd. 10. Required elements of action plans; training. (a) The preparedness and
169.23 incident response action plans to acts of violence must include:

169.24 (1) procedures for developing and providing the training required in subdivision 11 that
169.25 permits health care workers and their representatives to participate in developing the training;
169.26 and

169.27 (2) a requirement for cultural competency training and equity, diversity, and inclusion
169.28 training.

169.29 (b) The preparedness and incident response action plans to acts of violence must include
169.30 procedures to communicate with health care workers regarding workplace violence matters,
169.31 including:

169.32 (1) how health care workers will document and communicate to other health care workers
169.33 and between shifts and units information regarding conditions that may increase the potential
169.34 for workplace violence incidents;

170.1 (2) how health care workers can report a violent incident, threat, or other workplace
170.2 violence concern;

170.3 (3) how health care workers can communicate workplace violence concerns without
170.4 fear of reprisal; and

170.5 (4) how health care worker concerns will be investigated, and how health care workers
170.6 will be informed of the results of the investigation and any corrective actions to be taken.

170.7 Subd. 11. **Training required.** (e) A hospital ~~shall~~ must provide training to all health
170.8 care workers employed or contracted with the hospital on safety during acts of violence.
170.9 Each health care worker must receive safety training ~~annually and upon hire~~ during the
170.10 health care worker's orientation and before the health care worker completes a shift
170.11 independently, and annually thereafter. Training must, at a minimum, include:

170.12 (1) safety guidelines for response to and de-escalation of an act of violence;

170.13 (2) ways to identify potentially violent or abusive situations, including aggression and
170.14 violence predicting factors; ~~and~~

170.15 (3) the hospital's ~~incident response reaction plan and violence prevention plan~~
170.16 preparedness and incident response action plans for acts of violence, including how the
170.17 health care worker may report concerns about workplace violence within each hospital's
170.18 reporting structure without fear of reprisal, how the hospital will address workplace violence
170.19 incidents, and how the health care worker can participate in reviewing and revising the plan;
170.20 and

170.21 (4) any resources available to health care workers for coping with incidents of violence,
170.22 including but not limited to critical incident stress debriefing or employee assistance
170.23 programs.

170.24 Subd. 12. **Annual review and update of action plans.** (d) (a) As part of its annual
170.25 review ~~of preparedness and incident response action plans~~ required under ~~paragraph (a)~~
170.26 subdivision 2, the hospital must review with the designated committee:

170.27 (1) the effectiveness of its preparedness and incident response action plans, including
170.28 the sufficiency of security systems, alarms, emergency responses, and security personnel
170.29 availability;

170.30 (2) security risks associated with specific units, areas of the facility with uncontrolled
170.31 access, late night shifts, early morning shifts, and areas surrounding the facility such as
170.32 employee parking areas and other outdoor areas;

171.1 (3) the most recent gap analysis as provided by the commissioner; and
171.2 (3) (4) the number of acts of violence that occurred in the hospital during the previous
171.3 year, including injuries sustained, if any, and the unit in which the incident occurred;
171.4 (5) evaluations of staffing, including staffing patterns and patient classification systems
171.5 that contribute to, or are insufficient to address, the risk of violence; and
171.6 (6) any reports of discrimination or abuse that arise from security resources, including
171.7 from the behavior of security personnel.

171.8 (b) As part of the annual update of preparedness and incident response action plans
171.9 required under subdivision 2, the hospital must incorporate corrective actions into the action
171.10 plan to address workplace violence hazards identified during the annual action plan review,
171.11 reports of workplace violence, reports of workplace violence hazards, and reports of
171.12 discrimination or abuse that arise from the security resources.

171.13 Subd. 13. **Action plan updates.** Following the annual review of the action plan, a hospital
171.14 must update the action plans to reflect the corrective actions the hospital will implement to
171.15 mitigate the hazards and vulnerabilities identified during the annual review.

171.16 Subd. 14. **Requests for additional staffing.** A hospital shall create and implement a
171.17 procedure for a health care worker to officially request of hospital supervisors or
171.18 administration that additional staffing be provided. The hospital must document all requests
171.19 for additional staffing made because of a health care worker's concern over a risk of an act
171.20 of violence. If the request for additional staffing to reduce the risk of violence is denied,
171.21 the hospital must provide the health care worker who made the request a written reason for
171.22 the denial and must maintain documentation of that communication with the documentation
171.23 of requests for additional staffing. A hospital must make documentation regarding staffing
171.24 requests available to the commissioner for inspection at the commissioner's request. The
171.25 commissioner may use documentation regarding staffing requests to inform the
171.26 commissioner's determination on whether the hospital is providing adequate staffing and
171.27 security to address acts of violence, and may use documentation regarding staffing requests
171.28 if the commissioner imposes a penalty under subdivision 18.

171.29 Subd. 15. **Disclosure of action plans.** (e) (a) A hospital shall must make its most recent
171.30 action plans and the information listed in paragraph (d) most recent action plan reviews
171.31 available to ~~local law enforcement~~ all direct care staff and, if any of its workers are
171.32 represented by a collective bargaining unit, to the exclusive bargaining representatives of
171.33 those collective bargaining units.

172.1 (b) A hospital must also annually submit to the commissioner its most recent action plan
172.2 and the results of the most recent annual review conducted under subdivision 12.

172.3 Subd. 16. **Legislative report required.** (a) The commissioner must compile the
172.4 information into a single annual report and submit the report to the chairs and ranking
172.5 minority members of the legislative committees with jurisdiction over health care by January
172.6 15 of each year.

172.7 (b) This subdivision does not expire.

172.8 Subd. 17. **Interference prohibited.** (f) A hospital, including any individual, partner,
172.9 association, or any person or group of persons acting directly or indirectly in the interest of
172.10 the hospital, shall ~~shall~~ must not interfere with or discourage a health care worker if the health
172.11 care worker wishes to contact law enforcement or the commissioner regarding an act of
172.12 violence.

172.13 Subd. 18. **Penalties.** (g) Notwithstanding section 144.653, subdivision 6, the
172.14 commissioner may impose an administrative a fine of up to \$250 ~~\$250~~ \$10,000 for failure to
172.15 comply with the requirements of this ~~subdivision~~ section. The commissioner must allow
172.16 the hospital at least 30 calendar days to correct a violation of this section before assessing
172.17 a fine.

172.18 Sec. 74. **[144.587] REQUIREMENTS FOR SCREENING FOR ELIGIBILITY FOR**
172.19 **HEALTH COVERAGE OR ASSISTANCE.**

172.20 Subdivision 1. **Definitions.** (a) The terms defined in this subdivision apply to this section
172.21 and sections 144.588 to 144.589.

172.22 (b) "Charity care" means the provision of free or discounted care to a patient according
172.23 to a hospital's financial assistance policies.

172.24 (c) "Hospital" means a private, nonprofit, or municipal hospital licensed under sections
172.25 144.50 to 144.56.

172.26 (d) "Minnesota attorney general/hospital agreement" means the agreement between the
172.27 attorney general and certain Minnesota hospitals that is filed in Ramsey County District
172.28 Court and that establishes requirements for hospital litigation practices, garnishments, use
172.29 of collection agencies, central billing office practices, and practices for billing uninsured
172.30 patients.

172.31 (e) "Most favored insurer" means the nongovernmental third-party payor that provided
172.32 the most revenue to the provider during the previous calendar year.

173.1 (f) "Navigator" has the meaning given in section 62V.02, subdivision 9.

173.2 (g) "Premium tax credit" means a tax credit or premium subsidy under the federal Patient
173.3 Protection and Affordable Care Act, Public Law 111-148, as amended, including the federal
173.4 Health Care and Education Reconciliation Act of 2010, Public Law 111-152, and any
173.5 amendments to and federal guidance and regulations issued under these acts.

173.6 (h) "Presumptive eligibility" has the meaning given in section 256B.057, subdivision
173.7 12.

173.8 (i) "Revenue recapture" means the use of the procedures in chapter 270A to collect debt.

173.9 (j) "Uninsured service or treatment" means any service or treatment that is not covered
173.10 by: (1) a health plan, contract, or policy that provides health coverage to a patient; or (2)
173.11 any other type of insurance coverage, including but not limited to no-fault automobile
173.12 coverage, workers' compensation coverage, or liability coverage.

173.13 (k) "Unreasonable burden" includes requiring a patient to apply for enrollment in a state
173.14 or federal program for which the patient is obviously or categorically ineligible or has been
173.15 found to be ineligible in the previous 12 months.

173.16 Subd. 2. **Screening.** A hospital must screen a patient who is uninsured or whose insurance
173.17 coverage status is not known by the hospital for: eligibility for charity care from the hospital;
173.18 eligibility for state or federal public health care programs using presumptive eligibility or
173.19 another similar process; and eligibility for a premium tax credit. The hospital must attempt
173.20 to complete this screening process in person or by telephone within 30 days after the patient
173.21 receives services at the hospital or at the emergency department associated with the hospital.

173.22 Subd. 3. **Charity care.** (a) Upon completion of the screening process in subdivision 2,
173.23 the hospital must either assist the patient with applying for charity care and refer the patient
173.24 to the appropriate department in the hospital for follow-up or make a determination that the
173.25 patient is ineligible for charity care. A hospital may initiate one or more of the following
173.26 steps only after the hospital determines that the patient is ineligible for charity care and may
173.27 not initiate any of the following steps while the patient's application for charity care is
173.28 pending:

173.29 (1) offering to enroll or enrolling the patient in a payment plan;

173.30 (2) changing the terms of a patient's payment plan;

173.31 (3) offering the patient a loan or line of credit, application materials for a loan or line of
173.32 credit, or assistance with applying for a loan or line of credit, for the payment of medical
173.33 debt;

174.1 (4) referring a patient's debt for collections, including in-house collections, third-party
174.2 collections, revenue recapture, or any other process for the collection of debt;

174.3 (5) denying health care services to the patient or any member of the patient's household
174.4 because of outstanding medical debt, regardless of whether the services are deemed necessary
174.5 or may be available from another provider; or

174.6 (6) accepting a credit card payment of over \$500 for the medical debt owed to the hospital.

174.7 (b) A hospital may not impose application procedures for charity care that place an
174.8 unreasonable burden on the individual patient, taking into account the individual patient's
174.9 physical, mental, intellectual, or sensory deficiencies or language barriers that may hinder
174.10 the patient's ability to comply with application procedures.

174.11 (c) When a hospital evaluates a patient's eligibility for charity care, hospital requests to
174.12 the responsible party for verification of assets or income shall be limited to:

174.13 (1) information that is reasonably necessary and readily available to determine eligibility;
174.14 and

174.15 (2) facts that are relevant to determine eligibility.

174.16 A hospital must not demand duplicate forms of verification of assets.

174.17 **Subd. 4. Public health care program; premium tax credit.** (a) If a patient is
174.18 presumptively eligible for a public health care program, the hospital must assist the patient
174.19 in completing an insurance affordability program application, help the patient schedule an
174.20 appointment with a navigator organization, or provide the patient with contact information
174.21 for the nearest available navigator or certified application counselor services.

174.22 (b) If a patient is eligible for a premium tax credit, the hospital may schedule an
174.23 appointment for the patient with a navigator or a MNsure-certified insurance broker
174.24 organization or provide the patient with contact information for the nearest available navigator
174.25 services or a MNsure-certified insurance broker.

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

174.30 **Subd. 6. Notice.** (a) A hospital must post notice of the availability of charity care from
174.31 the hospital in at least the following locations: (1) areas of the hospital where patients are
174.32 admitted or registered; (2) emergency departments; and (3) the portion of the hospital's

175.1 financial services or billing department that is accessible to patients. The posted notice must
175.2 be in all languages spoken by more than five percent of the population in the hospital's
175.3 service area.

175.4 (b) A hospital must make available on the hospital's website, the current version of the
175.5 hospital's charity care policy, a plain-language summary of the policy, and the hospital's
175.6 charity care application form. The summary and application form must be available in all
175.7 languages spoken by more than five percent of the population in the hospital's service area.

175.8 **EFFECTIVE DATE.** This section is effective November 1, 2023.

175.9 **Sec. 75. [144.588] CERTIFICATION OF EXPERT REVIEW.**

175.10 Subdivision 1. **Requirement; referral to third-party debt collection agency.** (a) In
175.11 order to refer a patient's account to a third-party debt collection agency, a hospital must
175.12 complete an affidavit of expert review certifying that the hospital:

175.13 (1) confirmed the information required of the hospital in the most recent version of the
175.14 Minnesota attorney general/hospital agreement for referral of a specific patient's account
175.15 to a third-party debt collection agency; and

175.16 (2) unless the patient declined to participate, complied with the requirements in section
175.17 144.587 to conduct a patient screening and, as applicable, assist the patient in applying for
175.18 charity care, assist the patient with completing an insurance affordability program application,
175.19 or refer the patient to a navigator organization.

175.20 (b) The affidavit of expert review must be completed by a designated employee of the
175.21 hospital seeking to refer the patient's account to a third-party debt collection agency.

175.22 Subd. 2. **Penalty for noncompliance.** Failure to comply with subdivision 1 shall subject
175.23 a hospital to a fine assessed by the commissioner of health.

175.24 **EFFECTIVE DATE.** This section is effective November 1, 2023.

175.25 **Sec. 76. [144.589] BILLING OF UNINSURED PATIENTS.**

175.26 A hospital shall not charge a patient whose annual household income is less than \$125,000
175.27 for any uninsured service or treatment in an amount that exceeds the total amount the
175.28 provider would be reimbursed for that service or treatment from its most favored insurer.
175.29 The total amount the provider would be reimbursed for that service or treatment from its
175.30 most favored insurer includes both the amount the provider would be reimbursed directly

176.1 from its most favored insurer, and the amount the provider would be reimbursed from the
176.2 insured's policyholder under any applicable co-payments, deductibles, and coinsurance.

176.3 **EFFECTIVE DATE.** This section is effective November 1, 2023.

176.4 Sec. 77. **[144.593] REQUIREMENTS FOR CERTAIN HEALTH CARE ENTITY**
176.5 **TRANSACTIONS.**

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

176.8 (b) "Captive professional entity" means a professional corporation, limited liability
176.9 company, or other entity formed to render professional services in which a beneficial owner
176.10 is a health care provider employed by, controlled by, or subject to the direction of a hospital
176.11 or hospital system.

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

176.13 (d) "Health care entity" means:

176.14 (1) a hospital;

176.15 (2) a hospital system;

176.16 (3) a captive professional entity;

176.17 (4) a medical foundation;

176.18 (5) a health care provider group practice;

176.19 (6) an entity organized or controlled by an entity listed in clauses (1) to (5); or

176.20 (7) an entity that owns or exercised substantial control over an entity listed in clauses
176.21 (1) to (5).

176.22 (e) "Health care provider" means a physician licensed under chapter 147, a physician
176.23 assistant licensed under chapter 147A, or an advanced practice registered nurse as defined
176.24 in section 148.171, subdivision 3, who provides health care services, including but not
176.25 limited to medical care, consultation, diagnosis, or treatment.

176.26 (f) "Health care provider group practice" means two or more health care providers legally
176.27 organized in a partnership, professional corporation, limited liability company, medical
176.28 foundation, nonprofit corporation, faculty practice plan, or other similar entity:

176.29 (1) in which each health care provider who is a member of the group provides
176.30 substantially the full range of services that a health care provider routinely provides, including

177.1 but not limited to medical care, consultation, diagnosis, and treatment, through the joint use
177.2 of shared office space, facilities, equipment, or personnel;

177.3 (2) for which substantially all services of the health care providers who are group
177.4 members are provided through the group and are billed in the name of the group practice
177.5 and amounts so received are treated as receipts of the group; or

177.6 (3) in which the overhead expenses of, and the income from, the group are distributed
177.7 in accordance with methods previously determined by members of the group.

177.8 An entity that otherwise meets the definition of health care provider group practice in this
177.9 paragraph shall be considered a health care provider group practice even if its shareholders,
177.10 partners, or owners include single-health care provider professional corporations, limited
177.11 liability companies formed to render professional services, or other entities in which
177.12 beneficial owners are individual health care providers.

177.13 (g) "Hospital" means a health care facility licensed as a hospital under sections 144.50
177.14 to 144.56.

177.15 (h) "Medical foundation" means a nonprofit legal entity through which physicians or
177.16 other health care providers perform research or provide medical services.

177.17 (i) "Transaction" means a single action, or a series of actions within a five-year period,
177.18 that constitutes:

177.19 (1) a merger or exchange of a health care entity with another entity;

177.20 (2) the sale, lease, or transfer of 30 percent or more of the assets of a health care entity
177.21 to another entity;

177.22 (3) the granting of a security interest of 30 percent or more of the property and assets
177.23 of a health care entity to another entity;

177.24 (4) the transfer of 30 percent or more of the shares or other ownership of the health care
177.25 entity to another entity;

177.26 (5) an addition or substitution of one or more members of the health care entity's
177.27 governing body that effectively transfers control, responsibility for, or governance of the
177.28 health care entity to another entity;

177.29 (6) the creation of a new health care entity; or

177.30 (7) substantial investment of 30 percent or more in a health care entity that results in
177.31 sharing of revenues without a change in ownership or voting shares.

178.1 Subd. 2. Notice required. (a) This subdivision applies to all transactions where:

178.2 (1) the health care entity involved in the transaction has average revenue of at least
178.3 \$10,000,000 per year; or

178.4 (2) an entity created by the transaction is projected to have average revenue of at least
178.5 \$10,000,000 per year once the entity is operating at full capacity.

178.6 (b) A health care entity must provide notice to the attorney general and the commissioner
178.7 and comply with this subdivision before entering into a transaction. Notice must be provided
178.8 at least 180 days before the proposed completion date for the transaction.

178.9 (c) As part of the notice required under this subdivision, at least 180 days before the
178.10 proposed completion date of the transaction, a health care entity must affirmatively disclose
178.11 the following to the attorney general and the commissioner:

178.12 (1) the entities involved in the transaction;

178.13 (2) the leadership of the entities involved in the transaction, including all directors, board
178.14 members, and officers;

178.15 (3) the services provided by each entity and the attributed revenue for each entity by
178.16 location;

178.17 (4) the primary service area for each location;

178.18 (5) the proposed service area for each location;

178.19 (6) the current relationships between the entities and the health care providers and
178.20 practices affected, the locations of affected health care providers and practices, the services
178.21 provided by affected health care providers and practices, and the proposed relationships
178.22 between the entities and the health care providers and practices affected;

178.23 (7) the terms of the transaction agreement or agreements;

178.24 (8) the acquisition price;

178.25 (9) markets in which the entities expect postmerger synergies to produce a competitive
178.26 advantage;

178.27 (10) potential areas of expansion, whether in existing markets or new markets;

178.28 (11) plans to close facilities, reduce workforce, or reduce or eliminate services;

178.29 (12) the experts and consultants used to evaluate the transaction;

- 179.1 (13) the number of full-time equivalent positions at each location before and after the
179.2 transaction by job category, including administrative and contract positions; and
- 179.3 (14) any other information requested by the attorney general or commissioner.
- 179.4 (d) As part of the notice required under this subdivision, at least 180 days before the
179.5 proposed completion date of the transaction, a health care entity must affirmatively produce
179.6 the following to the attorney general and the commissioner:
- 179.7 (1) the current governing documents for all entities involved in the transaction and any
179.8 amendments to these documents;
- 179.9 (2) the transaction agreement or agreements and all related agreements;
- 179.10 (3) any collateral agreements related to the principal transaction, including leases,
179.11 management contracts, and service contracts;
- 179.12 (4) all expert or consultant reports or valuations conducted in evaluating the transaction,
179.13 including any valuation of the assets that are subject to the transaction prepared within three
179.14 years preceding the anticipated transaction completion date and any reports of financial or
179.15 economic analysis conducted in anticipation of the transaction;
- 179.16 (5) the results of any projections or modeling of health care utilization or financial
179.17 impacts related to the transaction, including but not limited to copies of reports by appraisers,
179.18 accountants, investment bankers, actuaries, and other experts;
- 179.19 (6) a financial and economic analysis and report prepared by an independent expert or
179.20 consultant on the effects of the transaction;
- 179.21 (7) an impact analysis report prepared by an independent expert or consultant on the
179.22 effects of the transaction on communities and the workforce, including any changes in
179.23 availability or accessibility of services;
- 179.24 (8) all documents reflecting the purposes of or restrictions on any related nonprofit
179.25 entity's charitable assets;
- 179.26 (9) copies of all filings submitted to federal regulators, including any Hart-Scott-Rodino
179.27 filing the entities submitted to the Federal Trade Commission in connection with the
179.28 transaction;
- 179.29 (10) a certification sworn under oath by each board member and chief executive officer
179.30 for any nonprofit entity involved in the transaction containing the following: an explanation
179.31 of how the completed transaction is in the public interest, addressing the factors in subdivision
179.32 5, paragraph (a); a disclosure of each declarant's compensation and benefits relating to the

180.1 transaction for the three years following the transaction's anticipated completion date; and
180.2 a disclosure of any conflicts of interest;

180.3 (11) audited and unaudited financial statements from all entities involved in the
180.4 transaction and tax filings for all entities involved in the transaction covering the preceding
180.5 five fiscal years; and

180.6 (12) any other information or documents requested by the attorney general or
180.7 commissioner.

180.8 (e) The commissioner may adopt rules to implement this section, and may alter, amend,
180.9 suspend, or repeal any of such rules. The requirements of section 14.125 do not apply to
180.10 the adoption of rules under this paragraph.

180.11 (f) The attorney general may extend the notice and waiting period required under
180.12 paragraph (b) for an additional 90 days by notifying the health care entity in writing of the
180.13 extension.

180.14 (g) The attorney general may waive all or any part of the notice and waiting period
180.15 required under paragraph (b).

180.16 (h) The attorney general or the commissioner may hold public listening sessions or
180.17 forums to obtain input on the transaction from providers or community members who may
180.18 be impacted by the transaction.

180.19 (i) The attorney general or the commissioner may bring an action in district court to
180.20 compel compliance with the notice requirements in this subdivision.

180.21 Subd. 3. **Prohibited transactions.** No health care entity may enter into a transaction
180.22 that will:

180.23 (1) substantially lessen competition; or

180.24 (2) tend to create a monopoly or monopsony.

180.25 Subd. 4. **Additional requirements for nonprofit health care entities.** A health care
180.26 entity that is incorporated under chapter 317A or organized under section 322C.1101, or
180.27 that is a subsidiary of any such entity, must, before entering into a transaction, ensure that:

180.28 (1) the transaction complies with chapters 317A and 501B and other applicable laws;

180.29 (2) the transaction does not involve or constitute a breach of charitable trust;

180.30 (3) the nonprofit health care entity will receive full and fair value for its public benefit
180.31 assets;

181.1 (4) the value of the public benefit assets to be transferred has not been manipulated in
181.2 a manner that causes or has caused the value of the assets to decrease;

181.3 (5) the proceeds of the transaction will be used in a manner consistent with the public
181.4 benefit for which the assets are held by the nonprofit health care entity;

181.5 (6) the transaction will not result in a breach of fiduciary duty; and

181.6 (7) there are procedures and policies in place to prohibit any officer, director, trustee,
181.7 or other executive of the nonprofit health care entity from directly or indirectly benefiting
181.8 from the transaction.

181.9 Subd. 5. **Attorney general enforcement and supplemental authority.** (a) The attorney
181.10 general may bring an action in district court to enjoin or unwind a transaction or seek other
181.11 equitable relief necessary to protect the public interest if a health care entity or transaction
181.12 violates this section, if the transaction is contrary to the public interest, or if both a health
181.13 care entity or transaction violates this section and the transaction is contrary to the public
181.14 interest. Factors informing whether a transaction is contrary to the public interest include
181.15 but are not limited to whether the transaction:

181.16 (1) will harm public health;

181.17 (2) will reduce the affected community's continued access to affordable and quality care
181.18 and to the range of services historically provided by the entities or will prevent members
181.19 in the affected community from receiving a comparable or better patient experience;

181.20 (3) will have a detrimental impact on competing health care options within primary and
181.21 dispersed service areas;

181.22 (4) will reduce delivery of health care to disadvantaged, uninsured, underinsured, and
181.23 underserved populations and to populations enrolled in public health care programs;

181.24 (5) will have a substantial negative impact on medical education and teaching programs,
181.25 health care workforce training, or medical research;

181.26 (6) will have a negative impact on the market for health care services, health insurance
181.27 services, or skilled health care workers;

181.28 (7) will increase health care costs for patients; or

181.29 (8) will adversely impact provider cost trends and containment of total health care
181.30 spending.

181.31 (b) The attorney general may enforce this section under section 8.31.

182.1 (c) Failure of the entities involved in a transaction to provide timely information as
182.2 required by the attorney general or the commissioner shall be an independent and sufficient
182.3 ground for a court to enjoin the transaction or provide other equitable relief, provided the
182.4 attorney general notified the entities of the inadequacy of the information provided and
182.5 provided the entities with a reasonable opportunity to remedy the inadequacy.

182.6 (d) The attorney general shall consult with the commissioner to determine whether a
182.7 transaction is contrary to the public interest. Any information exchanged between the attorney
182.8 general and the commissioner according to this subdivision is confidential data on individuals
182.9 as defined in section 13.02, subdivision 3, or protected nonpublic data as defined in section
182.10 13.02, subdivision 13. The commissioner may share with the attorney general, according
182.11 to section 13.05, subdivision 9, any not public data, as defined in section 13.02, subdivision
182.12 8a, held by the Department of Health to aid in the investigation and review of the transaction,
182.13 and the attorney general must maintain this data with the same classification according to
182.14 section 13.03, subdivision 4, paragraph (d).

182.15 **Subd. 6. Supplemental authority of commissioner.** (a) Notwithstanding any law to
182.16 the contrary, the commissioner may use data or information submitted under this section,
182.17 section 62U.04, and sections 144.695 to 144.705 to conduct analyses of the aggregate impact
182.18 of health care transactions on access to or the cost of health care services, health care market
182.19 consolidation, and health care quality.

182.20 (b) The commissioner shall issue periodic public reports on the number and types of
182.21 transactions subject to this section and on the aggregate impact of transactions on health
182.22 care cost, quality, and competition in Minnesota.

182.23 **Subd. 7. Relation to other law.** (a) The powers and authority under this section are in
182.24 addition to, and do not affect or limit, all other rights, powers, and authority of the attorney
182.25 general or the commissioner under chapter 8, 309, 317A, 325D, 501B, or other law.

182.26 (b) Nothing in this section shall suspend any obligation imposed under chapter 8, 309,
182.27 317A, 325D, 501B, or other law on the entities involved in a transaction.

182.28 **EFFECTIVE DATE.** This section is effective the day following final enactment and
182.29 applies to transactions completed on or after that date. In determining whether a transaction
182.30 was completed on or after the effective date, any actions or series of actions necessary to
182.31 the completion of the transaction that occurred prior to the effective date must be considered.

183.1 Sec. 78. Minnesota Statutes 2022, section 144.608, subdivision 1, is amended to read:

183.2 Subdivision 1. **Trauma Advisory Council established.** (a) A Trauma Advisory Council
183.3 is established to advise, consult with, and make recommendations to the commissioner on
183.4 the development, maintenance, and improvement of a statewide trauma system.

183.5 (b) The council shall consist of the following members:

183.6 (1) a trauma surgeon certified by the American Board of Surgery or the American
183.7 Osteopathic Board of Surgery who practices in a level I or II trauma hospital;

183.8 (2) a general surgeon certified by the American Board of Surgery or the American
183.9 Osteopathic Board of Surgery whose practice includes trauma and who practices in a
183.10 designated rural area as defined under section 144.1501, subdivision 1, ~~paragraph (e)~~;

183.11 (3) a neurosurgeon certified by the American Board of Neurological Surgery who
183.12 practices in a level I or II trauma hospital;

183.13 (4) a trauma program nurse manager or coordinator practicing in a level I or II trauma
183.14 hospital;

183.15 (5) an emergency physician certified by the American Board of Emergency Medicine
183.16 or the American Osteopathic Board of Emergency Medicine whose practice includes
183.17 emergency room care in a level I, II, III, or IV trauma hospital;

183.18 (6) a trauma program manager or coordinator who practices in a level III or IV trauma
183.19 hospital;

183.20 (7) a physician certified by the American Board of Family Medicine or the American
183.21 Osteopathic Board of Family Practice whose practice includes emergency department care
183.22 in a level III or IV trauma hospital located in a designated rural area as defined under section
183.23 144.1501, subdivision 1, ~~paragraph (e)~~;

183.24 (8) a nurse practitioner, as defined under section 144.1501, subdivision 1, ~~paragraph (l)~~,
183.25 or a physician assistant, as defined under section 144.1501, subdivision 1, ~~paragraph (o)~~,
183.26 whose practice includes emergency room care in a level IV trauma hospital located in a
183.27 designated rural area as defined under section 144.1501, subdivision 1, ~~paragraph (e)~~;

183.28 (9) a physician certified in pediatric emergency medicine by the American Board of
183.29 Pediatrics or certified in pediatric emergency medicine by the American Board of Emergency
183.30 Medicine or certified by the American Osteopathic Board of Pediatrics whose practice
183.31 primarily includes emergency department medical care in a level I, II, III, or IV trauma

184.1 hospital, or a surgeon certified in pediatric surgery by the American Board of Surgery whose
184.2 practice involves the care of pediatric trauma patients in a trauma hospital;

184.3 (10) an orthopedic surgeon certified by the American Board of Orthopaedic Surgery or
184.4 the American Osteopathic Board of Orthopedic Surgery whose practice includes trauma
184.5 and who practices in a level I, II, or III trauma hospital;

184.6 (11) the state emergency medical services medical director appointed by the Emergency
184.7 Medical Services Regulatory Board;

184.8 (12) a hospital administrator of a level III or IV trauma hospital located in a designated
184.9 rural area as defined under section 144.1501, subdivision 1, ~~paragraph (e)~~;

184.10 (13) a rehabilitation specialist whose practice includes rehabilitation of patients with
184.11 major trauma injuries or traumatic brain injuries and spinal cord injuries as defined under
184.12 section 144.661;

184.13 (14) an attendant or ambulance director who is an EMT, ~~EMT-I, or EMT-P~~ AEMT, or
184.14 paramedic within the meaning of section 144E.001 and who actively practices with a licensed
184.15 ambulance service in a primary service area located in a designated rural area as defined
184.16 under section 144.1501, subdivision 1, ~~paragraph (e)~~; and

184.17 (15) the commissioner of public safety or the commissioner's designee.

184.18 Sec. 79. Minnesota Statutes 2022, section 144.615, subdivision 7, is amended to read:

184.19 Subd. 7. **Limitations of services.** (a) The following limitations apply to the services
184.20 performed at a birth center:

184.21 (1) surgical procedures must be limited to those normally accomplished during an
184.22 uncomplicated birth, including episiotomy and repair; and

184.23 ~~(2) no abortions may be administered; and~~

184.24 ~~(3)~~ (2) no general or regional anesthesia may be administered.

184.25 (b) Notwithstanding paragraph (a), local anesthesia may be administered at a birth center
184.26 if the administration of the anesthetic is performed within the scope of practice of a health
184.27 care professional.

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

185.1 Sec. 80. Minnesota Statutes 2022, section 144.651, is amended by adding a subdivision
185.2 to read:

185.3 Subd. 10a. **Designated support person for pregnant patient.** (a) A health care provider
185.4 and a health care facility must allow, at a minimum, one designated support person of a
185.5 pregnant patient's choosing to be physically present while the patient is receiving health
185.6 care services including during a hospital stay.

185.7 (b) For purposes of this subdivision, "designated support person" means any person
185.8 necessary to provide comfort to the patient including but not limited to the patient's spouse,
185.9 partner, family member, or another person related by affinity. Certified doulas and traditional
185.10 midwives may not be counted toward the limit of one designated support person.

185.11 Sec. 81. Minnesota Statutes 2022, section 144.653, subdivision 5, is amended to read:

185.12 **Subd. 5. Correction orders.** Whenever a duly authorized representative of the state
185.13 commissioner of health finds upon inspection of a facility required to be licensed under the
185.14 provisions of sections 144.50 to 144.58 that the licensee of such facility is not in compliance
185.15 with sections 144.411 to 144.417, 144.50 to 144.58, 144.651, 144.7051 to 144.7058, or
185.16 626.557, or the applicable rules promulgated under those sections, a correction order shall
185.17 be issued to the licensee. The correction order shall state the deficiency, cite the specific
185.18 rule violated, and specify the time allowed for correction.

185.19 Sec. 82. Minnesota Statutes 2022, section 144.6535, subdivision 1, is amended to read:

185.20 **Subdivision 1. Request for variance or waiver.** A hospital may request that the
185.21 commissioner grant a variance or waiver from the provisions of ~~Minnesota Rules, chapter~~
185.22 ~~4640 or 4645~~ section 144.55, subdivision 3, paragraph (b). A request for a variance or waiver
185.23 must be submitted to the commissioner in writing. Each request must contain:

185.24 (1) the specific ~~rule or rules~~ requirement for which the variance or waiver is requested;

185.25 (2) the reasons for the request;

185.26 (3) the alternative measures that will be taken if a variance or waiver is granted;

185.27 (4) the length of time for which the variance or waiver is requested; and

185.28 (5) other relevant information deemed necessary by the commissioner to properly evaluate
185.29 the request for the variance or waiver.

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

186.1 Sec. 83. Minnesota Statutes 2022, section 144.6535, subdivision 2, is amended to read:

186.2 Subd. 2. **Criteria for evaluation.** The decision to grant or deny a variance or waiver
186.3 must be based on the commissioner's evaluation of the following criteria:

186.4 (1) whether the variance or waiver will adversely affect the health, treatment, comfort,
186.5 safety, or well-being of a patient;

186.6 (2) whether the alternative measures to be taken, if any, are equivalent to or superior to
186.7 those prescribed in ~~Minnesota Rules, chapter 4640 or 4645~~ section 144.55, subdivision 3,
186.8 paragraph (b); and

186.9 (3) whether compliance with the ~~rule or rules~~ requirements would impose an undue
186.10 burden upon the applicant.

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

186.12 Sec. 84. Minnesota Statutes 2022, section 144.6535, subdivision 4, is amended to read:

186.13 Subd. 4. **Effect of alternative measures or conditions.** (a) Alternative measures or
186.14 conditions attached to a variance or waiver have the same force and effect as the ~~rules~~
186.15 requirement under ~~Minnesota Rules, chapter 4640 or 4645~~ section 144.55, subdivision 3,
186.16 paragraph (b), and are subject to the issuance of correction orders and penalty assessments
186.17 in accordance with section 144.55.

186.18 (b) Fines for a violation of this section shall be in the same amount as that specified for
186.19 the particular ~~rule~~ requirement for which the variance or waiver was requested.

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

186.21 Sec. 85. Minnesota Statutes 2022, section 144.69, is amended to read:

186.22 **144.69 CLASSIFICATION OF DATA ON INDIVIDUALS.**

186.23 **Subdivision 1. Data collected by the cancer reporting system.** Notwithstanding any
186.24 law to the contrary, including section 13.05, subdivision 9, data collected on individuals by
186.25 the cancer ~~surveillance~~ reporting system, including the names and personal identifiers of
186.26 persons required in section 144.68 to report, shall be private and may only be used for the
186.27 purposes set forth in this section and sections 144.671, 144.672, and 144.68. Any disclosure
186.28 other than is provided for in this section and sections 144.671, 144.672, and 144.68, is
186.29 declared to be a misdemeanor and punishable as such. Except as provided by rule, and as
186.30 part of an epidemiologic investigation, an officer or employee of the commissioner of health
186.31 may interview patients named in any such report, or relatives of any such patient, only after

187.1 ~~the consent of notifying~~ the attending physician, advanced practice registered nurse, physician
187.2 assistant, or surgeon ~~is obtained~~. Research protections for patients must be consistent with
187.3 section 13.04, subdivision 2, and Code of Federal Regulations, title 45, part 46.

187.4 **Subd. 2. Transfers of information to state cancer registries and federal government**
187.5 **agencies.** (a) Information containing personal identifiers of a non-Minnesota resident
187.6 collected by the cancer reporting system may be provided to the statewide cancer registry
187.7 of the nonresident's home state solely for the purposes consistent with this section and
187.8 sections 144.671, 144.672, and 144.68, provided that the other state agrees to maintain the
187.9 classification of the information as provided under subdivision 1.

187.10 (b) Information, excluding direct identifiers such as name, Social Security number,
187.11 telephone number, and street address, collected by the cancer reporting system may be
187.12 provided to the Centers for Disease Control and Prevention's National Program of Cancer
187.13 Registries and the National Cancer Institute's Surveillance, Epidemiology, and End Results
187.14 Program registry.

187.15 Sec. 86. **[144.7051] DEFINITIONS.**

187.16 **Subdivision 1. Applicability.** For the purposes of sections 144.7051 to 144.7058, the
187.17 terms defined in this section have the meanings given.

187.18 **Subd. 2. Concern for safe staffing form.** "Concern for safe staffing form" means a
187.19 standard uniform form developed by the commissioner that may be used by any individual
187.20 to report unsafe staffing situations while maintaining the privacy of patients.

187.21 **Subd. 3. Commissioner.** "Commissioner" means the commissioner of health.

187.22 **Subd. 4. Daily staffing schedule.** "Daily staffing schedule" means the actual number
187.23 of full-time equivalent nonmanagerial care staff assigned to an inpatient care unit and
187.24 providing care in that unit during a 24-hour period and the actual number of patients assigned
187.25 to each direct care registered nurse present and providing care in the unit.

187.26 **Subd. 5. Direct-care registered nurse.** "Direct-care registered nurse" means a registered
187.27 nurse, as defined in section 148.171, subdivision 20, who is nonsupervisory and
187.28 nonmanagerial and who directly provides nursing care to patients more than 60 percent of
187.29 the time.

187.30 **Subd. 6. Hospital.** "Hospital" means any setting that is licensed under this chapter as a
187.31 hospital.

187.32 **EFFECTIVE DATE.** This section is effective July 1, 2025.

188.1 **Sec. 87. [144.7053] HOSPITAL NURSE STAFFING COMMITTEE.**

188.2 **Subdivision 1. Hospital nurse staffing committee required.** (a) Each hospital must
188.3 establish and maintain a functioning hospital nurse staffing committee. A hospital may
188.4 assign the functions and duties of a hospital nurse staffing committee to an existing committee
188.5 provided the existing committee meets the membership requirements applicable to a hospital
188.6 nurse staffing committee.

188.7 (b) The commissioner is not required to verify compliance with this section by an on-site
188.8 visit.

188.9 **Subd. 2. Staffing committee membership.** (a) At least 35 percent of the hospital nurse
188.10 staffing committee's membership must be direct care registered nurses typically assigned
188.11 to a specific unit for an entire shift and at least 15 percent of the committee's membership
188.12 must be other direct care workers typically assigned to a specific unit for an entire shift.
188.13 Direct care registered nurses and other direct care workers who are members of a collective
188.14 bargaining unit shall be appointed or elected to the committee according to the guidelines
188.15 of the applicable collective bargaining agreement. If there is no collective bargaining
188.16 agreement, direct care registered nurses shall be elected to the committee by direct care
188.17 registered nurses employed by the hospital and other direct care workers shall be elected
188.18 to the committee by other direct care workers employed by the hospital.

188.19 (b) The hospital shall appoint 50 percent of the hospital nurse staffing committee's
188.20 membership.

188.21 **Subd. 3. Staffing committee compensation.** A hospital must treat participation in the
188.22 hospital nurse staffing committee meetings by any hospital employee as scheduled work
188.23 time and compensate each committee member at the employee's existing rate of pay. A
188.24 hospital must relieve all direct care registered nurse members of the hospital nurse staffing
188.25 committee of other work duties during the times when the committee meets.

188.26 **Subd. 4. Staffing committee meeting frequency.** Each hospital nurse staffing committee
188.27 must meet at least quarterly.

188.28 **Subd. 5. Staffing committee duties.** (a) Each hospital nurse staffing committee shall
188.29 create, implement, continuously evaluate, and update as needed evidence-based written
188.30 core staffing plans to guide the creation of daily staffing schedules for each inpatient care
188.31 unit of the hospital.

188.32 (b) Each hospital nurse staffing committee must:

189.1 (1) establish a secure, uniform, and easily accessible method for any hospital employee,
189.2 patient, or patient family member to submit directly to the committee a concern for safe
189.3 staffing form;

189.4 (2) review each concern for safe staffing form;

189.5 (3) forward a copy of all concern for safe staffing forms to the relevant hospital nurse
189.6 workload committee;

189.7 (4) review the documentation of compliance maintained by the hospital under section
189.8 144.7056, subdivision 10;

189.9 (5) conduct a trend analysis of the data related to all reported concerns regarding safe
189.10 staffing;

189.11 (6) develop a mechanism for tracking and analyzing staffing trends within the hospital;

189.12 (7) submit a nurse staffing report to the commissioner;

189.13 (8) assist the commissioner in compiling data for the Nursing Workforce Report by
189.14 encouraging participation in the commissioner's independent study on reasons licensed
189.15 registered nurses are leaving the profession; and

189.16 (9) record in the committee minutes for each meeting a summary of the discussions and
189.17 recommendations of the committee. Each committee must maintain the minutes, records,
189.18 and distributed materials for five years.

189.19 **EFFECTIVE DATE.** This section is effective July 1, 2025.

189.20 Sec. 88. **[144.7054] HOSPITAL NURSE WORKLOAD COMMITTEE.**

189.21 **Subdivision 1. Hospital nurse workload committee required.** (a) Each hospital must
189.22 establish and maintain functioning hospital nurse workload committees for each unit.

189.23 (b) The commissioner is not required to verify compliance with this section by an on-site
189.24 visit.

189.25 **Subd. 2. Workload committee membership.** (a) At least 35 percent of each workload
189.26 committee's membership must be direct care registered nurses typically assigned to the unit
189.27 for an entire shift and at least 15 percent of the committee's membership must be other direct
189.28 care workers typically assigned to the unit for an entire shift. Direct care registered nurses
189.29 and other direct care workers who are members of a collective bargaining unit shall be
189.30 appointed or elected to the committee according to the guidelines of the applicable collective
189.31 bargaining agreement. If there is no collective bargaining agreement, direct care registered

190.1 nurses shall be elected to the committee by direct care registered nurses typically assigned
190.2 to the unit for an entire shift and other direct care workers shall be elected to the committee
190.3 by other direct care workers typically assigned to the unit for an entire shift.

190.4 (b) The hospital shall appoint 50 percent of each unit's nurse workload committee's
190.5 membership.

190.6 (c) Notwithstanding paragraphs (a) and (b), if a hospital has established a staffing
190.7 committee through collective bargaining, then the composition of that committee prevails.

190.8 Subd. 3. **Workload committee compensation.** A hospital must treat participation in a
190.9 hospital nurse workload committee meeting by any hospital employee as scheduled work
190.10 time and compensate each committee member at the employee's existing rate of pay. A
190.11 hospital must relieve all direct care registered nurse members of a hospital nurse workload
190.12 committee of other work duties during the times when the committee meets.

190.13 Subd. 4. **Workload committee meeting frequency.** Each hospital nurse workload
190.14 committee must meet at least monthly whenever the committee is in receipt of an unresolved
190.15 concern for safe staffing form.

190.16 Subd. 5. **Workload committee duties.** (a) Each hospital nurse workload committee
190.17 must create, implement, and maintain dispute resolution procedures to guide the committee's
190.18 development and implementation of solutions to the staffing concerns raised in concern for
190.19 safe staffing forms that have been forwarded to the committee. The dispute resolution
190.20 procedures must include an expedited arbitration process with an arbitrator who has expertise
190.21 in patient care. The committee must use the expedited arbitration process for any complaint
190.22 that remains unresolved 30 days after the submission of the concern for safe staffing form
190.23 that gave rise to the complaint.

190.24 (b) Each hospital nurse workload committee must attempt to expeditiously resolve
190.25 staffing issues the committee determines arise from a violation of the hospital's core staffing
190.26 plan.

190.27 **EFFECTIVE DATE.** This section is effective July 1, 2025.

190.28 Sec. 89. Minnesota Statutes 2022, section 144.7055, is amended to read:

190.29 **144.7055 HOSPITAL CORE STAFFING PLAN REPORTS.**

190.30 Subdivision 1. **Definitions.** (a) For the purposes of ~~this section~~ sections 144.7051 to
190.31 144.7058, the following terms have the meanings given.

191.1 (b) "Core staffing plan" means ~~the projected number of full-time equivalent~~
 191.2 ~~nonmanagerial care staff that will be assigned in a 24-hour period to an inpatient care unit~~
 191.3 a plan described in subdivision 2.

191.4 (c) "Nonmanagerial care staff" means registered nurses, licensed practical nurses, and
 191.5 other health care workers, which may include but is not limited to nursing assistants, nursing
 191.6 aides, patient care technicians, and patient care assistants, who perform nonmanagerial
 191.7 direct patient care functions for more than 50 percent of their scheduled hours on a given
 191.8 patient care unit.

191.9 (d) "Inpatient care unit" or "unit" means a designated inpatient area for assigning patients
 191.10 and staff for which a ~~distinct staffing plan~~ daily staffing schedule exists and that operates
 191.11 24 hours per day, seven days per week in a hospital setting. Inpatient care unit does not
 191.12 include any hospital-based clinic, long-term care facility, or outpatient hospital department.

191.13 (e) "Staffing hours per patient day" means the number of full-time equivalent
 191.14 nonmanagerial care staff who will ordinarily be assigned to provide direct patient care
 191.15 divided by the expected average number of patients upon which such assignments are based.

191.16 ~~(f) "Patient acuity tool" means a system for measuring an individual patient's need for~~
 191.17 ~~nursing care. This includes utilizing a professional registered nursing assessment of patient~~
 191.18 ~~condition to assess staffing need.~~

191.19 Subd. 2. **Hospital core staffing report plans.** (a) ~~The chief nursing executive or nursing~~
 191.20 ~~designee~~ hospital nurse staffing committee of every ~~reporting~~ hospital in Minnesota ~~under~~
 191.21 ~~section 144.50 will~~ must develop a core staffing plan for each ~~patient~~ inpatient care unit.

191.22 (b) The commissioner is not required to verify compliance with this section by an on-site
 191.23 visit.

191.24 ~~(b)~~ (c) Core staffing plans ~~shall~~ must specify all of the following:

191.25 (1) the projected number of full-time equivalent for nonmanagerial care staff that will
 191.26 be assigned in a 24-hour period to each patient inpatient care unit for each 24-hour period;

191.27 (2) the maximum number of patients on each inpatient care unit for whom a direct care
 191.28 nurse can typically safely care;

191.29 (3) criteria for determining when circumstances exist on each inpatient care unit such
 191.30 that a direct care nurse cannot safely care for the typical number of patients and when
 191.31 assigning a lower number of patients to each nurse on the inpatient unit would be appropriate;

192.1 (4) a procedure for each inpatient care unit to make shift-to-shift adjustments in staffing
192.2 levels when such adjustments are required by patient acuity and nursing intensity in the
192.3 unit;

192.4 (5) a contingency plan for each inpatient unit to safely address circumstances in which
192.5 patient care needs unexpectedly exceed the staffing resources provided for in a daily staffing
192.6 schedule. A contingency plan must include a method to quickly identify, for each daily
192.7 staffing schedule, additional direct care registered nurses who are available to provide direct
192.8 care on the inpatient care unit;

192.9 (6) strategies to enable direct care registered nurses to take breaks they are entitled to
192.10 under law or under an applicable collective bargaining agreement; and

192.11 (7) strategies to eliminate patient boarding in emergency departments that do not rely
192.12 on requiring direct care registered nurses to work additional hours to provide care.

192.13 ~~(e)~~ (d) Core staffing plans must ensure that:

192.14 (1) the person creating a daily staffing schedule has sufficiently detailed information to
192.15 create a daily staffing schedule that meets the requirements of the plan;

192.16 (2) daily staffing schedules do not rely on assigning individual nonmanagerial care staff
192.17 to work overtime hours in excess of 16 hours in a 24-hour period or to work consecutive
192.18 24-hour periods requiring 16 or more hours;

192.19 (3) a direct care registered nurse is not required or expected to perform functions outside
192.20 the nurse's professional license;

192.21 (4) a light duty direct care registered nurse is given appropriate assignments;

192.22 (5) a charge nurse does not have patient assignments; and

192.23 (6) daily staffing schedules do not interfere with applicable collective bargaining
192.24 agreements.

192.25 **Subd. 2a. Development of hospital core staffing plans.** (a) Prior to submitting
192.26 completing or updating the core staffing plan, as required in subdivision 3, hospitals shall
192.27 a hospital nurse staffing committee must consult with representatives of the hospital medical
192.28 staff, managerial and nonmanagerial care staff, and other relevant hospital personnel about
192.29 the core staffing plan and the expected average number of patients upon which the core
192.30 staffing plan is based.

192.31 (b) When developing a core staffing plan, a hospital nurse staffing committee must
192.32 consider all of the following:

- 193.1 (1) the individual needs and expected census of each inpatient care unit;
- 193.2 (2) unit-specific patient acuity, including fall risk and behaviors requiring intervention,
193.3 such as physical aggression toward self or others or destruction of property;
- 193.4 (3) unit-specific demands on direct care registered nurses' time, including: frequency of
193.5 admissions, discharges, and transfers; frequency and complexity of patient evaluations and
193.6 assessments; frequency and complexity of nursing care planning; planning for patient
193.7 discharge; assessing for patient referral; patient education; and implementing infectious
193.8 disease protocols;
- 193.9 (4) the architecture and geography of the inpatient care unit, including the placement of
193.10 patient rooms, treatment areas, nursing stations, medication preparation areas, and equipment;
- 193.11 (5) mechanisms and procedures to provide for one-to-one patient observation for patients
193.12 on psychiatric or other units;
- 193.13 (6) the stress that direct-care nurses experience when required to work extreme amounts
193.14 of overtime, such as shifts in excess of 12 hours or multiple consecutive double shifts;
- 193.15 (7) the need for specialized equipment and technology on the unit;
- 193.16 (8) other special characteristics of the unit or community patient population, including
193.17 age, cultural and linguistic diversity and needs, functional ability, communication skills,
193.18 and other relevant social and socioeconomic factors;
- 193.19 (9) the skill mix of personnel other than direct care registered nurses providing or
193.20 supporting direct patient care on the unit;
- 193.21 (10) mechanisms and procedures for identifying additional registered nurses who are
193.22 available for direct patient care when patients' unexpected needs exceed the planned workload
193.23 for direct care staff; and
- 193.24 (11) demands on direct care registered nurses' time not directly related to providing
193.25 direct care on a unit, such as involvement in quality improvement activities, professional
193.26 development, service to the hospital, including serving on the hospital nurse staffing
193.27 committee or the hospital nurse workload committee, and service to the profession.
- 193.28 Subd. 2b. **Failure to develop hospital core staffing plans.** If a hospital nurse staffing
193.29 committee cannot approve a hospital core staffing plan by a majority vote, the members of
193.30 the nurse staffing committee must enter an expedited arbitration process with an arbitrator
193.31 who understands patient care needs.

194.1 Subd. 2c. **Objections to hospital core staffing plans.** (a) If hospital management objects
194.2 to a core staffing plan approved by a majority vote of the hospital nurse staffing committee,
194.3 the hospital may elect to attempt to amend the core staffing plan through arbitration.

194.4 (b) During an ongoing dispute resolution process, a hospital must continue to implement
194.5 the core staffing plan as written and approved by the hospital nurse staffing committee.

194.6 (c) If the dispute resolution process results in an amendment to the core staffing plan,
194.7 the hospital must implement the amended core staffing plan.

194.8 Subd. 2d. **Mandatory submission of core staffing plan to commissioner.** Each hospital
194.9 must submit to the commissioner the core staffing plans approved by the hospital's nurse
194.10 staffing committee. A hospital must submit any substantial updates to any previously
194.11 approved plan, including any amendments to the plan resulting from arbitration, within 30
194.12 calendar days of approval of the update by the committee or the conclusion of arbitration.

194.13 Subd. 3. **Standard electronic reporting developed.** ~~(a) Hospitals must submit the core~~
194.14 ~~staffing plans to the Minnesota Hospital Association by January 1, 2014. The Minnesota~~
194.15 ~~Hospital Association shall include each reporting hospital's core staffing plan on the~~
194.16 ~~Minnesota Hospital Association's Minnesota Hospital Quality Report website by April 1,~~
194.17 ~~2014. any substantial changes to the core staffing plan shall be updated within 30 days.~~

194.18 ~~(b) The Minnesota Hospital Association shall include on its website for each reporting~~
194.19 ~~hospital on a quarterly basis the actual direct patient care hours per patient and per unit.~~
194.20 ~~Hospitals must submit the direct patient care report to the Minnesota Hospital Association~~
194.21 ~~by July 1, 2014, and quarterly thereafter.~~

194.22 **EFFECTIVE DATE.** This section is effective July 1, 2025.

194.23 Sec. 90. **[144.7056] IMPLEMENTATION OF HOSPITAL CORE STAFFING PLANS.**

194.24 Subdivision 1. **Plan implementation required.** (a) A hospital must implement the core
194.25 staffing plans approved by a majority vote of its hospital nurse staffing committee.

194.26 (b) The commissioner is not required to verify compliance with this section by on-site
194.27 visits during routine hospital surveys.

194.28 Subd. 2. **Public posting of core staffing plans.** A hospital must post its core staffing
194.29 plan for each inpatient care unit in a public area on the relevant unit.

194.30 Subd. 3. **Public posting of compliance with plan.** For each publicly posted core staffing
194.31 plan, a hospital must post a notice stating whether the current staffing on the unit complies
194.32 with the hospital's core staffing plan for that unit. The public notice of compliance must

195.1 include a list of the number of nonmanagerial care staff working on the unit during the
195.2 current shift and the number of patients assigned to each direct care registered nurse working
195.3 on the unit during the current shift. The list must enumerate the nonmanagerial care staff
195.4 by health care worker type. The public notice of compliance must be posted immediately
195.5 adjacent to the publicly posted core staffing plan.

195.6 Subd. 4. **Posting of compliance in patient rooms.** A hospital must post on a whiteboard
195.7 in a patient's room or make available through a television in a patient's room both the number
195.8 of patients a nurse on the patient's unit should be assigned under the relevant core staffing
195.9 plan and the number of patients actually assigned to a nurse during the current shift.

195.10 Subd. 5. **Deviations from core staffing plans.** (a) Before hospital management lowers
195.11 the staffing level of any unit, management must consult with and receive agreement from
195.12 at least 50 percent of the direct care registered nurses staffing the unit.

195.13 (b) Deviation from a core staffing plan with the agreement of at least 50 percent of the
195.14 direct care registered nurses staffing the unit does not constitute compliance with the core
195.15 staffing plan.

195.16 Subd. 6. **Public posting of emergency department wait times.** A hospital must maintain
195.17 on its website and publicly display in its emergency department the approximate wait time
195.18 for patients who are not in critical need of emergency care. The approximate wait time must
195.19 be updated at least hourly.

195.20 Subd. 7. **Disclosure of staffing plan upon admission.** A hospital must provide an
195.21 explanation of its core staffing plan to each patient upon admission.

195.22 Subd. 8. **Public distribution of core staffing plan and notice of compliance.** (a) A
195.23 hospital must include with the posted materials described in subdivisions 2 and 3 a statement
195.24 that individual copies of the posted materials are available upon request to any patient on
195.25 the unit or to any visitor of a patient on the unit. The statement must include specific
195.26 instructions for obtaining copies of the posted materials.

195.27 (b) A hospital must, within four hours after the request, provide individual copies of all
195.28 the posted materials described in subdivisions 2 and 3 to any patient on the unit or to any
195.29 visitor of a patient on the unit who requests the materials.

195.30 Subd. 9. **Reporting noncompliance.** (a) Any hospital employee, patient, or patient
195.31 family member may submit a concern for safe staffing form to report an instance of
195.32 noncompliance with a hospital's core staffing plan, to object to the contents of a core staffing
195.33 plan, or to challenge the process of the hospital nurse staffing committee.

196.1 (b) A hospital must not interfere with or retaliate against a hospital employee for
196.2 submitting a concern for safe staffing form.

196.3 (c) The commissioner of labor and industry may investigate any report of retaliation
196.4 against a hospital employee for submitting a concern for safe staffing form. The commissioner
196.5 of labor and industry may fine a hospital up to \$250,000 for each instance of substantiated
196.6 retaliation against a hospital employee for submitting a concern for safe staffing form.

196.7 Subd. 10. **Documentation of compliance.** Each hospital must document compliance
196.8 with its core nursing plans and maintain records demonstrating compliance for each inpatient
196.9 care unit for five years. Each hospital must provide to its nurse staffing committee access
196.10 to all documentation required under this subdivision.

196.11 **EFFECTIVE DATE.** This section is effective October 1, 2025.

196.12 Sec. 91. **[144.7057] HOSPITAL NURSE STAFFING REPORTS.**

196.13 Subdivision 1. **Nurse staffing report required.** Each hospital nurse staffing committee
196.14 must submit quarterly nurse staffing reports to the commissioner. Reports must be submitted
196.15 within 60 days of the end of the quarter.

196.16 Subd. 2. **Nurse staffing report.** Nurse staffing reports submitted to the commissioner
196.17 by a hospital nurse staffing committee must:

196.18 (1) identify any suspected incidents of the hospital failing during the reporting quarter
196.19 to meet the standards of one of its core staffing plans;

196.20 (2) identify each occurrence of the hospital accepting an elective surgery at a time when
196.21 the unit performing the surgery is out of compliance with its core staffing plan;

196.22 (3) identify problems of insufficient staffing, including but not limited to:

196.23 (i) inappropriate number of direct care registered nurses scheduled in a unit;

196.24 (ii) inappropriate number of direct care registered nurses present and delivering care in
196.25 a unit;

196.26 (iii) inappropriately experienced direct care registered nurses scheduled for a particular
196.27 unit;

196.28 (iv) inappropriately experienced direct care registered nurses present and delivering care
196.29 in a unit;

196.30 (v) inability for nurse supervisors to adjust daily nursing schedules for increased patient
196.31 acuity or nursing intensity in a unit; and

- 197.1 (vi) chronically unfilled direct care positions within the hospital;
197.2 (4) identify any units that pose a risk to patient safety due to inadequate staffing;
197.3 (5) propose solutions to solve insufficient staffing;
197.4 (6) propose solutions to reduce risks to patient safety in inadequately staffed units; and
197.5 (7) describe staffing trends within the hospital.

197.6 Subd. 3. **Public posting of nurse staffing reports.** The commissioner must include on
197.7 its website each quarterly nurse staffing report submitted to the commissioner under
197.8 subdivision 1.

197.9 Subd. 4. **Standardized reporting.** The commissioner shall develop and provide to each
197.10 hospital nurse staffing committee a uniform format or standard form the committee must
197.11 use to comply with the nurse staffing reporting requirements under this section. The format
197.12 or form developed by the commissioner must present the reported information in a manner
197.13 allowing patients and the public to clearly understand and compare staffing patterns and
197.14 actual levels of staffing across reporting hospitals. The commissioner must include, in the
197.15 uniform format or on the standardized form, space to allow the reporting hospital to include
197.16 a description of additional resources available to support unit-level patient care and a
197.17 description of the hospital.

197.18 Subd. 5. **Penalties.** Notwithstanding section 144.653, subdivisions 5 and 6, the
197.19 commissioner may impose an immediate fine of up to \$5,000 for each instance of a failure
197.20 to report an elective surgery requiring reporting under subdivision 2, clause (2). The facility
197.21 may request a hearing on the immediate fine under section 144.653, subdivision 8.

197.22 **EFFECTIVE DATE.** This section is effective October 1, 2025.

197.23 Sec. 92. **[144.7058] GRADING OF COMPLIANCE WITH CORE STAFFING PLANS.**

197.24 Subdivision 1. **Grading compliance with core staffing plans.** By January 1, 2026, the
197.25 commissioner must develop a uniform annual grading system that evaluates each hospital's
197.26 compliance with its own core staffing plan. The commissioner must assign each hospital a
197.27 compliance grade based on a review of the hospital's nurse staffing report submitted under
197.28 section 144.7057. The commissioner must assign a failing compliance grade to any hospital
197.29 that has not been in compliance with its staffing plan for six or more months during the
197.30 reporting year.

197.31 Subd. 2. **Grading factors.** When grading a hospital's compliance with its core staffing
197.32 plan, the commissioner must consider at least the following factors:

198.1 (1) the number of assaults and injuries occurring in the hospital involving patients;

198.2 (2) the prevalence of infections, pressure ulcers, and falls among patients;

198.3 (3) emergency department wait times;

198.4 (4) readmissions;

198.5 (5) use of restraints and other behavior interventions;

198.6 (6) employment turnover rates among direct care registered nurses and other direct care

198.7 health care workers;

198.8 (7) prevalence of overtime among direct care registered nurses and other direct care

198.9 health care workers;

198.10 (8) prevalence of missed shift breaks among direct care registered nurses and other direct

198.11 care health care workers;

198.12 (9) frequency of incidents of being out of compliance with a core staffing plan; and

198.13 (10) the extent of noncompliance with a core staffing plan.

198.14 Subd. 3. **Public disclosure of compliance grades.** Beginning January 1, 2027, the

198.15 commissioner must publish a compliance grade for each hospital on the department website

198.16 with a link to the hospital's core staffing plan, the hospital's nurse staffing reports, and an

198.17 accessible and easily understandable explanation of what the compliance grade means.

198.18 **EFFECTIVE DATE.** This section is effective January 1, 2026.

198.19 Sec. 93. **[144.7059] RETALIATION AGAINST NURSES PROHIBITED.**

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

198.21 the meanings given.

198.22 (b) "Emergency" means a period when replacement staff are not able to report for duty

198.23 for the next shift, or a period of increased patient need, because of unusual, unpredictable,

198.24 or unforeseen circumstances, including but not limited to an act of terrorism, a disease

198.25 outbreak, adverse weather conditions, or a natural disaster, that impacts continuity of patient

198.26 care.

198.27 (c) "Nurse" has the meaning given in section 148.171, subdivision 9, and includes nurses

198.28 employed by the state.

199.1 (d) "Taking action against" means discharging, disciplining, threatening, reporting to
199.2 the Board of Nursing, discriminating against, or penalizing regarding compensation, terms,
199.3 conditions, location, or privileges of employment.

199.4 Subd. 2. **Prohibited actions.** Except as provided in subdivision 5, a hospital or other
199.5 entity licensed under sections 144.50 to 144.58, and its agent, or other health care facility
199.6 licensed by the commissioner of health, and the facility's agent, is prohibited from taking
199.7 action against a nurse solely on the ground that the nurse fails to accept an assignment of
199.8 one or more additional patients because the nurse determines that accepting an additional
199.9 patient assignment, in the nurse's judgment, may create an unnecessary danger to a patient's
199.10 life, health, or safety or may otherwise constitute a ground for disciplinary action under
199.11 section 148.261. This subdivision does not apply to a nursing facility, an intermediate care
199.12 facility for persons with developmental disabilities, or a licensed boarding care home.

199.13 Subd. 3. **State nurses.** Subdivision 2 applies to nurses employed by the state regardless
199.14 of the type of facility where the nurse is employed and regardless of the facility's license,
199.15 if the nurse is involved in resident or patient care.

199.16 Subd. 4. **Collective bargaining rights.** This section does not diminish or impair the
199.17 rights of a person under any collective bargaining agreement.

199.18 Subd. 5. **Emergency.** A nurse may be required to accept an additional patient assignment
199.19 in an emergency.

199.20 Subd. 6. **Enforcement.** The commissioner of labor and industry shall enforce this section.
199.21 The commissioner of labor and industry may assess a fine of up to \$5,000 for each violation
199.22 of this section.

199.23 Sec. 94. Minnesota Statutes 2022, section 144.7067, subdivision 1, is amended to read:

199.24 **Subdivision 1. Establishment of reporting system.** (a) The commissioner shall establish
199.25 an adverse health event reporting system designed to facilitate quality improvement in the
199.26 health care system. The reporting system shall not be designed to punish errors by health
199.27 care practitioners or health care facility employees.

199.28 (b) The reporting system shall consist of:

199.29 (1) mandatory reporting by facilities of 27 adverse health care events;

199.30 (2) mandatory reporting by facilities of whether the unit where an adverse event occurred
199.31 was in compliance with the core staffing plan for the unit at the time of the adverse event;

200.1 (3) mandatory completion of a root cause analysis and a corrective action plan by the
200.2 facility and reporting of the findings of the analysis and the plan to the commissioner or
200.3 reporting of reasons for not taking corrective action;

200.4 ~~(3)~~ (4) analysis of reported information by the commissioner to determine patterns of
200.5 systemic failure in the health care system and successful methods to correct these failures;

200.6 ~~(4)~~ (5) sanctions against facilities for failure to comply with reporting system
200.7 requirements; and

200.8 ~~(5)~~ (6) communication from the commissioner to facilities, health care purchasers, and
200.9 the public to maximize the use of the reporting system to improve health care quality.

200.10 (c) The commissioner is not authorized to select from or between competing alternate
200.11 acceptable medical practices.

200.12 **EFFECTIVE DATE.** This section is effective October 1, 2025.

200.13 Sec. 95. Minnesota Statutes 2022, section 144.9501, subdivision 9, is amended to read:

200.14 Subd. 9. **Elevated blood lead level.** "Elevated blood lead level" means a diagnostic
200.15 blood lead test with a result that is equal to or greater than ~~ten~~ 3.5 micrograms of lead per
200.16 deciliter of whole blood in any person, unless the commissioner finds that a lower
200.17 concentration is necessary to protect public health.

200.18 Sec. 96. Minnesota Statutes 2022, section 144.9501, subdivision 17, is amended to read:

200.19 Subd. 17. **Lead hazard reduction.** (a) "Lead hazard reduction" means abatement, swab
200.20 team services, or interim controls undertaken to make a residence, child care facility, school,
200.21 playground, or other location where lead hazards are identified lead-safe by complying with
200.22 the lead standards and methods adopted under section 144.9508.

200.23 (b) Lead hazard reduction does not include renovation activity that is primarily intended
200.24 to remodel, repair, or restore a given structure or dwelling rather than abate or control
200.25 lead-based paint hazards.

200.26 (c) Lead hazard reduction does not include activities that disturb painted surfaces that
200.27 total:

200.28 (1) less than 20 square feet (two square meters) on exterior surfaces; or

200.29 (2) less than two square feet (0.2 square meters) in an interior room.

201.1 Sec. 97. Minnesota Statutes 2022, section 144.9501, subdivision 26a, is amended to read:

201.2 Subd. 26a. **Regulated lead work.** ~~(a)~~ "Regulated lead work" means:

201.3 (1) abatement;

201.4 (2) interim controls;

201.5 (3) a clearance inspection;

201.6 (4) a lead hazard screen;

201.7 (5) a lead inspection;

201.8 (6) a lead risk assessment;

201.9 (7) lead project designer services;

201.10 (8) lead sampling technician services;

201.11 (9) swab team services;

201.12 (10) renovation activities; ~~or~~

201.13 (11) lead hazard reduction; or

201.14 ~~(11)~~ (12) activities performed to comply with lead orders issued by a community health
201.15 ~~board~~ an assessing agency.

201.16 ~~(b) Regulated lead work does not include abatement, interim controls, swab team services,~~
201.17 ~~or renovation activities that disturb painted surfaces that total no more than:~~

201.18 ~~(1) 20 square feet (two square meters) on exterior surfaces; or~~

201.19 ~~(2) six square feet (0.6 square meters) in an interior room.~~

201.20 Sec. 98. Minnesota Statutes 2022, section 144.9501, subdivision 26b, is amended to read:

201.21 Subd. 26b. **Renovation.** (a) "Renovation" means the modification of any pre-1978

201.22 affected property for compensation that results in the disturbance of known or presumed

201.23 lead-containing painted surfaces defined under section 144.9508, unless that activity is

201.24 performed as lead hazard reduction. A renovation performed for the purpose of converting

201.25 a building or part of a building into an affected property is a renovation under this

201.26 subdivision.

201.27 (b) Renovation does not include minor repair and maintenance activities described in

201.28 this paragraph. All activities that disturb painted surfaces and are performed within 30 days

201.29 of other activities that disturb painted surfaces in the same room must be considered a single

202.1 project when applying the criteria below. Unless the activity involves window replacement
202.2 or demolition of a painted surface, building component, or portion of a structure, for purposes
202.3 of this paragraph, "minor repair and maintenance" means activities that disturb painted
202.4 surfaces totaling:

202.5 (1) less than 20 square feet (two square meters) on exterior surfaces; or

202.6 (2) less than six square feet (0.6 square meters) in an interior room.

202.7 (c) Renovation does not include total demolition of a freestanding structure. For purposes
202.8 of this paragraph, "total demolition" means demolition and disposal of all interior and
202.9 exterior painted surfaces, including windows. Unpainted foundation building components
202.10 remaining after total demolition may be reused.

202.11 Sec. 99. Minnesota Statutes 2022, section 144.9501, is amended by adding a subdivision
202.12 to read:

202.13 Subd. 33. **Compensation.** "Compensation" means money or other mutually agreed upon
202.14 form of payment given or received for regulated lead work, including rental payments,
202.15 rental income, or salaries derived from rental payments.

202.16 Sec. 100. Minnesota Statutes 2022, section 144.9501, is amended by adding a subdivision
202.17 to read:

202.18 Subd. 34. **Individual.** "Individual" means a natural person.

202.19 Sec. 101. Minnesota Statutes 2022, section 144.9505, subdivision 1, is amended to read:

202.20 Subdivision 1. **Licensing, certification, and permitting.** (a) Fees collected under this
202.21 section shall be deposited into the state treasury and credited to the state government special
202.22 revenue fund.

202.23 (b) Persons shall not advertise or otherwise present themselves as lead supervisors, lead
202.24 workers, lead inspectors, lead risk assessors, lead sampling technicians, lead project designers,
202.25 renovation firms, or lead firms unless they have licenses or certificates issued by the
202.26 commissioner under this section.

202.27 (c) The fees required in this section for inspectors, risk assessors, and certified lead firms
202.28 are waived for state or local government employees performing services for or as an assessing
202.29 agency.

202.30 (d) ~~An individual who is the owner of property on which regulated lead work is to be~~
202.31 ~~performed or an adult individual who is related to the property owner, as defined under~~

203.1 ~~section 245A.02, subdivision 13, is exempt from the requirements to obtain a license and~~
 203.2 ~~pay a fee according to this section.~~ Individual residential property owners who perform
 203.3 regulated lead work on their own residence are exempt from the licensure and firm
 203.4 certification requirements of this section. Notwithstanding the provisions of paragraphs (a)
 203.5 to (c), this exemption does not apply when the regulated lead work is a renovation performed
 203.6 for compensation, when a child with an elevated blood level has been identified in the
 203.7 residence or the building in which the residence is located, or when the residence is occupied
 203.8 by one or more individuals who are not related to the property owner, as defined under
 203.9 section 245A.02, subdivision 13.

203.10 ~~(e) A person that employs individuals to perform regulated lead work outside of the~~
 203.11 ~~person's property must obtain certification as a certified lead firm. An individual who~~
 203.12 ~~performs lead hazard reduction, lead hazard screens, lead inspections, lead risk assessments,~~
 203.13 ~~clearance inspections, lead project designer services, lead sampling technician services,~~
 203.14 ~~swab team services, and activities performed to comply with lead orders must be employed~~
 203.15 ~~by a certified lead firm, unless the individual is a sole proprietor and does not employ any~~
 203.16 ~~other individuals, the individual is employed by a person that does not perform regulated~~
 203.17 ~~lead work outside of the person's property, or the individual is employed by an assessing~~
 203.18 ~~agency.~~

203.19 Sec. 102. Minnesota Statutes 2022, section 144.9505, subdivision 1g, is amended to read:

203.20 Subd. 1g. **Certified lead firm.** A person who performs or employs individuals to perform
 203.21 regulated lead work, with the exception of renovation, ~~outside of the person's property~~ must
 203.22 obtain certification as a lead firm. The certificate must be in writing, contain an expiration
 203.23 date, be signed by the commissioner, and give the name and address of the person to whom
 203.24 it is issued. A lead firm certificate is valid for one year. The certification fee is \$100, is
 203.25 nonrefundable, and must be submitted with each application. The lead firm certificate or a
 203.26 copy of the certificate must be readily available at the worksite for review by the contracting
 203.27 entity, the commissioner, and other public health officials charged with the health, safety,
 203.28 and welfare of the state's citizens.

203.29 Sec. 103. Minnesota Statutes 2022, section 144.9505, subdivision 1h, is amended to read:

203.30 Subd. 1h. **Certified renovation firm.** A person who performs or employs individuals
 203.31 to perform renovation ~~activities outside of the person's property~~ for compensation must
 203.32 obtain certification as a renovation firm. The certificate must be in writing, contain an
 203.33 expiration date, be signed by the commissioner, and give the name and address of the person

204.1 to whom it is issued. A renovation firm certificate is valid for two years. The certification
204.2 fee is \$100, is nonrefundable, and must be submitted with each application. The renovation
204.3 firm certificate or a copy of the certificate must be readily available at the worksite for
204.4 review by the contracting entity, the commissioner, and other public health officials charged
204.5 with the health, safety, and welfare of the state's citizens.

204.6 Sec. 104. Minnesota Statutes 2022, section 144.9508, subdivision 2, is amended to read:

204.7 Subd. 2. **Regulated lead work standards and methods.** (a) The commissioner shall
204.8 adopt rules establishing regulated lead work standards and methods in accordance with the
204.9 provisions of this section, for lead in paint, dust, drinking water, and soil in a manner that
204.10 protects public health and the environment for all residences, including residences also used
204.11 for a commercial purpose, child care facilities, playgrounds, and schools.

204.12 (b) In the rules required by this section, the commissioner shall require lead hazard
204.13 reduction of intact paint only if the commissioner finds that the intact paint is on a chewable
204.14 or lead-dust producing surface that is a known source of actual lead exposure to a specific
204.15 individual. The commissioner shall prohibit methods that disperse lead dust into the air that
204.16 could accumulate to a level that would exceed the lead dust standard specified under this
204.17 section. The commissioner shall work cooperatively with the commissioner of administration
204.18 to determine which lead hazard reduction methods adopted under this section may be used
204.19 for lead-safe practices including prohibited practices, preparation, disposal, and cleanup.
204.20 The commissioner shall work cooperatively with the commissioner of the Pollution Control
204.21 Agency to develop disposal procedures. In adopting rules under this section, the
204.22 commissioner shall require the best available technology for regulated lead work methods,
204.23 paint stabilization, and repainting.

204.24 (c) The commissioner of health shall adopt regulated lead work standards and methods
204.25 for lead in bare soil in a manner to protect public health and the environment. The
204.26 commissioner shall adopt a maximum standard of 100 parts of lead per million in bare soil.
204.27 The commissioner shall set a soil replacement standard not to exceed 25 parts of lead per
204.28 million. Soil lead hazard reduction methods shall focus on erosion control and covering of
204.29 bare soil.

204.30 (d) The commissioner shall adopt regulated lead work standards and methods for lead
204.31 in dust in a manner to protect the public health and environment. Dust standards shall use
204.32 a weight of lead per area measure and include dust on the floor, on the window sills, and
204.33 on window wells. Lead hazard reduction methods for dust shall focus on dust removal and
204.34 other practices which minimize the formation of lead dust from paint, soil, or other sources.

205.1 (e) The commissioner shall adopt lead hazard reduction standards and methods for lead
205.2 in drinking water both at the tap and public water supply system or private well in a manner
205.3 to protect the public health and the environment. The commissioner may adopt the rules
205.4 for controlling lead in drinking water as contained in Code of Federal Regulations, title 40,
205.5 part 141. Drinking water lead hazard reduction methods may include an educational approach
205.6 of minimizing lead exposure from lead in drinking water.

205.7 (f) The commissioner of the Pollution Control Agency shall adopt rules to ensure that
205.8 removal of exterior lead-based coatings from residences and steel structures by abrasive
205.9 blasting methods is conducted in a manner that protects health and the environment.

205.10 (g) All regulated lead work standards shall provide reasonable margins of safety that
205.11 are consistent with more than a summary review of scientific evidence and an emphasis on
205.12 overprotection rather than underprotection when the scientific evidence is ambiguous.

205.13 (h) No unit of local government shall have an ordinance or regulation governing regulated
205.14 lead work standards or methods for lead in paint, dust, drinking water, or soil that require
205.15 a different regulated lead work standard or method than the standards or methods established
205.16 under this section.

205.17 (i) Notwithstanding paragraph (h), the commissioner may approve the use by a unit of
205.18 local government of an innovative lead hazard reduction method which is consistent in
205.19 approach with methods established under this section.

205.20 (j) The commissioner shall adopt rules for issuing lead orders required under section
205.21 144.9504, rules for notification of abatement or interim control activities requirements, and
205.22 other rules necessary to implement sections 144.9501 to 144.9512.

205.23 (k) The commissioner shall adopt rules consistent with section 402(c)(3) of the Toxic
205.24 Substances Control Act and all regulations adopted thereunder to ensure that renovation in
205.25 a pre-1978 affected property ~~where a child or pregnant female resides~~ is conducted in a
205.26 manner that protects health and the environment. Notwithstanding sections 14.125 and
205.27 14.128, the authority to adopt these rules does not expire.

205.28 (l) The commissioner shall adopt rules consistent with sections 406(a) and 406(b) of the
205.29 Toxic Substances Control Act. Notwithstanding sections 14.125 and 14.128, the authority
205.30 to adopt these rules does not expire.

205.31 Sec. 105. Minnesota Statutes 2022, section 144A.06, subdivision 2, is amended to read:

205.32 Subd. 2. **New license required; change of ownership.** (a) The commissioner of health
205.33 by rule shall prescribe procedures for licensure under this section.

206.1 (b) A new license is required and the prospective licensee must apply for a license prior
206.2 to operating a currently licensed nursing home. The licensee must change whenever one of
206.3 the following events occur:

206.4 (1) the form of the licensee's legal entity structure is converted or changed to a different
206.5 type of legal entity structure;

206.6 (2) the licensee dissolves, consolidates, or merges with another legal organization and
206.7 the licensee's legal organization does not survive;

206.8 (3) within the previous 24 months, 50 percent or more of the licensee's ownership interest
206.9 is transferred, whether by a single transaction or multiple transactions to:

206.10 (i) a different person or multiple different persons; or

206.11 (ii) a person or multiple persons who had less than a five percent ownership interest in
206.12 the facility at the time of the first transaction; or

206.13 (4) any other event or combination of events that results in a substitution, elimination,
206.14 or withdrawal of the licensee's responsibility for the facility.

206.15 Sec. 106. Minnesota Statutes 2022, section 144A.071, subdivision 2, is amended to read:

206.16 Subd. 2. **Moratorium.** (a) The commissioner of health, in coordination with the
206.17 commissioner of human services, shall deny each request for new licensed or certified
206.18 nursing home or certified boarding care beds except as provided in subdivision 3 or 4a, or
206.19 section 144A.073. "Certified bed" means a nursing home bed or a boarding care bed certified
206.20 by the commissioner of health for the purposes of the medical assistance program, under
206.21 United States Code, title 42, sections 1396 et seq. Certified beds in facilities which do not
206.22 allow medical assistance intake shall be deemed to be decertified for purposes of this section
206.23 only.

206.24 (b) The commissioner of human services, in coordination with the commissioner of
206.25 health, shall deny any request to issue a license under section 252.28 and chapter 245A to
206.26 a nursing home or boarding care home, if that license would result in an increase in the
206.27 medical assistance reimbursement amount.

206.28 (c) In addition, the commissioner of health must not approve any construction project
206.29 whose cost exceeds \$1,000,000, unless:

206.30 ~~(a)~~ (1) any construction costs exceeding \$1,000,000 are not added to the facility's
206.31 appraised value and are not included in the facility's payment rate for reimbursement under
206.32 the medical assistance program; or

207.1 ~~(b)~~ (2) the project:

207.2 ~~(1)~~ (i) has been approved through the process described in section 144A.073;

207.3 ~~(2)~~ (ii) meets an exception in subdivision 3 or 4a;

207.4 ~~(3)~~ (iii) is necessary to correct violations of state or federal law issued by the
207.5 commissioner of health;

207.6 ~~(4)~~ (iv) is necessary to repair or replace a portion of the facility that was damaged by
207.7 fire, lightning, ground shifts, or other such hazards, including environmental hazards,
207.8 provided that the provisions of subdivision 4a, clause (a), are met; or

207.9 ~~(5)~~ (v) is being proposed by a licensed nursing facility that is not certified to participate
207.10 in the medical assistance program and will not result in new licensed or certified beds.

207.11 (d) Prior to the final plan approval of any construction project, the commissioners of
207.12 health and human services shall be provided with an itemized cost estimate for the project
207.13 construction costs. If a construction project is anticipated to be completed in phases, the
207.14 total estimated cost of all phases of the project shall be submitted to the commissioners and
207.15 shall be considered as one construction project. Once the construction project is completed
207.16 and prior to the final clearance by the commissioners, the total project construction costs
207.17 for the construction project shall be submitted to the commissioners. If the final project
207.18 construction cost exceeds the dollar threshold in this subdivision, the commissioner of
207.19 human services shall not recognize any of the project construction costs or the related
207.20 financing costs in excess of this threshold in establishing the facility's property-related
207.21 payment rate.

207.22 (e) The dollar thresholds for construction projects are as follows: for construction projects
207.23 other than those authorized in ~~clauses (1) to (6)~~ paragraph (c), clause (2), items (i) to (v),
207.24 the dollar threshold is \$1,000,000. For projects authorized after July 1, 1993, under ~~clause~~
207.25 ~~(1)~~ paragraph (c), clause (2), item (i), the dollar threshold is the cost estimate submitted
207.26 with a proposal for an exception under section 144A.073, plus inflation as calculated
207.27 according to section 256B.431, subdivision 3f, paragraph (a). For projects authorized under
207.28 ~~clauses (2) to (4)~~ paragraph (c), clause (2), items (ii) to (iv), the dollar threshold is the
207.29 itemized estimate project construction costs submitted to the commissioner of health at the
207.30 time of final plan approval, plus inflation as calculated according to section 256B.431,
207.31 subdivision 3f, paragraph (a).

208.1 (f) The commissioner of health shall adopt rules to implement this section or to amend
208.2 the emergency rules for granting exceptions to the moratorium on nursing homes under
208.3 section 144A.073.

208.4 (g) All construction projects approved through section 144A.073, subdivision 3, after
208.5 March 1, 2020, are subject to the fair rental value property rate as described in section
208.6 256R.26.

208.7 **EFFECTIVE DATE.** This section is effective retroactively from March 1, 2020.

208.8 Sec. 107. Minnesota Statutes 2022, section 144A.073, subdivision 3b, is amended to read:

208.9 Subd. 3b. **Amendments to approved projects.** (a) Nursing facilities that have received
208.10 approval ~~on or after July 1, 1993,~~ for exceptions to the moratorium on nursing homes through
208.11 the process described in this section may request amendments to the designs of the projects
208.12 by writing the commissioner within 15 months of receiving approval. Applicants shall
208.13 submit supporting materials that demonstrate how the amended projects meet the criteria
208.14 described in paragraph (b).

208.15 (b) The commissioner shall approve requests for amendments for projects approved ~~on~~
208.16 ~~or after July 1, 1993,~~ according to the following criteria:

208.17 (1) the amended project designs must provide solutions to all of the problems addressed
208.18 by the original application that are at least as effective as the original solutions;

208.19 (2) the amended project designs may not reduce the space in each resident's living area
208.20 or in the total amount of common space devoted to resident and family uses by more than
208.21 five percent;

208.22 (3) the costs ~~recognized for reimbursement~~ of amended project designs shall be ~~the~~
208.23 ~~threshold amount of the original proposal as identified according to section 144A.071,~~
208.24 ~~subdivision 2~~ the cost estimate associated with the project as originally approved, except
208.25 under conditions described in clause (4); and

208.26 (4) total costs ~~up to ten percent greater than the cost identified in clause (3) may be~~
208.27 ~~recognized for reimbursement if~~ of the amendment are no greater than ten percent of the
208.28 cost estimate associated with the project as initially approved if the proposer can document
208.29 that one of the following circumstances is true:

208.30 (i) changes are needed due to a natural disaster;

208.31 (ii) conditions that affect the safety or durability of the project that could not have
208.32 reasonably been known prior to approval are discovered;

209.1 (iii) state or federal law require changes in project design; or

209.2 (iv) documentable circumstances occur that are beyond the control of the owner and
209.3 require changes in the design.

209.4 (c) Approval of a request for an amendment does not alter the expiration of approval of
209.5 the project according to subdivision 3.

209.6 (d) Reimbursement for amendments to approved projects is independent of the actual
209.7 construction costs and based on the allowable appraised value of the completed project. An
209.8 approved project may not be amended to reduce the scope of an approved project.

209.9 **EFFECTIVE DATE.** This section is effective retroactively from March 1, 2020.

209.10 Sec. 108. Minnesota Statutes 2022, section 144A.474, subdivision 3, is amended to read:

209.11 Subd. 3. **Survey process.** The survey process for core surveys shall include the following
209.12 as applicable to the particular licensee and setting surveyed:

209.13 (1) presurvey review of pertinent documents and notification to the ombudsman for
209.14 long-term care;

209.15 (2) an entrance conference with available staff;

209.16 (3) communication with managerial officials or the registered nurse in charge, if available,
209.17 and ongoing communication with key staff throughout the survey regarding information
209.18 needed by the surveyor, clarifications regarding home care requirements, and applicable
209.19 standards of practice;

209.20 (4) presentation of written contact information to the provider about the survey staff
209.21 conducting the survey, the supervisor, and the process for requesting a reconsideration of
209.22 the survey results;

209.23 (5) a brief tour of ~~a sample of the housing with services establishments~~ establishment
209.24 in which the provider is providing home care services;

209.25 (6) a sample selection of home care clients;

209.26 (7) information-gathering through client and staff observations, client and staff interviews,
209.27 and reviews of records, policies, procedures, practices, and other agency information;

209.28 (8) interviews of clients' family members, if available, with clients' consent when the
209.29 client can legally give consent;

209.30 (9) except for complaint surveys conducted by the Office of Health Facilities Complaints,
209.31 an ~~on-site~~ exit conference, with preliminary findings ~~shared and~~ discussed with the provider

210.1 within one business day after completion of survey activities, ~~documentation that an exit~~
210.2 ~~conference occurred~~, and with written information provided on the process for requesting
210.3 a reconsideration of the survey results; and

210.4 (10) postsurvey analysis of findings and formulation of survey results, including
210.5 correction orders when applicable.

210.6 Sec. 109. Minnesota Statutes 2022, section 144A.474, subdivision 9, is amended to read:

210.7 Subd. 9. **Follow-up surveys.** For providers that have Level 3 or Level 4 violations under
210.8 subdivision 11, ~~or any violations determined to be widespread~~, the department shall conduct
210.9 a follow-up survey within 90 calendar days of the survey. When conducting a follow-up
210.10 survey, the surveyor will focus on whether the previous violations have been corrected and
210.11 may also address any new violations that are observed while evaluating the corrections that
210.12 have been made.

210.13 Sec. 110. Minnesota Statutes 2022, section 144A.474, subdivision 12, is amended to read:

210.14 Subd. 12. **Reconsideration.** (a) The commissioner shall make available to home care
210.15 providers a correction order reconsideration process. This process may be used to challenge
210.16 the correction order issued, including the level and scope described in subdivision 11, and
210.17 any fine assessed. During the correction order reconsideration request, the issuance for the
210.18 correction orders under reconsideration are not stayed, but the department shall post
210.19 information on the website with the correction order that the licensee has requested a
210.20 reconsideration and that the review is pending.

210.21 (b) A licensed home care provider may request from the commissioner, in writing, a
210.22 correction order reconsideration regarding any correction order issued to the provider. The
210.23 written request for reconsideration must be received by the commissioner within 15 ~~calendar~~
210.24 business days of the correction order receipt date. The correction order reconsideration shall
210.25 not be reviewed by any surveyor, investigator, or supervisor that participated in the writing
210.26 or reviewing of the correction order being disputed. The correction order reconsiderations
210.27 may be conducted in person, by telephone, by another electronic form, or in writing, as
210.28 determined by the commissioner. The commissioner shall respond in writing to the request
210.29 from a home care provider for a correction order reconsideration within 60 days of the date
210.30 the provider requests a reconsideration. The commissioner's response shall identify the
210.31 commissioner's decision regarding each citation challenged by the home care provider.

210.32 (c) The findings of a correction order reconsideration process shall be one or more of
210.33 the following:

211.1 (1) supported in full, the correction order is supported in full, with no deletion of findings
211.2 to the citation;

211.3 (2) supported in substance, the correction order is supported, but one or more findings
211.4 are deleted or modified without any change in the citation;

211.5 (3) correction order cited an incorrect home care licensing requirement, the correction
211.6 order is amended by changing the correction order to the appropriate statutory reference;

211.7 (4) correction order was issued under an incorrect citation, the correction order is amended
211.8 to be issued under the more appropriate correction order citation;

211.9 (5) the correction order is rescinded;

211.10 (6) fine is amended, it is determined that the fine assigned to the correction order was
211.11 applied incorrectly; or

211.12 (7) the level or scope of the citation is modified based on the reconsideration.

211.13 (d) If the correction order findings are changed by the commissioner, the commissioner
211.14 shall update the correction order website.

211.15 (e) This subdivision does not apply to temporary licensees.

211.16 Sec. 111. Minnesota Statutes 2022, section 144A.4791, subdivision 10, is amended to
211.17 read:

211.18 Subd. 10. **Termination of service plan.** (a) If a home care provider terminates a service
211.19 plan with a client, and the client continues to need home care services, the home care provider
211.20 shall provide the client and the client's representative, if any, with a written notice of
211.21 termination which includes the following information:

211.22 (1) the effective date of termination;

211.23 (2) the reason for termination;

211.24 (3) a statement that the client may contact the Office of Ombudsman for Long-Term
211.25 Care to request an advocate to assist regarding the termination and contact information for
211.26 the office, including the office's central telephone number;

211.27 ~~(3)~~ (4) a list of known licensed home care providers in the client's immediate geographic
211.28 area;

211.29 ~~(4)~~ (5) a statement that the home care provider will participate in a coordinated transfer
211.30 of care of the client to another home care provider, health care provider, or caregiver, as
211.31 required by the home care bill of rights, section 144A.44, subdivision 1, clause (17);

212.1 ~~(5)~~ (6) the name and contact information of a person employed by the home care provider
212.2 with whom the client may discuss the notice of termination; and

212.3 ~~(6)~~ (7) if applicable, a statement that the notice of termination of home care services
212.4 does not constitute notice of termination of ~~the housing with services contract with a housing~~
212.5 ~~with services establishment~~ any housing contract.

212.6 (b) When the home care provider voluntarily discontinues services to all clients, the
212.7 home care provider must notify the commissioner, lead agencies, and ombudsman for
212.8 long-term care about its clients and comply with the requirements in this subdivision.

212.9 Sec. 112. Minnesota Statutes 2022, section 144G.16, subdivision 7, is amended to read:

212.10 Subd. 7. **Fines and penalties.** (a) The fee ~~fine~~ for failure to comply with the notification
212.11 requirements in section 144G.52, subdivision 7, is \$1,000.

212.12 (b) Fines and penalties collected under this section shall be deposited in a dedicated
212.13 special revenue account. On an annual basis, the balance in the special revenue account
212.14 shall be appropriated to the commissioner to implement the recommendations of the advisory
212.15 council established in section 144A.4799.

212.16 Sec. 113. Minnesota Statutes 2022, section 144G.18, is amended to read:

212.17 **144G.18 NOTIFICATION OF CHANGES IN INFORMATION.**

212.18 Subdivision 1. Notification. A provisional licensee or licensee shall notify the
212.19 commissioner in writing prior to a change in the manager or authorized agent and within
212.20 60 calendar days after any change in the information required in section 144G.12, subdivision
212.21 1, clause (1), (3), (4), (17), or (18).

212.22 Subd. 2. Fines and penalties. (a) The fine for failure to comply with the notification
212.23 requirements of this section is \$1,000.

212.24 (b) Fines and penalties collected under this subdivision shall be deposited in a dedicated
212.25 special revenue account. On an annual basis, the balance in the special revenue account
212.26 shall be appropriated to the commissioner to implement the recommendations of the advisory
212.27 council established in section 144A.4799.

212.28 Sec. 114. Minnesota Statutes 2022, section 144G.57, subdivision 8, is amended to read:

212.29 Subd. 8. ~~Fine~~ **Fines and penalties.** (a) The commissioner may impose a fine for failure
212.30 to follow the requirements of this section.

213.1 (b) The fine for failure to comply with this section is \$1,000.

213.2 (c) Fines and penalties collected under this section shall be deposited in a dedicated
213.3 special revenue account. On an annual basis, the balance in the special revenue account
213.4 shall be appropriated to the commissioner to implement the recommendations of the advisory
213.5 council established in section 144A.4799.

213.6 Sec. 115. Minnesota Statutes 2022, section 145.411, subdivision 1, is amended to read:

213.7 Subdivision 1. **Terms.** As used in sections 145.411 to ~~145.416~~ 145.414, the terms defined
213.8 in this section have the meanings given to them.

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

213.10 Sec. 116. Minnesota Statutes 2022, section 145.411, subdivision 5, is amended to read:

213.11 Subd. 5. **Abortion.** "Abortion" includes an act, procedure or use of any instrument,
213.12 medicine or drug which is supplied or prescribed for or administered to ~~a pregnant woman~~
213.13 an individual with the intention of terminating, and which results in the termination of,
213.14 pregnancy.

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

213.16 Sec. 117. Minnesota Statutes 2022, section 145.423, subdivision 1, is amended to read:

213.17 Subdivision 1. **Recognition; medical care.** ~~A born alive~~ An infant as a result of an
213.18 ~~abortion~~ who is born alive shall be fully recognized as a human person, and accorded
213.19 immediate protection under the law. All reasonable measures consistent with good medical
213.20 practice, including the compilation of appropriate medical records, shall be taken by the
213.21 responsible medical personnel to ~~preserve the life and health of the born alive infant~~ care
213.22 for the infant who is born alive.

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

213.24 Sec. 118. [145.561] 988 SUICIDE AND CRISIS LIFELINE.

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

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

213.28 (c) "Department" means the Department of Health.

214.1 (d) "988" means the universal telephone number designated as the universal telephone
214.2 number within the United States for the purpose of the national suicide prevention and
214.3 mental health crisis hotline system operating through the 988 Suicide and Crisis Lifeline,
214.4 or its successor, maintained by the Assistant Secretary for Mental Health and Substance
214.5 Use under section 520E-3 of the Public Health Service Act (United States Code, title 42,
214.6 sections 290bb-36c).

214.7 (e) "988 administrator" means the administrator of the national 988 Suicide and Crisis
214.8 Lifeline maintained by the Assistant Secretary for Mental Health and Substance Use under
214.9 section 520E-3 of the Public Health Service Act.

214.10 (f) "988 contact" means a communication with the 988 Suicide and Crisis Lifeline system
214.11 within the United States via modalities offered including call, chat, or text.

214.12 (g) "988 Lifeline Center" means a state-identified center that is a member of the Suicide
214.13 and Crisis Lifeline network that responds to statewide or regional 988 contacts.

214.14 (h) "988 Suicide and Crisis Lifeline" or "988 Lifeline" means the national suicide
214.15 prevention and mental health crisis hotline system maintained by the Assistant Secretary
214.16 for Mental Health and Substance Use under section 520E-3 of the Public Health Service
214.17 Act (United States Code, title 42, sections 290bb-36c).

214.18 (i) "Veterans Crisis Line" means the Veterans Crisis Line maintained by the Secretary
214.19 of Veterans Affairs under United States Code, title 38, section 170F(h).

214.20 Subd. 2. **988 Lifeline.** (a) The commissioner shall administer the designation of and
214.21 oversight for a 988 Lifeline center or a network of 988 Lifeline centers to answer contacts
214.22 from individuals accessing the Suicide and Crisis Lifeline from any jurisdiction within the
214.23 state 24 hours per day, seven days per week.

214.24 (b) The designated 988 Lifeline Center must:

214.25 (1) have an active agreement with the 988 Suicide and Crisis Lifeline program for
214.26 participation in the network and the department;

214.27 (2) meet the 988 Lifeline program requirements and best practice guidelines for
214.28 operational and clinical standards;

214.29 (3) provide data and reports, and participate in evaluations and related quality
214.30 improvement activities as required by the 988 Lifeline program and the department;

215.1 (4) identify or adapt technology that is demonstrated to be interoperable across Mobile
215.2 Crisis and Public Safety Answering Points used in the state for the purpose of crisis care
215.3 coordination;

215.4 (5) facilitate crisis and outgoing services, including mobile crisis teams in accordance
215.5 with guidelines established by the 988 Lifeline program and the department;

215.6 (6) actively collaborate and coordinate service linkages with mental health and substance
215.7 use disorder treatment providers, local community mental health centers including certified
215.8 community behavioral health clinics and community behavioral health centers, mobile crisis
215.9 teams, and community based and hospital emergency departments;

215.10 (7) offer follow-up services to individuals accessing the 988 Lifeline Center that are
215.11 consistent with guidance established by the 988 Lifeline program and the department; and

215.12 (8) meet the requirements set by the 988 Lifeline program and the department for serving
215.13 at-risk and specialized populations.

215.14 (c) The department shall adopt rules and regulations to allow appropriate information
215.15 sharing and communication between and across crisis and emergency response systems.

215.16 (d) The department, having primary oversight of suicide prevention, shall work with the
215.17 988 Lifeline program, veterans crisis line, and other SAMHSA-approved networks for the
215.18 purpose of ensuring consistency of public messaging about 988 services. The department
215.19 may use funds under this section or provide grants to organizations in order to publicize
215.20 and raise awareness about 988 services.

215.21 (e) The department shall work with representatives from 988 Lifeline Centers and public
215.22 safety answering points, other public safety agencies, and the commissioner of public safety
215.23 to facilitate the development of protocols and procedures for interactions between 988 and
215.24 911 services across Minnesota. Protocols and procedures shall be developed following
215.25 available national standards and guidelines.

215.26 (f) The department shall provide an annual report of the 988 Lifeline usage including
215.27 answer rates, abandoned calls, and referrals to 911 emergency response.

215.28 Subd. 3. **988 special revenue account established.** (a) There is established a dedicated
215.29 account in the special revenue fund to create and maintain a statewide 988 suicide and crisis
215.30 lifeline system pursuant to the National Suicide Hotline Designation Act of 2020, the Federal
215.31 Communications Commission's rules adopted July 16, 2020, and national guidelines for
215.32 crisis care.

215.33 (b) The account shall consist of:

- 216.1 (1) a 988 telecommunication fee imposed under this section;
- 216.2 (2) a prepaid wireless 988 fee imposed under section 403.161;
- 216.3 (3) appropriations made by the state legislature;
- 216.4 (4) grants and gifts intended for deposit;
- 216.5 (5) interest, premiums, gains, or other earnings on the account; and
- 216.6 (6) money from any other source that is deposited in or transferred to the account.
- 216.7 (c) The account shall be administered by the department, and money in the account shall
- 216.8 be expended to offset costs that are or can be reasonably attributed to:
- 216.9 (1) implementing, maintaining, and improving the 988 suicide and crisis lifeline including
- 216.10 staffing and technological infrastructure enhancements necessary to achieve operational
- 216.11 standards and best practices set by the 988 lifeline and the department;
- 216.12 (2) personnel for 988 lifeline centers;
- 216.13 (3) data collection, reporting, participation in evaluations, public promotion, and related
- 216.14 quality improvement activities as required by the 988 administrator and the department;
- 216.15 and
- 216.16 (4) administration, oversight, and evaluation of the account.
- 216.17 (d) Money in the fund:
- 216.18 (1) does not revert at the end of any state fiscal year but remains available for the purposes
- 216.19 of the account in subsequent state fiscal years;
- 216.20 (2) is not subject to transfer to any other fund or to transfer, assignment, or reassignment
- 216.21 for any other use or purpose; and
- 216.22 (3) is appropriated to the commissioner for the purposes of the account.
- 216.23 (e) An annual report of funds, deposits, and expenditures shall be made to the Federal
- 216.24 Communications Commission.
- 216.25 Subd. 4. **988 telecommunication fee.** (a) In compliance with the National Suicide Hotline
- 216.26 Designation Act of 2020, the department shall impose a monthly statewide fee on each
- 216.27 subscriber of a wireline, wireless, and IP-enabled voice service at a rate that provides for
- 216.28 the robust creation, operation, and maintenance of a statewide 988 suicide prevention and
- 216.29 crisis system.

217.1 (b) The commissioner shall annually recommend to the Public Utilities Commission an
217.2 adequate and appropriate fee to implement this section. The commissioner shall provide
217.3 telecommunication service providers and carriers a minimum of 30 days' notice of each fee
217.4 change.

217.5 (c) The amount of the 988 telecommunication fee must not be less than 12 cents and no
217.6 more than 25 cents a month on or after January 1, 2024, for each consumer access line,
217.7 including trunk equivalents as designated by the commission pursuant to section 403.11,
217.8 subdivision 1. The 988 telecommunication fee must be the same for all subscribers.

217.9 (d) Each wireline, wireless, and IP-enabled voice telecommunications service provider
217.10 shall collect the 988 telecommunication fee and transfer the amounts collected to the
217.11 commissioner of public safety in the same manner as provided in section 403.11, subdivision
217.12 1, paragraph (d).

217.13 (e) The commissioner of public safety shall deposit the money collected from the 988
217.14 telecommunication fee to the 988 account to be expended only in support of 988 services,
217.15 or enhancements of such services.

217.16 (f) Consistent with United States Code, title 47, section 251(a), the revenue generated
217.17 by a 988 telecommunication fee must only be used to offset costs that are or will be
217.18 reasonably attributed to:

217.19 (1) ensuring the efficient and effective routing and handling of calls, chats, and texts
217.20 made to the 988 Lifeline centers including staffing and technological infrastructure
217.21 enhancements necessary to achieve operational, performance, and clinical standards and
217.22 best practices set by the 988 Lifeline program and the department; and

217.23 (2) personnel and providing acute mental health and crisis outreach services by directly
217.24 responding to the 988 Suicide and Crisis Lifeline.

217.25 (g) All 988 telecommunication fee revenue must be used to supplement, not supplant,
217.26 any federal, state, or local funding for suicide prevention.

217.27 (h) The 988 telecommunication fee amount shall be adjusted as needed to provide for
217.28 continuous operation, volume increases, and maintenance of the 988 service.

217.29 (i) The commissioner shall report on revenue generated by the 988 telecommunication
217.30 fee to the Federal Communications Commission.

217.31 Subd. 5. 988 fee for prepaid wireless telecommunications services. (a) The 988
217.32 telecommunication fee established in subdivision 4 does not apply to prepaid wireless

218.1 telecommunications services. Prepaid wireless telecommunications services are subject to
218.2 the prepaid wireless 988 fee established in section 403.161, subdivision 1, paragraph (c).

218.3 (b) Collection, remittance, and deposit of prepaid wireless 988 fees are governed by
218.4 sections 403.161 and 403.162.

218.5 Subd. 6. **Biennial budget; annual financial report.** The commissioner must prepare a
218.6 biennial budget for maintaining the 988 system. By December 15 of each year, the
218.7 commissioner must submit a report to the legislature detailing the expenditures for
218.8 maintaining the 988 system, the 988 fees collected, the balance of the 988 account, the
218.9 988-related administrative expenses of the commissioner, and the most recent forecast of
218.10 revenues and expenditures for the 988 account, including a separate projection of 988 fees
218.11 from prepaid wireless customers and projections of year-end fund balances.

218.12 Subd. 7. **Waiver.** A wireless telecommunications service provider or wire-line
218.13 telecommunications service provider may petition the commissioner for a waiver of all or
218.14 portions of the requirements of this section. The commissioner may grant a waiver upon a
218.15 demonstration by the petitioner that the requirement is economically infeasible.

218.16 Sec. 119. Minnesota Statutes 2022, section 145.87, subdivision 4, is amended to read:

218.17 Subd. 4. ~~Administrative costs~~ **Administration.** The commissioner may use up to seven
218.18 percent of the annual appropriation under this section to provide training and technical
218.19 assistance and to administer and evaluate the program. The commissioner may contract for
218.20 training, capacity-building support for grantees or potential grantees, technical assistance,
218.21 and evaluation support.

218.22 Sec. 120. **[145.903] SCHOOL-BASED HEALTH CENTERS.**

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

218.25 (b) "School-based health center" or "comprehensive school-based health center" means
218.26 a safety net health care delivery model that is located in or near a school facility and that
218.27 offers comprehensive health care, including preventive and behavioral health services,
218.28 provided by licensed and qualified health professionals in accordance with federal, state,
218.29 and local law. When not located on school property, the school-based health center must
218.30 have an established relationship with one or more schools in the community and operate to
218.31 primarily serve those student groups.

219.1 (c) "Sponsoring organization" means any of the following that operate a school-based
219.2 health center:

219.3 (1) health care providers;

219.4 (2) community clinics;

219.5 (3) hospitals;

219.6 (4) federally qualified health centers and look-alikes as defined in section 145.9269;

219.7 (5) health care foundations or nonprofit organizations;

219.8 (6) higher education institutions; or

219.9 (7) local health departments.

219.10 Subd. 2. **Expansion of Minnesota school-based health centers.** (a) The commissioner
219.11 of health shall administer a program to provide grants to school districts and school-based
219.12 health centers to support existing centers and facilitate the growth of school-based health
219.13 centers in Minnesota.

219.14 (b) Grant funds distributed under this subdivision shall be used to support new or existing
219.15 school-based health centers that:

219.16 (1) operate in partnership with a school or school district and with the permission of the
219.17 school or school district board;

219.18 (2) provide health services through a sponsoring organization; and

219.19 (3) provide health services to all students and youth within a school or school district,
219.20 regardless of ability to pay, insurance coverage, or immigration status, and in accordance
219.21 with federal, state, and local law.

219.22 (c) The commissioner of health shall administer a grant to a nonprofit organization to
219.23 facilitate a community of practice among school-based health centers to improve quality,
219.24 equity, and sustainability of care delivered through school-based health centers; encourage
219.25 cross-sharing among school-based health centers; support existing clinics; and expand
219.26 school-based health centers in new communities in Minnesota.

219.27 (d) Grant recipients shall report their activities and annual performance measures as
219.28 defined by the commissioner in a format and time specified by the commissioner.

219.29 (e) The commissioners of health and of education shall coordinate the projects and
219.30 initiatives funded under this section with other efforts at the local, state, or national level
219.31 to avoid duplication and promote coordinated efforts.

- 220.1 Subd. 3. School-based health center services. Services provided by a school-based
 220.2 health center may include but are not limited to:
- 220.3 (1) preventive health care;
- 220.4 (2) chronic medical condition management, including diabetes and asthma care;
- 220.5 (3) mental health care and crisis management;
- 220.6 (4) acute care for illness and injury;
- 220.7 (5) oral health care;
- 220.8 (6) vision care;
- 220.9 (7) nutritional counseling;
- 220.10 (8) substance abuse counseling;
- 220.11 (9) referral to a specialist, medical home, or hospital for care;
- 220.12 (10) additional services that address social determinants of health; and
- 220.13 (11) emerging services such as mobile health and telehealth.

220.14 Subd. 4. Sponsoring organizations. A sponsoring organization that agrees to operate
 220.15 a school-based health center must enter into a memorandum of agreement with the school
 220.16 or school district. The memorandum of agreement must require the sponsoring organization
 220.17 to be financially responsible for the operation of school-based health centers in the school
 220.18 or school district and must identify the costs that are the responsibility of the school or
 220.19 school district, such as Internet access, custodial services, utilities, and facility maintenance.
 220.20 To the greatest extent possible, a sponsoring organization must bill private insurers, medical
 220.21 assistance, and other public programs for services provided in the school-based health
 220.22 centers in order to maintain the financial sustainability of school-based health centers.

220.23 Sec. 121. Minnesota Statutes 2022, section 145.924, is amended to read:

220.24 **145.924 AIDS HIV PREVENTION GRANTS.**

220.25 (a) The commissioner may award grants to community health boards as defined in section
 220.26 145A.02, subdivision 5, state agencies, state councils, or nonprofit corporations to provide
 220.27 evaluation and counseling services to populations at risk for acquiring human
 220.28 immunodeficiency virus infection, including, but not limited to, ~~minorities~~ communities of
 220.29 color, adolescents, intravenous drug users women, people who inject drugs, and homosexual
 220.30 men gay, bisexual, and transgender individuals.

221.1 (b) The commissioner may award grants to agencies experienced in providing services
 221.2 to communities of color, for the design of innovative outreach and education programs for
 221.3 targeted groups within the community who may be at risk of acquiring the human
 221.4 immunodeficiency virus infection, including ~~intravenous drug users~~ people who inject drugs
 221.5 and their partners, adolescents, women, and gay ~~and~~, bisexual, and transgender individuals
 221.6 ~~and women~~. Grants shall be awarded on a request for proposal basis and shall include funds
 221.7 for administrative costs. Priority for grants shall be given to agencies or organizations that
 221.8 have experience in providing service to the particular community which the grantee proposes
 221.9 to serve; that have policy makers representative of the targeted population; that have
 221.10 experience in dealing with issues relating to HIV/AIDS; and that have the capacity to deal
 221.11 effectively with persons of differing sexual orientations. For purposes of this paragraph,
 221.12 the "communities of color" are: the American-Indian community; the Hispanic community;
 221.13 the African-American community; and the Asian-Pacific Islander community.

221.14 (c) All state grants awarded under this section for programs targeted to adolescents shall
 221.15 include the promotion of abstinence from sexual activity and drug use.

221.16 (d) The commissioner shall administer a grant program to provide funds to organizations,
 221.17 including Tribal health agencies, to assist with HIV/AIDS outbreaks.

221.18 Sec. 122. Minnesota Statutes 2022, section 145.925, is amended to read:

221.19 **145.925 FAMILY PLANNING SEXUAL AND REPRODUCTIVE HEALTH**
 221.20 **SERVICES GRANTS.**

221.21 Subdivision 1. ~~Eligible organizations; purpose~~ **Goal and establishment.** ~~The~~
 221.22 ~~commissioner of health may make special grants to cities, counties, groups of cities or~~
 221.23 ~~counties, or nonprofit corporations to provide pre-pregnancy family planning services. (a)~~
 221.24 It is the goal of the state to increase access to sexual and reproductive health services for
 221.25 people who experience barriers, whether geographic, cultural, financial, or other, in access
 221.26 to such services. The commissioner of health shall administer grants to facilitate access to
 221.27 sexual and reproductive health services for people of reproductive age, particularly those
 221.28 from populations that experience barriers to these services.

221.29 (b) The commissioner of health shall coordinate with other efforts at the local, state, or
 221.30 national level to avoid duplication and promote complementary efforts in sexual and
 221.31 reproductive health service promotion among people of reproductive age.

221.32 ~~Subd. 1a. Family planning services; defined.~~ "Family planning services" means
 221.33 ~~counseling by trained personnel regarding family planning; distribution of information~~

222.1 ~~relating to family planning, referral to licensed physicians or local health agencies for~~
222.2 ~~consultation, examination, medical treatment, genetic counseling, and prescriptions for the~~
222.3 ~~purpose of family planning; and the distribution of family planning products, such as charts,~~
222.4 ~~thermometers, drugs, medical preparations, and contraceptive devices. For purposes of~~
222.5 ~~sections 145A.01 to 145A.14, family planning shall mean voluntary action by individuals~~
222.6 ~~to prevent or aid conception but does not include the performance, or make referrals for~~
222.7 ~~encouragement of voluntary termination of pregnancy.~~

222.8 ~~Subd. 2. **Prohibition.** The commissioner shall not make special grants pursuant to this~~
222.9 ~~section to any nonprofit corporation which performs abortions. No state funds shall be used~~
222.10 ~~under contract from a grantee to any nonprofit corporation which performs abortions. This~~
222.11 ~~provision shall not apply to hospitals licensed pursuant to sections 144.50 to 144.56, or~~
222.12 ~~health maintenance organizations certified pursuant to chapter 62D.~~

222.13 ~~Subd. 2a. **Sexual and reproductive health services defined.** For purposes of this section,~~
222.14 ~~"sexual and reproductive health services" means services that promote a state of complete~~
222.15 ~~physical, mental, and social well-being in relation to sexuality and reproduction, and not~~
222.16 ~~merely the absence of disease or infirmity, in all matters relating to the reproductive system~~
222.17 ~~and its functions and processes, and to sexuality. These services must be provided in accord~~
222.18 ~~with nationally recognized standards and include but are not limited to sexual and~~
222.19 ~~reproductive health counseling, voluntary and informed decision-making on sexual and~~
222.20 ~~reproductive health, information on and provision of contraceptive methods, sexual and~~
222.21 ~~reproductive health screenings and treatment, pregnancy testing and counseling, and other~~
222.22 ~~preconception services.~~

222.23 ~~Subd. 3. **Minors Grants authorized.** No funds provided by grants made pursuant to~~
222.24 ~~this section shall be used to support any family planning services for any unemancipated~~
222.25 ~~minor in any elementary or secondary school building. (a) The commissioner of health shall~~
222.26 ~~award grants to eligible community organizations, including nonprofit organizations,~~
222.27 ~~community health boards, and Tribal communities in rural and metropolitan areas of the~~
222.28 ~~state to support, sustain, expand, or implement reproductive and sexual health programs for~~
222.29 ~~people of reproductive age to increase access to and availability of medically accurate sexual~~
222.30 ~~and reproductive health services.~~

222.31 ~~(b) The commissioner of health shall establish application scoring criteria in the evaluation~~
222.32 ~~of applications submitted for award under this section. These criteria shall include but are~~
222.33 ~~not limited to the degree to which applicants' programming responds to demographic factors~~
222.34 ~~relevant to subdivision 1, paragraph (a), and paragraph (f).~~

223.1 (c) When determining whether to award a grant or the amount of a grant under this
223.2 section, the commissioner of health may identify and stratify geographic regions based on
223.3 the region's need for sexual and reproductive health services. In this stratification, the
223.4 commissioner may consider data on the prevalence of poverty and other factors relevant to
223.5 a geographic region's need for sexual and reproductive health services.

223.6 (d) The commissioner of health may consider geographic and Tribal communities'
223.7 representation in the award of grants.

223.8 (e) Current recipients of funding under this section shall not be afforded priority over
223.9 new applicants.

223.10 (f) Grant funds shall be used to support new or existing sexual and reproductive health
223.11 programs that provide person-centered, accessible services; that are culturally and
223.12 linguistically appropriate, inclusive of all people, and trauma-informed; that protect the
223.13 dignity of the individual; and that ensure equitable, quality services consistent with nationally
223.14 recognized standards of care. These services shall include:

223.15 (1) education and outreach on medically accurate sexual and reproductive health
223.16 information;

223.17 (2) contraceptive counseling, provision of contraceptive methods, and follow-up;

223.18 (3) screening, testing, and treatment of sexually transmitted infections and other sexual
223.19 or reproductive concerns; and

223.20 (4) referral and follow-up for medical, financial, mental health, and other services in
223.21 accord with a service recipient's needs.

223.22 ~~Subd. 4. **Parental notification.** Except as provided in sections 144.341 and 144.342,~~
223.23 ~~any person employed to provide family planning services who is paid in whole or in part~~
223.24 ~~from funds provided under this section who advises an abortion or sterilization to any~~
223.25 ~~unemancipated minor shall, following such a recommendation, so notify the parent or~~
223.26 ~~guardian of the reasons for such an action.~~

223.27 ~~Subd. 5. **Rules.** The commissioner of health shall promulgate rules for approval of plans~~
223.28 ~~and budgets of prospective grant recipients, for the submission of annual financial and~~
223.29 ~~statistical reports, and the maintenance of statements of source and application of funds by~~
223.30 ~~grant recipients. The commissioner of health may not require that any home rule charter or~~
223.31 ~~statutory city or county apply for or receive grants under this subdivision as a condition for~~
223.32 ~~the receipt of any state or federal funds unrelated to family planning services.~~

224.1 Subd. 6. **Public services; individual ~~and employee rights~~.** The request of any person
 224.2 for ~~family planning~~ sexual and reproductive health services or the refusal to accept any
 224.3 service shall in no way affect the right of the person to receive public assistance, public
 224.4 health services, or any other public service. Nothing in this section shall abridge the right
 224.5 of the ~~individual~~ person to make decisions concerning ~~family planning~~ sexual and
 224.6 reproductive health, nor shall any ~~individual~~ person be required to state a reason for refusing
 224.7 any offer of ~~family planning~~ sexual and reproductive health services.

224.8 ~~Any employee of the agencies engaged in the administration of the provisions of this~~
 224.9 ~~section may refuse to accept the duty of offering family planning services to the extent that~~
 224.10 ~~the duty is contrary to personal beliefs. A refusal shall not be grounds for dismissal,~~
 224.11 ~~suspension, demotion, or any other discrimination in employment. The directors or~~
 224.12 ~~supervisors of the agencies shall reassign the duties of employees in order to carry out the~~
 224.13 ~~provisions of this section.~~

224.14 All information gathered by any agency, entity, or individual conducting programs in
 224.15 ~~family planning~~ sexual and reproductive health is private data on individuals within the
 224.16 meaning of section 13.02, subdivision 12. For any person or entity meeting the definition
 224.17 of a "provider" under section 144.291, subdivision 2, paragraph (i), all sexual and
 224.18 reproductive health services information provided to, gathered about, or received from a
 224.19 person under this section is also subject to the Minnesota Health Records Act, in sections
 224.20 144.291 to 144.298.

224.21 Subd. 7. **Family planning services; information required.** ~~A grant recipient shall~~
 224.22 ~~inform any person requesting counseling on family planning methods or procedures of:~~

224.23 ~~(1) Any methods or procedures which may be followed, including identification of any~~
 224.24 ~~which are experimental or any which may pose a health hazard to the person;~~

224.25 ~~(2) A description of any attendant discomforts or risks which might reasonably be~~
 224.26 ~~expected;~~

224.27 ~~(3) A fair explanation of the likely results, should a method fail;~~

224.28 ~~(4) A description of any benefits which might reasonably be expected of any method;~~

224.29 ~~(5) A disclosure of appropriate alternative methods or procedures;~~

224.30 ~~(6) An offer to answer any inquiries concerning methods or procedures; and~~

224.31 ~~(7) An instruction that the person is free either to decline commencement of any method~~
 224.32 ~~or procedure or to withdraw consent to a method or procedure at any reasonable time.~~

225.1 ~~Subd. 8. **Coercion; penalty.** Any person who receives compensation for services under~~
225.2 ~~any program receiving financial assistance under this section, who coerces or endeavors to~~
225.3 ~~coerce any person to undergo an abortion or sterilization procedure by threatening the person~~
225.4 ~~with the loss of or disqualification for the receipt of any benefit or service under a program~~
225.5 ~~receiving state or federal financial assistance shall be guilty of a misdemeanor.~~

225.6 ~~Subd. 9. **Amount of grant; rules.** Notwithstanding any rules to the contrary, including~~
225.7 ~~rules proposed in the State Register on April 1, 1991, the commissioner, in allocating grant~~
225.8 ~~funds for family planning special projects, shall not limit the total amount of funds that can~~
225.9 ~~be allocated to an organization. The commissioner shall allocate to an organization receiving~~
225.10 ~~grant funds on July 1, 1997, at least the same amount of grant funds for the 1998 to 1999~~
225.11 ~~grant cycle as the organization received for the 1996 to 1997 grant cycle, provided the~~
225.12 ~~organization submits an application that meets grant funding criteria. This subdivision does~~
225.13 ~~not affect any procedure established in rule for allocating special project money to the~~
225.14 ~~different regions. The commissioner shall revise the rules for family planning special project~~
225.15 ~~grants so that they conform to the requirements of this subdivision. In adopting these~~
225.16 ~~revisions, the commissioner is not subject to the rulemaking provisions of chapter 14, but~~
225.17 ~~is bound by section 14.386, paragraph (a), clauses (1) and (3). Section 14.386, paragraph~~
225.18 ~~(b), does not apply to these rules.~~

225.19 **Sec. 123. [145.9257] COMMUNITY SOLUTIONS FOR HEALTHY CHILD**
225.20 **DEVELOPMENT GRANT PROGRAM.**

225.21 Subdivision 1. **Establishment.** The commissioner of health shall establish a grant
225.22 program to improve child development outcomes and the well-being of children of color
225.23 and American Indian children from prenatal to grade 3 and their families. The purposes of
225.24 the program are to:

225.25 (1) improve child development outcomes related to the well-being of children of color
225.26 and American Indian children from prenatal to grade 3 and their families, including but not
225.27 limited to the goals outlined by the Department of Human Services' early childhood systems
225.28 reform effort: early learning; health and well-being; economic security; and safe, stable,
225.29 nurturing relationships and environments by funding community-based solutions for
225.30 challenges that are identified by the affected community;

225.31 (2) reduce racial disparities in children's health and development from prenatal to grade
225.32 3; and

225.33 (3) promote racial and geographic equity.

226.1 Subd. 2. Commissioner's duties. The commissioner of health shall:

226.2 (1) develop a request for proposals for the community solutions healthy child development
226.3 grant program in consultation with the community solutions advisory council;

226.4 (2) provide outreach, technical assistance, and program development support to increase
226.5 capacity for new and existing service providers in order to better meet statewide needs,
226.6 particularly in greater Minnesota and areas where services to reduce health disparities have
226.7 not been established;

226.8 (3) review responses to requests for proposals, in consultation with the community
226.9 solutions advisory council, and award grants under this section;

226.10 (4) ensure communication with the ethnic councils, Minnesota Indian Affairs Council,
226.11 and the State Advisory Council on Early Childhood Education and Care on the request for
226.12 proposal process;

226.13 (5) establish a transparent and objective accountability process, in consultation with the
226.14 community solutions advisory council, focused on outcomes that grantees agree to achieve;

226.15 (6) provide grantees with access to data to assist grantees in establishing and
226.16 implementing effective community-led solutions;

226.17 (7) maintain data on outcomes reported by grantees; and

226.18 (8) contract with an independent third-party entity to evaluate the success of the grant
226.19 program and to build the evidence base for effective community solutions in reducing health
226.20 disparities of children of color and American Indian children from prenatal to grade 3.

226.21 Subd. 3. Community solutions advisory council; establishment; duties;

226.22 compensation. (a) No later than October 1, 2023, the commissioner shall have convened
226.23 a 12-member community solutions advisory council as follows:

226.24 (1) two members representing the African Heritage community;

226.25 (2) two members representing the Latino community;

226.26 (3) two members representing the Asian-Pacific Islander community;

226.27 (4) two members representing the American Indian community;

226.28 (5) two parents of children who are under nine years of age and are Black, nonwhite
226.29 people of color, or American Indian;

226.30 (6) one member with research or academic expertise in racial equity and healthy child
226.31 development; and

227.1 (7) one member representing an organization that advocates on behalf of communities
227.2 of color or American Indians.

227.3 (b) At least three of the 12 members of the advisory council must come from outside
227.4 the seven-county metropolitan area.

227.5 (c) The community solutions advisory council shall:

227.6 (1) advise the commissioner on the development of the request for proposals for
227.7 community solutions healthy child development grants. In advising the commissioner, the
227.8 council must consider how to build on the capacity of communities to promote child and
227.9 family well-being and address social determinants of healthy child development;

227.10 (2) review responses to requests for proposals and advise the commissioner on the
227.11 selection of grantees and grant awards;

227.12 (3) advise the commissioner on the establishment of a transparent and objective
227.13 accountability process focused on outcomes the grantees agree to achieve;

227.14 (4) advise the commissioner on ongoing oversight and necessary support in the
227.15 implementation of the program; and

227.16 (5) support the commissioner on other racial equity and early childhood grant efforts.

227.17 (d) Each advisory council member shall be compensated in accordance with section
227.18 15.059, subdivision 3.

227.19 Subd. 4. **Eligible grantees.** Organizations eligible to receive grant funding under this
227.20 section include: (1) organizations or entities that work with Black, non-white communities
227.21 of color, and American Indian communities;

227.22 (2) Tribal nations and Tribal organizations as defined in section 658P of the Child Care
227.23 and Development Block Grant Act of 1990; and

227.24 (3) organizations or entities focused on supporting healthy child development.

227.25 Subd. 5. **Strategic consideration and priority of proposals; eligible populations;**
227.26 **grant awards.** (a) The commissioner, in consultation with the community solutions advisory
227.27 council, shall develop a request for proposals for healthy child development grants. In
227.28 developing the proposals and awarding the grants, the commissioner shall consider building
227.29 on the capacity of communities to promote child and family well-being and address social
227.30 determinants of healthy child development. Proposals must focus on increasing racial equity
227.31 and healthy child development and reducing health disparities experienced by children who

228.1 are Black, nonwhite people of color, or American Indian from prenatal to grade 3 and their
228.2 families.

228.3 (b) In awarding the grants, the commissioner shall provide strategic consideration and
228.4 give priority to proposals from:

228.5 (1) organizations or entities led by Black and other nonwhite people of color and serving
228.6 Black and nonwhite communities of color;

228.7 (2) organizations or entities led by American Indians and serving American Indians,
228.8 including Tribal nations and Tribal organizations;

228.9 (3) organizations or entities with proposals focused on healthy development from prenatal
228.10 to grade three;

228.11 (4) organizations or entities with proposals focusing on multigenerational solutions;

228.12 (5) organizations or entities located in or with proposals to serve communities located
228.13 in counties that are moderate to high risk according to the Wilder Research Risk and Reach
228.14 Report; and

228.15 (6) community-based organizations that have historically served communities of color
228.16 and American Indians and have not traditionally had access to state grant funding.

228.17 The advisory council may recommend additional strategic considerations and priorities
228.18 to the commissioner.

228.19 Subd. 6. **Geographic distribution of grants.** The commissioner and the advisory council
228.20 shall ensure that grant funds are prioritized and awarded to organizations and entities that
228.21 are within counties that have a higher proportion of Black, nonwhite communities of color,
228.22 and American Indians than the state average, to the extent possible.

228.23 Subd. 7. **Report.** Grantees must report grant program outcomes to the commissioner on
228.24 the forms and according to the timelines established by the commissioner.

228.25 Sec. 124. **[145.9272] LEAD REMEDIATION IN SCHOOL AND CHILD CARE**
228.26 **SETTINGS GRANT PROGRAM.**

228.27 Subdivision 1. **Establishment; purpose.** The commissioner of health shall develop a
228.28 grant program for the purpose of remediating identified sources of lead in drinking water
228.29 in schools and licensed child care settings.

228.30 Subd. 2. **Grants authorized.** The commissioner shall award grants through a request
228.31 for proposals process to schools and licensed child care settings. Priority shall be given to

229.1 schools and licensed child care settings with higher levels of lead detected in water samples,
229.2 evidence of lead service lines, or lead plumbing materials and school districts that serve
229.3 disadvantaged communities.

229.4 Subd. 3. **Grant allocation.** Grantees must use the funds to address sources of lead
229.5 contamination in their facilities including but not limited to service connections and premise
229.6 plumbing, and to implement best practices for water management within the building.

229.7 Sec. 125. **[145.9273] TESTING FOR LEAD IN DRINKING WATER IN CHILD**
229.8 **CARE SETTINGS.**

229.9 Subdivision 1. **Requirement to test.** By July 1, 2024, licensed child care providers must
229.10 develop a plan to accurately and efficiently test for the presence of lead in drinking water
229.11 in child care facilities following either the Department of Health's document "Reducing
229.12 Lead in Drinking Water: A Technical Guidance for Minnesota's School and Child Care
229.13 Facilities" or the Environmental Protection Agency's "3Ts: Training, Testing, Taking Action"
229.14 guidance materials.

229.15 Subd. 2. **Scope and frequency of testing.** The plan under subdivision 1 must include
229.16 testing every building serving children and all water fixtures used for consumption of water,
229.17 including water used in food preparation. All taps must be tested at least once every five
229.18 years. A licensed child care provider must begin testing in buildings by July 1, 2024, and
229.19 complete testing in all buildings that serve students within five years.

229.20 Subd. 3. **Remediation of lead in drinking water.** The plan under subdivision 1 must
229.21 include steps to remediate if lead is present in drinking water. A licensed child care provider
229.22 that finds lead at concentrations at or exceeding five parts per billion at a specific location
229.23 providing water to children within its facilities must take action to reduce lead exposure
229.24 following guidance and verify the success of remediation by retesting the location for lead.
229.25 Remediation actions are actions that reduce lead levels from the drinking water fixture as
229.26 demonstrated by testing. This includes using certified filters, implementing, and documenting
229.27 a building-wide flushing program, and replacing or removing fixtures with elevated lead
229.28 levels.

229.29 Subd. 4. **Reporting results.** (a) A licensed child care provider that tested its buildings
229.30 for the presence of lead shall make the results of the testing and any remediation steps taken
229.31 available to parents and staff and notify them of the availability of results. Reporting shall
229.32 occur no later than 30 days from receipt of results and annually thereafter.

230.1 (b) Beginning July 1, 2024, a licensed child care provider must report the provider's test
230.2 results and remediation activities to the commissioner of health annually on or before July
230.3 1 of each year.

230.4 Sec. 126. **[145.987] HEALTH EQUITY ADVISORY AND LEADERSHIP (HEAL)**
230.5 **COUNCIL.**

230.6 Subdivision 1. **Establishment; composition of advisory council.** The commissioner
230.7 shall establish and appoint a health equity advisory and leadership (HEAL) council to
230.8 provide guidance to the commissioner of health regarding strengthening and improving the
230.9 health of communities most impacted by health inequities across the state. The council shall
230.10 consist of 18 members who will provide representation from the following groups:

230.11 (1) African American and African heritage communities;

230.12 (2) Asian American and Pacific Islander communities;

230.13 (3) Latina/o/x communities;

230.14 (4) American Indian communities and Tribal governments and nations;

230.15 (5) disability communities;

230.16 (6) lesbian, gay, bisexual, transgender, and queer (LGBTQ) communities; and

230.17 (7) representatives who reside outside the seven-county metropolitan area.

230.18 Subd. 2. **Organization and meetings.** The advisory council shall be organized and
230.19 administered under section 15.059. Meetings shall be held at least quarterly and hosted by
230.20 the department. Subcommittees may be convened as necessary. Advisory council meetings
230.21 are subject to the open meeting law under chapter 13D.

230.22 Subd. 3. **Duties.** The advisory council shall:

230.23 (1) advise the commissioner on health equity issues and the health equity priorities and
230.24 concerns of the populations specified in subdivision 1;

230.25 (2) assist the agency in efforts to advance health equity, including consulting on specific
230.26 agency policies and programs, providing ideas and input about potential budget and policy
230.27 proposals, and recommending review of agency policies, standards, or procedures that may
230.28 create or perpetuate health inequities; and

230.29 (3) assist the agency in developing and monitoring meaningful performance measures
230.30 related to advancing health equity.

231.1 Subd. 4. **Expiration.** The advisory council shall remain in existence until health inequities
231.2 in the state are eliminated. Health inequities will be considered eliminated when race,
231.3 ethnicity, income, gender, gender identity, geographic location, or other identity or social
231.4 marker will no longer be predictors of health outcomes in the state. Section 145.928 describes
231.5 nine health disparities that must be considered when determining whether health inequities
231.6 have been eliminated in the state.

231.7 Sec. 127. Minnesota Statutes 2022, section 145A.131, subdivision 1, is amended to read:

231.8 Subdivision 1. **Funding formula for community health boards.** (a) Base funding for
231.9 each community health board eligible for a local public health grant under section 145A.03,
231.10 subdivision 7, shall be determined by each community health board's fiscal year 2003
231.11 allocations, prior to unallotment, for the following grant programs: community health
231.12 services subsidy; state and federal maternal and child health special projects grants; family
231.13 home visiting grants; TANF MN ENABL grants; TANF youth risk behavior grants; and
231.14 available women, infants, and children grant funds in fiscal year 2003, prior to unallotment,
231.15 distributed based on the proportion of WIC participants served in fiscal year 2003 within
231.16 the CHS service area.

231.17 (b) Base funding for a community health board eligible for a local public health grant
231.18 under section 145A.03, subdivision 7, as determined in paragraph (a), shall be adjusted by
231.19 the percentage difference between the base, as calculated in paragraph (a), and the funding
231.20 available for the local public health grant.

231.21 (c) Multicounty or multicity community health boards shall receive a local partnership
231.22 base of up to \$5,000 per year for each county or city in the case of a multicity community
231.23 health board included in the community health board.

231.24 (d) The State Community Health Advisory Committee may recommend a formula to
231.25 the commissioner to use in distributing funds to community health boards.

231.26 (e) Notwithstanding any adjustment in paragraph (b), community health boards, all or
231.27 a portion of which are located outside of the counties of Anoka, Chisago, Carver, Dakota,
231.28 Hennepin, Isanti, Ramsey, Scott, Sherburne, Washington, and Wright, are eligible to receive
231.29 an increase equal to ten percent of the grant award to the community health board under
231.30 paragraph (a) starting July 1, 2015. The increase in calendar year 2015 shall be prorated for
231.31 the last six months of the year. For calendar years beginning on or after January 1, 2016,
231.32 the amount distributed under this paragraph shall be adjusted each year based on available
231.33 funding and the number of eligible community health boards.

232.1 (f) Funding for foundational public health responsibilities must be distributed based on
232.2 a formula determined by the commissioner in consultation with the State Community Health
232.3 Services Advisory Committee. A portion of these funds may be used to fund new
232.4 organizational models, including multijurisdictional and regional partnerships. These funds
232.5 shall be used in accordance with subdivision 5.

232.6 Sec. 128. Minnesota Statutes 2022, section 145A.131, subdivision 5, is amended to read:

232.7 Subd. 5. **Use of funds.** (a) Community health boards may use the base funding of their
232.8 local public health grant funds as outlined in subdivision 1, paragraphs (a) to (e), to address
232.9 the areas of public health responsibility and local priorities developed through the community
232.10 health assessment and community health improvement planning process.

232.11 (b) Funding for foundational public health responsibilities as outlined in subdivision 1,
232.12 paragraph (f), must be used to fulfill foundational public health responsibilities as defined
232.13 by the commissioner in consultation with the State Community Health Services Advisory
232.14 Committee unless a community health board can demonstrate fulfillment of foundational
232.15 public health responsibilities. If a community health board can demonstrate foundational
232.16 public health responsibilities are fulfilled, funds may be used for local priorities developed
232.17 through the community health assessment and community health improvement planning
232.18 process.

232.19 (c) By July 1, 2028, all local public health grant funds must be used first to fulfill
232.20 foundational public health responsibilities. Once a community health board can demonstrate
232.21 foundational public health responsibilities are fulfilled, funds can be used for local priorities
232.22 developed through the community health assessment and community health improvement
232.23 planning process.

232.24 Sec. 129. Minnesota Statutes 2022, section 145A.14, is amended by adding a subdivision
232.25 to read:

232.26 Subd. 2b. **Grants to Tribes.** The commissioner shall distribute grants to Tribal
232.27 governments for foundational public health responsibilities as defined by each Tribal
232.28 government.

232.29 Sec. 130. Minnesota Statutes 2022, section 147A.08, is amended to read:

232.30 **147A.08 EXEMPTIONS.**

232.31 (a) This chapter does not apply to, control, prevent, or restrict the practice, service, or
232.32 activities of persons listed in section 147.09, clauses (1) to (6) and (8) to (13);² persons

233.1 regulated under section 214.01, subdivision 2; or ~~persons~~ midlevel practitioners, nurses,
233.2 or nurse-midwives as defined in section 144.1501, subdivision 1, paragraphs (i), (k), and
233.3 (l).

233.4 (b) Nothing in this chapter shall be construed to require licensure of:

233.5 (1) a physician assistant student enrolled in a physician assistant educational program
233.6 accredited by the Accreditation Review Commission on Education for the Physician Assistant
233.7 or by its successor agency approved by the board;

233.8 (2) a physician assistant employed in the service of the federal government while
233.9 performing duties incident to that employment; or

233.10 (3) technicians, other assistants, or employees of physicians who perform delegated
233.11 tasks in the office of a physician but who do not identify themselves as a physician assistant.

233.12 Sec. 131. Minnesota Statutes 2022, section 148.261, subdivision 1, is amended to read:

233.13 Subdivision 1. **Grounds listed.** The board may deny, revoke, suspend, limit, or condition
233.14 the license and registration of any person to practice advanced practice, professional, or
233.15 practical nursing under sections 148.171 to 148.285, or to otherwise discipline a licensee
233.16 or applicant as described in section 148.262. The following are grounds for disciplinary
233.17 action:

233.18 (1) Failure to demonstrate the qualifications or satisfy the requirements for a license
233.19 contained in sections 148.171 to 148.285 or rules of the board. In the case of a person
233.20 applying for a license, the burden of proof is upon the applicant to demonstrate the
233.21 qualifications or satisfaction of the requirements.

233.22 (2) Employing fraud or deceit in procuring or attempting to procure a permit, license,
233.23 or registration certificate to practice advanced practice, professional, or practical nursing
233.24 or attempting to subvert the licensing examination process. Conduct that subverts or attempts
233.25 to subvert the licensing examination process includes, but is not limited to:

233.26 (i) conduct that violates the security of the examination materials, such as removing
233.27 examination materials from the examination room or having unauthorized possession of
233.28 any portion of a future, current, or previously administered licensing examination;

233.29 (ii) conduct that violates the standard of test administration, such as communicating with
233.30 another examinee during administration of the examination, copying another examinee's
233.31 answers, permitting another examinee to copy one's answers, or possessing unauthorized
233.32 materials; or

234.1 (iii) impersonating an examinee or permitting an impersonator to take the examination
234.2 on one's own behalf.

234.3 (3) Conviction of a felony or gross misdemeanor reasonably related to the practice of
234.4 professional, advanced practice registered, or practical nursing. Conviction as used in this
234.5 subdivision includes a conviction of an offense that if committed in this state would be
234.6 considered a felony or gross misdemeanor without regard to its designation elsewhere, or
234.7 a criminal proceeding where a finding or verdict of guilt is made or returned but the
234.8 adjudication of guilt is either withheld or not entered.

234.9 (4) Revocation, suspension, limitation, conditioning, or other disciplinary action against
234.10 the person's professional or practical nursing license or advanced practice registered nursing
234.11 credential, in another state, territory, or country; failure to report to the board that charges
234.12 regarding the person's nursing license or other credential are pending in another state,
234.13 territory, or country; or having been refused a license or other credential by another state,
234.14 territory, or country.

234.15 (5) Failure to or inability to perform professional or practical nursing as defined in section
234.16 148.171, subdivision 14 or 15, with reasonable skill and safety, including failure of a
234.17 registered nurse to supervise or a licensed practical nurse to monitor adequately the
234.18 performance of acts by any person working at the nurse's direction.

234.19 (6) Engaging in unprofessional conduct, including, but not limited to, a departure from
234.20 or failure to conform to board rules of professional or practical nursing practice that interpret
234.21 the statutory definition of professional or practical nursing as well as provide criteria for
234.22 violations of the statutes, or, if no rule exists, to the minimal standards of acceptable and
234.23 prevailing professional or practical nursing practice, or any nursing practice that may create
234.24 unnecessary danger to a patient's life, health, or safety. Actual injury to a patient need not
234.25 be established under this clause.

234.26 (7) Failure of an advanced practice registered nurse to practice with reasonable skill and
234.27 safety or departure from or failure to conform to standards of acceptable and prevailing
234.28 advanced practice registered nursing.

234.29 (8) Delegating or accepting the delegation of a nursing function or a prescribed health
234.30 care function when the delegation or acceptance could reasonably be expected to result in
234.31 unsafe or ineffective patient care.

234.32 (9) Actual or potential inability to practice nursing with reasonable skill and safety to
234.33 patients by reason of illness, use of alcohol, drugs, chemicals, or any other material, or as
234.34 a result of any mental or physical condition.

235.1 (10) Adjudication as mentally incompetent, mentally ill, a chemically dependent person,
235.2 or a person dangerous to the public by a court of competent jurisdiction, within or without
235.3 this state.

235.4 (11) Engaging in any unethical conduct, including, but not limited to, conduct likely to
235.5 deceive, defraud, or harm the public, or demonstrating a willful or careless disregard for
235.6 the health, welfare, or safety of a patient. Actual injury need not be established under this
235.7 clause.

235.8 (12) Engaging in conduct with a patient that is sexual or may reasonably be interpreted
235.9 by the patient as sexual, or in any verbal behavior that is seductive or sexually demeaning
235.10 to a patient, or engaging in sexual exploitation of a patient or former patient.

235.11 (13) Obtaining money, property, or services from a patient, other than reasonable fees
235.12 for services provided to the patient, through the use of undue influence, harassment, duress,
235.13 deception, or fraud.

235.14 (14) Revealing a privileged communication from or relating to a patient except when
235.15 otherwise required or permitted by law.

235.16 (15) Engaging in abusive or fraudulent billing practices, including violations of federal
235.17 Medicare and Medicaid laws or state medical assistance laws.

235.18 (16) Improper management of patient records, including failure to maintain adequate
235.19 patient records, to comply with a patient's request made pursuant to sections 144.291 to
235.20 144.298, or to furnish a patient record or report required by law.

235.21 (17) Knowingly aiding, assisting, advising, or allowing an unlicensed person to engage
235.22 in the unlawful practice of advanced practice, professional, or practical nursing.

235.23 (18) Violating a rule adopted by the board, an order of the board, or a state or federal
235.24 law relating to the practice of advanced practice, professional, or practical nursing, or a
235.25 state or federal narcotics or controlled substance law.

235.26 (19) Knowingly providing false or misleading information that is directly related to the
235.27 care of that patient unless done for an accepted therapeutic purpose such as the administration
235.28 of a placebo.

235.29 (20) Aiding suicide or aiding attempted suicide in violation of section 609.215 as
235.30 established by any of the following:

235.31 (i) a copy of the record of criminal conviction or plea of guilty for a felony in violation
235.32 of section 609.215, subdivision 1 or 2;

236.1 (ii) a copy of the record of a judgment of contempt of court for violating an injunction
236.2 issued under section 609.215, subdivision 4;

236.3 (iii) a copy of the record of a judgment assessing damages under section 609.215,
236.4 subdivision 5; or

236.5 (iv) a finding by the board that the person violated section 609.215, subdivision 1 or 2.
236.6 The board shall investigate any complaint of a violation of section 609.215, subdivision 1
236.7 or 2.

236.8 (21) Practicing outside the scope of practice authorized by section 148.171, subdivision
236.9 5, 10, 11, 13, 14, 15, or 21.

236.10 (22) Making a false statement or knowingly providing false information to the board,
236.11 failing to make reports as required by section 148.263, or failing to cooperate with an
236.12 investigation of the board as required by section 148.265.

236.13 (23) Engaging in false, fraudulent, deceptive, or misleading advertising.

236.14 (24) Failure to inform the board of the person's certification or recertification status as
236.15 a certified registered nurse anesthetist, certified nurse-midwife, certified nurse practitioner,
236.16 or certified clinical nurse specialist.

236.17 (25) Engaging in clinical nurse specialist practice, nurse-midwife practice, nurse
236.18 practitioner practice, or registered nurse anesthetist practice without a license and current
236.19 certification or recertification by a national nurse certification organization acceptable to
236.20 the board.

236.21 ~~(26) Engaging in conduct that is prohibited under section 145.412.~~

236.22 ~~(27)~~ (26) Failing to report employment to the board as required by section 148.211,
236.23 subdivision 2a, or knowingly aiding, assisting, advising, or allowing a person to fail to report
236.24 as required by section 148.211, subdivision 2a.

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

236.26 Sec. 132. Minnesota Statutes 2022, section 148.512, subdivision 10a, is amended to read:

236.27 Subd. 10a. **Hearing aid.** "Hearing aid" means ~~an instrument~~ a prescribed aid, or any of
236.28 its parts, worn in the ear canal and designed to or represented as being able to aid ~~or enhance~~
236.29 human hearing. "Hearing aid" includes the aid's parts, attachments, or accessories, including,
236.30 but not limited to, ear molds and behind the ear (BTE) devices with or without an ear mold.
236.31 Batteries and cords are not parts, attachments, or accessories of a hearing aid. Surgically

237.1 implanted hearing aids, and assistive listening devices not worn within the ear canal, are
237.2 not hearing aids.

237.3 Sec. 133. Minnesota Statutes 2022, section 148.512, subdivision 10b, is amended to read:

237.4 Subd. 10b. **Hearing aid dispensing.** "Hearing aid dispensing" means making ear mold
237.5 impressions, prescribing, ~~or recommending~~ a hearing aid, assisting the consumer in
237.6 prescription aid selection, selling hearing aids at retail, or testing human hearing in connection
237.7 with these activities regardless of whether the person conducting these activities has a
237.8 monetary interest in the dispensing of prescription hearing aids to the consumer. Hearing
237.9 aid dispensing does not include selling over-the-counter hearing aids.

237.10 Sec. 134. Minnesota Statutes 2022, section 148.512, is amended by adding a subdivision
237.11 to read:

237.12 Subd. 10c. **Over-the-counter hearing aid or OTC hearing aid.** "Over-the-counter
237.13 hearing aid" or "OTC hearing aid" has the meaning given to that term in Code of Federal
237.14 Regulations, title 21, section 800.30(b).

237.15 Sec. 135. Minnesota Statutes 2022, section 148.512, is amended by adding a subdivision
237.16 to read:

237.17 Subd. 13a. **Prescription hearing aid.** "Prescription hearing aid" means a hearing aid
237.18 requiring a prescription from a certified hearing aid dispenser or licensed audiologist that
237.19 is not an OTC hearing aid.

237.20 Sec. 136. Minnesota Statutes 2022, section 148.513, is amended by adding a subdivision
237.21 to read:

237.22 Subd. 4. **Over-the-counter hearing aids.** Nothing in sections 148.511 to 148.5198 shall
237.23 preclude licensed audiologists from dispensing or selling over-the-counter hearing aids.

237.24 Sec. 137. Minnesota Statutes 2022, section 148.515, subdivision 6, is amended to read:

237.25 Subd. 6. **Dispensing audiologist examination requirements.** (a) Audiologists are
237.26 exempt from the written examination requirement in section 153A.14, subdivision 2h,
237.27 paragraph (a), clause (1).

237.28 (b) After July 31, 2005, all applicants for audiologist licensure under sections 148.512
237.29 to 148.5198 must achieve a passing score on the practical tests of proficiency described in

238.1 section 153A.14, subdivision 2h, paragraph (a), clause (2), within the time period described
238.2 in section 153A.14, subdivision 2h, paragraph (c).

238.3 (c) In order to dispense prescription hearing aids as a sole proprietor, member of a
238.4 partnership, or for a limited liability company, corporation, or any other entity organized
238.5 for profit, a licensee who obtained audiologist licensure under sections 148.512 to 148.5198,
238.6 before August 1, 2005, and who is not certified to dispense prescription hearing aids under
238.7 chapter 153A, must achieve a passing score on the practical tests of proficiency described
238.8 in section 153A.14, subdivision 2h, paragraph (a), clause (2), within the time period described
238.9 in section 153A.14, subdivision 2h, paragraph (c). All other audiologist licensees who
238.10 obtained licensure before August 1, 2005, are exempt from the practical tests.

238.11 (d) An applicant for an audiology license who obtains a temporary license under section
238.12 148.5175 may dispense prescription hearing aids only under supervision of a licensed
238.13 audiologist who dispenses prescription hearing aids.

238.14 Sec. 138. Minnesota Statutes 2022, section 148.5175, is amended to read:

238.15 **148.5175 TEMPORARY LICENSURE.**

238.16 (a) The commissioner shall issue temporary licensure as a speech-language pathologist,
238.17 an audiologist, or both, to an applicant who:

238.18 (1) submits a signed and dated affidavit stating that the applicant is not the subject of a
238.19 disciplinary action or past disciplinary action in this or another jurisdiction and is not
238.20 disqualified on the basis of section 148.5195, subdivision 3; and

238.21 (2) either:

238.22 (i) provides a copy of a current credential as a speech-language pathologist, an audiologist,
238.23 or both, held in the District of Columbia or a state or territory of the United States; or

238.24 (ii) provides a copy of a current certificate of clinical competence issued by the American
238.25 Speech-Language-Hearing Association or board certification in audiology by the American
238.26 Board of Audiology.

238.27 (b) A temporary license issued to a person under this subdivision expires 90 days after
238.28 it is issued or on the date the commissioner grants or denies licensure, whichever occurs
238.29 first.

238.30 (c) Upon application, a temporary license shall be renewed twice to a person who is able
238.31 to demonstrate good cause for failure to meet the requirements for licensure within the
238.32 initial temporary licensure period and who is not the subject of a disciplinary action or

239.1 disqualified on the basis of section 148.5195, subdivision 3. Good cause includes but is not
239.2 limited to inability to take and complete the required practical exam for dispensing
239.3 prescription hearing instruments aids.

239.4 (d) Upon application, a temporary license shall be issued to a person who meets the
239.5 requirements of section 148.515, subdivisions 2a and 4, but has not completed the
239.6 requirement in section 148.515, subdivision 6.

239.7 Sec. 139. Minnesota Statutes 2022, section 148.5195, subdivision 3, is amended to read:

239.8 Subd. 3. **Grounds for disciplinary action by commissioner.** The commissioner may
239.9 take any of the disciplinary actions listed in subdivision 4 on proof that the individual has:

239.10 (1) intentionally submitted false or misleading information to the commissioner or the
239.11 advisory council;

239.12 (2) failed, within 30 days, to provide information in response to a written request by the
239.13 commissioner or advisory council;

239.14 (3) performed services of a speech-language pathologist or audiologist in an incompetent
239.15 or negligent manner;

239.16 (4) violated sections 148.511 to 148.5198;

239.17 (5) failed to perform services with reasonable judgment, skill, or safety due to the use
239.18 of alcohol or drugs, or other physical or mental impairment;

239.19 (6) violated any state or federal law, rule, or regulation, and the violation is a felony or
239.20 misdemeanor, an essential element of which is dishonesty, or which relates directly or
239.21 indirectly to the practice of speech-language pathology or audiology. Conviction for violating
239.22 any state or federal law which relates to speech-language pathology or audiology is
239.23 necessarily considered to constitute a violation, except as provided in chapter 364;

239.24 (7) aided or abetted another person in violating any provision of sections 148.511 to
239.25 148.5198;

239.26 (8) been or is being disciplined by another jurisdiction, if any of the grounds for the
239.27 discipline is the same or substantially equivalent to those under sections 148.511 to 148.5198;

239.28 (9) not cooperated with the commissioner or advisory council in an investigation
239.29 conducted according to subdivision 1;

239.30 (10) advertised in a manner that is false or misleading;

240.1 (11) engaged in conduct likely to deceive, defraud, or harm the public; or demonstrated
240.2 a willful or careless disregard for the health, welfare, or safety of a client;

240.3 (12) failed to disclose to the consumer any fee splitting or any promise to pay a portion
240.4 of a fee to any other professional other than a fee for services rendered by the other
240.5 professional to the client;

240.6 (13) engaged in abusive or fraudulent billing practices, including violations of federal
240.7 Medicare and Medicaid laws, Food and Drug Administration regulations, or state medical
240.8 assistance laws;

240.9 (14) obtained money, property, or services from a consumer through the use of undue
240.10 influence, high pressure sales tactics, harassment, duress, deception, or fraud;

240.11 (15) performed services for a client who had no possibility of benefiting from the services;

240.12 (16) failed to refer a client for medical evaluation or to other health care professionals
240.13 when appropriate or when a client indicated symptoms associated with diseases that could
240.14 be medically or surgically treated;

240.15 (17) had the certification required by chapter 153A denied, suspended, or revoked
240.16 according to chapter 153A;

240.17 (18) used the term doctor of audiology, doctor of speech-language pathology, AuD, or
240.18 SLPD without having obtained the degree from an institution accredited by the North Central
240.19 Association of Colleges and Secondary Schools, the Council on Academic Accreditation
240.20 in Audiology and Speech-Language Pathology, the United States Department of Education,
240.21 or an equivalent;

240.22 (19) failed to comply with the requirements of section 148.5192 regarding supervision
240.23 of speech-language pathology assistants; or

240.24 (20) if the individual is an audiologist or certified hearing ~~instrument~~ aid dispenser:

240.25 (i) prescribed ~~or otherwise recommended~~ to a consumer or potential consumer the use
240.26 of a prescription hearing instrument aid, unless the prescription from a physician ~~or~~
240.27 ~~recommendation from~~, an audiologist, or a certified dispenser is in writing, is based on an
240.28 audiogram that is delivered to the consumer or potential consumer when the prescription
240.29 ~~or recommendation~~ is made, and bears the following information in all capital letters of
240.30 12-point or larger boldface type: "THIS PRESCRIPTION ~~OR RECOMMENDATION~~
240.31 MAY BE FILLED BY, AND PRESCRIPTION HEARING INSTRUMENTS AIDS MAY
240.32 BE PURCHASED FROM, THE LICENSED AUDIOLOGIST OR CERTIFIED DISPENSER
240.33 OF YOUR CHOICE";

- 241.1 (ii) failed to give a copy of the audiogram, upon which the prescription or
241.2 ~~recommendation~~ is based, to the consumer when the consumer requests a copy;
- 241.3 (iii) failed to provide the consumer rights brochure required by section 148.5197,
241.4 subdivision 3;
- 241.5 (iv) failed to comply with restrictions on sales of prescription hearing instruments aids
241.6 in sections 148.5197, subdivision 3, and 148.5198;
- 241.7 (v) failed to return a consumer's prescription hearing instrument aid used as a trade-in
241.8 or for a discount in the price of a new prescription hearing instrument aid when requested
241.9 by the consumer upon cancellation of the purchase agreement;
- 241.10 (vi) failed to follow Food and Drug Administration or Federal Trade Commission
241.11 regulations relating to dispensing prescription hearing instruments aids;
- 241.12 (vii) failed to dispense a prescription hearing instrument aid in a competent manner or
241.13 without appropriate training;
- 241.14 (viii) delegated prescription hearing instrument aid dispensing authority to a person not
241.15 authorized to dispense a prescription hearing instrument aid under this chapter or chapter
241.16 153A;
- 241.17 (ix) failed to comply with the requirements of an employer or supervisor of a hearing
241.18 instrument aid dispenser trainee;
- 241.19 (x) violated a state or federal court order or judgment, including a conciliation court
241.20 judgment, relating to the activities of the individual's prescription hearing instrument aid
241.21 dispensing; or
- 241.22 (xi) failed to include on the audiogram the practitioner's printed name, credential type,
241.23 credential number, signature, and date.
- 241.24 Sec. 140. Minnesota Statutes 2022, section 148.5196, subdivision 1, is amended to read:
- 241.25 Subdivision 1. **Membership.** The commissioner shall appoint 12 persons to a
241.26 Speech-Language Pathologist and Audiologist Advisory Council. The 12 persons must
241.27 include:
- 241.28 (1) three public members, as defined in section 214.02. Two of the public members shall
241.29 be either persons receiving services of a speech-language pathologist or audiologist, or
241.30 family members of or caregivers to such persons, and at least one of the public members
241.31 shall be either a hearing instrument aid user or an advocate of one;

242.1 (2) three speech-language pathologists licensed under sections 148.511 to 148.5198,
242.2 one of whom is currently and has been, for the five years immediately preceding the
242.3 appointment, engaged in the practice of speech-language pathology in Minnesota and each
242.4 of whom is employed in a different employment setting including, but not limited to, private
242.5 practice, hospitals, rehabilitation settings, educational settings, and government agencies;

242.6 (3) one speech-language pathologist licensed under sections 148.511 to 148.5198, who
242.7 is currently and has been, for the five years immediately preceding the appointment,
242.8 employed by a Minnesota public school district or a Minnesota public school district
242.9 consortium that is authorized by Minnesota Statutes and who is licensed in speech-language
242.10 pathology by the Professional Educator Licensing and Standards Board;

242.11 (4) three audiologists licensed under sections 148.511 to 148.5198, two of whom are
242.12 currently and have been, for the five years immediately preceding the appointment, engaged
242.13 in the practice of audiology and the dispensing of prescription hearing instruments aids in
242.14 Minnesota and each of whom is employed in a different employment setting including, but
242.15 not limited to, private practice, hospitals, rehabilitation settings, educational settings, industry,
242.16 and government agencies;

242.17 (5) one nonaudiologist hearing ~~instrument~~ aid dispenser recommended by a professional
242.18 association representing hearing ~~instrument~~ aid dispensers; and

242.19 (6) one physician licensed under chapter 147 and certified by the American Board of
242.20 Otolaryngology, Head and Neck Surgery.

242.21 Sec. 141. Minnesota Statutes 2022, section 148.5197, is amended to read:

242.22 **148.5197 HEARING AID DISPENSING.**

242.23 Subdivision 1. **Content of contracts.** Oral statements made by an audiologist or certified
242.24 dispenser regarding the provision of warranties, refunds, and service on the prescription
242.25 hearing aid or aids dispensed must be written on, and become part of, the contract of sale,
242.26 specify the item or items covered, and indicate the person or business entity obligated to
242.27 provide the warranty, refund, or service.

242.28 Subd. 2. **Required use of license number.** The audiologist's license number or certified
242.29 dispenser's certificate number must appear on all contracts, bills of sale, and receipts used
242.30 in the sale of prescription hearing aids.

242.31 Subd. 3. **Consumer rights information.** An audiologist or certified dispenser shall, at
242.32 the time of the ~~recommendation~~ or prescription, give a consumer rights brochure, prepared
242.33 by the commissioner and containing information about legal requirements pertaining to

243.1 dispensing of prescription hearing aids, to each potential consumer of a prescription hearing
243.2 aid. The brochure must contain information about the consumer information center described
243.3 in section 153A.18. A contract for a prescription hearing aid must note the receipt of the
243.4 brochure by the consumer, along with the consumer's signature or initials.

243.5 Subd. 4. **Liability for contracts.** Owners of entities in the business of dispensing
243.6 prescription hearing aids, employers of audiologists or persons who dispense prescription
243.7 hearing aids, supervisors of trainees or audiology students, and hearing aid dispensers
243.8 conducting the transaction at issue are liable for satisfying all terms of contracts, written or
243.9 oral, made by their agents, employees, assignees, affiliates, or trainees, including terms
243.10 relating to products, repairs, warranties, service, and refunds. The commissioner may enforce
243.11 the terms of prescription hearing aid contracts against the principal, employer, supervisor,
243.12 or dispenser who conducted the transaction and may impose any remedy provided for in
243.13 this chapter.

243.14 Sec. 142. Minnesota Statutes 2022, section 148.5198, is amended to read:

243.15 **148.5198 RESTRICTION ON SALE OF PRESCRIPTION HEARING AIDS.**

243.16 Subdivision 1. **45-calendar-day guarantee and buyer right to cancel.** (a) An audiologist
243.17 or certified dispenser dispensing a prescription hearing aid in this state must comply with
243.18 paragraphs (b) and (c).

243.19 (b) The audiologist or certified dispenser must provide the buyer with a 45-calendar-day
243.20 written money-back guarantee. The guarantee must permit the buyer to cancel the purchase
243.21 for any reason within 45 calendar days after receiving the prescription hearing aid by giving
243.22 or mailing written notice of cancellation to the audiologist or certified dispenser. If the buyer
243.23 mails the notice of cancellation, the 45-calendar-day period is counted using the postmark
243.24 date, to the date of receipt by the audiologist or certified dispenser. If the prescription hearing
243.25 aid must be repaired, remade, or adjusted during the 45-calendar-day money-back guarantee
243.26 period, the running of the 45-calendar-day period is suspended one day for each 24-hour
243.27 period that the prescription hearing aid is not in the buyer's possession. A repaired, remade,
243.28 or adjusted prescription hearing aid must be claimed by the buyer within three business
243.29 days after notification of availability, after which time the running of the 45-calendar-day
243.30 period resumes. The guarantee must entitle the buyer, upon cancellation, to receive a refund
243.31 of payment within 30 days of return of the prescription hearing aid to the audiologist or
243.32 certified dispenser. The audiologist or certified dispenser may retain as a cancellation fee
243.33 no more than \$250 of the buyer's total purchase price of the prescription hearing aid.

244.1 (c) The audiologist or certified dispenser shall provide the buyer with a contract written
244.2 in plain English, that contains uniform language and provisions that meet the requirements
244.3 under the Plain Language Contract Act, sections 325G.29 to 325G.36. The contract must
244.4 include, but is not limited to, the following: in immediate proximity to the space reserved
244.5 for the signature of the buyer, or on the first page if there is no space reserved for the
244.6 signature of the buyer, a clear and conspicuous disclosure of the following specific statement
244.7 in all capital letters of no less than 12-point boldface type: "MINNESOTA STATE LAW
244.8 GIVES THE BUYER THE RIGHT TO CANCEL THIS PURCHASE FOR ANY REASON
244.9 AT ANY TIME PRIOR TO MIDNIGHT OF THE 45TH CALENDAR DAY AFTER
244.10 RECEIPT OF THE PRESCRIPTION HEARING AID(S). THIS CANCELLATION MUST
244.11 BE IN WRITING AND MUST BE GIVEN OR MAILED TO THE AUDIOLOGIST OR
244.12 CERTIFIED DISPENSER. IF THE BUYER DECIDES TO RETURN THE PRESCRIPTION
244.13 HEARING AID(S) WITHIN THIS 45-CALENDAR-DAY PERIOD, THE BUYER WILL
244.14 RECEIVE A REFUND OF THE TOTAL PURCHASE PRICE OF THE AID(S) FROM
244.15 WHICH THE AUDIOLOGIST OR CERTIFIED DISPENSER MAY RETAIN AS A
244.16 CANCELLATION FEE NO MORE THAN \$250."

244.17 Subd. 2. **Itemized repair bill.** Any audiologist, certified dispenser, or company who
244.18 agrees to repair a prescription hearing aid must provide the owner of the prescription hearing
244.19 aid, or the owner's representative, with a bill that describes the repair and services rendered.
244.20 The bill must also include the repairing audiologist's, certified dispenser's, or company's
244.21 name, address, and telephone number.

244.22 This subdivision does not apply to an audiologist, certified dispenser, or company that
244.23 repairs a prescription hearing aid pursuant to an express warranty covering the entire
244.24 prescription hearing aid and the warranty covers the entire cost, both parts and labor, of the
244.25 repair.

244.26 Subd. 3. **Repair warranty.** Any guarantee of prescription hearing aid repairs must be
244.27 in writing and delivered to the owner of the prescription hearing aid, or the owner's
244.28 representative, stating the repairing audiologist's, certified dispenser's, or company's name,
244.29 address, telephone number, length of guarantee, model, and serial number of the prescription
244.30 hearing aid and all other terms and conditions of the guarantee.

244.31 Subd. 4. **Misdemeanor.** A person found to have violated this section is guilty of a
244.32 misdemeanor.

245.1 Subd. 5. **Additional.** In addition to the penalty provided in subdivision 4, a person found
245.2 to have violated this section is subject to the penalties and remedies provided in section
245.3 325F.69, subdivision 1.

245.4 Subd. 6. **Estimates.** Upon the request of the owner of a prescription hearing aid or the
245.5 owner's representative for a written estimate and prior to the commencement of repairs, a
245.6 repairing audiologist, certified dispenser, or company shall provide the customer with a
245.7 written estimate of the price of repairs. If a repairing audiologist, certified dispenser, or
245.8 company provides a written estimate of the price of repairs, it must not charge more than
245.9 the total price stated in the estimate for the repairs. If the repairing audiologist, certified
245.10 dispenser, or company after commencing repairs determines that additional work is necessary
245.11 to accomplish repairs that are the subject of a written estimate and if the repairing audiologist,
245.12 certified dispenser, or company did not unreasonably fail to disclose the possible need for
245.13 the additional work when the estimate was made, the repairing audiologist, certified
245.14 dispenser, or company may charge more than the estimate for the repairs if the repairing
245.15 audiologist, certified dispenser, or company immediately provides the owner or owner's
245.16 representative a revised written estimate pursuant to this section and receives authorization
245.17 to continue with the repairs. If continuation of the repairs is not authorized, the repairing
245.18 audiologist, certified dispenser, or company shall return the prescription hearing aid as close
245.19 as possible to its former condition and shall release the prescription hearing aid to the owner
245.20 or owner's representative upon payment of charges for repairs actually performed and not
245.21 in excess of the original estimate.

245.22 Sec. 143. Minnesota Statutes 2022, section 151.37, subdivision 12, is amended to read:

245.23 Subd. 12. **Administration of opiate antagonists for drug overdose.** (a) A licensed
245.24 physician, a licensed advanced practice registered nurse authorized to prescribe drugs
245.25 pursuant to section 148.235, or a licensed physician assistant may authorize the following
245.26 individuals to administer opiate antagonists, as defined in section 604A.04, subdivision 1:

- 245.27 (1) an emergency medical responder registered pursuant to section 144E.27;
- 245.28 (2) a peace officer as defined in section 626.84, subdivision 1, paragraphs (c) and (d);
- 245.29 (3) correctional employees of a state or local political subdivision;
- 245.30 (4) staff of community-based health disease prevention or social service programs;
- 245.31 (5) a volunteer firefighter; and

246.1 (6) a ~~licensed school nurse or certified public health nurse~~ any other personnel employed
246.2 by, or under contract with, a ~~school board under section 121A.21~~ charter, public, or private
246.3 school.

246.4 (b) For the purposes of this subdivision, opiate antagonists may be administered by one
246.5 of these individuals only if:

246.6 (1) the licensed physician, licensed physician assistant, or licensed advanced practice
246.7 registered nurse has issued a standing order to, or entered into a protocol with, the individual;
246.8 and

246.9 (2) the individual has training in the recognition of signs of opiate overdose and the use
246.10 of opiate antagonists as part of the emergency response to opiate overdose.

246.11 (c) Nothing in this section prohibits the possession and administration of naloxone
246.12 pursuant to section 604A.04.

246.13 (d) Notwithstanding section 148.235, subdivisions 8 and 9, a licensed practical nurse is
246.14 authorized to possess and administer according to this subdivision an opiate antagonist in
246.15 a school setting.

246.16 Sec. 144. Minnesota Statutes 2022, section 153A.13, subdivision 3, is amended to read:

246.17 Subd. 3. **Hearing instrument aid.** "Hearing instrument aid" means an instrument, ~~or~~
246.18 ~~any of its parts, worn in the ear canal and designed to or represented as being able to aid or~~
246.19 ~~enhance human hearing. "Hearing instrument" includes the instrument's parts, attachments,~~
246.20 ~~or accessories, including, but not limited to, ear molds and behind the ear (BTE) devices~~
246.21 ~~with or without an ear mold. Batteries and cords are not parts, attachments, or accessories~~
246.22 ~~of a hearing instrument. Surgically implanted hearing instruments, and assistive listening~~
246.23 ~~devices not worn within the ear canal, are not hearing instruments. as defined in section~~
246.24 148.512, subdivision 10a.

246.25 Sec. 145. Minnesota Statutes 2022, section 153A.13, subdivision 4, is amended to read:

246.26 Subd. 4. **Hearing instrument aid dispensing.** "Hearing instrument aid dispensing"
246.27 ~~means making ear mold impressions, prescribing, or recommending a hearing instrument,~~
246.28 ~~assisting the consumer in instrument selection, selling hearing instruments at retail, or testing~~
246.29 ~~human hearing in connection with these activities regardless of whether the person conducting~~
246.30 ~~these activities has a monetary interest in the sale of hearing instruments to the consumer.~~
246.31 has the meaning given in section 148.512, subdivision 10b.

247.1 Sec. 146. Minnesota Statutes 2022, section 153A.13, subdivision 5, is amended to read:

247.2 Subd. 5. **Dispenser of hearing ~~instruments~~ aids.** "Dispenser of hearing ~~instruments~~
247.3 aids" means a natural person who engages in prescription hearing instrument aid dispensing,
247.4 whether or not certified by the commissioner of health or licensed by an existing
247.5 health-related board, except that a person described as follows is not a dispenser of hearing
247.6 instruments aids:

247.7 (1) a student participating in supervised field work that is necessary to meet requirements
247.8 of an accredited educational program if the student is designated by a title which clearly
247.9 indicates the student's status as a student trainee; or

247.10 (2) a person who helps a dispenser of hearing ~~instruments aids~~ in an administrative or
247.11 clerical manner and does not engage in prescription hearing instrument aid dispensing.

247.12 A person who offers to dispense a prescription hearing instrument aid, or a person who
247.13 advertises, holds out to the public, or otherwise represents that the person is authorized to
247.14 dispense prescription hearing instruments aids, must be certified by the commissioner except
247.15 when the person is an audiologist as defined in section 148.512.

247.16 Sec. 147. Minnesota Statutes 2022, section 153A.13, subdivision 6, is amended to read:

247.17 Subd. 6. **Advisory council.** "Advisory council" means the Minnesota Hearing ~~Instrument~~
247.18 Aid Dispenser Advisory Council, or a committee of ~~it~~ the council, established under section
247.19 153A.20.

247.20 Sec. 148. Minnesota Statutes 2022, section 153A.13, subdivision 7, is amended to read:

247.21 Subd. 7. **ANSI.** "ANSI" means ~~ANSI S3.6-1989~~, American National Standard
247.22 Specification for Audiometers ~~from the American National Standards Institute. This~~
247.23 ~~document is available through the Minitex interlibrary loan system~~ as defined in the United
247.24 States Food and Drug Administration, Code of Federal Regulations, title 21, section
247.25 874.1050.

247.26 Sec. 149. Minnesota Statutes 2022, section 153A.13, subdivision 9, is amended to read:

247.27 Subd. 9. **Supervision.** "Supervision" means monitoring activities of, and accepting
247.28 responsibility for, the prescription hearing instrument aid dispensing activities of a trainee.

248.1 Sec. 150. Minnesota Statutes 2022, section 153A.13, subdivision 10, is amended to read:

248.2 Subd. 10. **Direct supervision or directly supervised.** "Direct supervision" or "directly
248.3 supervised" means the on-site and contemporaneous location of a supervisor and trainee,
248.4 when the supervisor observes the trainee engaging in prescription hearing instrument aid
248.5 dispensing with a consumer.

248.6 Sec. 151. Minnesota Statutes 2022, section 153A.13, subdivision 11, is amended to read:

248.7 Subd. 11. **Indirect supervision or indirectly supervised.** "Indirect supervision" or
248.8 "indirectly supervised" means the remote and independent performance of prescription
248.9 hearing instrument aid dispensing by a trainee when authorized under section 153A.14,
248.10 subdivision 4a, paragraph (b).

248.11 Sec. 152. Minnesota Statutes 2022, section 153A.13, is amended by adding a subdivision
248.12 to read:

248.13 Subd. 12. **Over-the-counter hearing aid or OTC hearing aid.** "Over-the-counter
248.14 hearing aid" or "OTC hearing aid" has the meaning given in section 148.512, subdivision
248.15 10c.

248.16 Sec. 153. Minnesota Statutes 2022, section 153A.13, is amended by adding a subdivision
248.17 to read:

248.18 Subd. 13. **Prescription hearing aid.** "Prescription hearing aid" has the meaning given
248.19 in section 148.512, subdivision 13a.

248.20 Sec. 154. Minnesota Statutes 2022, section 153A.14, subdivision 1, is amended to read:

248.21 Subdivision 1. **Application for certificate.** An applicant must:

248.22 (1) be 21 years of age or older;

248.23 (2) apply to the commissioner for a certificate to dispense prescription hearing instruments
248.24 aids on application forms provided by the commissioner;

248.25 (3) at a minimum, provide the applicant's name, Social Security number, business address
248.26 and phone number, employer, and information about the applicant's education, training,
248.27 and experience in testing human hearing and fitting prescription hearing instruments aids;

248.28 (4) include with the application a statement that the statements in the application are
248.29 true and correct to the best of the applicant's knowledge and belief;

249.1 (5) include with the application a written and signed authorization that authorizes the
249.2 commissioner to make inquiries to appropriate regulatory agencies in this or any other state
249.3 where the applicant has sold prescription hearing instruments aids;

249.4 (6) submit certification to the commissioner that the applicant's audiometric equipment
249.5 has been calibrated to meet current ANSI standards within 12 months of the date of the
249.6 application;

249.7 (7) submit evidence of continuing education credits, if required;

249.8 (8) submit all fees as required under section 153A.17; and

249.9 (9) consent to a fingerprint-based criminal history records check required under section
249.10 144.0572, pay all required fees, and cooperate with all requests for information. An applicant
249.11 must complete a new criminal background check if more than one year has elapsed since
249.12 the applicant last applied for a license.

249.13 Sec. 155. Minnesota Statutes 2022, section 153A.14, subdivision 2, is amended to read:

249.14 Subd. 2. **Issuance of certificate.** (a) The commissioner shall issue a certificate to each
249.15 dispenser of hearing instruments aids who applies under subdivision 1 if the commissioner
249.16 determines that the applicant is in compliance with this chapter, has passed an examination
249.17 administered by the commissioner, has met the continuing education requirements, if
249.18 required, and has paid the fee set by the commissioner. The commissioner may reject or
249.19 deny an application for a certificate if there is evidence of a violation or failure to comply
249.20 with this chapter.

249.21 (b) The commissioner shall not issue a certificate to an applicant who refuses to consent
249.22 to a criminal history background check as required by section 144.0572 within 90 days after
249.23 submission of an application or fails to submit fingerprints to the Department of Human
249.24 Services. Any fees paid by the applicant to the Department of Health shall be forfeited if
249.25 the applicant refuses to consent to the background study.

249.26 Sec. 156. Minnesota Statutes 2022, section 153A.14, subdivision 2h, is amended to read:

249.27 Subd. 2h. **Certification by examination.** An applicant must achieve a passing score,
249.28 as determined by the commissioner, on an examination according to paragraphs (a) to (c).

249.29 (a) The examination must include, but is not limited to:

249.30 (1) A written examination approved by the commissioner covering the following areas
249.31 as they pertain to prescription hearing instrument aid selling:

- 250.1 (i) basic physics of sound;
- 250.2 (ii) the anatomy and physiology of the ear;
- 250.3 (iii) the function of prescription hearing instruments aids; and
- 250.4 (iv) the principles of prescription hearing instrument aid selection.
- 250.5 (2) Practical tests of proficiency in the following techniques as they pertain to prescription
- 250.6 hearing instrument aid selling:
- 250.7 (i) pure tone audiometry, including air conduction testing and bone conduction testing;
- 250.8 (ii) live voice or recorded voice speech audiometry including speech recognition
- 250.9 (discrimination) testing, most comfortable loudness level, and uncomfortable loudness
- 250.10 measurements of tolerance thresholds;
- 250.11 (iii) masking when indicated;
- 250.12 (iv) recording and evaluation of audiograms and speech audiometry to determine proper
- 250.13 selection and fitting of a prescription hearing instrument aid;
- 250.14 (v) taking ear mold impressions;
- 250.15 (vi) using an otoscope for the visual observation of the entire ear canal; and
- 250.16 (vii) state and federal laws, rules, and regulations.
- 250.17 (b) The practical examination shall be administered by the commissioner at least twice
- 250.18 a year.
- 250.19 (c) An applicant must achieve a passing score on all portions of the examination within
- 250.20 a two-year period. An applicant who does not achieve a passing score on all portions of the
- 250.21 examination within a two-year period must retake the entire examination and achieve a
- 250.22 passing score on each portion of the examination. An applicant who does not apply for
- 250.23 certification within one year of successful completion of the examination must retake the
- 250.24 examination and achieve a passing score on each portion of the examination. An applicant
- 250.25 may not take any part of the practical examination more than three times in a two-year
- 250.26 period.
- 250.27 Sec. 157. Minnesota Statutes 2022, section 153A.14, subdivision 2i, is amended to read:
- 250.28 Subd. 2i. **Continuing education requirement.** On forms provided by the commissioner,
- 250.29 each certified dispenser must submit with the application for renewal of certification evidence
- 250.30 of completion of ten course hours of continuing education earned within the 12-month
- 250.31 period of November 1 to October 31, between the effective and expiration dates of

251.1 certification. Continuing education courses must be directly related to prescription hearing
251.2 ~~instrument~~ aid dispensing and approved by the International Hearing Society, the American
251.3 Speech-Language-Hearing Association, or the American Academy of Audiology. Evidence
251.4 of completion of the ten course hours of continuing education must be submitted by
251.5 December 1 of each year. This requirement does not apply to dispensers certified for less
251.6 than one year.

251.7 Sec. 158. Minnesota Statutes 2022, section 153A.14, subdivision 2j, is amended to read:

251.8 Subd. 2j. **Required use of certification number.** The certification holder must use the
251.9 certification number on all contracts, bills of sale, and receipts used in the sale of prescription
251.10 hearing ~~instruments~~ aids.

251.11 Sec. 159. Minnesota Statutes 2022, section 153A.14, subdivision 4, is amended to read:

251.12 Subd. 4. **Dispensing of prescription hearing ~~instruments~~ aids without**
251.13 **certificate.** Except as provided in subdivisions 4a and 4c, and in sections 148.512 to
251.14 148.5198, it is unlawful for any person not holding a valid certificate to dispense a
251.15 prescription hearing ~~instrument~~ aid as defined in section 153A.13, subdivision 3. A person
251.16 who dispenses a prescription hearing ~~instrument~~ aid without the certificate required by this
251.17 section is guilty of a gross misdemeanor.

251.18 Sec. 160. Minnesota Statutes 2022, section 153A.14, subdivision 4a, is amended to read:

251.19 Subd. 4a. **Trainees.** (a) A person who is not certified under this section may dispense
251.20 prescription hearing ~~instruments~~ aids as a trainee for a period not to exceed 12 months if
251.21 the person:

251.22 (1) submits an application on forms provided by the commissioner;

251.23 (2) is under the supervision of a certified dispenser meeting the requirements of this
251.24 subdivision;

251.25 (3) meets all requirements for certification except passage of the examination required
251.26 by this section; and

251.27 (4) uses the title "dispenser trainee" in contacts with the patients, clients, or consumers.

251.28 (b) A certified hearing ~~instrument~~ aid dispenser may not supervise more than two trainees
251.29 at the same time and may not directly supervise more than one trainee at a time. The certified
251.30 dispenser is responsible for all actions or omissions of a trainee in connection with the
251.31 dispensing of prescription hearing ~~instruments~~ aids. A certified dispenser may not supervise

252.1 a trainee if there are any commissioner, court, or other orders, currently in effect or issued
252.2 within the last five years, that were issued with respect to an action or omission of a certified
252.3 dispenser or a trainee under the certified dispenser's supervision.

252.4 Until taking and passing the practical examination testing the techniques described in
252.5 subdivision 2h, paragraph (a), clause (2), trainees must be directly supervised in all areas
252.6 described in subdivision 4b, and the activities tested by the practical examination. Thereafter,
252.7 trainees may dispense prescription hearing instruments aids under indirect supervision until
252.8 expiration of the trainee period. Under indirect supervision, the trainee must complete two
252.9 monitored activities a week. Monitored activities may be executed by correspondence,
252.10 telephone, or other telephonic devices, and include, but are not limited to, evaluation of
252.11 audiograms, written reports, and contracts. The time spent in supervision must be recorded
252.12 and the record retained by the supervisor.

252.13 Sec. 161. Minnesota Statutes 2022, section 153A.14, subdivision 4b, is amended to read:

252.14 Subd. 4b. **Prescription hearing testing protocol.** A dispenser when conducting a hearing
252.15 test for the purpose of prescription hearing instrument aid dispensing must:

252.16 (1) comply with the United States Food and Drug Administration warning regarding
252.17 potential medical conditions required by Code of Federal Regulations, title 21, section
252.18 ~~801.420~~ 801.422;

252.19 (2) complete a case history of the client's hearing;

252.20 (3) inspect the client's ears with an otoscope; and

252.21 (4) conduct the following tests on both ears of the client and document the results, and
252.22 if for any reason one of the following tests cannot be performed pursuant to the United
252.23 States Food and Drug Administration guidelines, an audiologist shall evaluate the hearing
252.24 and the need for a prescription hearing instrument aid:

252.25 (i) air conduction at 250, 500, 1,000, 2,000, 4,000, and 8,000 Hertz. When a difference
252.26 of 20 dB or more occurs between adjacent octave frequencies the interoctave frequency
252.27 must be tested;

252.28 (ii) bone conduction at 500, 1,000, 2,000, and 4,000 Hertz for any frequency where the
252.29 air conduction threshold is greater than 15 dB HL;

252.30 (iii) monaural word recognition (discrimination), with a minimum of 25 words presented
252.31 for each ear; and

253.1 (iv) loudness discomfort level, monaural, for setting a prescription hearing instrument's
253.2 aid's maximum power output; and

253.3 (5) include masking in all tests whenever necessary to ensure accurate results.

253.4 Sec. 162. Minnesota Statutes 2022, section 153A.14, subdivision 4c, is amended to read:

253.5 Subd. 4c. **Reciprocity.** (a) A person who has dispensed prescription hearing instruments
253.6 aids in another jurisdiction may dispense prescription hearing instruments aids as a trainee
253.7 under indirect supervision if the person:

253.8 (1) satisfies the provisions of subdivision 4a, paragraph (a);

253.9 (2) submits a signed and dated affidavit stating that the applicant is not the subject of a
253.10 disciplinary action or past disciplinary action in this or another jurisdiction and is not
253.11 disqualified on the basis of section 153A.15, subdivision 1; and

253.12 (3) provides a copy of a current credential as a hearing ~~instrument~~ aid dispenser held in
253.13 the District of Columbia or a state or territory of the United States.

253.14 (b) A person becoming a trainee under this subdivision who fails to take and pass the
253.15 practical examination described in subdivision 2h, paragraph (a), clause (2), when next
253.16 offered must cease dispensing prescription hearing instruments aids unless under direct
253.17 supervision.

253.18 Sec. 163. Minnesota Statutes 2022, section 153A.14, subdivision 4e, is amended to read:

253.19 Subd. 4e. **Prescription hearing aids; enforcement.** Costs incurred by the Minnesota
253.20 Department of Health for conducting investigations of unlicensed prescription hearing aid
253.21 ~~dispensers~~ dispensing shall be apportioned between all licensed or credentialed professions
253.22 that dispense prescription hearing aids.

253.23 Sec. 164. Minnesota Statutes 2022, section 153A.14, subdivision 6, is amended to read:

253.24 Subd. 6. **Prescription hearing ~~instruments~~ aids to comply with federal and state**
253.25 **requirements.** The commissioner shall ensure that prescription hearing instruments aids
253.26 are dispensed in compliance with state requirements and the requirements of the United
253.27 States Food and Drug Administration. Failure to comply with state or federal regulations
253.28 may be grounds for enforcement actions under section 153A.15, subdivision 2.

254.1 Sec. 165. Minnesota Statutes 2022, section 153A.14, subdivision 9, is amended to read:

254.2 Subd. 9. **Consumer rights.** A hearing ~~instrument~~ aid dispenser shall comply with the
254.3 requirements of sections 148.5195, subdivision 3, clause (20); 148.5197; and 148.5198.

254.4 Sec. 166. Minnesota Statutes 2022, section 153A.14, subdivision 11, is amended to read:

254.5 Subd. 11. **Requirement to maintain current information.** A dispenser must notify the
254.6 commissioner in writing within 30 days of the occurrence of any of the following:

254.7 (1) a change of name, address, home or business telephone number, or business name;

254.8 (2) the occurrence of conduct prohibited by section 153A.15;

254.9 (3) a settlement, conciliation court judgment, or award based on negligence, intentional
254.10 acts, or contractual violations committed in the dispensing of prescription hearing instruments
254.11 aids by the dispenser; and

254.12 (4) the cessation of prescription hearing instrument aid dispensing activities as an
254.13 individual or a business.

254.14 Sec. 167. Minnesota Statutes 2022, section 153A.14, is amended by adding a subdivision
254.15 to read:

254.16 Subd. 12. **Over-the-counter hearing aids.** Nothing in this chapter shall preclude certified
254.17 hearing aid dispensers from dispensing or selling over-the-counter hearing aids.

254.18 Sec. 168. Minnesota Statutes 2022, section 153A.15, subdivision 1, is amended to read:

254.19 Subdivision 1. **Prohibited acts.** The commissioner may take enforcement action as
254.20 provided under subdivision 2 against a dispenser of prescription hearing instruments aids
254.21 for the following acts and conduct:

254.22 (1) dispensing a prescription hearing instrument aid to a minor person 18 years or younger
254.23 unless evaluated by an audiologist for hearing evaluation and prescription hearing aid
254.24 evaluation;

254.25 (2) being disciplined through a revocation, suspension, restriction, or limitation by
254.26 another state for conduct subject to action under this chapter;

254.27 (3) presenting advertising that is false or misleading;

254.28 (4) providing the commissioner with false or misleading statements of credentials,
254.29 training, or experience;

- 255.1 (5) engaging in conduct likely to deceive, defraud, or harm the public; or demonstrating
255.2 a willful or careless disregard for the health, welfare, or safety of a consumer;
- 255.3 (6) splitting fees or promising to pay a portion of a fee to any other professional other
255.4 than a fee for services rendered by the other professional to the client;
- 255.5 (7) engaging in abusive or fraudulent billing practices, including violations of federal
255.6 Medicare and Medicaid laws, Food and Drug Administration regulations, or state medical
255.7 assistance laws;
- 255.8 (8) obtaining money, property, or services from a consumer through the use of undue
255.9 influence, high pressure sales tactics, harassment, duress, deception, or fraud;
- 255.10 (9) performing the services of a certified hearing ~~instrument~~ aid dispenser in an
255.11 incompetent or negligent manner;
- 255.12 (10) failing to comply with the requirements of this chapter as an employer, supervisor,
255.13 or trainee;
- 255.14 (11) failing to provide information in a timely manner in response to a request by the
255.15 commissioner, commissioner's designee, or the advisory council;
- 255.16 (12) being convicted within the past five years of violating any laws of the United States,
255.17 or any state or territory of the United States, and the violation is a felony, gross misdemeanor,
255.18 or misdemeanor, an essential element of which relates to prescription hearing ~~instrument~~
255.19 aid dispensing, except as provided in chapter 364;
- 255.20 (13) failing to cooperate with the commissioner, the commissioner's designee, or the
255.21 advisory council in any investigation;
- 255.22 (14) failing to perform prescription hearing ~~instrument~~ aid dispensing with reasonable
255.23 judgment, skill, or safety due to the use of alcohol or drugs, or other physical or mental
255.24 impairment;
- 255.25 (15) failing to fully disclose actions taken against the applicant or the applicant's legal
255.26 authorization to dispense prescription hearing ~~instruments~~ aids in this or another state;
- 255.27 (16) violating a state or federal court order or judgment, including a conciliation court
255.28 judgment, relating to the activities of the applicant in prescription hearing ~~instrument~~ aid
255.29 dispensing;
- 255.30 (17) having been or being disciplined by the commissioner of the Department of Health,
255.31 or other authority, in this or another jurisdiction, if any of the grounds for the discipline are
255.32 the same or substantially equivalent to those in sections 153A.13 to 153A.18;

256.1 (18) misrepresenting the purpose of hearing tests, or in any way communicating that the
256.2 hearing test or hearing test protocol required by section 153A.14, subdivision 4b, is a medical
256.3 evaluation, a diagnostic hearing evaluation conducted by an audiologist, or is other than a
256.4 test to select a prescription hearing instrument aid, except that the hearing instrument aid
256.5 dispenser can determine the need for or recommend the consumer obtain a medical evaluation
256.6 consistent with requirements of the United States Food and Drug Administration;

256.7 (19) violating any of the provisions of sections 148.5195, subdivision 3, clause (20);
256.8 148.5197; 148.5198; and 153A.13 to 153A.18; and

256.9 (20) aiding or abetting another person in violating any of the provisions of sections
256.10 148.5195, subdivision 3, clause (20); 148.5197; 148.5198; and 153A.13 to 153A.18.

256.11 Sec. 169. Minnesota Statutes 2022, section 153A.15, subdivision 2, is amended to read:

256.12 Subd. 2. **Enforcement actions.** When the commissioner finds that a dispenser of
256.13 prescription hearing instruments aids has violated one or more provisions of this chapter,
256.14 the commissioner may do one or more of the following:

256.15 (1) deny or reject the application for a certificate;

256.16 (2) revoke the certificate;

256.17 (3) suspend the certificate;

256.18 (4) impose, for each violation, a civil penalty that deprives the dispenser of any economic
256.19 advantage gained by the violation and that reimburses the Department of Health for costs
256.20 of the investigation and proceeding resulting in disciplinary action, including the amount
256.21 paid for services of the Office of Administrative Hearings, the amount paid for services of
256.22 the Office of the Attorney General, attorney fees, court reporters, witnesses, reproduction
256.23 of records, advisory council members' per diem compensation, department staff time, and
256.24 expenses incurred by advisory council members and department staff;

256.25 (5) censure or reprimand the dispenser;

256.26 (6) revoke or suspend the right to supervise trainees;

256.27 (7) revoke or suspend the right to be a trainee;

256.28 (8) impose a civil penalty not to exceed \$10,000 for each separate violation; or

256.29 (9) any other action reasonably justified by the individual case.

257.1 Sec. 170. Minnesota Statutes 2022, section 153A.15, subdivision 4, is amended to read:

257.2 Subd. 4. **Penalties.** Except as provided in section 153A.14, subdivision 4, a person
257.3 violating this chapter is guilty of a misdemeanor. The commissioner may impose an automatic
257.4 civil penalty equal to one-fourth the renewal fee on each hearing ~~instrument seller~~ aid
257.5 dispenser who fails to renew the certificate required in section 153A.14 by the renewal
257.6 deadline.

257.7 Sec. 171. Minnesota Statutes 2022, section 153A.17, is amended to read:

257.8 **153A.17 EXPENSES; FEES.**

257.9 (a) The expenses for administering the certification requirements, including the complaint
257.10 handling system for hearing aid dispensers in sections 153A.14 and 153A.15, and the
257.11 Consumer Information Center under section 153A.18, must be paid from initial application
257.12 and examination fees, renewal fees, penalties, and fines. The commissioner shall only use
257.13 fees collected under this section for the purposes of administering this chapter. The legislature
257.14 must not transfer money generated by these fees from the state government special revenue
257.15 fund to the general fund. ~~Surcharges collected by the commissioner of health under section~~
257.16 ~~16E.22 are not subject to this paragraph.~~

257.17 (b) The fees are as follows:

257.18 (1) the initial certification application fee is \$772.50;

257.19 (2) the annual renewal certification application fee is \$750;

257.20 (3) the initial examination fee for the practical portion is \$1,200, and \$600 for each time
257.21 it is taken, thereafter; for individuals meeting the requirements of section 148.515, subdivision
257.22 2, the fee for the practical portion of the prescription hearing instrument aid dispensing
257.23 examination is \$600 each time it is taken;

257.24 (4) the trainee application fee is \$230;

257.25 (5) the penalty fee for late submission of a renewal application is \$260; and

257.26 (6) the fee for verification of certification to other jurisdictions or entities is \$25.

257.27 (c) The commissioner may prorate the certification fee for new applicants based on the
257.28 number of quarters remaining in the annual certification period.

257.29 (d) All fees are nonrefundable. All fees, penalties, and fines received must be deposited
257.30 in the state government special revenue fund.

258.1 (e) Hearing instrument dispensers who were certified before January 1, 2018, shall pay
258.2 a onetime surcharge of \$22.50 to renew their certification when it expires after October 31,
258.3 2020. The surcharge shall cover the commissioner's costs associated with criminal
258.4 background checks.

258.5 Sec. 172. Minnesota Statutes 2022, section 153A.175, is amended to read:

258.6 **153A.175 PENALTY FEES.**

258.7 (a) The penalty fee for holding oneself out as a hearing ~~instrument~~ aid dispenser without
258.8 a current certificate after the credential has expired and before it is renewed is one-half the
258.9 amount of the certificate renewal fee for any part of the first day, plus one-half the certificate
258.10 renewal fee for any part of any subsequent days up to 30 days.

258.11 (b) The penalty fee for applicants who hold themselves out as hearing ~~instrument~~ aid
258.12 dispensers after expiration of the trainee period and before being issued a certificate is
258.13 one-half the amount of the certificate application fee for any part of the first day, plus
258.14 one-half the certificate application fee for any part of any subsequent days up to 30 days.
258.15 This paragraph does not apply to applicants not qualifying for a certificate who hold
258.16 themselves out as hearing ~~instrument~~ aid dispensers.

258.17 (c) The penalty fee for practicing prescription hearing ~~instrument~~ aid dispensing and
258.18 failing to submit a continuing education report by the due date with the correct number or
258.19 type of hours in the correct time period is \$200 plus \$200 for each missing clock hour.
258.20 "Missing" means not obtained between the effective and expiration dates of the certificate,
258.21 the one-month period following the certificate expiration date, or the 30 days following
258.22 notice of a penalty fee for failing to report all continuing education hours. The certificate
258.23 holder must obtain the missing number of continuing education hours by the next reporting
258.24 due date.

258.25 (d) Civil penalties and discipline incurred by certificate holders prior to August 1, 2005,
258.26 for conduct described in paragraph (a), (b), or (c) shall be recorded as nondisciplinary penalty
258.27 fees. Payment of a penalty fee does not preclude any disciplinary action reasonably justified
258.28 by the individual case.

258.29 Sec. 173. Minnesota Statutes 2022, section 153A.18, is amended to read:

258.30 **153A.18 CONSUMER INFORMATION CENTER.**

258.31 The commissioner shall establish a Consumer Information Center to assist actual and
258.32 potential purchasers of prescription hearing aids by providing them with information

259.1 regarding prescription hearing instrument aid sales. The Consumer Information Center shall
259.2 disseminate information about consumers' legal rights related to prescription hearing
259.3 instrument aid sales, provide information relating to complaints about dispensers of
259.4 prescription hearing instruments aids, and provide information about outreach and advocacy
259.5 services for consumers of prescription hearing instruments aids. In establishing the center
259.6 and developing the information, the commissioner shall consult with representatives of
259.7 hearing instrument aid dispensers, audiologists, physicians, and consumers.

259.8 Sec. 174. Minnesota Statutes 2022, section 153A.20, is amended to read:

259.9 **153A.20 HEARING INSTRUMENT AID DISPENSER ADVISORY COUNCIL.**

259.10 Subdivision 1. **Membership.** (a) The commissioner shall appoint seven persons to a
259.11 Hearing Instrument Aid Dispenser Advisory Council.

259.12 (b) The seven persons must include:

259.13 (1) three public members, as defined in section 214.02. At least one of the public members
259.14 shall be a prescription hearing instrument aid user and one of the public members shall be
259.15 either a prescription hearing instrument aid user or an advocate of one;

259.16 (2) three hearing instrument aid dispensers certified under sections 153A.14 to 153A.20,
259.17 each of whom is currently, and has been for the five years immediately preceding their
259.18 appointment, engaged in prescription hearing instrument aid dispensing in Minnesota and
259.19 who represent the occupation of prescription hearing instrument aid dispensing and who
259.20 are not audiologists; and

259.21 (3) one audiologist licensed as an audiologist under chapter 148 who dispenses
259.22 prescription hearing instruments aids, recommended by a professional association
259.23 representing audiologists and speech-language pathologists.

259.24 (c) The factors the commissioner may consider when appointing advisory council
259.25 members include, but are not limited to, professional affiliation, geographical location, and
259.26 type of practice.

259.27 (d) No two members of the advisory council shall be employees of, or have binding
259.28 contracts requiring sales exclusively for, the same prescription hearing instrument aid
259.29 manufacturer or the same employer.

259.30 Subd. 2. **Organization.** The advisory council shall be organized and administered
259.31 according to section 15.059. The council may form committees to carry out its duties.

259.32 Subd. 3. **Duties.** At the commissioner's request, the advisory council shall:

260.1 (1) advise the commissioner regarding hearing ~~instrument~~ aid dispenser certification
260.2 standards;

260.3 (2) provide for distribution of information regarding hearing ~~instrument~~ aid dispenser
260.4 certification standards;

260.5 (3) review investigation summaries of competency violations and make recommendations
260.6 to the commissioner as to whether the allegations of incompetency are substantiated; and

260.7 (4) perform other duties as directed by the commissioner.

260.8 Sec. 175. Minnesota Statutes 2022, section 256B.434, subdivision 4f, is amended to read:

260.9 Subd. 4f. **Construction project rate adjustments effective October 1, 2006.** (a)
260.10 Effective October 1, 2006, facilities reimbursed under this section may receive a property
260.11 rate adjustment for construction projects exceeding the threshold in section 256B.431,
260.12 subdivision 16, and below the threshold in section 144A.071, subdivision 2, ~~clause (a)~~
260.13 paragraph (c), clause (1). For these projects, capital assets purchased shall be counted as
260.14 construction project costs for a rate adjustment request made by a facility if they are: (1)
260.15 purchased within 24 months of the completion of the construction project; (2) purchased
260.16 after the completion date of any prior construction project; and (3) are not purchased prior
260.17 to July 14, 2005. Except as otherwise provided in this subdivision, the definitions, rate
260.18 calculation methods, and principles in sections 144A.071 and 256B.431 and Minnesota
260.19 Rules, parts 9549.0010 to 9549.0080, shall be used to calculate rate adjustments for allowable
260.20 construction projects under this subdivision and section 144A.073. Facilities completing
260.21 construction projects between October 1, 2005, and October 1, 2006, are eligible to have a
260.22 property rate adjustment effective October 1, 2006. Facilities completing projects after
260.23 October 1, 2006, are eligible for a property rate adjustment effective on the first day of the
260.24 month following the completion date. Facilities completing projects after January 1, 2018,
260.25 are eligible for a property rate adjustment effective on the first day of the month of January
260.26 or July, whichever occurs immediately following the completion date.

260.27 (b) Notwithstanding subdivision 18, as of July 14, 2005, facilities with rates set under
260.28 section 256B.431 and Minnesota Rules, parts 9549.0010 to 9549.0080, that commenced a
260.29 construction project on or after October 1, 2004, and do not have a contract under subdivision
260.30 3 by September 30, 2006, are eligible to request a rate adjustment under section 256B.431,
260.31 subdivision 10, through September 30, 2006. If the request results in the commissioner
260.32 determining a rate adjustment is allowable, the rate adjustment is effective on the first of
260.33 the month following project completion. These facilities shall be allowed to accumulate
260.34 construction project costs for the period October 1, 2004, to September 30, 2006.

261.1 (c) Facilities shall be allowed construction project rate adjustments no sooner than 12
261.2 months after completing a previous construction project. Facilities must request the rate
261.3 adjustment according to section 256B.431, subdivision 10.

261.4 (d) Capacity days shall be computed according to Minnesota Rules, part 9549.0060,
261.5 subpart 11. For rate calculations under this section, the number of licensed beds in the
261.6 nursing facility shall be the number existing after the construction project is completed and
261.7 the number of days in the nursing facility's reporting period shall be 365.

261.8 (e) The value of assets to be recognized for a total replacement project as defined in
261.9 section 256B.431, subdivision 17d, shall be computed as described in clause (1). The value
261.10 of assets to be recognized for all other projects shall be computed as described in clause
261.11 (2).

261.12 (1) Replacement-cost-new limits under section 256B.431, subdivision 17e, and the
261.13 number of beds allowed under subdivision 3a, paragraph (c), shall be used to compute the
261.14 maximum amount of assets allowable in a facility's property rate calculation. If a facility's
261.15 current request for a rate adjustment results from the completion of a construction project
261.16 that was previously approved under section 144A.073, the assets to be used in the rate
261.17 calculation cannot exceed the lesser of the amount determined under sections 144A.071,
261.18 subdivision 2, and 144A.073, subdivision 3b, or the actual allowable costs of the construction
261.19 project. A current request that is not the result of a project under section 144A.073 cannot
261.20 exceed the limit under section 144A.071, subdivision 2, paragraph ~~(a)~~ (c), clause (1).
261.21 Applicable credits must be deducted from the cost of the construction project.

261.22 (2)(i) Replacement-cost-new limits under section 256B.431, subdivision 17e, and the
261.23 number of beds allowed under section 256B.431, subdivision 3a, paragraph (c), shall be
261.24 used to compute the maximum amount of assets allowable in a facility's property rate
261.25 calculation.

261.26 (ii) The value of a facility's assets to be compared to the amount in item (i) begins with
261.27 the total appraised value from the last rate notice a facility received when its rates were set
261.28 under section 256B.431 and Minnesota Rules, parts 9549.0010 to 9549.0080. This value
261.29 shall be indexed by the factor in section 256B.431, subdivision 3f, paragraph (a), for each
261.30 rate year the facility received an inflation factor on its property-related rate when its rates
261.31 were set under this section. The value of assets listed as previous capital additions, capital
261.32 additions, and special projects on the facility's base year rate notice and the value of assets
261.33 related to a construction project for which the facility received a rate adjustment when its
261.34 rates were determined under this section shall be added to the indexed appraised value.

262.1 (iii) The maximum amount of assets to be recognized in computing a facility's rate
262.2 adjustment after a project is completed is the lesser of the aggregate replacement-cost-new
262.3 limit computed in (i) minus the assets recognized in (ii) or the actual allowable costs of the
262.4 construction project.

262.5 (iv) If a facility's current request for a rate adjustment results from the completion of a
262.6 construction project that was previously approved under section 144A.073, the assets to be
262.7 added to the rate calculation cannot exceed the lesser of the amount determined under
262.8 sections 144A.071, subdivision 2, and 144A.073, subdivision 3b, or the actual allowable
262.9 costs of the construction project. A current request that is not the result of a project under
262.10 section 144A.073 cannot exceed the limit stated in section 144A.071, subdivision 2,
262.11 paragraph ~~(a)~~ (c), clause (1). Assets disposed of as a result of a construction project and
262.12 applicable credits must be deducted from the cost of the construction project.

262.13 (f) For construction projects approved under section 144A.073, allowable debt may
262.14 never exceed the lesser of the cost of the assets purchased, the threshold limit in section
262.15 144A.071, subdivision 2, or the replacement-cost-new limit less previously existing capital
262.16 debt.

262.17 (g) For construction projects that were not approved under section 144A.073, allowable
262.18 debt is limited to the lesser of the threshold in section 144A.071, subdivision 2, for such
262.19 construction projects or the applicable limit in paragraph (e), clause (1) or (2), less previously
262.20 existing capital debt. Amounts of debt taken out that exceed the costs of a construction
262.21 project shall not be allowed regardless of the use of the funds.

262.22 For all construction projects being recognized, interest expense and average debt shall
262.23 be computed based on the first 12 months following project completion. "Previously existing
262.24 capital debt" means capital debt recognized on the last rate determined under section
262.25 256B.431 and Minnesota Rules, parts 9549.0010 to 9549.0080, and the amount of debt
262.26 recognized for a construction project for which the facility received a rate adjustment when
262.27 its rates were determined under this section.

262.28 For a total replacement project as defined in section 256B.431, subdivision 17d, the
262.29 value of previously existing capital debt shall be zero.

262.30 (h) In addition to the interest expense allowed from the application of paragraph (f), the
262.31 amounts allowed under section 256B.431, subdivision 17a, paragraph (a), clauses (2) and
262.32 (3), will be added to interest expense.

262.33 (i) The equity portion of the construction project shall be computed as the allowable
262.34 assets in paragraph (e), less the average debt in paragraph (f). The equity portion must be

263.1 multiplied by 5.66 percent and the allowable interest expense in paragraph (f) must be added.
263.2 This sum must be divided by 95 percent of capacity days to compute the construction project
263.3 rate adjustment.

263.4 (j) For projects that are not a total replacement of a nursing facility, the amount in
263.5 paragraph (i) is adjusted for nonreimbursable areas and then added to the current property
263.6 payment rate of the facility.

263.7 (k) For projects that are a total replacement of a nursing facility, the amount in paragraph
263.8 (i) becomes the new property payment rate after being adjusted for nonreimbursable areas.
263.9 Any amounts existing in a facility's rate before the effective date of the construction project
263.10 for equity incentives under section 256B.431, subdivision 16; capital repairs and replacements
263.11 under section 256B.431, subdivision 15; or refinancing incentives under section 256B.431,
263.12 subdivision 19, shall be removed from the facility's rates.

263.13 (l) No additional equipment allowance is allowed under Minnesota Rules, part 9549.0060,
263.14 subpart 10, as the result of construction projects under this section. Allowable equipment
263.15 shall be included in the construction project costs.

263.16 (m) Capital assets purchased after the completion date of a construction project shall be
263.17 counted as construction project costs for any future rate adjustment request made by a facility
263.18 under section 144A.071, subdivision 2, ~~clause (a)~~ paragraph (c), clause (1), if they are
263.19 purchased within 24 months of the completion of the future construction project.

263.20 (n) In subsequent rate years, the property payment rate for a facility that results from
263.21 the application of this subdivision shall be the amount inflated in subdivision 4.

263.22 (o) Construction projects are eligible for an equity incentive under section 256B.431,
263.23 subdivision 16. When computing the equity incentive for a construction project under this
263.24 subdivision, only the allowable costs and allowable debt related to the construction project
263.25 shall be used. The equity incentive shall not be a part of the property payment rate and not
263.26 inflated under subdivision 4. Effective October 1, 2006, all equity incentives for nursing
263.27 facilities reimbursed under this section shall be allowed for a duration determined under
263.28 section 256B.431, subdivision 16, paragraph (c).

263.29 Sec. 176. Minnesota Statutes 2022, section 256B.692, subdivision 2, is amended to read:

263.30 Subd. 2. **Duties of commissioner of health.** (a) Notwithstanding chapters 62D and 62N,
263.31 a county that elects to purchase medical assistance in return for a fixed sum without regard
263.32 to the frequency or extent of services furnished to any particular enrollee is not required to
263.33 obtain a certificate of authority under chapter 62D or 62N. The county board of

264.1 commissioners is the governing body of a county-based purchasing program. In a multicounty
264.2 arrangement, the governing body is a joint powers board established under section 471.59.

264.3 (b) A county that elects to purchase medical assistance services under this section must
264.4 satisfy the commissioner of health that the requirements for assurance of consumer protection,
264.5 provider protection, and fiscal solvency of chapter 62D, applicable to health maintenance
264.6 organizations will be met according to the following schedule:

264.7 (1) for a county-based purchasing plan approved on or before June 30, 2008, the plan
264.8 must have in reserve:

264.9 (i) at least 50 percent of the minimum amount required under chapter 62D as of January
264.10 1, 2010;

264.11 (ii) at least 75 percent of the minimum amount required under chapter 62D as of January
264.12 1, 2011;

264.13 (iii) at least 87.5 percent of the minimum amount required under chapter 62D as of
264.14 January 1, 2012; and

264.15 (iv) at least 100 percent of the minimum amount required under chapter 62D as of January
264.16 1, 2013; and

264.17 (2) for a county-based purchasing plan first approved after June 30, 2008, the plan must
264.18 have in reserve:

264.19 (i) at least 50 percent of the minimum amount required under chapter 62D at the time
264.20 the plan begins enrolling enrollees;

264.21 (ii) at least 75 percent of the minimum amount required under chapter 62D after the first
264.22 full calendar year;

264.23 (iii) at least 87.5 percent of the minimum amount required under chapter 62D after the
264.24 second full calendar year; and

264.25 (iv) at least 100 percent of the minimum amount required under chapter 62D after the
264.26 third full calendar year.

264.27 (c) Until a plan is required to have reserves equaling at least 100 percent of the minimum
264.28 amount required under chapter 62D, the plan may demonstrate its ability to cover any losses
264.29 by satisfying the requirements of chapter 62N. A county-based purchasing plan must also
264.30 assure the commissioner of health that the requirements of sections 62J.041; 62J.48; 62J.71
264.31 to 62J.73; all applicable provisions of chapter 62Q, including sections 62Q.075; 62Q.1055;

265.1 62Q.106; 62Q.12; 62Q.135; 62Q.14; ~~62Q.145~~; 62Q.19; 62Q.23, paragraph (c); 62Q.43;
265.2 62Q.47; 62Q.50; 62Q.52 to 62Q.56; 62Q.58; 62Q.68 to 62Q.72; and 72A.201 will be met.

265.3 (d) All enforcement and rulemaking powers available under chapters 62D, 62J, 62N,
265.4 and 62Q are hereby granted to the commissioner of health with respect to counties that
265.5 purchase medical assistance services under this section.

265.6 (e) The commissioner, in consultation with county government, shall develop
265.7 administrative and financial reporting requirements for county-based purchasing programs
265.8 relating to sections 62D.041, 62D.042, 62D.045, 62D.08, 62N.28, 62N.29, and 62N.31,
265.9 and other sections as necessary, that are specific to county administrative, accounting, and
265.10 reporting systems and consistent with other statutory requirements of counties.

265.11 (f) The commissioner shall collect from a county-based purchasing plan under this
265.12 section the following fees:

265.13 (1) fees attributable to the costs of audits and other examinations of plan financial
265.14 operations. These fees are subject to the provisions of Minnesota Rules, part 4685.2800,
265.15 subpart 1, item F; and

265.16 (2) an annual fee of \$21,500, to be paid by June 15 of each calendar year.

265.17 All fees collected under this paragraph shall be deposited in the state government special
265.18 revenue fund.

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

265.20 Sec. 177. Minnesota Statutes 2022, section 403.161, is amended to read:

265.21 **403.161 PREPAID WIRELESS FEES IMPOSED; COLLECTION; REMITTANCE.**

265.22 Subdivision 1. **Fees imposed.** (a) A prepaid wireless E911 fee of 80 cents per retail
265.23 transaction is imposed on prepaid wireless telecommunications service until the fee is
265.24 adjusted as an amount per retail transaction under subdivision 7.

265.25 (b) A prepaid wireless telecommunications access Minnesota fee, in the amount of the
265.26 monthly charge provided for in section 237.52, subdivision 2, is imposed on each retail
265.27 transaction for prepaid wireless telecommunications service until the fee is adjusted as an
265.28 amount per retail transaction under subdivision 7.

265.29 (c) A prepaid wireless 988 fee, in the amount of the monthly charge, is imposed on each
265.30 retail transaction for prepaid wireless telecommunications service until the fee is adjusted
265.31 as an amount per retail transaction under subdivision 7.

266.1 Subd. 2. **Exemption.** The fees established under subdivision 1 are not imposed on a
266.2 minimal amount of prepaid wireless telecommunications service that is sold with a prepaid
266.3 wireless device and is charged a single nonitemized price, and a seller may not apply the
266.4 fees to such a transaction. For purposes of this subdivision, a minimal amount of service
266.5 means an amount of service denominated as either ten minutes or less or \$5 or less.

266.6 Subd. 3. **Fee collected.** The prepaid wireless E911 ~~and~~₂ telecommunications access
266.7 Minnesota, and 988 fees must be collected by the seller from the consumer for each retail
266.8 transaction occurring in this state. The amount of each fee must be combined into one
266.9 amount, which must be separately stated on an invoice, receipt, or other similar document
266.10 that is provided to the consumer by the seller.

266.11 Subd. 4. **Sales and use tax treatment.** For purposes of this section, a retail transaction
266.12 conducted in person by a consumer at a business location of the seller must be treated as
266.13 occurring in this state if that business location is in this state, and any other retail transaction
266.14 must be treated as occurring in this state if the retail transaction is treated as occurring in
266.15 this state for purposes of the sales and use tax as specified in section 297A.669, subdivision
266.16 3, paragraph (c).

266.17 Subd. 5. **Remittance.** The prepaid wireless E911 ~~and~~₂ telecommunications access
266.18 Minnesota, and 988 fees are the liability of the consumer and not of the seller or of any
266.19 provider, except that the seller is liable to remit all fees as provided in section 403.162.

266.20 Subd. 6. **Exclusion for calculating other charges.** The combined amount of the prepaid
266.21 wireless E911 ~~and~~₂ telecommunications access Minnesota, and 988 fees collected by a seller
266.22 from a consumer must not be included in the base for measuring any tax, fee, surcharge, or
266.23 other charge that is imposed by this state, any political subdivision of this state, or any
266.24 intergovernmental agency.

266.25 Subd. 7. **Fee changes.** (a) The prepaid wireless E911 ~~and~~₂ telecommunications access
266.26 Minnesota ~~fee~~, and 988 fees must be proportionately increased or reduced upon any change
266.27 to the fee imposed under section 403.11, subdivision 1, paragraph (c), after July 1, 2013,
266.28 ~~or~~ the fee imposed under section 237.52, subdivision 2, or the fee imposed under section
266.29 145.561, subdivision 4, as applicable.

266.30 (b) The department shall post notice of any fee changes on its website at least 30 days
266.31 in advance of the effective date of the fee changes. It is the responsibility of sellers to monitor
266.32 the department's website for notice of fee changes.

267.1 (c) Fee changes are effective 60 days after the first day of the first calendar month after
267.2 the commissioner of public safety or the Public Utilities Commission, as applicable, changes
267.3 the fee.

267.4 Sec. 178. Minnesota Statutes 2022, section 403.162, is amended to read:

267.5 **403.162 ADMINISTRATION OF PREPAID WIRELESS E911 FEES.**

267.6 Subdivision 1. **Remittance.** Prepaid wireless E911 ~~and~~₂ telecommunications access
267.7 Minnesota, and 988 fees collected by sellers must be remitted to the commissioner of revenue
267.8 at the times and in the manner provided by chapter 297A with respect to the general sales
267.9 and use tax. The commissioner of revenue shall establish registration and payment procedures
267.10 that substantially coincide with the registration and payment procedures that apply in chapter
267.11 297A.

267.12 Subd. 2. **Seller's fee retention.** A seller may deduct and retain three percent of prepaid
267.13 wireless E911 ~~and~~₂ telecommunications access Minnesota, and 988 fees collected by the
267.14 seller from consumers.

267.15 Subd. 3. **Department of Revenue provisions.** The audit, assessment, appeal, collection,
267.16 refund, penalty, interest, enforcement, and administrative provisions of chapters 270C and
267.17 289A that are applicable to the taxes imposed by chapter 297A apply to any fee imposed
267.18 under section 403.161.

267.19 Subd. 4. **Procedures for resale transactions.** The commissioner of revenue shall
267.20 establish procedures by which a seller of prepaid wireless telecommunications service may
267.21 document that a sale is not a retail transaction. These procedures must substantially coincide
267.22 with the procedures for documenting sale for resale transactions as provided in chapter
267.23 297A.

267.24 Subd. 5. **Fees deposited.** (a) The commissioner of revenue shall, based on the relative
267.25 proportion of the prepaid wireless E911 fee ~~and~~₂ the prepaid wireless telecommunications
267.26 access Minnesota fee, and the prepaid wireless 988 fee, imposed per retail transaction, divide
267.27 the fees collected in corresponding proportions. Within 30 days of receipt of the collected
267.28 fees, the commissioner shall:

267.29 (1) deposit the proportion of the collected fees attributable to the prepaid wireless E911
267.30 fee in the 911 emergency telecommunications service account in the special revenue fund;
267.31 ~~and~~

268.1 (2) deposit the proportion of collected fees attributable to the prepaid wireless
268.2 telecommunications access Minnesota fee in the telecommunications access fund established
268.3 in section 237.52, subdivision 1; and

268.4 (3) deposit the proportion of the collected fees attributable to the prepaid wireless 988
268.5 fee in the 988 special revenue account established.

268.6 (b) The commissioner of revenue may deduct and deposit in a special revenue account
268.7 an amount not to exceed two percent of collected fees. Money in the account is annually
268.8 appropriated to the commissioner of revenue to reimburse its direct costs of administering
268.9 the collection and remittance of prepaid wireless E911 fees, ~~and~~ prepaid wireless
268.10 telecommunications access Minnesota fees, and prepaid wireless 988 fees.

268.11 Sec. 179. Minnesota Statutes 2022, section 518A.39, subdivision 2, is amended to read:

268.12 Subd. 2. **Modification.** (a) The terms of an order respecting maintenance or support
268.13 may be modified upon a showing of one or more of the following, any of which makes the
268.14 terms unreasonable and unfair: (1) substantially increased or decreased gross income of an
268.15 obligor or obligee; (2) substantially increased or decreased need of an obligor or obligee or
268.16 the child or children that are the subject of these proceedings; (3) receipt of assistance under
268.17 the AFDC program formerly codified under sections 256.72 to 256.87 or 256B.01 to ~~256B.40~~
268.18 256B.39, or chapter 256J or 256K; (4) a change in the cost of living for either party as
268.19 measured by the federal Bureau of Labor Statistics; (5) extraordinary medical expenses of
268.20 the child not provided for under section 518A.41; (6) a change in the availability of
268.21 appropriate health care coverage or a substantial increase or decrease in health care coverage
268.22 costs; (7) the addition of work-related or education-related child care expenses of the obligee
268.23 or a substantial increase or decrease in existing work-related or education-related child care
268.24 expenses; or (8) upon the emancipation of the child, as provided in subdivision 5.

268.25 (b) It is presumed that there has been a substantial change in circumstances under
268.26 paragraph (a) and the terms of a current support order shall be rebuttably presumed to be
268.27 unreasonable and unfair if:

268.28 (1) the application of the child support guidelines in section 518A.35, to the current
268.29 circumstances of the parties results in a calculated court order that is at least 20 percent and
268.30 at least \$75 per month higher or lower than the current support order or, if the current support
268.31 order is less than \$75, it results in a calculated court order that is at least 20 percent per
268.32 month higher or lower;

269.1 (2) the medical support provisions of the order established under section 518A.41 are
269.2 not enforceable by the public authority or the obligee;

269.3 (3) health coverage ordered under section 518A.41 is not available to the child for whom
269.4 the order is established by the parent ordered to provide;

269.5 (4) the existing support obligation is in the form of a statement of percentage and not a
269.6 specific dollar amount;

269.7 (5) the gross income of an obligor or obligee has decreased by at least 20 percent through
269.8 no fault or choice of the party; or

269.9 (6) a deviation was granted based on the factor in section 518A.43, subdivision 1, clause
269.10 (4), and the child no longer resides in a foreign country or the factor is otherwise no longer
269.11 applicable.

269.12 (c) A child support order is not presumptively modifiable solely because an obligor or
269.13 obligee becomes responsible for the support of an additional nonjoint child, which is born
269.14 after an existing order. Section 518A.33 shall be considered if other grounds are alleged
269.15 which allow a modification of support.

269.16 (d) If child support was established by applying a parenting expense adjustment or
269.17 presumed equal parenting time calculation under previously existing child support guidelines
269.18 and there is no parenting plan or order from which overnights or overnight equivalents can
269.19 be determined, there is a rebuttable presumption that the established adjustment or calculation
269.20 will continue after modification so long as the modification is not based on a change in
269.21 parenting time. In determining an obligation under previously existing child support
269.22 guidelines, it is presumed that the court shall:

269.23 (1) if a 12 percent parenting expense adjustment was applied, multiply the obligor's
269.24 share of the combined basic support obligation calculated under section 518A.34, paragraph
269.25 (b), clause (5), by 0.88; or

269.26 (2) if the parenting time was presumed equal but the parents' parental incomes for
269.27 determining child support were not equal:

269.28 (i) multiply the combined basic support obligation under section 518A.34, paragraph
269.29 (b), clause (5), by 0.75;

269.30 (ii) prorate the amount under item (i) between the parents based on each parent's
269.31 proportionate share of the combined PICS; and

269.32 (iii) subtract the lower amount from the higher amount.

270.1 (e) On a motion for modification of maintenance, including a motion for the extension
270.2 of the duration of a maintenance award, the court shall apply, in addition to all other relevant
270.3 factors, the factors for an award of maintenance under section 518.552 that exist at the time
270.4 of the motion. On a motion for modification of support, the court:

270.5 (1) shall apply section 518A.35, and shall not consider the financial circumstances of
270.6 each party's spouse, if any; and

270.7 (2) shall not consider compensation received by a party for employment in excess of a
270.8 40-hour work week, provided that the party demonstrates, and the court finds, that:

270.9 (i) the excess employment began after entry of the existing support order;

270.10 (ii) the excess employment is voluntary and not a condition of employment;

270.11 (iii) the excess employment is in the nature of additional, part-time employment, or
270.12 overtime employment compensable by the hour or fractions of an hour;

270.13 (iv) the party's compensation structure has not been changed for the purpose of affecting
270.14 a support or maintenance obligation;

270.15 (v) in the case of an obligor, current child support payments are at least equal to the
270.16 guidelines amount based on income not excluded under this clause; and

270.17 (vi) in the case of an obligor who is in arrears in child support payments to the obligee,
270.18 any net income from excess employment must be used to pay the arrearages until the
270.19 arrearages are paid in full.

270.20 (f) A modification of support or maintenance, including interest that accrued pursuant
270.21 to section 548.091, may be made retroactive only with respect to any period during which
270.22 the petitioning party has pending a motion for modification but only from the date of service
270.23 of notice of the motion on the responding party and on the public authority if public assistance
270.24 is being furnished or the county attorney is the attorney of record, unless the court adopts
270.25 an alternative effective date under paragraph (l). The court's adoption of an alternative
270.26 effective date under paragraph (l) shall not be considered a retroactive modification of
270.27 maintenance or support.

270.28 (g) Except for an award of the right of occupancy of the homestead, provided in section
270.29 518.63, all divisions of real and personal property provided by section 518.58 shall be final,
270.30 and may be revoked or modified only where the court finds the existence of conditions that
270.31 justify reopening a judgment under the laws of this state, including motions under section
270.32 518.145, subdivision 2. The court may impose a lien or charge on the divided property at
270.33 any time while the property, or subsequently acquired property, is owned by the parties or

271.1 either of them, for the payment of maintenance or support money, or may sequester the
271.2 property as is provided by section 518A.71.

271.3 (h) The court need not hold an evidentiary hearing on a motion for modification of
271.4 maintenance or support.

271.5 (i) Sections 518.14 and 518A.735 shall govern the award of attorney fees for motions
271.6 brought under this subdivision.

271.7 (j) An enactment, amendment, or repeal of law constitutes a substantial change in the
271.8 circumstances for purposes of modifying a child support order when it meets the standards
271.9 for modification in this section.

271.10 (k) On the first modification following implementation of amended child support
271.11 guidelines, the modification of basic support may be limited if the amount of the full variance
271.12 would create hardship for either the obligor or the obligee. Hardship includes, but is not
271.13 limited to, eligibility for assistance under chapter 256J.

271.14 (l) The court may select an alternative effective date for a maintenance or support order
271.15 if the parties enter into a binding agreement for an alternative effective date.

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

271.17 Sec. 180. Laws 2017, First Special Session chapter 6, article 5, section 11, as amended
271.18 by Laws 2019, First Special Session chapter 9, article 8, section 20, is amended to read:

271.19 **Sec. 11. MORATORIUM ON CONVERSION TRANSACTIONS.**

271.20 (a) Notwithstanding Laws 2017, chapter 2, article 2, a nonprofit health service plan
271.21 corporation operating under Minnesota Statutes, chapter 62C, or a nonprofit health
271.22 maintenance organization operating under Minnesota Statutes, chapter 62D, as of January
271.23 1, 2017, may only merge or consolidate with; convert; or transfer, as part of a single
271.24 transaction or a series of transactions within a 24-month period, all or a material amount of
271.25 its assets to an entity that is a corporation organized under Minnesota Statutes, chapter
271.26 317A; or to a Minnesota nonprofit hospital within the same integrated health system as the
271.27 health maintenance organization. For purposes of this section, "material amount" means
271.28 the lesser of ten percent of such an entity's total admitted net assets as of December 31 of
271.29 the previous year, or \$50,000,000.

271.30 (b) Paragraph (a) does not apply if the nonprofit service plan corporation or nonprofit
271.31 health maintenance organization files an intent to dissolve due to insolvency of the

272.1 corporation in accordance with Minnesota Statutes, chapter 317A, or insolvency proceedings
272.2 are commenced under Minnesota Statutes, chapter 60B.

272.3 (c) Nothing in this section shall be construed to authorize a nonprofit health maintenance
272.4 organization or a nonprofit service plan corporation to engage in any transaction or activities
272.5 not otherwise permitted under state law.

272.6 (d) This section expires July 1, ~~2023~~ 2026.

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

272.8 Sec. 181. Laws 2022, chapter 99, article 1, section 46, is amended to read:

272.9 Sec. 46. **MENTAL HEALTH GRANTS FOR HEALTH CARE PROFESSIONALS.**

272.10 Subdivision 1. **Grants authorized.** (a) The commissioner of health shall develop a grant
272.11 program to award grants to health care entities, including but not limited to health care
272.12 systems, hospitals, nursing facilities, community health clinics or consortium of clinics,
272.13 federally qualified health centers, rural health clinics, or health professional associations
272.14 for the purpose of establishing or expanding programs focused on improving the mental
272.15 health of health care professionals.

272.16 (b) Grants shall be awarded for programs that are evidenced-based or evidenced-informed
272.17 and are focused on addressing the mental health of health care professionals by:

272.18 (1) identifying and addressing the barriers to and stigma among health care professionals
272.19 associated with seeking self-care, including mental health and substance use disorder services;

272.20 (2) encouraging health care professionals to seek support and care for mental health and
272.21 substance use disorder concerns;

272.22 (3) identifying risk factors associated with suicide and other mental health conditions;

272.23 ~~or~~

272.24 (4) developing and making available resources to support health care professionals with
272.25 self-care and resiliency; or

272.26 (5) identifying and modifying structural barriers in health care delivery that create
272.27 unnecessary stress in the workplace.

272.28 Subd. 2. **Allocation of grants.** (a) To receive a grant, a health care entity must submit
272.29 an application to the commissioner by the deadline established by the commissioner. An
272.30 application must be on a form and contain information as specified by the commissioner
272.31 and at a minimum must contain:

- 273.1 (1) a description of the purpose of the program for which the grant funds will be used;
- 273.2 (2) a description of the achievable objectives of the program and how these objectives
- 273.3 will be met; and
- 273.4 (3) a process for documenting and evaluating the results of the program.

273.5 (b) The commissioner shall give priority to programs that involve peer-to-peer support.

273.6 Subd. 2a. **Grant term.** Notwithstanding Minnesota Statutes, section 16A.28, subdivision

273.7 6, encumbrances for grants under this section issued by June 30 of each year may be certified

273.8 for a period of up to three years beyond the year in which the funds were originally

273.9 appropriated.

273.10 Subd. 3. **Evaluation.** The commissioner shall evaluate the overall effectiveness of the

273.11 grant program by conducting a periodic evaluation of the impact and outcomes of the grant

273.12 program on health care professional burnout and retention. The commissioner shall submit

273.13 the results of the evaluation and any recommendations for improving the grant program to

273.14 the chairs and ranking minority members of the legislative committees with jurisdiction

273.15 over health care policy and finance by October 15, 2024.

273.16 Sec. 182. Laws 2022, chapter 99, article 3, section 9, is amended to read:

273.17 Sec. 9. **APPROPRIATION; MENTAL HEALTH GRANTS FOR HEALTH CARE**

273.18 **PROFESSIONALS.**

273.19 \$1,000,000 in fiscal year 2023 is appropriated from the general fund to the commissioner

273.20 of health for the health care professionals mental health grant program. This is a onetime

273.21 appropriation and is available until June 30, 2027.

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

273.23 Sec. 183. **ADOLESCENT MENTAL HEALTH PROMOTION; GRANTS**

273.24 **AUTHORIZED.**

273.25 Subdivision 1. **Goal and establishment.** (a) It is the goal of the state to increase protective

273.26 factors for mental well-being and decrease disparities in rates of mental health issues among

273.27 adolescent populations. The commissioner of health shall administer grants to

273.28 community-based organizations to facilitate mental health promotion programs for

273.29 adolescents, particularly those from populations that report higher rates of specific mental

273.30 health needs.

274.1 (b) The commissioner of health shall coordinate with other efforts at the local, state, or
274.2 national level to avoid duplication and promote complementary efforts in mental health
274.3 promotion among adolescents.

274.4 Subd. 2. **Grants authorized.** (a) The commissioner of health shall award grants to
274.5 eligible community organizations, including nonprofit organizations, community health
274.6 boards, and Tribal public health entities, to implement community-based mental health
274.7 promotion programs for adolescents in community settings to improve adolescent mental
274.8 health and reduce disparities between adolescent populations in reported rates of mental
274.9 health needs.

274.10 (b) The commissioner of health, in collaboration with community and professional
274.11 stakeholders, shall establish criteria for review of applications received under this subdivision
274.12 to ensure funded programs operate using best practices such as trauma-informed care and
274.13 positive youth development principles.

274.14 (c) Grant funds distributed under this subdivision shall be used to support new or existing
274.15 community-based mental health promotion programs that include but are not limited to:

274.16 (1) training community-based members to facilitate discussions or courses on adolescent
274.17 mental health promotion skills;

274.18 (2) training trusted community members to model positive mental health skills and
274.19 practices in their existing roles;

274.20 (3) training and supporting adolescents to provide peer support; and

274.21 (4) supporting community dialogue on mental health promotion and collective stress or
274.22 trauma.

274.23 Subd. 3. **Evaluation.** The commissioner shall conduct an evaluation of the
274.24 community-based grant programs funded under this section. Grant recipients shall cooperate
274.25 with the commissioner in the evaluation, and at the direction of the commissioner, shall
274.26 provide the commissioner with the information needed to conduct the evaluation.

274.27 Sec. 184. **ADVANCING HEALTH EQUITY THROUGH CAPACITY BUILDING**
274.28 **AND RESOURCE ALLOCATION.**

274.29 Subdivision 1. **Establishment of grant program.** The commissioner of health shall:

274.30 (1) establish an annual grant program to award infrastructure capacity building grants
274.31 to help metro and rural community and faith-based organizations serving populations of
274.32 color, American Indians, LGBTQIA+ communities, and those with disabilities in Minnesota

275.1 who have been disproportionately impacted by health and other inequities to be better
275.2 equipped and prepared for success in procuring grants and contracts at the department and
275.3 addressing inequities; and

275.4 (2) create a framework at the department to maintain equitable practices in grantmaking
275.5 to ensure that internal grantmaking and procurement policies and practices prioritize equity,
275.6 transparency, and accessibility to include:

275.7 (i) a tracking system for the department to better monitor and evaluate equitable
275.8 procurement and grantmaking processes and their impacts; and

275.9 (ii) technical assistance and coaching to department leadership in grantmaking and
275.10 procurement processes and programs and providing tools and guidance to ensure equitable
275.11 and transparent competitive grantmaking processes and award distribution across
275.12 communities most impacted by inequities and develop measures to track progress over time.

275.13 Subd. 2. **Commissioner's duties.** The commissioner of health shall:

275.14 (1) in consultation with community stakeholders, community health boards, and Tribal
275.15 nations, develop a request for proposals for an infrastructure capacity building grant program
275.16 to help community-based organizations, including faith-based organizations, to be better
275.17 equipped and prepared for success in procuring grants and contracts at the department and
275.18 beyond;

275.19 (2) provide outreach, technical assistance, and program development support to increase
275.20 capacity for new and existing community-based organizations and other service providers
275.21 in order to better meet statewide needs particularly in greater Minnesota and areas where
275.22 services to reduce health disparities have not been established;

275.23 (3) in consultation with community stakeholders, review responses to requests for
275.24 proposals and award grants under this section;

275.25 (4) ensure communication with the ethnic councils; Minnesota Indian Affairs Council;
275.26 Minnesota Council on Disability; Minnesota Commission of the Deaf, Deafblind, and Hard
275.27 of Hearing; and the governor's office on the request for proposal process;

275.28 (5) in consultation with community stakeholders, establish a transparent and objective
275.29 accountability process focused on outcomes that grantees agree to achieve;

275.30 (6) maintain data on outcomes reported by grantees; and

276.1 (7) establish a process or mechanism to evaluate the success of the capacity building
276.2 grant program and to build the evidence base for effective community-based organizational
276.3 capacity building in reducing disparities.

276.4 Subd. 3. **Eligible grantees.** Organizations eligible to receive grant funding under this
276.5 section include: organizations or entities that work with diverse communities such as
276.6 populations of color, American Indians, LGBTQIA+ communities, and those with disabilities
276.7 in metro and rural communities.

276.8 Subd. 4. **Strategic consideration and priority of proposals; eligible populations;**
276.9 **grant awards.** (a) The commissioner, in consultation with community stakeholders, shall
276.10 develop a request for proposals for equity in procurement and grantmaking capacity building
276.11 grant program to help community-based organizations, including faith-based organizations
276.12 to be better equipped and prepared for success in procuring grants and contracts at the
276.13 department and addressing inequities.

276.14 (b) In awarding the grants, the commissioner shall provide strategic consideration and
276.15 give priority to proposals from organizations or entities led by populations of color or
276.16 American Indians, and those serving communities of color, American Indians, LGBTQIA+
276.17 communities, and disability communities.

276.18 Subd. 5. **Geographic distribution of grants.** The commissioner shall ensure that grant
276.19 funds are prioritized and awarded to organizations and entities that are within counties that
276.20 have a higher proportion of Black or African American, nonwhite Latino(a), LGBTQIA+,
276.21 and disability communities to the extent possible.

276.22 Subd. 6. **Report.** Grantees must report grant program outcomes to the commissioner on
276.23 the forms and according to the timelines established by the commissioner.

276.24 Sec. 185. **CLIMATE RESILIENCY.**

276.25 Subdivision 1. **Climate resiliency program.** The commissioner of health shall implement
276.26 a climate resiliency program to:

276.27 (1) increase awareness of climate change;

276.28 (2) track the public health impacts of climate change and extreme weather events;

276.29 (3) provide technical assistance and tools that support climate resiliency to local public
276.30 health departments, Tribal health departments, soil and water conservation districts, and
276.31 other local governmental and nongovernmental organizations; and

277.1 (4) coordinate with the commissioners of the Pollution Control Agency, natural resources,
277.2 and agriculture and other state agencies in climate resiliency related planning and
277.3 implementation.

277.4 Subd. 2. **Grants authorized; allocation.** (a) The commissioner of health shall manage
277.5 a grant program for the purpose of climate resiliency planning. The commissioner shall
277.6 award grants through a request for proposals process to local public health departments,
277.7 Tribal health departments, soil and water conservation districts, or other local organizations
277.8 for planning for the health impacts of extreme weather events and developing adaptation
277.9 actions. Priority shall be given to organizations that serve communities that are
277.10 disproportionately impacted by climate change.

277.11 (b) Grantees must use the funds to develop a plan or implement strategies that will reduce
277.12 the risk of health impacts from extreme weather events. The grant application must include:

277.13 (1) a description of the plan or project for which the grant funds will be used;

277.14 (2) a description of the pathway between the plan or project and its impacts on health;

277.15 (3) a description of the objectives, a work plan, and a timeline for implementation; and

277.16 (4) the community or group on which the grant proposes to focus.

277.17 Sec. 186. **CRITICAL ACCESS DENTAL INFRASTRUCTURE PROGRAM.**

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

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

277.21 (c) "Critical access dental provider" means a critical access dental provider as defined
277.22 in Minnesota Statutes, section 256B.76, subdivision 4.

277.23 (d) "Dental infrastructure" means:

277.24 (1) physical infrastructure of a dental setting, including but not limited to the operations
277.25 and clinical spaces in a dental clinic; associated heating, ventilation, and air conditioning
277.26 infrastructure and other mechanical infrastructure; and dental equipment needed to operate
277.27 a dental clinic; or

277.28 (2) mobile dental equipment or other equipment needed to provide dental services via
277.29 a hub-and-spoke service delivery model or via teledentistry.

278.1 Subd. 2. **Grant and loan program established.** The commissioner shall make grants
278.2 and forgivable loans to critical access dental providers for eligible dental infrastructure
278.3 projects.

278.4 Subd. 3. **Eligible projects.** In order to be eligible for a grant or forgivable loan under
278.5 this section, a dental infrastructure project must be proposed by a critical access dental
278.6 provider and must allow the provider to maintain or expand the provider's capacity to serve
278.7 Minnesota health care program enrollees.

278.8 Subd. 4. **Application.** (a) The commissioner must develop forms and procedures for
278.9 soliciting and reviewing applications for grants and forgivable loans under this section and
278.10 for awarding grants and forgivable loans. Critical access dental providers seeking a grant
278.11 or forgivable loan under this section must apply to the commissioner in a time and manner
278.12 specified by the commissioner. In evaluating applications for grants or forgivable loans for
278.13 eligible projects, the commissioner must review applications for completeness and must
278.14 determine the extent to which:

278.15 (1) the project would ensure that the critical access dental provider is able to continue
278.16 to serve Minnesota health care program enrollees in a manner that would not be possible
278.17 but for the project; or

278.18 (2) the project would increase the number of Minnesota health care program enrollees
278.19 served by the provider or the clinical complexity of the Minnesota health care program
278.20 enrollees served by the provider.

278.21 (b) The commissioner must award grants and forgivable loans based on the information
278.22 provided in the grant application.

278.23 Subd. 5. **Program oversight.** The commissioner may require and collect from grant and
278.24 loan recipients any information needed to evaluate the program.

278.25 Sec. 187. **DIRECTION TO COMMISSIONER OF HEALTH; DEVELOPMENT**
278.26 **OF ANALYTICAL TOOLS.**

278.27 (a) The commissioner of health, in consultation with the Minnesota Nurses Association
278.28 and other professional nursing organizations, must develop a means of analyzing available
278.29 adverse event data, available staffing data, and available data from concern for safe staffing
278.30 forms to examine potential causal links between adverse events and understaffing.

278.31 (b) The commissioner must develop an initial means of conducting the analysis described
278.32 in paragraph (a) by January 1, 2025, and publish a public report on the commissioner's
278.33 initial findings by January 1, 2026.

279.1 (c) By January 1, 2024, the commissioner must submit to the chairs and ranking minority
279.2 members of the house and senate committees with jurisdiction over the regulation of hospitals
279.3 a report on the available data, potential sources of additional useful data, and any additional
279.4 statutory authority the commissioner requires to collect additional useful information from
279.5 hospitals.

279.6 **EFFECTIVE DATE.** This section is effective August 1, 2023.

279.7 Sec. 188. **DIRECTION TO COMMISSIONER OF HEALTH; NURSING**
279.8 **WORKFORCE REPORT.**

279.9 (a) The commissioner of health must publish a public report on the current status of the
279.10 state's nursing workforce employed by hospitals. In preparing the report, the commissioner
279.11 shall utilize information collected in collaboration with the Board of Nursing as directed
279.12 under Minnesota Statutes, sections 144.051 and 144.052, on Minnesota's supply of active
279.13 licensed nurses and reasons licensed nurses are leaving direct care positions at hospitals;
279.14 information collected and shared by the Minnesota Hospital Association on retention by
279.15 hospitals of licensed nurses; information collected through an independent study on reasons
279.16 licensed nurses are choosing not to renew their licenses and leaving the profession; and
279.17 other publicly available data the commissioner deems useful.

279.18 (b) The commissioner must publish the report by January 1, 2026.

279.19 Sec. 189. **EMMETT LOUIS TILL VICTIMS RECOVERY PROGRAM.**

279.20 Subdivision 1. **Short title.** This section shall be known as the Emmett Louis Till Victims
279.21 Recovery Program.

279.22 Subd. 2. **Program established; grants.** (a) The commissioner of health shall establish
279.23 the Emmett Louis Till Victims Recovery Program to address the health and wellness needs
279.24 of:

279.25 (1) victims who experienced trauma, including historical trauma, resulting from events
279.26 such as assault or another violent physical act, intimidation, false accusations, wrongful
279.27 conviction, a hate crime, the violent death of a family member, or experiences of
279.28 discrimination or oppression based on the victim's race, ethnicity, or national origin; and

279.29 (2) the families and heirs of victims described in clause (1), who experienced trauma,
279.30 including historical trauma, because of their proximity or connection to the victim.

280.1 (b) The commissioner, in consultation with victims, families, and heirs described in
280.2 paragraph (a), shall award competitive grants to applicants for projects to provide the
280.3 following services to victims, families, and heirs described in paragraph (a):

280.4 (1) health and wellness services, which may include services and support to address
280.5 physical health, mental health, and cultural needs;

280.6 (2) remembrance and legacy preservation activities;

280.7 (3) cultural awareness services; and

280.8 (4) community resources and services to promote healing for victims, families, and heirs
280.9 described in paragraph (a).

280.10 (c) In awarding grants under this section, the commissioner must prioritize grant awards
280.11 to community-based organizations experienced in providing support and services to victims,
280.12 families, and heirs described in paragraph (a).

280.13 Subd. 3. **Evaluation.** Grant recipients must provide the commissioner with information
280.14 required by the commissioner to evaluate the grant program, in a time and manner specified
280.15 by the commissioner.

280.16 Subd. 4. **Reports.** The commissioner must submit a status report by January 15, 2024,
280.17 and an additional report by January 15, 2025, on the operation and results of the grant
280.18 program, to the extent available. These reports must be submitted to the chairs and ranking
280.19 minority members of the legislative committees with jurisdiction over health care. The
280.20 report due January 15, 2024, must include information on grant program activities to date
280.21 and an assessment of the need to continue to offer services provided by grant recipients to
280.22 victims, families, and heirs who experienced trauma resulting from government-sponsored
280.23 activities. The report due January 15, 2025, must include a summary of the services offered
280.24 by grant recipients; an assessment of the need to continue to offer services provided by
280.25 grant recipients to victims, families, and heirs described in subdivision 2, paragraph (a);
280.26 and an evaluation of the grant program's goals and outcomes.

280.27 Sec. 190. **HEALTHY BEGINNINGS, HEALTHY FAMILIES ACT.**

280.28 Subdivision 1. **Purpose.** The purpose of the Healthy Beginnings, Healthy Families Act
280.29 is to build equitable, inclusive, and culturally and linguistically responsive systems that
280.30 ensure the health and well-being of young children and their families by supporting the
280.31 Minnesota perinatal quality collaborative, establishing the Minnesota partnership to prevent
280.32 infant mortality, increasing access to culturally relevant developmental and social-emotional

281.1 screening with follow-up, and sustaining and expanding the model jail practices for children
281.2 of incarcerated parents in Minnesota jails.

281.3 Subd. 2. **Minnesota perinatal quality collaborative.** The Minnesota perinatal quality
281.4 collaborative is established to improve pregnancy outcomes for pregnant people and
281.5 newborns through efforts to:

281.6 (1) advance evidence-based and evidence-informed clinics and other health service
281.7 practices and processes through quality care review, chart audits, and continuous quality
281.8 improvement initiatives that enable equitable outcomes;

281.9 (2) review current data, trends, and research on best practices to inform and prioritize
281.10 quality improvement initiatives;

281.11 (3) identify methods that incorporate antiracism into individual practice and organizational
281.12 guidelines in the delivery of perinatal health services;

281.13 (4) support quality improvement initiatives to address substance use disorders in pregnant
281.14 people and infants with neonatal abstinence syndrome or other effects of substance use;

281.15 (5) provide a forum to discuss state-specific system and policy issues to guide quality
281.16 improvement efforts that improve population-level perinatal outcomes;

281.17 (6) reach providers and institutions in a multidisciplinary, collaborative, and coordinated
281.18 effort across system organizations to reinforce a continuum of care model; and

281.19 (7) support health care facilities in monitoring interventions through rapid data collection
281.20 and applying system changes to provide improved care in perinatal health.

281.21 Subd. 3. **Eligible organizations.** The commissioner of health shall make a grant to a
281.22 nonprofit organization to create or sustain a multidisciplinary network of representatives
281.23 of health care systems, health care providers, academic institutions, local and state agencies,
281.24 and community partners that will collaboratively improve pregnancy and infant outcomes
281.25 through evidence-based, population-level quality improvement initiatives.

281.26 Subd. 4. **Grants authorized.** The commissioner shall award one grant to a nonprofit
281.27 organization to support efforts that improve maternal and infant health outcomes aligned
281.28 with the purpose outlined in subdivision 2. The commissioner shall give preference to a
281.29 nonprofit organization that has the ability to provide these services throughout the state.
281.30 The commissioner shall provide content expertise to the grant recipient to further the
281.31 accomplishment of the purpose.

282.1 Subd. 5. Minnesota partnership to prevent infant mortality program. (a) The
282.2 commissioner of health shall establish the Minnesota partnership to prevent infant mortality
282.3 program that is a statewide partnership program to engage communities, exchange best
282.4 practices, share summary data on infant health, and promote policies to improve birth
282.5 outcomes and eliminate preventable infant mortality.

282.6 (b) The goals of the Minnesota partnership to prevent infant mortality program are to:

282.7 (1) build a statewide multisectoral partnership including the state government, local
282.8 public health agencies, Tribes, private sector, and community nonprofit organizations with
282.9 the shared goal of decreasing infant mortality rates among populations with significant
282.10 disparities, including among Black, American Indian, and other nonwhite communities,
282.11 and rural populations;

282.12 (2) address the leading causes of poor infant health outcomes such as premature birth,
282.13 infant sleep-related deaths, and congenital anomalies through strategies to change social
282.14 and environmental determinants of health; and

282.15 (3) promote the development, availability, and use of data-informed, community-driven
282.16 strategies to improve infant health outcomes.

282.17 Subd. 5a. Grants authorized. (a) The commissioner of health shall award grants to
282.18 eligible applicants to convene, coordinate, and implement data-driven strategies and culturally
282.19 relevant activities to improve infant health by reducing preterm births, sleep-related infant
282.20 deaths, and congenital malformations and address social and environmental determinants
282.21 of health. Grants shall be awarded to support community nonprofit organizations, Tribal
282.22 governments, and community health boards. In accordance with available funding, grants
282.23 shall be noncompetitively awarded to the eleven sovereign Tribal governments if their
282.24 respective proposals demonstrate the ability to implement programs designed to achieve
282.25 the purposes in subdivision 5 and meet other requirements of this section. An eligible
282.26 applicant must submit a complete application to the commissioner of health by the deadline
282.27 established by the commissioner. The commissioner shall award all other grants competitively
282.28 to eligible applicants in metropolitan and rural areas of the state and may consider geographic
282.29 representation in grant awards.

282.30 (b) Grantee activities shall:

282.31 (1) address the leading cause or causes of infant mortality;

282.32 (2) be based on community input;

282.33 (3) focus on policy, systems, and environmental changes that support infant health; and

283.1 (4) address the health disparities and inequities that are experienced in the grantee's
283.2 community.

283.3 (c) The commissioner shall review each application to determine whether the application
283.4 is complete and whether the applicant and the project are eligible for a grant. In evaluating
283.5 applications according to subdivision 5, the commissioner shall establish criteria including
283.6 but not limited to: the eligibility of the applicant's project under this section; the applicant's
283.7 thoroughness and clarity in describing the infant health issues grant funds are intended to
283.8 address; a description of the applicant's proposed project; the project's likelihood to achieve
283.9 the grant's purposes as described in this section; a description of the population demographics
283.10 and service area of the proposed project; and evidence of efficiencies and effectiveness
283.11 gained through collaborative efforts.

283.12 (d) Grant recipients shall report their activities to the commissioner in a format and at
283.13 a time specified by the commissioner.

283.14 Subd. 5b. **Technical assistance.** (a) The commissioner shall provide content expertise,
283.15 technical expertise, training to grant recipients, and advice on data-driven strategies.

283.16 (b) For the purposes of carrying out the grant program under subdivision 5, including
283.17 for administrative purposes, the commissioner shall award contracts to appropriate entities
283.18 to assist in training and provide technical assistance to grantees.

283.19 (c) Contracts awarded under paragraph (b) may be used to provide technical assistance
283.20 and training in the areas of:

283.21 (1) partnership development and capacity building;

283.22 (2) Tribal support;

283.23 (3) implementation support for specific infant health strategies;

283.24 (4) communications by convening and sharing lessons learned; and

283.25 (5) health equity.

283.26 Subd. 6. **Developmental and social-emotional screening with follow-up.** The goal of
283.27 the developmental and social-emotional screening is to identify young children at risk for
283.28 developmental and behavioral concerns and provide follow-up services to connect families
283.29 and young children to appropriate community-based resources and programs. The
283.30 commissioner of health shall work with the commissioners of human services and education
283.31 to implement this section and promote interagency coordination with other early childhood
283.32 programs including those that provide screening and assessment.

284.1 Subd. 6a. **Duties.** The commissioner shall:

284.2 (1) increase the awareness of developmental and social-emotional screening with
284.3 follow-up in coordination with community and state partners;

284.4 (2) expand existing electronic screening systems to administer developmental and
284.5 social-emotional screening to children birth to kindergarten entrance;

284.6 (3) provide screening for developmental and social-emotional delays based on current
284.7 recommended best practices;

284.8 (4) review and share the results of the screening with the parent or guardian. Support
284.9 families in their role as caregivers by providing anticipatory guidance around typical growth
284.10 and development;

284.11 (5) ensure children and families are referred to and linked with appropriate
284.12 community-based services and resources when any developmental or social-emotional
284.13 concerns are identified through screening; and

284.14 (6) establish performance measures and collect, analyze, and share program data regarding
284.15 population-level outcomes of developmental and social-emotional screening, referrals to
284.16 community-based services, and follow-up services.

284.17 Subd. 6b. **Grants authorized.** The commissioner shall award grants to community-based
284.18 organizations, community health boards, and Tribal nations to support follow-up services
284.19 for children with developmental or social-emotional concerns identified through screening
284.20 in order to link children and their families to appropriate community-based services and
284.21 resources. Grants shall also be awarded to community-based organizations to train and
284.22 utilize cultural liaisons to help families navigate the screening and follow-up process in a
284.23 culturally and linguistically responsive manner. The commissioner shall provide technical
284.24 assistance, content expertise, and training to grant recipients to ensure that follow-up services
284.25 are effectively provided.

284.26 Subd. 7. **Model jail practices for incarcerated parents.** (a) The commissioner of health
284.27 may make special grants to counties and groups of counties to implement model jail practices
284.28 and to county governments, Tribal governments, or nonprofit organizations in corresponding
284.29 geographic areas to build partnerships with county jails to support children of incarcerated
284.30 parents and their caregivers.

284.31 (b) "Model jail practices" means a set of practices that correctional administrators can
284.32 implement to remove barriers that may prevent children from cultivating or maintaining

285.1 relationships with their incarcerated parents during and immediately after incarceration
285.2 without compromising safety or security of the correctional facility.

285.3 Subd. 7a. **Grants authorized; model jail practices.** (a) The commissioner of health
285.4 shall award grants to eligible county jails to implement model jail practices and separate
285.5 grants to county governments, Tribal governments, or nonprofit organizations in
285.6 corresponding geographic areas to build partnerships with county jails to support children
285.7 of incarcerated parents and their caregivers.

285.8 (b) Grantee activities include but are not limited to:

285.9 (1) parenting classes or groups;

285.10 (2) family-centered intake and assessment of inmate programs;

285.11 (3) family notification, information, and communication strategies;

285.12 (4) correctional staff training;

285.13 (5) policies and practices for family visits; and

285.14 (6) family-focused reentry planning.

285.15 (c) Grant recipients shall report their activities to the commissioner in a format and at a
285.16 time specified by the commissioner.

285.17 Subd. 7b. **Technical assistance and oversight; model jail practices.** (a) The
285.18 commissioner shall provide content expertise, training to grant recipients, and advice on
285.19 evidence-based strategies, including evidence-based training to support incarcerated parents.

285.20 (b) For the purposes of carrying out the grant program under subdivision 7a, including
285.21 for administrative purposes, the commissioner shall award contracts to appropriate entities
285.22 to assist in training and provide technical assistance to grantees.

285.23 (c) Contracts awarded under paragraph (b) may be used to provide technical assistance
285.24 and training in the areas of:

285.25 (1) evidence-based training for incarcerated parents;

285.26 (2) partnership building and community engagement;

285.27 (3) evaluation of process and outcomes of model jail practices; and

285.28 (4) expert guidance on reducing the harm caused to children of incarcerated parents and
285.29 application of model jail practices.

286.1 Sec. 191. **HELP ME CONNECT RESOURCE AND REFERRAL SYSTEM FOR**
286.2 **CHILDREN.**

286.3 **Subdivision 1. Establishment; purpose.** The commissioner shall establish the Help Me
286.4 Connect resource and referral system for children as a comprehensive, collaborative resource
286.5 and referral system for children from the prenatal stage through age eight, and their families.
286.6 The commissioner of health shall work collaboratively with the commissioners of human
286.7 services and education to implement this section.

286.8 **Subd. 2. Duties.** (a) The Help Me Connect system shall facilitate collaboration across
286.9 sectors, including child health, early learning and education, child welfare, and family
286.10 supports by:

286.11 (1) providing early childhood provider outreach to support knowledge of and access to
286.12 local resources that provide early detection and intervention services;

286.13 (2) identifying and providing access to early childhood and family support navigation
286.14 specialists that can support families and their children's needs; and

286.15 (3) linking children and families to appropriate community-based services.

286.16 (b) The Help Me Connect system shall provide community outreach that includes support
286.17 for, and participation in, the Help Me Connect system, including disseminating information
286.18 on the system and compiling and maintaining a current resource directory that includes but
286.19 is not limited to primary and specialty medical care providers, early childhood education
286.20 and child care programs, developmental disabilities assessment and intervention programs,
286.21 mental health services, family and social support programs, child advocacy and legal services,
286.22 public health services and resources, and other appropriate early childhood information.

286.23 (c) The Help Me Connect system shall maintain a centralized access point for parents
286.24 and professionals to obtain information, resources, and other support services.

286.25 (d) The Help Me Connect system shall collect data to increase understanding of the
286.26 current and ongoing system of support and resources for expectant families and children
286.27 through age eight and their families, including identification of gaps in service, barriers to
286.28 finding and receiving appropriate services, and lack of resources.

287.1 Sec. 192. **INITIAL IMPLEMENTATION OF THE KEEPING NURSES AT THE**
287.2 **BEDSIDE ACT.**

287.3 (a) By October 1, 2024, each hospital must establish and convene a hospital nurse staffing
287.4 committee as described under Minnesota Statutes, section 144.7053, and a hospital nurse
287.5 workload committee as described under Minnesota Statutes, section 144.7054.

287.6 (b) By October 1, 2025, each hospital must implement core staffing plans developed by
287.7 its hospital nurse staffing committee and satisfy the plan posting requirements under
287.8 Minnesota Statutes, section 144.7056.

287.9 (c) By October 1, 2025, each hospital must submit to the commissioner of health core
287.10 staffing plans meeting the requirements of Minnesota Statutes, section 144.7055.

287.11 (d) By October 1, 2025, the commissioner of health must develop a standard concern
287.12 for safe staffing form and provide an electronic means of submitting the form to the relevant
287.13 hospital nurse staffing committee. The commissioner must base the form on the existing
287.14 concern for safe staffing form maintained by the Minnesota Nurses' Association.

287.15 (e) By January 1, 2026, the commissioner of health must provide electronic access to
287.16 the uniform format or standard form for nurse staffing reporting described under Minnesota
287.17 Statutes, section 144.7057, subdivision 4.

287.18 Sec. 193. **LONG COVID.**

287.19 Subdivision 1. **Definition.** For the purpose of this section, "long COVID" means health
287.20 problems that people experience four or more weeks after being infected with SARS-CoV-2,
287.21 the virus that causes COVID-19. Long COVID is also called post COVID conditions,
287.22 long-haul COVID, chronic COVID, post-acute COVID, or post-acute sequelae of COVID-19
287.23 (PASC).

287.24 Subd. 2. **Establishment.** The commissioner of health shall establish a program to conduct
287.25 community assessments and epidemiologic investigations to monitor and address impacts
287.26 of long COVID. The purposes of these activities are to:

287.27 (1) monitor trends in: incidence, prevalence, mortality, and health outcomes; care
287.28 management and costs; changes in disability status, employment, and quality of life; and
287.29 service needs of individuals with long COVID and to detect potential public health problems,
287.30 predict risks, and assist in investigating long COVID health inequities;

287.31 (2) more accurately target information and resources for communities and patients and
287.32 their families;

288.1 (3) inform health professionals and citizens about risks and early detection of long
288.2 COVID known to be elevated in their communities; and

288.3 (4) promote evidence-based practices around long COVID prevention and management
288.4 and to address public concerns and questions about long COVID.

288.5 Subd. 3. **Partnerships.** The commissioner of health shall, in consultation with health
288.6 care professionals, the Department of Human Services, local public health, health insurers,
288.7 employers, schools, long COVID survivors, and community organizations serving people
288.8 at high risk of long COVID, identify priority actions and activities to address the needs for
288.9 communication, services, resources, tools, strategies, and policies to support long COVID
288.10 survivors and their families.

288.11 Subd. 4. **Grants and contracts.** The commissioner of health shall coordinate and
288.12 collaborate with community and organizational partners to implement evidence-informed
288.13 priority actions through community-based grants and contracts. The commissioner of health
288.14 shall award contracts and grants to organizations that serve communities disproportionately
288.15 impacted by COVID-19 and long COVID, including but not limited to rural and low-income
288.16 areas, Black and African Americans, African immigrants, American Indians, Asian
288.17 American-Pacific Islanders, Latino(a) communities, LGBTQ+ communities, and persons
288.18 with disabilities. Organizations may also address intersectionality within the groups. The
288.19 commissioner shall award grants and contracts to eligible organizations to plan, construct,
288.20 and disseminate resources and information to support survivors of long COVID, including
288.21 caregivers, health care providers, ancillary health care workers, workplaces, schools,
288.22 communities, and local and Tribal public health.

288.23 Sec. 194. **MEMBERSHIP TERMS; PALLIATIVE CARE ADVISORY COUNCIL.**

288.24 Notwithstanding the terms of office specified to the members upon their appointment,
288.25 the terms for members appointed to the Palliative Care Advisory Council under Minnesota
288.26 Statutes, section 144.059, on or after February 1, 2022, shall be three years, as provided in
288.27 Minnesota Statutes, section 144.059, subdivision 3.

288.28 Sec. 195. **PSYCHEDELIC MEDICINE TASK FORCE.**

288.29 Subdivision 1. **Establishment; purpose.** The Psychedelic Medicine Task Force is
288.30 established to advise the legislature on the legal, medical, and policy issues associated with
288.31 the legalization of psychedelic medicine in the state. For purposes of this section,
288.32 "psychedelic medicine" means 3,4-methylenedioxymethamphetamine (MDMA), psilocybin,
288.33 and LSD.

- 289.1 Subd. 2. **Membership; compensation.** (a) The Psychedelic Medicine Task Force shall
289.2 consist of:
- 289.3 (1) the governor or a designee;
- 289.4 (2) two members of the house of representatives appointed by the speaker of the house
289.5 and two senators appointed by the president of the senate;
- 289.6 (3) the commissioner of health or a designee;
- 289.7 (4) the commissioner of public safety or a designee;
- 289.8 (5) the commissioner of human services or a designee;
- 289.9 (6) the attorney general or a designee;
- 289.10 (7) the executive director of the Board of Pharmacy or a designee;
- 289.11 (8) the commissioner of commerce or a designee; and
- 289.12 (9) members of the public, appointed by the governor, who have relevant knowledge
289.13 and expertise, including:
- 289.14 (i) two members representing Indian Tribes within the boundaries of Minnesota, one
289.15 representing the Ojibwe Tribes and one representing the Dakota Tribes;
- 289.16 (ii) one member with expertise in the treatment of substance use disorders;
- 289.17 (iii) one member with experience working in public health policy;
- 289.18 (iv) two veterans with treatment-resistant mental health conditions;
- 289.19 (v) two patients with treatment-resistant mental health conditions;
- 289.20 (vi) one physician with experience treating treatment-resistant mental health conditions,
289.21 including post-traumatic stress disorder;
- 289.22 (vii) one health care practitioner with experience in integrative medicine;
- 289.23 (viii) one psychologist with experience treating treatment-resistant mental health
289.24 conditions, including post-traumatic stress disorder; and
- 289.25 (ix) one member with demonstrable experience in the medical use of psychedelic
289.26 medicine.
- 289.27 (b) Members listed in paragraph (a), clauses (1) and (3) to (8), and members appointed
289.28 under paragraph (a), clause (9), may be reimbursed for expenses under Minnesota Statutes,
289.29 section 15.059, subdivision 6. Members appointed under paragraph (a), clause (2), may

290.1 receive per diem compensation from their respective bodies according to the rules of their
290.2 respective bodies.

290.3 (c) Members shall be designated or appointed to the task force by July 15, 2023.

290.4 Subd. 3. **Organization.** (a) The commissioner of health or the commissioner's designee
290.5 shall convene the first meeting of the task force.

290.6 (b) At the first meeting, the members of the task force shall elect a chairperson and other
290.7 officers as the members deem necessary.

290.8 (c) The first meeting of the task force shall occur by August 1, 2023. The task force shall
290.9 meet monthly or as determined by the chairperson.

290.10 Subd. 4. **Staff.** The commissioner of health shall provide support staff, office and meeting
290.11 space, and administrative services for the task force.

290.12 Subd. 5. **Duties.** The task force shall:

290.13 (1) survey existing studies in the scientific literature on the therapeutic efficacy of
290.14 psychedelic medicine in the treatment of mental health conditions, including depression,
290.15 anxiety, post-traumatic stress disorder, bipolar disorder, and any other mental health
290.16 conditions and medical conditions for which a psychedelic medicine may provide an effective
290.17 treatment option;

290.18 (2) compare the efficacy of psychedelic medicine in treating the conditions described
290.19 in clause (1) with the efficacy of treatments currently used for these conditions; and

290.20 (3) develop a comprehensive plan that covers:

290.21 (i) statutory changes necessary for the legalization of psychedelic medicine;

290.22 (ii) state and local regulation of psychedelic medicine;

290.23 (iii) federal law, policy, and regulation of psychedelic medicine, with a focus on retaining
290.24 state autonomy to act without conflicting with federal law, including methods to resolve
290.25 conflicts such as seeking an administrative exemption to the federal Controlled Substances
290.26 Act under United States Code, title 21, section 822(d), and Code of Federal Regulations,
290.27 title 21, part 1307.03; seeking a judicially created exemption to the federal Controlled
290.28 Substances Act; petitioning the United States Attorney General to establish a research
290.29 program under United States Code, title 21, section 872(e); using the Food and Drug
290.30 Administration's expanded access program; and using authority under the federal Right to
290.31 Try Act; and

291.1 (iv) education of the public on recommendations made to the legislature and others about
291.2 necessary and appropriate actions related to the legalization of psychedelic medicine in the
291.3 state.

291.4 Subd. 6. **Reports.** The task force shall submit two reports to the chairs and ranking
291.5 minority members of the legislative committees with jurisdiction over health and human
291.6 services that detail the task force's findings regarding the legalization of psychedelic medicine
291.7 in the state, including the comprehensive plan developed under subdivision 5. The first
291.8 report must be submitted by February 1, 2024, and the second report must be submitted by
291.9 January 1, 2025.

291.10 Sec. 196. **REPORT ON TRANSPARENCY OF HEALTH CARE PAYMENTS.**

291.11 Subdivision 1. **Definitions.** (a) The terms defined in this subdivision apply to this section.

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

291.13 (c) "Nonclaims-based payments" means payments to health care providers designed to
291.14 support and reward value of health care services over volume of health care services and
291.15 includes alternative payment models or incentives, payments for infrastructure expenditures
291.16 or investments, and payments for workforce expenditures or investments.

291.17 (d) "Nonpublic data" has the meaning given in Minnesota Statutes, section 13.02,
291.18 subdivision 9.

291.19 (e) "Primary care services" means integrated, accessible health care services provided
291.20 by clinicians who are accountable for addressing a large majority of personal health care
291.21 needs, developing a sustained partnership with patients, and practicing in the context of
291.22 family and community. Primary care services include but are not limited to preventive
291.23 services, office visits, administration of vaccines, annual physicals, pre-operative physicals,
291.24 assessments, care coordination, development of treatment plans, management of chronic
291.25 conditions, and diagnostic tests.

291.26 Subd. 2. **Report.** (a) To provide the legislature with information needed to meet the
291.27 evolving health care needs of Minnesotans, the commissioner shall report to the legislature
291.28 by February 15, 2024, on the volume and distribution of health care spending across payment
291.29 models used by health plan companies and third-party administrators, with a particular focus
291.30 on value-based care models and primary care spending.

291.31 (b) The report must include specific health plan and third-party administrator estimates
291.32 of health care spending for claims-based payments and nonclaims-based payments for the
291.33 most recent available year, reported separately for Minnesotans enrolled in state health care

292.1 programs, Medicare Advantage, and commercial health insurance. The report must also
292.2 include recommendations on changes needed to gather better data from health plan companies
292.3 and third-party administrators on the use of value-based payments that pay for value of
292.4 health care services provided over volume of services provided, promote the health of all
292.5 Minnesotans, reduce health disparities, and support the provision of primary care services
292.6 and preventive services.

292.7 (c) In preparing the report, the commissioner shall:

292.8 (1) describe the form, manner, and timeline for submission of data by health plan
292.9 companies and third-party administrators to produce estimates as specified in paragraph
292.10 (b);

292.11 (2) collect summary data that permits the computation of:

292.12 (i) the percentage of total payments that are nonclaims-based payments; and

292.13 (ii) the percentage of payments in item (i) that are for primary care services;

292.14 (3) where data was not directly derived, specify the methods used to estimate data
292.15 elements;

292.16 (4) notwithstanding Minnesota Statutes, section 62U.04, subdivision 11, conduct analyses
292.17 of the magnitude of primary care payments using data collected by the commissioner under
292.18 Minnesota Statutes, section 62U.04; and

292.19 (5) conduct interviews with health plan companies and third-party administrators to
292.20 better understand the types of nonclaims-based payments and models in use, the purposes
292.21 or goals of each, the criteria for health care providers to qualify for these payments, and the
292.22 timing and structure of health plan companies or third-party administrators making these
292.23 payments to health care provider organizations.

292.24 (d) Health plan companies and third-party administrators must comply with data requests
292.25 from the commissioner under this section within 60 days after receiving the request.

292.26 (e) Data collected under this section is nonpublic data. Notwithstanding the definition
292.27 of summary data in Minnesota Statutes, section 13.02, subdivision 19, summary data prepared
292.28 under this section may be derived from nonpublic data. The commissioner shall establish
292.29 procedures and safeguards to protect the integrity and confidentiality of any data maintained
292.30 by the commissioner.

293.1 Sec. 197. RETURN OF CHARITABLE ASSETS.

293.2 If a health system that is organized as a charitable organization, and that includes M
293.3 Health Fairview University of Minnesota Medical Center, sells or transfers control to an
293.4 out-of-state nonprofit entity or to any for-profit entity, the health system must return to the
293.5 general fund any charitable assets the health system received from the state.

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

293.8 Sec. 198. STUDY AND RECOMMENDATIONS; NONPROFIT HEALTH
293.9 MAINTENANCE ORGANIZATION CONVERSIONS AND OTHER
293.10 TRANSACTIONS.

293.11 (a) The commissioner of health shall study and develop recommendations on the
293.12 regulation of conversions, mergers, transfers of assets, and other transactions affecting
293.13 Minnesota-domiciled nonprofit health maintenance organizations and for-profit health
293.14 maintenance organizations. The recommendations must at least address:

293.15 (1) monitoring and regulation of Minnesota-domiciled for-profit health maintenance
293.16 organizations;

293.17 (2) issues related to public benefit assets held by a nonprofit health maintenance
293.18 organization, including identifying the portion of the organization's assets that are considered
293.19 public benefit assets to be protected, establishing a fair and independent process to value
293.20 to the assets, and how public benefit assets should be stewarded for the public good;

293.21 (3) designating a state agency or executive branch office with authority to review and
293.22 approve or deny a nonprofit health maintenance organization's plan to convert to a for-profit
293.23 organization; and

293.24 (4) establishing a process for the public to learn about and provide input on a nonprofit
293.25 health maintenance organization's proposed conversion to a for-profit organization.

293.26 (b) To fulfill the requirements under this section, the commissioner:

293.27 (1) may consult with the commissioners of human services and commerce;

293.28 (2) may enter into one or more contracts for professional or technical services;

293.29 (3) notwithstanding any law to the contrary, may use data submitted under Minnesota
293.30 Statutes, sections 62U.04 and 144.695 to 144.705, and other data held by the commissioner
293.31 for purposes of regulating health maintenance organizations or already submitted to the
293.32 commissioner by health carriers; and

294.1 (4) may collect from health maintenance organizations and their parent or affiliated
294.2 companies, financial data and other information, including nonpublic data and trade secret
294.3 data, that are deemed necessary by the commissioner to conduct the study and develop the
294.4 recommendations under this section. Health maintenance organizations must provide the
294.5 commissioner with any information requested by the commissioner under this clause, in
294.6 the form and manner specified by the commissioner. Any data collected by the commissioner
294.7 under this clause is classified as confidential data as defined in Minnesota Statutes, section
294.8 13.02, subdivision 3 or protected nonpublic data as defined in Minnesota Statutes, section
294.9 13.02, subdivision 13.

294.10 (c) No later than October 1, 2023, the commissioner must seek public comments on the
294.11 regulation of conversion transactions involving nonprofit health maintenance organizations.

294.12 (d) The commissioner may use the enforcement authority in Minnesota Statutes, section
294.13 62D.17, if a health maintenance organization fails to comply with a request for information
294.14 under paragraph (b), clause (4).

294.15 (e) The commissioner shall submit preliminary findings from this study to the chairs of
294.16 the legislative committees with jurisdiction over health and human services by January 15,
294.17 2024, and shall submit a final report and recommendations to the legislature by June 30,
294.18 2024.

294.19 **Sec. 199. STUDY OF THE DEVELOPMENT OF A STATEWIDE REGISTRY FOR**
294.20 **PROVIDER ORDERS FOR LIFE-SUSTAINING TREATMENT.**

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

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

294.24 (c) "Life-sustaining treatment" means any medical procedure, pharmaceutical drug,
294.25 medical device, or medical intervention that maintains life by sustaining, restoring, or
294.26 supplanting a vital function. Life-sustaining treatment does not include routine care necessary
294.27 to sustain patient cleanliness and comfort.

294.28 (d) "POLST" means a provider order for life-sustaining treatment, signed by a physician,
294.29 advanced practice registered nurse, or physician assistant, to ensure that the medical treatment
294.30 preferences of a patient with an advanced serious illness who is nearing the end of the their
294.31 life are honored.

295.1 (e) "POLST form" means a portable medical form used to communicate a physician's
295.2 order to help ensure that a patient's medical treatment preferences are conveyed to emergency
295.3 medical service personnel and other health care providers.

295.4 Subd. 2. **Establishment.** (a) The commissioner, in consultation with the advisory
295.5 committee established in paragraph (c), shall develop recommendations for a statewide
295.6 registry of POLST forms to ensure that a patient's medical treatment preferences are followed
295.7 by all health care providers. The registry must allow for the submission of completed POLST
295.8 forms and for the forms to be accessed by health care providers and emergency medical
295.9 service personnel in a timely manner for the provision of care or services.

295.10 (b) The commissioner shall develop recommendations on the following:

295.11 (1) electronic capture, storage, and security of information in the registry;

295.12 (2) procedures to protect the accuracy and confidentiality of information submitted to
295.13 the registry;

295.14 (3) limits as to who can access the registry;

295.15 (4) where the registry should be housed;

295.16 (5) ongoing funding models for the registry; and

295.17 (6) any other action needed to ensure that patients' rights are protected and that their
295.18 health care decisions are followed.

295.19 (c) The commissioner shall create an advisory committee with members representing
295.20 physicians, physician assistants, advanced practice registered nurses, nursing homes,
295.21 emergency medical system providers, hospice and palliative care providers, the disability
295.22 community, attorneys, medical ethicists, and the religious community.

295.23 Subd. 3. **Report.** The commissioner shall submit recommendations on establishing a
295.24 statewide registry of POLST forms to the chairs and ranking minority members of the
295.25 legislative committees with jurisdiction over health and human services policy and finance
295.26 by February 1, 2024, and implement the registry no later than December 1, 2024.

295.27 Sec. 200. **VACCINES FOR UNINSURED AND UNDERINSURED ADULTS.**

295.28 The commissioner of health shall administer a program to provide vaccines to uninsured
295.29 and underinsured adults. The commissioner shall determine adult eligibility for free or
295.30 low-cost vaccines under this program and shall enroll clinics to participate in the program
295.31 and administer vaccines recommended by the Centers for Disease Control and Prevention.
295.32 In administering the program, the commissioner shall address racial and ethnic disparities

296.1 in vaccine coverage rates. State money appropriated for purposes of this section shall be
296.2 used to supplement, but not supplant, available federal funding for purposes of this section.

296.3 Sec. 201. **WORKPLACE SAFETY GRANTS; HEALTH CARE ENTITIES AND**
296.4 **HUMAN SERVICES PROVIDERS.**

296.5 Subdivision 1. **Grant program established.** The commissioner of health shall administer
296.6 a program to award workplace safety grants to health care entities and human services
296.7 providers to increase safety measures at health care settings and at human services workplaces
296.8 providing behavioral health care; services for children, families, and vulnerable adults;
296.9 services for older adults and people with disabilities; and other social services or related
296.10 care.

296.11 Subd. 2. **Eligible applicants; application.** (a) Entities eligible for a grant under this
296.12 section shall include health systems, hospitals, medical clinics, dental clinics, ambulance
296.13 services, community health clinics, county human services agencies, Tribal human services
296.14 agencies, and other human services provider organizations.

296.15 (b) An entity seeking a grant under this section must submit an application to the
296.16 commissioner in a form and manner prescribed by the commissioner. An application must
296.17 include information about:

296.18 (1) the type of entity or organization seeking grant funding;

296.19 (2) the specific safety measures or activities for which the applicant will use the grant
296.20 funding;

296.21 (3) the specific policies that will be implemented or upheld to ensure that individuals'
296.22 rights to privacy and data protection are protected during the use of safety equipment obtained
296.23 or operated through grant funding;

296.24 (4) a proposed budget for each of the specific activities for which the applicant will use
296.25 the grant funding;

296.26 (5) an outline of efforts to enhance or improve existing safety measures or proposed
296.27 new measures to improve the safety of staff at the entity, agency, or organization;

296.28 (6) sample consent forms for any safety equipment that has capacity to record, store, or
296.29 share audio or video that will be collected from patients or clients prior to implementation
296.30 of grant-funded safety measures, excluding equipment located in public spaces in
296.31 provider-controlled, licensed settings;

297.1 (7) how the grant-funded measures will lead to long-term improvements in safety and
297.2 stability for staff and for patients and clients accessing health care or services from the
297.3 applicant; and

297.4 (8) methods the applicant will use to evaluate effectiveness of the safety measures and
297.5 changes that will be made if the measures are deemed ineffective.

297.6 Subd. 3. **Grant awards.** Grants must be awarded to eligible applicants that meet
297.7 application requirements on a first-come, first-served basis. Forty percent of grant funds
297.8 must be awarded to eligible applicants located outside of the seven-county metropolitan
297.9 area. Each grant award must be for at least \$5,000, but no more than \$100,000.

297.10 Subd. 4. **Allowable uses of grant funds.** (a) Grant funds may be used for one or more
297.11 of the following:

297.12 (1) the procurement and installation of safety equipment, including but not limited to
297.13 cellular telephones; personal radios; wearable tracking devices for staff to share their location
297.14 with supervisors, subject to the federal Health Insurance Portability and Accountability Act
297.15 of 1996 (HIPAA) data privacy requirements outlined in Code of Federal Regulations, title
297.16 45, parts 160 and 164, subparts A and E; security systems and cameras in public spaces of
297.17 provider-controlled, licensed settings or of health care settings; and panic buttons;

297.18 (2) training for staff, which may include:

297.19 (i) sessions and exercises for crisis management, strategies for de-escalating conflict
297.20 situations, safety planning, and self-defense in accordance with positive support strategies
297.21 under Minnesota Rules, chapter 9544, and person-centered planning and service delivery
297.22 according to Minnesota Statutes, section 245D.07, subdivision 1a;

297.23 (ii) training in culturally informed and culturally affirming practices, including linguistic
297.24 training;

297.25 (iii) training in trauma-informed social, emotional, and behavioral support; and

297.26 (iv) other training topics, sessions, and exercises the commissioner determines to be
297.27 appropriate;

297.28 (3) facility safety improvements, including but not limited to a threat and vulnerability
297.29 review and barrier protection;

297.30 (4) support services, counseling, and additional resources for staff who have experienced
297.31 safety concerns or trauma-related incidents in the workplace;

298.1 (5) installation and implementation of an internal data incident tracking system to track
298.2 and prevent workplace safety incidents; and

298.3 (6) other prevention and mitigation measures and safety training, resources, and support
298.4 services the commissioner determines to be appropriate.

298.5 (b) The following restrictions apply to the eligible uses of grant funds under paragraph
298.6 (a):

298.7 (1) safety equipment must not include:

298.8 (i) tools or devices that facilitate physical or chemical restraint;

298.9 (ii) barriers, environmental modifications, or other tools or devices that facilitate
298.10 individual seclusion, except plexiglass barriers in office settings are allowed;

298.11 (iii) wearable body cameras; or

298.12 (iv) wearable tracking devices that have the capacity to store location data;

298.13 (2) security cameras must only be used in staff spaces and entry points of buildings and
298.14 may not be used in common areas, bedrooms, and bathrooms;

298.15 (3) in settings that are required to comply with the positive supports rule, all safety
298.16 equipment or measures must comply with Minnesota Rules, chapter 9544;

298.17 (4) settings licensed under Minnesota Statutes, section 245D, must follow person-centered
298.18 practices according to Minnesota Statutes, section 245D.07;

298.19 (5) any safety equipment purchased with grant funding that has electronic monitoring
298.20 capacity must be used according to Minnesota Statutes, section 144.6502, or the brain injury,
298.21 community alternative care, community access for disability inclusion, and developmental
298.22 disabilities federal waiver plan language that outlines monitoring technology use;

298.23 (6) prior to the use of safety equipment that has capacity to record, store, and share audio,
298.24 video, or a combination thereof, the grant recipient must:

298.25 (i) provide patients or clients with information about electronic monitoring in a way that
298.26 is most accessible to the patients or clients, including the definition of electronic monitoring,
298.27 the type of device that will be in use, how the footage captured will be used, with whom
298.28 the footage captured will be shared, and a statement that a patient or client has the right to
298.29 decline use of safety equipment that has capacity to record, store, and share audio, video,
298.30 or a combination thereof;

298.31 (ii) provide notice every time electronic monitoring devices are in use; and

299.1 (iii) obtain written consent from anyone whose audio or video may be recorded during
299.2 the time the device is in use and, if applicable, from guardians of individuals whose audio
299.3 or video may be recorded during the time the device is in use; and

299.4 (7) in settings that provide home and community-based services, if at any point a client
299.5 or their guardian declines the use of safety equipment that has capacity to record, store, or
299.6 share audio, video, or a combination thereof or revokes prior consent to such use, the provider
299.7 must cease using the safety equipment immediately and indefinitely. A provider may not
299.8 deny or delay the provision of services as a result of an individual's decision to decline the
299.9 use of safety equipment that has capacity to record, store, or share audio, video, or a
299.10 combination thereof.

299.11 (c) All video, audio, or other personally identifiable information collected through safety
299.12 equipment paid for by grant funds under this section must:

299.13 (1) be treated consistently with the federal Health Insurance Portability and Accountability
299.14 Act of 1996 (HIPAA) requirements outlined in Code of Federal Regulations, title 45, parts
299.15 160 and 164, subparts A and E;

299.16 (2) be subject to applicable rules of evidence and procedure if admitted into evidence
299.17 in a civil, criminal, or administrative proceeding; and

299.18 (3) not result in the denial or delay of services provided to an individual.

299.19 Subd. 5. **Report.** Within two years after receiving grant funds under this section, each
299.20 grant recipient must submit a report to the commissioner. The commissioner must submit
299.21 a compilation of the reports to the chairs and ranking minority members of the legislative
299.22 committees with jurisdiction over health and human services, the Office of Ombudsman
299.23 for Long-Term Care, and Office of Ombudsman for Mental Health and Developmental
299.24 Disabilities. Grant recipient reports to the commissioner must include:

299.25 (1) the number of workplace safety incidents that occurred over the course of the grant
299.26 period;

299.27 (2) the number and type of safety measures funded by the grants, and how those safety
299.28 measures helped alleviate or de-escalate workplace safety incidents;

299.29 (3) the number of staff benefiting from safety measures implemented through grant
299.30 funding;

299.31 (4) the number of patients or clients benefiting from safety measures implemented
299.32 through grant funding;

300.1 (5) practices implemented concurrently with the use of safety equipment that ensured
300.2 that the rights of patients or clients served were upheld;

300.3 (6) the number of patients or clients who declined to consent to the use of any safety
300.4 equipment that had capacity to record, store, or share audio, video, or a combination thereof;

300.5 (7) an evaluation of the effectiveness of the safety measures, including assessment of
300.6 whether and how the grant funding has led or will lead to improved safety and service
300.7 provisions for staff, patients, and clients; and

300.8 (8) changes to policy or practice that were made if safety measures implemented using
300.9 grant funds were deemed ineffective.

300.10 Subd. 6. **Technical assistance.** The commissioner must provide technical assistance to
300.11 grant applicants throughout the application process and to applicants and grant recipients
300.12 regarding grant distribution and required grant recipient reporting

300.13 Sec. 202. **TASK FORCE ON PREGNANCY HEALTH AND SUBSTANCE USE**
300.14 **DISORDERS.**

300.15 Subdivision 1. **Establishment.** The Task Force on Pregnancy Health and Substance Use
300.16 Disorders is established to recommend protocols for when physicians, advanced practice
300.17 registered nurses, and physician assistants should administer a toxicology test and
300.18 requirements for reporting for prenatal exposure to a controlled substance.

300.19 Subd. 2. **Membership.** (a) The task force shall consist of the following members:

300.20 (1) a physician licensed in Minnesota to practice obstetrics and gynecology who provides
300.21 care primarily to medical assistance enrollees during pregnancy appointed by the American
300.22 College of Obstetricians and Gynecologists;

300.23 (2) a physician licensed in Minnesota to practice pediatrics or family medicine who
300.24 provides care primarily to medical assistance enrollees with substance use disorders or who
300.25 provides addiction medicine care during pregnancy appointed by the Minnesota Medical
300.26 Association;

300.27 (3) a certified nurse-midwife licensed as an advanced practice registered nurse in
300.28 Minnesota who provides care primarily to medical assistance enrollees with substance use
300.29 disorders or provides addiction medicine care during pregnancy appointed by the Minnesota
300.30 Advanced Practice Registered Nurses Coalition;

300.31 (4) two representatives of county social services agencies, one from a county outside
300.32 the seven-county metropolitan area and one from a county within the seven-county

301.1 metropolitan area, appointed by the Minnesota Association of County Social Service
301.2 Administrators;

301.3 (5) one representative from the Board of Social Work;

301.4 (6) two Tribal representatives appointed by the Minnesota Indian Affairs Council;

301.5 (7) two members who identify as Black or African American and who have lived
301.6 experience with the child welfare system and substance use disorders appointed by the
301.7 Cultural and Ethnic Communities Leadership Council;

301.8 (8) two members who are licensed substance use disorder treatment providers appointed
301.9 by the Minnesota Association of Resources for Recovery and Chemical Health;

301.10 (9) one member representing hospitals appointed by the Minnesota Hospital Association;

301.11 (10) one designee of the commissioner of health with expertise in substance use disorders
301.12 and treatment;

301.13 (11) two members who identify as Native American or American Indian and who have
301.14 lived experience with the child welfare system and substance use disorders appointed by
301.15 the Minnesota Indian Affairs Council;

301.16 (12) two members from the Council for Minnesotans of African Heritage; and

301.17 (13) one member of the Minnesota Perinatal Quality Collaborative.

301.18 (b) Appointments to the task force must be made by October 1, 2023.

301.19 Subd. 3. **Chairs; meetings.** (a) The task force shall elect a chair and cochair at the first
301.20 meeting, which shall be convened no later than October 15, 2023.

301.21 (b) Task force meetings are subject to the Minnesota Open Meeting Law under Minnesota
301.22 Statutes, chapter 13D.

301.23 Subd. 4. **Administrative support.** The Department of Health must provide administrative
301.24 support and meeting space for the task force.

301.25 Subd. 5. **Duties; reports.** (a) The task force shall develop recommended protocols for
301.26 when a toxicology test for prenatal exposure to a controlled substance should be administered
301.27 to a birthing parent and a newborn infant. The task force must also recommend protocols
301.28 for providing notice or reporting of prenatal exposure to a controlled substance to local
301.29 welfare agencies under Minnesota Statutes, chapter 260E.

301.30 (b) No later than December 1, 2024, the task force must submit a written report to the
301.31 chairs and ranking minority members of the legislative committees and divisions with

302.1 jurisdiction over health and human services on the task force's activities and recommendations
302.2 on the protocols developed under paragraph (a).

302.3 Subd. 6. **Expiration.** The task force shall expire upon submission of the report required
302.4 under subdivision 5, paragraph (b), or December 1, 2024, whichever is later.

302.5 Sec. 203. **REVISOR INSTRUCTION.**

302.6 (a) The revisor of statutes shall change the term "cancer surveillance system" to "cancer
302.7 reporting system" wherever it appears in the next edition of Minnesota Statutes and Minnesota
302.8 Rules and in the online publication.

302.9 (b) The revisor of statutes shall amend the headnote for Minnesota Statutes, section
302.10 145.423, to read "RECOGNITION OF INFANT WHO IS BORN ALIVE."

302.11 (c) In Minnesota Statutes, section 144.7055, the revisor shall renumber paragraphs (b)
302.12 to (e) alphabetically as individual subdivisions under Minnesota Statutes, section 144.7051.
302.13 The revisor shall make any necessary changes to sentence structure for this renumbering
302.14 while preserving the meaning of the text. The revisor shall also make necessary
302.15 cross-reference changes in Minnesota Statutes and Minnesota Rules consistent with the
302.16 renumbering.

302.17 Sec. 204. **REPEALER.**

302.18 (a) Minnesota Rules, parts 4640.1500; 4640.1600; 4640.1700; 4640.1800; 4640.1900;
302.19 4640.2000; 4640.2100; 4640.2200; 4640.2300; 4640.2400; 4640.2500; 4640.2600;
302.20 4640.2700; 4640.2800; 4640.2900; 4640.3000; 4640.3100; 4640.3200; 4640.3300;
302.21 4640.3400; 4640.3500; 4640.3600; 4640.3700; 4640.3800; 4640.3900; 4640.4000;
302.22 4640.4100; 4640.4200; 4640.4300; 4640.6100; 4640.6200; 4640.6300; 4640.6400;
302.23 4645.0300; 4645.0400; 4645.0500; 4645.0600; 4645.0700; 4645.0800; 4645.0900;
302.24 4645.1000; 4645.1100; 4645.1200; 4645.1300; 4645.1400; 4645.1500; 4645.1600;
302.25 4645.1700; 4645.1800; 4645.1900; 4645.2000; 4645.2100; 4645.2200; 4645.2300;
302.26 4645.2400; 4645.2500; 4645.2600; 4645.2700; 4645.2800; 4645.2900; 4645.3000;
302.27 4645.3100; 4645.3200; 4645.3300; 4645.3400; 4645.3500; 4645.3600; 4645.3700;
302.28 4645.3800; 4645.3805; 4645.3900; 4645.4000; 4645.4100; 4645.4200; 4645.4300;
302.29 4645.4400; 4645.4500; 4645.4600; 4645.4700; 4645.4800; 4645.4900; 4645.5100; and
302.30 4645.5200, are repealed effective January 1, 2024.

303.1 (b) Minnesota Statutes 2022, sections 62J.84, subdivision 5; 62U.10, subdivisions 6, 7,
303.2 and 8; 144.059, subdivision 10; 144.9505, subdivision 3; 145.4235; and 153A.14, subdivision
303.3 5, are repealed.

303.4 (c) Minnesota Rules, part 4615.3600, is repealed effective the day following final
303.5 enactment.

303.6 (d) Minnesota Rules, parts 4700.1900; 4700.2000; 4700.2100; 4700.2210; 4700.2300,
303.7 subparts 1, 3, 4, 4a, and 5; 4700.2410; 4700.2420; and 4700.2500, are repealed.

303.8 (e) Minnesota Statutes 2022, sections 62Q.145; 145.1621; 145.411, subdivisions 2 and
303.9 4; 145.412; 145.413, subdivisions 2 and 3; 145.4131; 145.4132; 145.4133; 145.4134;
303.10 145.4135; 145.4136; 145.415; 145.416; 145.423, subdivisions 2, 3, 4, 5, 6, 7, 8, and 9;
303.11 145.4241; 145.4242; 145.4243; 145.4244; 145.4245; 145.4246; 145.4247; 145.4248;
303.12 145.4249; 256B.011; 256B.40; 261.28; and 393.07, subdivision 11, are repealed effective
303.13 the day following final enactment.

303.14 ARTICLE 4

303.15 MEDICAL EDUCATION AND RESEARCH COSTS

303.16 Section 1. Minnesota Statutes 2022, section 62J.692, subdivision 1, is amended to read:

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

303.19 (b) "Accredited clinical training" means the clinical training provided by a medical
303.20 education program that is accredited through an organization recognized by the Department
303.21 of Education, the Centers for Medicare and Medicaid Services, or another national body
303.22 who reviews the accrediting organizations for multiple disciplines and whose standards for
303.23 recognizing accrediting organizations are reviewed and approved by the commissioner of
303.24 health.

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

303.26 (d) "Clinical medical education program" means the accredited clinical training of
303.27 physicians (medical students and residents), doctor of pharmacy practitioners (pharmacy
303.28 students and residents), doctors of chiropractic, dentists (dental students and residents),
303.29 advanced practice registered nurses (clinical nurse specialists, certified registered nurse
303.30 anesthetists, nurse practitioners, and certified nurse midwives), physician assistants, dental
303.31 therapists and advanced dental therapists, psychologists, clinical social workers, community
303.32 paramedics, and community health workers.

304.1 (e) "Sponsoring institution" means a hospital, school, or consortium located in Minnesota
304.2 that sponsors and maintains primary organizational and financial responsibility for a clinical
304.3 medical education program in Minnesota and which is accountable to the accrediting body.

304.4 (f) "Teaching institution" means a hospital, medical center, clinic, or other organization
304.5 that conducts a clinical medical education program in Minnesota.

304.6 (g) "Trainee" means a student or resident involved in a clinical medical education
304.7 program.

304.8 (h) "Eligible trainee FTE's" means the number of trainees, as measured by full-time
304.9 equivalent counts, that are at training sites located in Minnesota with currently active medical
304.10 assistance enrollment status and a National Provider Identification (NPI) number where
304.11 training occurs in either an inpatient or ambulatory patient care setting and where the training
304.12 is funded, in part, by patient care revenues. Training that occurs in nursing facility settings
304.13 is not eligible for funding under this section.

304.14 Sec. 2. Minnesota Statutes 2022, section 62J.692, subdivision 3, is amended to read:

304.15 Subd. 3. **Application process.** (a) A clinical medical education program conducted in
304.16 Minnesota by a teaching institution to train physicians, doctor of pharmacy practitioners,
304.17 dentists, chiropractors, physician assistants, dental therapists and advanced dental therapists,
304.18 psychologists, clinical social workers, community paramedics, or community health workers
304.19 is eligible for funds under subdivision 4 if the program:

304.20 (1) is funded, in part, by patient care revenues;

304.21 (2) occurs in patient care settings that face increased financial pressure as a result of
304.22 competition with nonteaching patient care entities; and

304.23 (3) emphasizes primary care or specialties that are in undersupply in Minnesota.

304.24 (b) A clinical medical education program for advanced practice nursing is eligible for
304.25 funds under subdivision 4 if the program meets the eligibility requirements in paragraph
304.26 (a), clauses (1) to (3), and is sponsored by the University of Minnesota Academic Health
304.27 Center, the Mayo Foundation, or institutions that are part of the Minnesota State Colleges
304.28 and Universities system or members of the Minnesota Private College Council.

304.29 (c) Applications must be submitted to the commissioner by a sponsoring institution on
304.30 behalf of an eligible clinical medical education program ~~and must be received by October~~
304.31 ~~31 of each year for distribution in the following year~~ on a timeline determined by the
304.32 commissioner. An application for funds must contain ~~the following information:~~ information

312.1 in subdivision 1, paragraph (a), or the percentage change in the case mix adjusted cost per
312.2 claim. The commissioner shall establish the base year for each rebasing period considering
312.3 the most recent year or years for which filed Medicare cost reports are available. The
312.4 estimated change in the average payment per hospital discharge resulting from a scheduled
312.5 rebasing must be calculated and made available to the legislature by January 15 of each
312.6 year in which rebasing is scheduled to occur, and must include by hospital the differential
312.7 in payment rates compared to the individual hospital's costs.

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

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

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

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

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

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

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

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

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

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

313.10 (6) geographic location.

313.11 (k) Effective for discharges occurring on or after January 1, 2024, the rates paid to
313.12 hospitals described in paragraph (a), clauses (2) to (4), must include a rate factor specific
313.13 to each hospital that qualifies for a medical education and research cost distribution under
313.14 section 62J.692 subdivision 4, paragraph (a).

313.15 Sec. 8. Minnesota Statutes 2022, section 256B.75, is amended to read:

313.16 **256B.75 HOSPITAL OUTPATIENT REIMBURSEMENT.**

313.17 (a) For outpatient hospital facility fee payments for services rendered on or after October
313.18 1, 1992, the commissioner of human services shall pay the lower of (1) submitted charge,
313.19 or (2) 32 percent above the rate in effect on June 30, 1992, except for those services for
313.20 which there is a federal maximum allowable payment. Effective for services rendered on
313.21 or after January 1, 2000, payment rates for nonsurgical outpatient hospital facility fees and
313.22 emergency room facility fees shall be increased by eight percent over the rates in effect on
313.23 December 31, 1999, except for those services for which there is a federal maximum allowable
313.24 payment. Services for which there is a federal maximum allowable payment shall be paid
313.25 at the lower of (1) submitted charge, or (2) the federal maximum allowable payment. Total
313.26 aggregate payment for outpatient hospital facility fee services shall not exceed the Medicare
313.27 upper limit. If it is determined that a provision of this section conflicts with existing or
313.28 future requirements of the United States government with respect to federal financial
313.29 participation in medical assistance, the federal requirements prevail. The commissioner
313.30 may, in the aggregate, prospectively reduce payment rates to avoid reduced federal financial
313.31 participation resulting from rates that are in excess of the Medicare upper limitations.

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

314.1 144.1483, clause (9), shall be paid on a cost-based payment system that is based on the
314.2 cost-finding methods and allowable costs of the Medicare program. Effective for services
314.3 provided on or after July 1, 2015, rates established for critical access hospitals under this
314.4 paragraph for the applicable payment year shall be the final payment and shall not be settled
314.5 to actual costs. Effective for services delivered on or after the first day of the hospital's fiscal
314.6 year ending in 2017, the rate for outpatient hospital services shall be computed using
314.7 information from each hospital's Medicare cost report as filed with Medicare for the year
314.8 that is two years before the year that the rate is being computed. Rates shall be computed
314.9 using information from Worksheet C series until the department finalizes the medical
314.10 assistance cost reporting process for critical access hospitals. After the cost reporting process
314.11 is finalized, rates shall be computed using information from Title XIX Worksheet D series.
314.12 The outpatient rate shall be equal to ancillary cost plus outpatient cost, excluding costs
314.13 related to rural health clinics and federally qualified health clinics, divided by ancillary
314.14 charges plus outpatient charges, excluding charges related to rural health clinics and federally
314.15 qualified health clinics. Effective for services delivered on or after January 1, 2024, the
314.16 rates paid to critical access hospitals under this section must be adjusted to include the
314.17 amount of any distributions under section 62J.692, subdivision 4, paragraph (a), that were
314.18 not included in the rate adjustment described under section 256.969, subdivision 2b,
314.19 paragraph (k).

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

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

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

315.1 (f) In addition to the reductions in paragraphs (d) and (e), the total payment for
 315.2 fee-for-service services provided on or after July 1, 2008, made to hospitals for outpatient
 315.3 hospital facility services before third-party liability and spenddown, is reduced three percent
 315.4 from the current statutory rates. Mental health services and facilities defined under section
 315.5 256.969, subdivision 16, are excluded from this paragraph.

315.6 Sec. 9. Minnesota Statutes 2022, section 297F.10, subdivision 1, is amended to read:

315.7 Subdivision 1. **Tax and use tax on cigarettes.** Revenue received from cigarette taxes,
 315.8 as well as related penalties, interest, license fees, and miscellaneous sources of revenue
 315.9 shall be deposited by the commissioner in the state treasury and credited as follows:

315.10 (1) \$22,250,000 each year must be credited to the Academic Health Center special
 315.11 revenue fund hereby created and is annually appropriated to the Board of Regents at the
 315.12 University of Minnesota for Academic Health Center funding at the University of Minnesota;
 315.13 and

315.14 (2) ~~\$3,937,000~~ \$3,788,000 each year must be credited to the medical education and
 315.15 research costs account hereby created in the special revenue fund and is annually appropriated
 315.16 to the commissioner of health for distribution under section 62J.692, subdivision 4, paragraph
 315.17 (a); and

315.18 (3) the balance of the revenues derived from taxes, penalties, and interest (under this
 315.19 chapter) and from license fees and miscellaneous sources of revenue shall be credited to
 315.20 the general fund.

315.21 Sec. 10. **REPEALER.**

315.22 Minnesota Statutes 2022, sections 62J.692, subdivisions 4a, 7, and 7a; 137.38, subdivision
 315.23 1; and 256B.69, subdivision 5c, are repealed.

315.24 ARTICLE 5

315.25 HEALTH-RELATED LICENSING BOARDS

315.26 Section 1. Minnesota Statutes 2022, section 144E.001, subdivision 1, is amended to read:

315.27 Subdivision 1. **Scope.** For the purposes of ~~sections 144E.001 to 144E.52~~ this chapter,
 315.28 the terms defined in this section have the meanings given them.

316.1 Sec. 2. Minnesota Statutes 2022, section 144E.001, is amended by adding a subdivision
316.2 to read:

316.3 Subd. 8b. **Medical resource communication center.** "Medical resource communication
316.4 center" means an entity that:

316.5 (1) facilitates hospital-to-ambulance communications for ambulance services, the regional
316.6 emergency medical services systems, and the board by coordinating patient care and
316.7 transportation for ground and air operations;

316.8 (2) is integrated with the state's Allied Radio Matrix for Emergency Response (ARMER)
316.9 radio system; and

316.10 (3) is the point of contact and a communication resource for statewide public safety
316.11 entities, hospitals, and communities.

316.12 Sec. 3. Minnesota Statutes 2022, section 144E.101, subdivision 6, is amended to read:

316.13 Subd. 6. **Basic life support.** (a) Except as provided in paragraph (e), a basic life-support
316.14 ambulance shall be staffed by at least two EMTs, one of whom must accompany the patient
316.15 and provide a level of care so as to ensure that:

316.16 (1) life-threatening situations and potentially serious injuries are recognized;

316.17 (2) patients are protected from additional hazards;

316.18 (3) basic treatment to reduce the seriousness of emergency situations is administered;

316.19 and

316.20 (4) patients are transported to an appropriate medical facility for treatment.

316.21 (b) A basic life-support service shall provide basic airway management.

316.22 (c) A basic life-support service shall provide automatic defibrillation.

316.23 (d) A basic life-support service licensee's medical director may authorize ambulance
316.24 service personnel to perform intravenous infusion and use equipment that is within the
316.25 licensure level of the ambulance service, ~~including~~. A basic life-support licensee's medical
316.26 director must authorize ambulance service personnel to perform administration of an opiate
316.27 antagonist. Ambulance service personnel must be properly trained. Documentation of
316.28 authorization for use, guidelines for use, continuing education, and skill verification must
316.29 be maintained in the licensee's files.

316.30 (e) For emergency ambulance calls and interfacility transfers, an ambulance service may
316.31 staff its basic life-support ambulances with one EMT, who must accompany the patient,

317.1 and one registered emergency medical responder driver. For purposes of this paragraph,
317.2 "ambulance service" means either an ambulance service whose primary service area is
317.3 mainly located outside the metropolitan counties listed in section 473.121, subdivision 4,
317.4 and outside the cities of Duluth, Mankato, Moorhead, Rochester, and St. Cloud; or an
317.5 ambulance service based in a community with a population of less than 2,500.

317.6 Sec. 4. Minnesota Statutes 2022, section 144E.101, subdivision 7, is amended to read:

317.7 Subd. 7. **Advanced life support.** (a) Except as provided in paragraphs (f) and (g), an
317.8 advanced life-support ambulance shall be staffed by at least:

317.9 (1) one EMT or one AEMT and one paramedic;

317.10 (2) one EMT or one AEMT and one registered nurse who is an EMT or an AEMT, is
317.11 currently practicing nursing, and has passed a paramedic practical skills test approved by
317.12 the board and administered by an education program; or

317.13 (3) one EMT or one AEMT and one physician assistant who is an EMT or an AEMT,
317.14 is currently practicing as a physician assistant, and has passed a paramedic practical skills
317.15 test approved by the board and administered by an education program.

317.16 (b) An advanced life-support service shall provide basic life support, as specified under
317.17 subdivision 6, paragraph (a), advanced airway management, manual defibrillation, ~~and~~
317.18 administration of intravenous fluids and pharmaceuticals, and administration of opiate
317.19 antagonists.

317.20 (c) In addition to providing advanced life support, an advanced life-support service may
317.21 staff additional ambulances to provide basic life support according to subdivision 6 and
317.22 section 144E.103, subdivision 1.

317.23 (d) An ambulance service providing advanced life support shall have a written agreement
317.24 with its medical director to ensure medical control for patient care 24 hours a day, seven
317.25 days a week. The terms of the agreement shall include a written policy on the administration
317.26 of medical control for the service. The policy shall address the following issues:

317.27 (1) two-way communication for physician direction of ambulance service personnel;

317.28 (2) patient triage, treatment, and transport;

317.29 (3) use of standing orders; and

317.30 (4) the means by which medical control will be provided 24 hours a day.

318.1 The agreement shall be signed by the licensee's medical director and the licensee or the
318.2 licensee's designee and maintained in the files of the licensee.

318.3 (e) When an ambulance service provides advanced life support, the authority of a
318.4 paramedic, Minnesota registered nurse-EMT, or Minnesota registered physician
318.5 assistant-EMT to determine the delivery of patient care prevails over the authority of an
318.6 EMT.

318.7 (f) Upon application from an ambulance service that includes evidence demonstrating
318.8 hardship, the board may grant a variance from the staff requirements in paragraph (a), clause
318.9 (1), and may authorize an advanced life-support ambulance to be staffed by a registered
318.10 emergency medical responder driver with a paramedic for all emergency calls and interfacility
318.11 transfers. The variance shall apply to advanced life-support ambulance services until the
318.12 ambulance service renews its license. When the variance expires, an ambulance service
318.13 may apply for a new variance under this paragraph. This paragraph applies only to an
318.14 ambulance service whose primary service area is mainly located outside the metropolitan
318.15 counties listed in section 473.121, subdivision 4, and outside the cities of Duluth, Mankato,
318.16 Moorhead, Rochester, and St. Cloud, or an ambulance based in a community with a
318.17 population of less than 1,000 persons.

318.18 (g) After an initial emergency ambulance call, each subsequent emergency ambulance
318.19 response, until the initial ambulance is again available, and interfacility transfers, may be
318.20 staffed by one registered emergency medical responder driver and an EMT or paramedic.
318.21 This paragraph applies only to an ambulance service whose primary service area is mainly
318.22 located outside the metropolitan counties listed in section 473.121, subdivision 4, and outside
318.23 the cities of Duluth, Mankato, Moorhead, Rochester, and St. Cloud, or an ambulance based
318.24 in a community with a population of less than 1,000 persons.

318.25 Sec. 5. Minnesota Statutes 2022, section 144E.103, subdivision 1, is amended to read:

318.26 Subdivision 1. **General requirements.** Every ambulance in service for patient care shall
318.27 carry, at a minimum:

318.28 (1) oxygen;

318.29 (2) airway maintenance equipment in various sizes to accommodate all age groups;

318.30 (3) splinting equipment in various sizes to accommodate all age groups;

318.31 (4) dressings, bandages, commercially manufactured tourniquets, and bandaging
318.32 equipment;

- 319.1 (5) an emergency obstetric kit;
- 319.2 (6) equipment to determine vital signs in various sizes to accommodate all age groups;
- 319.3 (7) a stretcher;
- 319.4 (8) a defibrillator; ~~and~~
- 319.5 (9) a fire extinguisher; and
- 319.6 (10) opiate antagonists.

319.7 Sec. 6. Minnesota Statutes 2022, section 144E.35, is amended to read:

319.8 **144E.35 REIMBURSEMENT TO ~~NONPROFIT~~ AMBULANCE SERVICES FOR**

319.9 **VOLUNTEER EDUCATION COSTS.**

319.10 Subdivision 1. **Repayment for volunteer education.** A licensed ambulance service

319.11 shall be reimbursed by the board for the necessary expense of the initial education of a

319.12 volunteer ambulance attendant upon successful completion by the attendant of an EMT

319.13 education course, or a continuing education course for EMT care, or both, which has been

319.14 approved by the board, pursuant to section 144E.285. Reimbursement may include tuition,

319.15 transportation, food, lodging, hourly payment for the time spent in the education course,

319.16 and other necessary expenditures, except that in no instance shall a volunteer ambulance

319.17 attendant be reimbursed more than ~~\$600~~ \$900 for successful completion of an initial

319.18 education course, and ~~\$275~~ \$375 for successful completion of a continuing education course.

319.19 Subd. 2. **Reimbursement provisions.** Reimbursement ~~will~~ must be paid under provisions

319.20 of this section when documentation is provided to the board that the individual has served

319.21 for one year from the date of the final certification exam as an active member of a Minnesota

319.22 licensed ambulance service.

319.23 Sec. 7. **[144E.53] MEDICAL RESOURCE COMMUNICATION CENTER GRANTS.**

319.24 The board shall distribute medical resource communication center grants annually to

319.25 the two medical resource communication centers that were in operation in the state prior to

319.26 January 1, 2000.

319.27 Sec. 8. Minnesota Statutes 2022, section 147.02, subdivision 1, is amended to read:

319.28 Subdivision 1. **United States or Canadian medical school graduates.** The board shall

319.29 issue a license to practice medicine to a person not currently licensed in another state or

319.30 Canada and who meets the requirements in paragraphs (a) to (i).

320.1 (a) An applicant for a license shall file a written application on forms provided by the
 320.2 board, showing to the board's satisfaction that the applicant is of good moral character and
 320.3 satisfies the requirements of this section.

320.4 (b) The applicant shall present evidence satisfactory to the board of being a graduate of
 320.5 a medical or osteopathic medical school located in the United States, its territories or Canada,
 320.6 and approved by the board based upon its faculty, curriculum, facilities, accreditation by a
 320.7 recognized national accrediting organization approved by the board, and other relevant data,
 320.8 or is currently enrolled in the final year of study at the school.

320.9 (c) The applicant must have passed an examination as described in clause (1) or (2).

320.10 (1) The applicant must have passed a comprehensive examination for initial licensure
 320.11 prepared and graded by the National Board of Medical Examiners, the Federation of State
 320.12 Medical Boards, the Medical Council of Canada, the National Board of Osteopathic
 320.13 Examiners, or the appropriate state board that the board determines acceptable. The board
 320.14 shall by rule determine what constitutes a passing score in the examination.

320.15 (2) The applicant taking the United States Medical Licensing Examination (USMLE)
 320.16 or Comprehensive Osteopathic Medical Licensing Examination (COMLEX-USA) must
 320.17 have passed steps or levels one, two, and three. Step or level three must be passed within
 320.18 five years of passing step or level two, or before the end of residency training. The applicant
 320.19 must pass each of steps or levels one, two, and three with passing scores as recommended
 320.20 by the USMLE program or National Board of Osteopathic Medical Examiners within three
 320.21 attempts. The applicant taking combinations of Federation of State Medical Boards, National
 320.22 Board of Medical Examiners, and USMLE may be accepted only if the combination is
 320.23 approved by the board as comparable to existing comparable examination sequences and
 320.24 all examinations are completed prior to the year 2000.

320.25 (d) The applicant shall present evidence satisfactory to the board of the completion of
 320.26 one year of graduate, clinical medical training in a program accredited by a national
 320.27 accrediting organization approved by the board ~~or other graduate training approved in~~
 320.28 ~~advance by the board as meeting standards similar to those of a national accrediting~~
 320.29 ~~organization.~~

320.30 (e) The applicant may make arrangements with the executive director to appear in person
 320.31 before the board or its designated representative to show that the applicant satisfies the
 320.32 requirements of this section. The board may establish as internal operating procedures the
 320.33 procedures or requirements for the applicant's personal presentation.

321.1 (f) The applicant shall pay a nonrefundable fee established by the board. Upon application
321.2 or notice of license renewal, the board must provide notice to the applicant and to the person
321.3 whose license is scheduled to be issued or renewed of any additional fees, surcharges, or
321.4 other costs which the person is obligated to pay as a condition of licensure. The notice must:

321.5 (1) state the dollar amount of the additional costs; and

321.6 (2) clearly identify to the applicant the payment schedule of additional costs.

321.7 (g) The applicant must not be under license suspension or revocation by the licensing
321.8 board of the state or jurisdiction in which the conduct that caused the suspension or revocation
321.9 occurred.

321.10 (h) The applicant must not have engaged in conduct warranting disciplinary action
321.11 against a licensee, or have been subject to disciplinary action other than as specified in
321.12 paragraph (g). If the applicant does not satisfy the requirements stated in this paragraph,
321.13 the board may issue a license only on the applicant's showing that the public will be protected
321.14 through issuance of a license with conditions and limitations the board considers appropriate.

321.15 (i) If the examination in paragraph (c) was passed more than ten years ago, the applicant
321.16 must either:

321.17 (1) pass the special purpose examination of the Federation of State Medical Boards with
321.18 a score of 75 or better within three attempts; or

321.19 (2) have a current certification by a specialty board of the American Board of Medical
321.20 Specialties, of the American Osteopathic Association, the Royal College of Physicians and
321.21 Surgeons of Canada, or of the College of Family Physicians of Canada.

321.22 Sec. 9. Minnesota Statutes 2022, section 147.03, subdivision 1, is amended to read:

321.23 Subdivision 1. **Endorsement; reciprocity.** (a) The board may issue a license to practice
321.24 medicine to any person who satisfies the requirements in paragraphs (b) to (e).

321.25 (b) The applicant shall satisfy all the requirements established in section 147.02,
321.26 subdivision 1, paragraphs (a), (b), (d), (e), and (f), or section 147.037, subdivision 1,
321.27 paragraphs (a) to (e).

321.28 (c) The applicant shall:

321.29 (1) have passed an examination prepared and graded by the Federation of State Medical
321.30 Boards, the National Board of Medical Examiners, or the United States Medical Licensing
321.31 Examination (USMLE) program in accordance with section 147.02, subdivision 1, paragraph

322.1 (c), clause (2); the National Board of Osteopathic Medical Examiners; or the Medical Council
322.2 of Canada; and

322.3 (2) have a current license from the equivalent licensing agency in another state or Canada
322.4 and, if the examination in clause (1) was passed more than ten years ago, either:

322.5 (i) pass the Special Purpose Examination of the Federation of State Medical Boards ~~with~~
322.6 ~~a score of 75 or better~~ (SPEX) within three attempts; or

322.7 (ii) have a current certification by a specialty board of the American Board of Medical
322.8 Specialties, of the American Osteopathic Association, the Royal College of Physicians and
322.9 Surgeons of Canada, or of the College of Family Physicians of Canada; or

322.10 (3) if the applicant fails to meet the requirement established in section 147.02, subdivision
322.11 1, paragraph (c), clause (2), because the applicant failed to pass within the permitted three
322.12 attempts each of steps or levels one, two, and three of the USMLE ~~within the required three~~
322.13 ~~attempts~~ or the Comprehensive Osteopathic Medical Licensing Examination
322.14 (COMLEX-USA), the applicant may be granted a license provided the applicant:

322.15 (i) has passed each of steps or levels one, two, and three within no more than four attempts
322.16 for any of the three steps or levels with passing scores as recommended by the USMLE or
322.17 COMLEX-USA program ~~within no more than four attempts for any of the three steps;~~

322.18 (ii) is currently licensed in another state; and

322.19 (iii) has current certification by a specialty board of the American Board of Medical
322.20 Specialties, the American Osteopathic Association ~~Bureau of Professional Education~~, the
322.21 Royal College of Physicians and Surgeons of Canada, or the College of Family Physicians
322.22 of Canada.

322.23 (d) The applicant must not be under license suspension or revocation by the licensing
322.24 board of the state or jurisdiction in which the conduct that caused the suspension or revocation
322.25 occurred.

322.26 (e) The applicant must not have engaged in conduct warranting disciplinary action against
322.27 a licensee, or have been subject to disciplinary action other than as specified in paragraph
322.28 (d). If an applicant does not satisfy the requirements stated in this paragraph, the board may
322.29 issue a license only on the applicant's showing that the public will be protected through
322.30 issuance of a license with conditions or limitations the board considers appropriate.

322.31 (f) Upon the request of an applicant, the board may conduct the final interview of the
322.32 applicant by teleconference.

323.1 Sec. 10. Minnesota Statutes 2022, section 147.037, subdivision 1, is amended to read:

323.2 Subdivision 1. **Requirements.** The board shall issue a license to practice medicine to
323.3 any person who satisfies the requirements in paragraphs (a) to (g).

323.4 (a) The applicant shall satisfy all the requirements established in section 147.02,
323.5 subdivision 1, paragraphs (a), (e), (f), (g), and (h).

323.6 (b) The applicant shall present evidence satisfactory to the board that the applicant is a
323.7 graduate of a medical or osteopathic school approved by the board as equivalent to accredited
323.8 United States or Canadian schools based upon its faculty, curriculum, facilities, accreditation,
323.9 or other relevant data. If the applicant is a graduate of a medical or osteopathic program
323.10 that is not accredited by the Liaison Committee for Medical Education or the American
323.11 Osteopathic Association, the applicant may use the Federation of State Medical Boards'
323.12 Federation Credentials Verification Service (FCVS) or its successor. If the applicant uses
323.13 this service as allowed under this paragraph, the physician application fee may be less than
323.14 \$200 but must not exceed the cost of administering this paragraph.

323.15 (c) The applicant shall present evidence satisfactory to the board that the applicant has
323.16 been awarded a certificate by the Educational Council for Foreign Medical Graduates, and
323.17 the applicant has a working ability in the English language sufficient to communicate with
323.18 patients and physicians and to engage in the practice of medicine.

323.19 (d) The applicant shall present evidence satisfactory to the board of the completion of
323.20 one year of graduate, clinical medical training in a program accredited by a national
323.21 accrediting organization approved by the board ~~or other graduate training approved in
323.22 advance by the board as meeting standards similar to those of a national accrediting
323.23 organization.~~ This requirement does not apply to an applicant who is admitted pursuant to
323.24 the rules of the United States Department of Labor and:

323.25 (1) ~~to an applicant who is~~ was admitted as a permanent immigrant to the United States
323.26 on or before October 1, 1991, as a person of exceptional ability in the sciences according
323.27 to Code of Federal Regulations, title 20, section 656.22(d); or

323.28 (2) ~~to an applicant holding~~ who holds a valid license to practice medicine in another
323.29 country and was issued a permanent immigrant visa after October 1, 1991, as a person of
323.30 extraordinary ability in the field of science or as an outstanding professor or researcher
323.31 according to Code of Federal Regulations, title 8, section 204.5(h) and (i), or a temporary
323.32 nonimmigrant visa as a person of extraordinary ability in the field of science according to
323.33 Code of Federal Regulations, title 8, section 214.2(o);

324.1 ~~provided that a person under clause (1) or (2) is admitted pursuant to rules of the United~~
324.2 ~~States Department of Labor.~~

324.3 (e) The applicant must:

324.4 (1) have passed an examination prepared and graded by the Federation of State Medical
324.5 Boards, the United States Medical Licensing Examination (USMLE) program in accordance
324.6 with section 147.02, subdivision 1, paragraph (c), clause (2), or the Medical Council of
324.7 Canada; and

324.8 (2) if the examination in clause (1) was passed more than ten years ago, either:

324.9 (i) pass the Special Purpose Examination of the Federation of State Medical Boards ~~with~~
324.10 ~~a score of 75 or better within three attempts~~ (SPEX) or the Comprehensive Osteopathic
324.11 Medical Variable-Purpose Examination of the National Board of Osteopathic Medical
324.12 Examiners (COMVEX). The applicant must pass the SPEX or COMVEX within no more
324.13 than three attempts of taking the SPEX, COMVEX, or a combination of the SPEX and
324.14 COMVEX; or

324.15 (ii) have a current certification by a specialty board of the American Board of Medical
324.16 Specialties, ~~of~~ the American Osteopathic Association, ~~of~~ the Royal College of Physicians
324.17 and Surgeons of Canada, or ~~of~~ the College of Family Physicians of Canada; or

324.18 (3) if the applicant fails to meet the requirement established in section 147.02, subdivision
324.19 1, paragraph (c), clause (2), because the applicant failed to pass within the permitted three
324.20 attempts each of steps or levels one, two, and three of the USMLE ~~within the required three~~
324.21 ~~attempts~~ or the Comprehensive Osteopathic Medical Licensing Examination
324.22 (COMLEX-USA), the applicant may be granted a license provided the applicant:

324.23 (i) has passed each of steps or levels one, two, and three within no more than four attempts
324.24 for any of the three steps or levels with passing scores as recommended by the USMLE or
324.25 COMLEX-USA program ~~within no more than four attempts for any of the three steps~~;

324.26 (ii) is currently licensed in another state; and

324.27 (iii) has current certification by a specialty board of the American Board of Medical
324.28 Specialties, the American Osteopathic Association, the Royal College of Physicians and
324.29 Surgeons of Canada, or the College of Family Physicians of Canada.

324.30 (f) The applicant must not be under license suspension or revocation by the licensing
324.31 board of the state or jurisdiction in which the conduct that caused the suspension or revocation
324.32 occurred.

325.1 (g) The applicant must not have engaged in conduct warranting disciplinary action
 325.2 against a licensee, or have been subject to disciplinary action other than as specified in
 325.3 paragraph (f). If an applicant does not satisfy the requirements stated in this paragraph, the
 325.4 board may issue a license only on the applicant's showing that the public will be protected
 325.5 through issuance of a license with conditions or limitations the board considers appropriate.

325.6 Sec. 11. Minnesota Statutes 2022, section 147.141, is amended to read:

325.7 **147.141 FORMS OF DISCIPLINARY ACTION.**

325.8 When the board finds that a licensed physician or a physician registered under section
 325.9 147.032 has violated a provision or provisions of sections 147.01 to 147.22, it may do one
 325.10 or more of the following:

325.11 (1) revoke the license;

325.12 (2) suspend the license;

325.13 (3) revoke or suspend registration to perform interstate telehealth;

325.14 (4) impose limitations or conditions on the physician's practice of medicine, including
 325.15 limiting the limitation of scope of practice to designated field specialties; ~~the imposition of~~
 325.16 imposing retraining or rehabilitation requirements; ~~the requirement of~~ requiring practice
 325.17 under supervision; or ~~the conditioning of~~ continued practice on demonstration of knowledge
 325.18 or skills by appropriate examination or other review of skill and competence;

325.19 (5) impose a civil penalty not exceeding \$10,000 for each separate violation, the amount
 325.20 of the civil penalty to be fixed ~~so as~~ to deprive the physician of any economic advantage
 325.21 gained by reason of the violation charged or to reimburse the board for the cost of the
 325.22 investigation and proceeding;

325.23 (6) order the physician to provide unremunerated professional service under supervision
 325.24 at a designated public hospital, clinic, or other health care institution; or

325.25 (7) censure or reprimand the licensed physician.

325.26 Sec. 12. Minnesota Statutes 2022, section 147A.16, is amended to read:

325.27 **147A.16 FORMS OF DISCIPLINARY ACTION.**

325.28 (a) When the board finds that a licensed physician assistant has violated a provision of
 325.29 this chapter, it may do one or more of the following:

325.30 (1) revoke the license;

326.1 (2) suspend the license;

326.2 (3) impose limitations or conditions on the physician assistant's practice, including
326.3 limiting the scope of practice to designated field specialties; imposing retraining or
326.4 rehabilitation requirements; or limiting practice until demonstration of knowledge or skills
326.5 by appropriate examination or other review of skill and competence;

326.6 (4) impose a civil penalty not exceeding \$10,000 for each separate violation, the amount
326.7 of the civil penalty to be fixed so as to deprive the physician assistant of any economic
326.8 advantage gained by reason of the violation charged or to reimburse the board for the cost
326.9 of the investigation and proceeding; or

326.10 (5) censure or reprimand the licensed physician assistant.

326.11 (b) Upon judicial review of any board disciplinary action taken under this chapter, the
326.12 reviewing court shall seal the administrative record, except for the board's final decision,
326.13 and shall not make the administrative record available to the public.

326.14 Sec. 13. Minnesota Statutes 2022, section 147B.02, subdivision 4, is amended to read:

326.15 Subd. 4. **Exceptions.** (a) The following persons may practice acupuncture within the
326.16 scope of their practice without an acupuncture license:

326.17 (1) a physician licensed under chapter 147;

326.18 (2) an osteopathic physician licensed under chapter 147;

326.19 (3) a chiropractor licensed under chapter 148;

326.20 ~~(4) a person who is studying in a formal course of study or tutorial intern program~~
326.21 ~~approved by the acupuncture advisory council established in section 147B.05 so long as~~
326.22 ~~the person's acupuncture practice is supervised by a licensed acupuncturist or a person who~~
326.23 ~~is exempt under clause (5);~~

326.24 (4) a person who is studying in a formal course of study so long as the person's
326.25 acupuncture practice is supervised by a licensed acupuncturist or a person who is exempt
326.26 under clause (5);

326.27 (5) a visiting acupuncturist practicing acupuncture within an instructional setting for the
326.28 sole purpose of teaching at a school registered with the Minnesota Office of Higher
326.29 Education, who may practice without a license for a period of one year, with two one-year
326.30 extensions permitted; and

327.1 (6) a visiting acupuncturist who is in the state for the sole purpose of providing a tutorial
327.2 or workshop not to exceed 30 days in one calendar year.

327.3 (b) This chapter does not prohibit a person who does not have an acupuncturist license
327.4 from practicing specific noninvasive techniques, such as acupressure, that are within the
327.5 scope of practice as set forth in section 147B.06, subdivision 4.

327.6 Sec. 14. Minnesota Statutes 2022, section 147B.02, subdivision 7, is amended to read:

327.7 Subd. 7. **Licensure requirements.** (a) ~~After June 30, 1997,~~ An applicant for licensure
327.8 must:

327.9 (1) submit a completed application for licensure on forms provided by the board, which
327.10 must include the applicant's name and address of record, which shall be public;

327.11 (2) unless licensed under subdivision 5 or 6, submit ~~a notarized copy of a~~ evidence
327.12 satisfactory to the board of current NCCAOM certification;

327.13 (3) sign a statement that the information in the application is true and correct to the best
327.14 of the applicant's knowledge and belief;

327.15 (4) submit with the application all fees required; and

327.16 (5) sign a waiver authorizing the board to obtain access to the applicant's records in this
327.17 state or any state in which the applicant has engaged in the practice of acupuncture.

327.18 (b) The board may ask the applicant to provide any additional information necessary to
327.19 ensure that the applicant is able to practice with reasonable skill and safety to the public.

327.20 (c) The board may investigate information provided by an applicant to determine whether
327.21 the information is accurate and complete. The board shall notify an applicant of action taken
327.22 on the application and the reasons for denying licensure if licensure is denied.

327.23 Sec. 15. [148.635] FEE.

327.24 Subdivision 1. Nonrefundable fee. The fee in this section is nonrefundable.

327.25 Subd. 2. Licensure verification fee. The fee for verification of licensure is \$20.

327.26 Sec. 16. Minnesota Statutes 2022, section 148B.392, subdivision 2, is amended to read:

327.27 Subd. 2. **Licensure and application fees.** Licensure and application fees established
327.28 by the board shall not exceed the following amounts:

327.29 (1) application fee for national examination is ~~\$110~~ \$150;

328.1 (2) application fee for Licensed Marriage and Family Therapist (LMFT) state examination
328.2 is ~~\$110~~ \$150;

328.3 (3) initial LMFT license fee is prorated, but cannot exceed \$125;

328.4 (4) annual renewal fee for LMFT license is ~~\$125~~ \$225;

328.5 (5) late fee for LMFT license renewal is ~~\$50~~ \$100;

328.6 (6) application fee for LMFT licensure by reciprocity is ~~\$220~~ \$300;

328.7 (7) fee for initial Licensed Associate Marriage and Family Therapist (LAMFT) license
328.8 is ~~\$75~~ \$100;

328.9 (8) annual renewal fee for LAMFT license is ~~\$75~~ \$100;

328.10 (9) late fee for LAMFT renewal is ~~\$25~~ \$50;

328.11 (10) fee for reinstatement of license is \$150;

328.12 (11) fee for emeritus status is ~~\$125~~ \$225; and

328.13 (12) fee for temporary license for members of the military is \$100.

328.14 Sec. 17. Minnesota Statutes 2022, section 148F.11, is amended by adding a subdivision
328.15 to read:

328.16 Subd. 2a. **Former students.** (a) A former student may practice alcohol and drug
328.17 counseling for 90 days from the former student's degree conferral date from an accredited
328.18 school or educational program or from the last date the former student received credit for
328.19 an alcohol and drug counseling course from an accredited school or educational program.
328.20 The former student's practice must be supervised by an alcohol and drug counselor or an
328.21 alcohol and drug counselor supervisor, as defined in section 245G.11. The former student's
328.22 practice is limited to the site where the student completed their internship or practicum. A
328.23 former student must be paid for work performed during the 90-day period.

328.24 (b) The former student's right to practice automatically expires after 90 days from the
328.25 former student's degree conferral date or date of last course credit for an alcohol and drug
328.26 counseling course, whichever occurs last.

328.27 Sec. 18. Minnesota Statutes 2022, section 150A.08, subdivision 1, is amended to read:

328.28 Subdivision 1. **Grounds.** The board may refuse or by order suspend or revoke, limit or
328.29 modify by imposing conditions it deems necessary, the license of a dentist, dental therapist,
328.30 dental hygienist, or dental ~~assistant~~ assistant upon any of the following grounds:

329.1 (1) fraud or deception in connection with the practice of dentistry or the securing of a
329.2 license certificate;

329.3 (2) conviction, including a finding or verdict of guilt, an admission of guilt, or a no
329.4 contest plea, in any court of a felony or gross misdemeanor reasonably related to the practice
329.5 of dentistry as evidenced by a certified copy of the conviction;

329.6 (3) conviction, including a finding or verdict of guilt, an admission of guilt, or a no
329.7 contest plea, in any court of an offense involving moral turpitude as evidenced by a certified
329.8 copy of the conviction;

329.9 (4) habitual overindulgence in the use of intoxicating liquors;

329.10 (5) improper or unauthorized prescription, dispensing, administering, or personal or
329.11 other use of any legend drug as defined in chapter 151, of any chemical as defined in chapter
329.12 151, or of any controlled substance as defined in chapter 152;

329.13 (6) conduct unbecoming a person licensed to practice dentistry, dental therapy, dental
329.14 hygiene, or dental assisting, or conduct contrary to the best interest of the public, as such
329.15 conduct is defined by the rules of the board;

329.16 (7) gross immorality;

329.17 (8) any physical, mental, emotional, or other disability which adversely affects a dentist's,
329.18 dental therapist's, dental hygienist's, or dental assistant's ability to perform the service for
329.19 which the person is licensed;

329.20 (9) revocation or suspension of a license or equivalent authority to practice, or other
329.21 disciplinary action or denial of a license application taken by a licensing or credentialing
329.22 authority of another state, territory, or country as evidenced by a certified copy of the
329.23 licensing authority's order, if the disciplinary action or application denial was based on facts
329.24 that would provide a basis for disciplinary action under this chapter and if the action was
329.25 taken only after affording the credentialed person or applicant notice and opportunity to
329.26 refute the allegations or pursuant to stipulation or other agreement;

329.27 (10) failure to maintain adequate safety and sanitary conditions for a dental office in
329.28 accordance with the standards established by the rules of the board;

329.29 (11) employing, assisting, or enabling in any manner an unlicensed person to practice
329.30 dentistry;

329.31 (12) failure or refusal to attend, testify, and produce records as directed by the board
329.32 under subdivision 7;

330.1 (13) violation of, or failure to comply with, any other provisions of sections 150A.01 to
330.2 150A.12, the rules of the Board of Dentistry, or any disciplinary order issued by the board,
330.3 sections 144.291 to 144.298 or 595.02, subdivision 1, paragraph (d), or for any other just
330.4 cause related to the practice of dentistry. Suspension, revocation, modification or limitation
330.5 of any license shall not be based upon any judgment as to therapeutic or monetary value of
330.6 any individual drug prescribed or any individual treatment rendered, but only upon a repeated
330.7 pattern of conduct;

330.8 (14) knowingly providing false or misleading information that is directly related to the
330.9 care of that patient unless done for an accepted therapeutic purpose such as the administration
330.10 of a placebo; or

330.11 (15) aiding suicide or aiding attempted suicide in violation of section 609.215 as
330.12 established by any of the following:

330.13 (i) a copy of the record of criminal conviction or plea of guilty for a felony in violation
330.14 of section 609.215, subdivision 1 or 2;

330.15 (ii) a copy of the record of a judgment of contempt of court for violating an injunction
330.16 issued under section 609.215, subdivision 4;

330.17 (iii) a copy of the record of a judgment assessing damages under section 609.215,
330.18 subdivision 5; or

330.19 (iv) a finding by the board that the person violated section 609.215, subdivision 1 or 2.
330.20 The board shall investigate any complaint of a violation of section 609.215, subdivision 1
330.21 or 2.

330.22 Sec. 19. Minnesota Statutes 2022, section 150A.08, subdivision 5, is amended to read:

330.23 Subd. 5. **Medical examinations.** If the board has probable cause to believe that a dentist,
330.24 dental therapist, dental hygienist, dental assistant, or applicant engages in acts described in
330.25 subdivision 1, clause (4) or (5), or has a condition described in subdivision 1, clause (8), it
330.26 shall direct the dentist, dental therapist, dental hygienist, dental assistant, or applicant to
330.27 submit to a mental or physical examination or a substance use disorder assessment. For the
330.28 purpose of this subdivision, every dentist, dental therapist, dental hygienist, or dental assistant
330.29 licensed under this chapter or person submitting an application for a license is deemed to
330.30 have given consent to submit to a mental or physical examination when directed in writing
330.31 by the board and to have waived all objections in any proceeding under this section to the
330.32 admissibility of the examining physician's testimony or examination reports on the ground
330.33 that they constitute a privileged communication. Failure to submit to an examination without

331.1 just cause may result in an application being denied or a default and final order being entered
331.2 without the taking of testimony or presentation of evidence, other than evidence which may
331.3 be submitted by affidavit, that the licensee or applicant did not submit to the examination.
331.4 A dentist, dental therapist, dental hygienist, dental assistant, or applicant affected under this
331.5 section shall at reasonable intervals be afforded an opportunity to demonstrate ability to
331.6 start or resume the competent practice of dentistry or perform the duties of a dental therapist,
331.7 dental hygienist, or dental assistant with reasonable skill and safety to patients. In any
331.8 proceeding under this subdivision, neither the record of proceedings nor the orders entered
331.9 by the board is admissible, is subject to subpoena, or may be used against the dentist, dental
331.10 therapist, dental hygienist, dental assistant, or applicant in any proceeding not commenced
331.11 by the board. Information obtained under this subdivision shall be classified as private
331.12 pursuant to the Minnesota Government Data Practices Act.

331.13 Sec. 20. Minnesota Statutes 2022, section 150A.091, is amended by adding a subdivision
331.14 to read:

331.15 Subd. 23. **Mailing list services.** Each licensee must submit a nonrefundable \$5 fee to
331.16 request a mailing address list.

331.17 Sec. 21. Minnesota Statutes 2022, section 150A.13, subdivision 10, is amended to read:

331.18 Subd. 10. **Failure to report.** ~~On or after August 1, 2012,~~ Any person, institution, insurer,
331.19 or organization that fails to report as required under subdivisions 2 to 6 shall be subject to
331.20 civil penalties for failing to report as required by law.

331.21 Sec. 22. Minnesota Statutes 2022, section 151.01, subdivision 27, is amended to read:

331.22 Subd. 27. **Practice of pharmacy.** (a) "Practice of pharmacy" means:

331.23 (1) interpretation and evaluation of prescription drug orders;

331.24 (2) compounding, labeling, and dispensing drugs and devices (except labeling by a
331.25 manufacturer or packager of nonprescription drugs or commercially packaged legend drugs
331.26 and devices);

331.27 (3) participation in clinical interpretations and monitoring of drug therapy for assurance
331.28 of safe and effective use of drugs, including the performance of laboratory tests that are
331.29 waived under the federal Clinical Laboratory Improvement Act of 1988, United States Code,
331.30 title 42, section 263a et seq., provided that a pharmacist may interpret the results of laboratory
331.31 tests but may modify drug therapy only pursuant to a protocol or collaborative practice
331.32 agreement;

332.1 (4) participation in drug and therapeutic device selection; drug administration for first
332.2 dosage and medical emergencies; intramuscular and subcutaneous drug administration under
332.3 a prescription drug order; drug regimen reviews; and drug or drug-related research;

332.4 (5) drug administration, through intramuscular and subcutaneous administration used
332.5 to treat mental illnesses as permitted under the following conditions:

332.6 (i) upon the order of a prescriber and the prescriber is notified after administration is
332.7 complete; or

332.8 (ii) pursuant to a protocol or collaborative practice agreement as defined by section
332.9 151.01, subdivisions 27b and 27c, and participation in the initiation, management,
332.10 modification, administration, and discontinuation of drug therapy is according to the protocol
332.11 or collaborative practice agreement between the pharmacist and a dentist, optometrist,
332.12 physician, physician assistant, podiatrist, or veterinarian, or an advanced practice registered
332.13 nurse authorized to prescribe, dispense, and administer under section 148.235. Any changes
332.14 in drug therapy or medication administration made pursuant to a protocol or collaborative
332.15 practice agreement must be documented by the pharmacist in the patient's medical record
332.16 or reported by the pharmacist to a practitioner responsible for the patient's care;

332.17 (6) participation in administration of influenza vaccines and vaccines authorized or
332.18 approved by the United States Food and Drug Administration related to COVID-19 or
332.19 SARS-CoV-2 to all eligible individuals six years of age and older and all other vaccines to
332.20 patients 13 years of age and older by written protocol with a physician licensed under chapter
332.21 147, a physician assistant authorized to prescribe drugs under chapter 147A, or an advanced
332.22 practice registered nurse authorized to prescribe drugs under section 148.235, provided that:

332.23 (i) the protocol includes, at a minimum:

332.24 (A) the name, dose, and route of each vaccine that may be given;

332.25 (B) the patient population for whom the vaccine may be given;

332.26 (C) contraindications and precautions to the vaccine;

332.27 (D) the procedure for handling an adverse reaction;

332.28 (E) the name, signature, and address of the physician, physician assistant, or advanced
332.29 practice registered nurse;

332.30 (F) a telephone number at which the physician, physician assistant, or advanced practice
332.31 registered nurse can be contacted; and

332.32 (G) the date and time period for which the protocol is valid;

333.1 (ii) the pharmacist has successfully completed a program approved by the Accreditation
333.2 Council for Pharmacy Education (ACPE) specifically for the administration of immunizations
333.3 or a program approved by the board;

333.4 (iii) the pharmacist utilizes the Minnesota Immunization Information Connection to
333.5 assess the immunization status of individuals prior to the administration of vaccines, except
333.6 when administering influenza vaccines to individuals age nine and older;

333.7 (iv) the pharmacist reports the administration of the immunization to the Minnesota
333.8 Immunization Information Connection; ~~and~~

333.9 (v) the pharmacist complies with guidelines for vaccines and immunizations established
333.10 by the federal Advisory Committee on Immunization Practices, except that a pharmacist
333.11 does not need to comply with those portions of the guidelines that establish immunization
333.12 schedules when administering a vaccine pursuant to a valid, patient-specific order issued
333.13 by a physician licensed under chapter 147, a physician assistant authorized to prescribe
333.14 drugs under chapter 147A, or an advanced practice registered nurse authorized to prescribe
333.15 drugs under section 148.235, provided that the order is consistent with the United States
333.16 Food and Drug Administration approved labeling of the vaccine; and

333.17 (vi) the pharmacist has a current certificate in cardiopulmonary resuscitation;

333.18 (7) participation in the initiation, management, modification, and discontinuation of
333.19 drug therapy according to a written protocol or collaborative practice agreement between:
333.20 (i) one or more pharmacists and one or more dentists, optometrists, physicians, physician
333.21 assistants, podiatrists, or veterinarians; or (ii) one or more pharmacists and one or more
333.22 physician assistants authorized to prescribe, dispense, and administer under chapter 147A,
333.23 or advanced practice registered nurses authorized to prescribe, dispense, and administer
333.24 under section 148.235. Any changes in drug therapy made pursuant to a protocol or
333.25 collaborative practice agreement must be documented by the pharmacist in the patient's
333.26 medical record or reported by the pharmacist to a practitioner responsible for the patient's
333.27 care;

333.28 (8) participation in the storage of drugs and the maintenance of records;

333.29 (9) patient counseling on therapeutic values, content, hazards, and uses of drugs and
333.30 devices;

333.31 (10) offering or performing those acts, services, operations, or transactions necessary
333.32 in the conduct, operation, management, and control of a pharmacy;

334.1 (11) participation in the initiation, management, modification, and discontinuation of
334.2 therapy with opiate antagonists, as defined in section 604A.04, subdivision 1, pursuant to:

334.3 (i) a written protocol as allowed under clause (7); or

334.4 (ii) a written protocol with a community health board medical consultant or a practitioner
334.5 designated by the commissioner of health, as allowed under section 151.37, subdivision 13;

334.6 (12) prescribing self-administered hormonal contraceptives; nicotine replacement
334.7 medications; and opiate antagonists for the treatment of an acute opiate overdose pursuant
334.8 to section 151.37, subdivision 14, 15, or 16; and

334.9 (13) participation in the placement of drug monitoring devices according to a prescription,
334.10 protocol, or collaborative practice agreement.

334.11 (b) A pharmacist may delegate the authority to administer vaccines under paragraph (a),
334.12 clause (6), to a pharmacy technician or pharmacist intern who has completed training in
334.13 vaccine administration if:

334.14 (1) the pharmacy technician or pharmacist intern has successfully completed a program
334.15 approved by the ACPE specifically for the administration of immunizations or a program
334.16 approved by the board;

334.17 (2) the pharmacy technician or pharmacist intern has a current certificate in
334.18 cardiopulmonary resuscitation;

334.19 (3) the pharmacist intern has the ability, under the direct supervision of a pharmacist,
334.20 to utilize the Minnesota Immunization Information Connection to assess the immunization
334.21 status of individuals prior to the administration of vaccines, except when administering
334.22 influenza vaccines to individuals age nine and older;

334.23 (4) the pharmacy technician has completed a minimum of two hours of ACPE-approved,
334.24 immunization-related continuing pharmacy education as part of the pharmacy technician's
334.25 two-year continuing education schedule;

334.26 (5) the pharmacy technician has completed one of the training programs listed under
334.27 Minnesota Rules, part 6800.3850, subpart 1h, item B; and

334.28 (6) the pharmacy technician or pharmacist intern administering vaccinations is supervised
334.29 by a licensed pharmacist according to the following requirements:

334.30 (i) the supervising pharmacist is readily and immediately available to the immunizing
334.31 pharmacy technician or pharmacist intern; and

335.1 (ii) direct supervision under this clause is provided in person and not through telehealth,
335.2 as defined under section 62A.673, subdivision 2.

335.3 Sec. 23. Minnesota Statutes 2022, section 151.065, subdivision 1, is amended to read:

335.4 Subdivision 1. **Application fees.** Application fees for licensure and registration are as
335.5 follows:

335.6 (1) pharmacist licensed by examination, ~~\$175~~ \$210;

335.7 (2) pharmacist licensed by reciprocity, ~~\$275~~ \$300;

335.8 (3) pharmacy intern, ~~\$50~~ \$75;

335.9 (4) pharmacy technician, ~~\$50~~ \$60;

335.10 (5) pharmacy, ~~\$260~~ \$300;

335.11 (6) drug wholesaler, legend drugs only, ~~\$5,260~~ \$5,300;

335.12 (7) drug wholesaler, legend and nonlegend drugs, ~~\$5,260~~ \$5,300;

335.13 (8) drug wholesaler, nonlegend drugs, veterinary legend drugs, or both, ~~\$5,260~~ \$5,300;

335.14 (9) drug wholesaler, medical gases, ~~\$5,260~~ \$5,300 for the first facility and ~~\$260~~ \$300
335.15 for each additional facility;

335.16 (10) third-party logistics provider, ~~\$260~~ \$300;

335.17 (11) drug manufacturer, nonopiate legend drugs only, ~~\$5,260~~ \$5,300;

335.18 (12) drug manufacturer, nonopiate legend and nonlegend drugs, ~~\$5,260~~ \$5,300;

335.19 (13) drug manufacturer, nonlegend or veterinary legend drugs, ~~\$5,260~~ \$5,300;

335.20 (14) drug manufacturer, medical gases, ~~\$5,260~~ \$5,300 for the first facility and ~~\$260~~
335.21 \$300 for each additional facility;

335.22 (15) drug manufacturer, also licensed as a pharmacy in Minnesota, ~~\$5,260~~ \$5,300;

335.23 (16) drug manufacturer of opiate-containing controlled substances listed in section
335.24 152.02, subdivisions 3 to 5, ~~\$55,260~~ \$55,300;

335.25 (17) medical gas dispenser, \$260;

335.26 (18) controlled substance researcher, ~~\$75~~ \$150; and

335.27 (19) pharmacy professional corporation, \$150.

336.1 Sec. 24. Minnesota Statutes 2022, section 151.065, subdivision 2, is amended to read:

336.2 Subd. 2. **Original license fee.** The pharmacist original licensure fee, ~~\$175~~ \$210.

336.3 Sec. 25. Minnesota Statutes 2022, section 151.065, subdivision 3, is amended to read:

336.4 Subd. 3. **Annual renewal fees.** Annual licensure and registration renewal fees are as
336.5 follows:

336.6 (1) pharmacist, ~~\$175~~ \$210;

336.7 (2) pharmacy technician, ~~\$50~~ \$60;

336.8 (3) pharmacy, ~~\$260~~ \$300;

336.9 (4) drug wholesaler, legend drugs only, ~~\$5,260~~ \$5,300;

336.10 (5) drug wholesaler, legend and nonlegend drugs, ~~\$5,260~~ \$5,300;

336.11 (6) drug wholesaler, nonlegend drugs, veterinary legend drugs, or both, ~~\$5,260~~ \$5,300;

336.12 (7) drug wholesaler, medical gases, ~~\$5,260~~ \$5,300 for the first facility and ~~\$260~~ \$300
336.13 for each additional facility;

336.14 (8) third-party logistics provider, ~~\$260~~ \$300;

336.15 (9) drug manufacturer, nonopiate legend drugs only, ~~\$5,260~~ \$5,300;

336.16 (10) drug manufacturer, nonopiate legend and nonlegend drugs, ~~\$5,260~~ \$5,300;

336.17 (11) drug manufacturer, nonlegend, veterinary legend drugs, or both, ~~\$5,260~~ \$5,300;

336.18 (12) drug manufacturer, medical gases, ~~\$5,260~~ \$5,300 for the first facility and ~~\$260~~
336.19 \$300 for each additional facility;

336.20 (13) drug manufacturer, also licensed as a pharmacy in Minnesota, ~~\$5,260~~ \$5,300;

336.21 (14) drug manufacturer of opiate-containing controlled substances listed in section
336.22 152.02, subdivisions 3 to 5, ~~\$55,260~~ \$55,300;

336.23 (15) medical gas dispenser, \$260;

336.24 (16) controlled substance researcher, ~~\$75~~ \$150; and

336.25 (17) pharmacy professional corporation, ~~\$100~~ \$150.

336.26 Sec. 26. Minnesota Statutes 2022, section 151.065, subdivision 4, is amended to read:

336.27 Subd. 4. **Miscellaneous fees.** Fees for issuance of affidavits and duplicate licenses and
336.28 certificates are as follows:

- 337.1 (1) intern affidavit, ~~\$20~~ \$30;
- 337.2 (2) duplicate small license, ~~\$20~~ \$30; and
- 337.3 (3) duplicate large certificate, \$30.

337.4 Sec. 27. Minnesota Statutes 2022, section 151.065, subdivision 6, is amended to read:

337.5 Subd. 6. **Reinstatement fees.** (a) A pharmacist who has allowed the pharmacist's license
337.6 to lapse may reinstate the license with board approval and upon payment of any fees and
337.7 late fees in arrears, up to a maximum of \$1,000.

337.8 (b) A pharmacy technician who has allowed the technician's registration to lapse may
337.9 reinstate the registration with board approval and upon payment of any fees and late fees
337.10 in arrears, up to a maximum of ~~\$90~~ \$250.

337.11 (c) An owner of a pharmacy, a drug wholesaler, a drug manufacturer, third-party logistics
337.12 provider, or a medical gas dispenser who has allowed the license of the establishment to
337.13 lapse may reinstate the license with board approval and upon payment of any fees and late
337.14 fees in arrears.

337.15 (d) A controlled substance researcher who has allowed the researcher's registration to
337.16 lapse may reinstate the registration with board approval and upon payment of any fees and
337.17 late fees in arrears.

337.18 (e) A pharmacist owner of a professional corporation who has allowed the corporation's
337.19 registration to lapse may reinstate the registration with board approval and upon payment
337.20 of any fees and late fees in arrears.

337.21 Sec. 28. Minnesota Statutes 2022, section 151.555, is amended to read:

337.22 **151.555 ~~PRESCRIPTION DRUG~~ MEDICATION REPOSITORY PROGRAM.**

337.23 Subdivision 1. **Definitions.** (a) For the purposes of this section, the terms defined in this
337.24 subdivision have the meanings given.

337.25 (b) "Central repository" means a wholesale distributor that meets the requirements under
337.26 subdivision 3 and enters into a contract with the Board of Pharmacy in accordance with this
337.27 section.

337.28 (c) "Distribute" means to deliver, other than by administering or dispensing.

337.29 (d) "Donor" means:

337.30 (1) a health care facility as defined in this subdivision;

- 338.1 (2) a skilled nursing facility licensed under chapter 144A;
- 338.2 (3) an assisted living facility licensed under chapter 144G;
- 338.3 (4) a pharmacy licensed under section 151.19, and located either in the state or outside
338.4 the state;
- 338.5 (5) a drug wholesaler licensed under section 151.47;
- 338.6 (6) a drug manufacturer licensed under section 151.252; or
- 338.7 (7) an individual at least 18 years of age, provided that the drug or medical supply that
338.8 is donated was obtained legally and meets the requirements of this section for donation.
- 338.9 (e) "Drug" means any prescription drug that has been approved for medical use in the
338.10 United States, is listed in the United States Pharmacopoeia or National Formulary, and
338.11 meets the criteria established under this section for donation; or any over-the-counter
338.12 medication that meets the criteria established under this section for donation. This definition
338.13 includes cancer drugs and antirejection drugs, but does not include controlled substances,
338.14 as defined in section 152.01, subdivision 4, or a prescription drug that can only be dispensed
338.15 to a patient registered with the drug's manufacturer in accordance with federal Food and
338.16 Drug Administration requirements.
- 338.17 (f) "Health care facility" means:
- 338.18 (1) a physician's office or health care clinic where licensed practitioners provide health
338.19 care to patients;
- 338.20 (2) a hospital licensed under section 144.50;
- 338.21 (3) a pharmacy licensed under section 151.19 and located in Minnesota; or
- 338.22 (4) a nonprofit community clinic, including a federally qualified health center; a rural
338.23 health clinic; public health clinic; or other community clinic that provides health care utilizing
338.24 a sliding fee scale to patients who are low-income, uninsured, or underinsured.
- 338.25 (g) "Local repository" means a health care facility that elects to accept donated drugs
338.26 and medical supplies and meets the requirements of subdivision 4.
- 338.27 (h) "Medical supplies" or "supplies" means any prescription ~~and~~ or nonprescription
338.28 medical supplies needed to administer a ~~prescription~~ drug.
- 338.29 (i) "Original, sealed, unopened, tamper-evident packaging" means packaging that is
338.30 sealed, unopened, and tamper-evident, including a manufacturer's original unit dose or
338.31 unit-of-use container, a repackager's original unit dose or unit-of-use container, or unit-dose

339.1 packaging prepared by a licensed pharmacy according to the standards of Minnesota Rules,
339.2 part 6800.3750.

339.3 (j) "Practitioner" has the meaning given in section 151.01, subdivision 23, except that
339.4 it does not include a veterinarian.

339.5 Subd. 2. **Establishment; contract and oversight.** ~~By January 1, 2020,~~ (a) The Board
339.6 of Pharmacy shall establish a ~~drug~~ medication repository program, through which donors
339.7 may donate a drug or medical supply for use by an individual who meets the eligibility
339.8 criteria specified under subdivision 5.

339.9 (b) The board shall contract with a central repository that meets the requirements of
339.10 subdivision 3 to implement and administer the ~~prescription drug~~ medication repository
339.11 program. The contract must:

339.12 (1) require the board to transfer to the central repository any money appropriated by the
339.13 legislature for the purpose of operating the medication repository program and require the
339.14 central repository to spend any money transferred only for purposes specified in the contract;

339.15 (2) require the central repository to report the following performance measures to the
339.16 board:

339.17 (i) the number of individuals served and the types of medications these individuals
339.18 received;

339.19 (ii) the number of clinics, pharmacies, and long-term care facilities with which the central
339.20 repository partnered;

339.21 (iii) the number and cost of medications accepted for inventory, disposed of, and
339.22 dispensed to individuals in need; and

339.23 (iv) locations within the state to which medications were shipped or delivered; and

339.24 (3) require the board to annually audit the expenditure by the central repository of any
339.25 money appropriated by the legislature and transferred by the board to ensure that this money
339.26 is used only for purposes specified in the contract.

339.27 Subd. 3. **Central repository requirements.** (a) The board may publish a request for
339.28 proposal for participants who meet the requirements of this subdivision and are interested
339.29 in acting as the central repository for the ~~drug~~ medication repository program. If the board
339.30 publishes a request for proposal, it shall follow all applicable state procurement procedures
339.31 in the selection process. The board may also work directly with the University of Minnesota
339.32 to establish a central repository.

340.1 (b) To be eligible to act as the central repository, the participant must be a wholesale
340.2 drug distributor located in Minnesota, licensed pursuant to section 151.47, and in compliance
340.3 with all applicable federal and state statutes, rules, and regulations.

340.4 (c) The central repository shall be subject to inspection by the board pursuant to section
340.5 151.06, subdivision 1.

340.6 (d) The central repository shall comply with all applicable federal and state laws, rules,
340.7 and regulations pertaining to the ~~drug~~ medication repository program, drug storage, and
340.8 dispensing. The facility must maintain in good standing any state license or registration that
340.9 applies to the facility.

340.10 Subd. 4. **Local repository requirements.** (a) To be eligible for participation in the ~~drug~~
340.11 medication repository program, a health care facility must agree to comply with all applicable
340.12 federal and state laws, rules, and regulations pertaining to the ~~drug~~ medication repository
340.13 program, drug storage, and dispensing. The facility must also agree to maintain in good
340.14 standing any required state license or registration that may apply to the facility.

340.15 (b) A local repository may elect to participate in the program by submitting the following
340.16 information to the central repository on a form developed by the board and made available
340.17 on the board's website:

340.18 (1) the name, street address, and telephone number of the health care facility and any
340.19 state-issued license or registration number issued to the facility, including the issuing state
340.20 agency;

340.21 (2) the name and telephone number of a responsible pharmacist or practitioner who is
340.22 employed by or under contract with the health care facility; and

340.23 (3) a statement signed and dated by the responsible pharmacist or practitioner indicating
340.24 that the health care facility meets the eligibility requirements under this section and agrees
340.25 to comply with this section.

340.26 (c) Participation in the ~~drug~~ medication repository program is voluntary. A local
340.27 repository may withdraw from participation in the ~~drug~~ medication repository program at
340.28 any time by providing written notice to the central repository on a form developed by the
340.29 board and made available on the board's website. The central repository shall provide the
340.30 board with a copy of the withdrawal notice within ten business days from the date of receipt
340.31 of the withdrawal notice.

341.1 Subd. 5. **Individual eligibility and application requirements.** (a) To be eligible for
341.2 the ~~drug~~ medication repository program, an individual must submit to a local repository an
341.3 intake application form that is signed by the individual and attests that the individual:

341.4 (1) is a resident of Minnesota;

341.5 (2) is uninsured and is not enrolled in the medical assistance program under chapter
341.6 256B or the MinnesotaCare program under chapter 256L, has no prescription drug coverage,
341.7 or is underinsured;

341.8 (3) acknowledges that the drugs or medical supplies to be received through the program
341.9 may have been donated; and

341.10 (4) consents to a waiver of the child-resistant packaging requirements of the federal
341.11 Poison Prevention Packaging Act.

341.12 (b) Upon determining that an individual is eligible for the program, the local repository
341.13 shall furnish the individual with an identification card. The card shall be valid for one year
341.14 from the date of issuance and may be used at any local repository. A new identification card
341.15 may be issued upon expiration once the individual submits a new application form.

341.16 (c) The local repository shall send a copy of the intake application form to the central
341.17 repository by regular mail, facsimile, or secured email within ten days from the date the
341.18 application is approved by the local repository.

341.19 (d) The board shall develop and make available on the board's website an application
341.20 form and the format for the identification card.

341.21 Subd. 6. **Standards and procedures for accepting donations of drugs and supplies.** (a)
341.22 A donor may donate ~~prescription~~ drugs or medical supplies to the central repository or a
341.23 local repository if the drug or supply meets the requirements of this section as determined
341.24 by a pharmacist or practitioner who is employed by or under contract with the central
341.25 repository or a local repository.

341.26 (b) A ~~prescription~~ drug is eligible for donation under the ~~drug~~ medication repository
341.27 program if the following requirements are met:

341.28 (1) the donation is accompanied by a ~~drug~~ medication repository donor form described
341.29 under paragraph (d) that is signed by an individual who is authorized by the donor to attest
341.30 to the donor's knowledge in accordance with paragraph (d);

341.31 (2) the drug's expiration date is at least six months after the date the drug was donated.
341.32 If a donated drug bears an expiration date that is less than six months from the donation

342.1 date, the drug may be accepted and distributed if the drug is in high demand and can be
342.2 dispensed for use by a patient before the drug's expiration date;

342.3 (3) the drug is in its original, sealed, unopened, tamper-evident packaging that includes
342.4 the expiration date. Single-unit-dose drugs may be accepted if the single-unit-dose packaging
342.5 is unopened;

342.6 (4) the drug or the packaging does not have any physical signs of tampering, misbranding,
342.7 deterioration, compromised integrity, or adulteration;

342.8 (5) the drug does not require storage temperatures other than normal room temperature
342.9 as specified by the manufacturer or United States Pharmacopoeia, unless the drug is being
342.10 donated directly by its manufacturer, a wholesale drug distributor, or a pharmacy located
342.11 in Minnesota; and

342.12 (6) the ~~prescription~~ drug is not a controlled substance.

342.13 (c) A medical supply is eligible for donation under the ~~drug~~ medication repository
342.14 program if the following requirements are met:

342.15 (1) the supply has no physical signs of tampering, misbranding, or alteration and there
342.16 is no reason to believe it has been adulterated, tampered with, or misbranded;

342.17 (2) the supply is in its original, unopened, sealed packaging;

342.18 (3) the donation is accompanied by a ~~drug~~ medication repository donor form described
342.19 under paragraph (d) that is signed by an individual who is authorized by the donor to attest
342.20 to the donor's knowledge in accordance with paragraph (d); and

342.21 (4) if the supply bears an expiration date, the date is at least six months later than the
342.22 date the supply was donated. If the donated supply bears an expiration date that is less than
342.23 six months from the date the supply was donated, the supply may be accepted and distributed
342.24 if the supply is in high demand and can be dispensed for use by a patient before the supply's
342.25 expiration date.

342.26 (d) The board shall develop the ~~drug~~ medication repository donor form and make it
342.27 available on the board's website. The form must state that to the best of the donor's knowledge
342.28 the donated drug or supply has been properly stored under appropriate temperature and
342.29 humidity conditions and that the drug or supply has never been opened, used, tampered
342.30 with, adulterated, or misbranded.

342.31 (e) Donated drugs and supplies may be shipped or delivered to the premises of the central
342.32 repository or a local repository, and shall be inspected by a pharmacist or an authorized

343.1 practitioner who is employed by or under contract with the repository and who has been
343.2 designated by the repository to accept donations. A drop box must not be used to deliver
343.3 or accept donations.

343.4 (f) The central repository and local repository shall inventory all drugs and supplies
343.5 donated to the repository. For each drug, the inventory must include the drug's name, strength,
343.6 quantity, manufacturer, expiration date, and the date the drug was donated. For each medical
343.7 supply, the inventory must include a description of the supply, its manufacturer, the date
343.8 the supply was donated, and, if applicable, the supply's brand name and expiration date.

343.9 **Subd. 7. Standards and procedures for inspecting and storing donated ~~prescription~~**
343.10 **drugs and supplies.** (a) A pharmacist or authorized practitioner who is employed by or
343.11 under contract with the central repository or a local repository shall inspect all donated
343.12 ~~prescription~~ drugs and supplies before the drug or supply is dispensed to determine, to the
343.13 extent reasonably possible in the professional judgment of the pharmacist or practitioner,
343.14 that the drug or supply is not adulterated or misbranded, has not been tampered with, is safe
343.15 and suitable for dispensing, has not been subject to a recall, and meets the requirements for
343.16 donation. The pharmacist or practitioner who inspects the drugs or supplies shall sign an
343.17 inspection record stating that the requirements for donation have been met. If a local
343.18 repository receives drugs and supplies from the central repository, the local repository does
343.19 not need to reinspect the drugs and supplies.

343.20 (b) The central repository and local repositories shall store donated drugs and supplies
343.21 in a secure storage area under environmental conditions appropriate for the drug or supply
343.22 being stored. Donated drugs and supplies may not be stored with nondonated inventory.

343.23 (c) The central repository and local repositories shall dispose of all ~~prescription~~ drugs
343.24 and medical supplies that are not suitable for donation in compliance with applicable federal
343.25 and state statutes, regulations, and rules concerning hazardous waste.

343.26 (d) In the event that controlled substances or ~~prescription~~ drugs that can only be dispensed
343.27 to a patient registered with the drug's manufacturer are shipped or delivered to a central or
343.28 local repository for donation, the shipment delivery must be documented by the repository
343.29 and returned immediately to the donor or the donor's representative that provided the drugs.

343.30 (e) Each repository must develop drug and medical supply recall policies and procedures.
343.31 If a repository receives a recall notification, the repository shall destroy all of the drug or
343.32 medical supply in its inventory that is the subject of the recall and complete a record of
343.33 destruction form in accordance with paragraph (f). If a drug or medical supply that is the
343.34 subject of a Class I or Class II recall has been dispensed, the repository shall immediately

344.1 notify the recipient of the recalled drug or medical supply. A drug that potentially is subject
344.2 to a recall need not be destroyed if its packaging bears a lot number and that lot of the drug
344.3 is not subject to the recall. If no lot number is on the drug's packaging, it must be destroyed.

344.4 (f) A record of destruction of donated drugs and supplies that are not dispensed under
344.5 subdivision 8, are subject to a recall under paragraph (e), or are not suitable for donation
344.6 shall be maintained by the repository for at least two years. For each drug or supply destroyed,
344.7 the record shall include the following information:

344.8 (1) the date of destruction;

344.9 (2) the name, strength, and quantity of the drug destroyed; and

344.10 (3) the name of the person or firm that destroyed the drug.

344.11 Subd. 8. **Dispensing requirements.** (a) Donated drugs and supplies may be dispensed
344.12 if the drugs or supplies are prescribed by a practitioner for use by an eligible individual and
344.13 are dispensed by a pharmacist or practitioner. A repository shall dispense drugs and supplies
344.14 to eligible individuals in the following priority order: (1) individuals who are uninsured;
344.15 (2) individuals with no prescription drug coverage; and (3) individuals who are underinsured.
344.16 A repository shall dispense donated ~~prescription~~ drugs in compliance with applicable federal
344.17 and state laws and regulations for dispensing ~~prescription~~ drugs, including all requirements
344.18 relating to packaging, labeling, record keeping, drug utilization review, and patient
344.19 counseling.

344.20 (b) Before dispensing or administering a drug or supply, the pharmacist or practitioner
344.21 shall visually inspect the drug or supply for adulteration, misbranding, tampering, and date
344.22 of expiration. Drugs or supplies that have expired or appear upon visual inspection to be
344.23 adulterated, misbranded, or tampered with in any way must not be dispensed or administered.

344.24 (c) Before a drug or supply is dispensed or administered to an individual, the individual
344.25 must sign a drug repository recipient form acknowledging that the individual understands
344.26 the information stated on the form. The board shall develop the form and make it available
344.27 on the board's website. The form must include the following information:

344.28 (1) that the drug or supply being dispensed or administered has been donated and may
344.29 have been previously dispensed;

344.30 (2) that a visual inspection has been conducted by the pharmacist or practitioner to ensure
344.31 that the drug or supply has not expired, has not been adulterated or misbranded, and is in
344.32 its original, unopened packaging; and

345.1 (3) that the dispensing pharmacist, the dispensing or administering practitioner, the
345.2 central repository or local repository, the Board of Pharmacy, and any other participant of
345.3 the ~~drug~~ medication repository program cannot guarantee the safety of the drug or medical
345.4 supply being dispensed or administered and that the pharmacist or practitioner has determined
345.5 that the drug or supply is safe to dispense or administer based on the accuracy of the donor's
345.6 form submitted with the donated drug or medical supply and the visual inspection required
345.7 to be performed by the pharmacist or practitioner before dispensing or administering.

345.8 Subd. 9. **Handling fees.** (a) The central or local repository may charge the individual
345.9 receiving a drug or supply a handling fee of no more than 250 percent of the medical
345.10 assistance program dispensing fee for each drug or medical supply dispensed or administered
345.11 by that repository.

345.12 (b) A repository that dispenses or administers a drug or medical supply through the ~~drug~~
345.13 medication repository program shall not receive reimbursement under the medical assistance
345.14 program or the MinnesotaCare program for that dispensed or administered drug or supply.

345.15 Subd. 10. **Distribution of donated drugs and supplies.** (a) The central repository and
345.16 local repositories may distribute drugs and supplies donated under the ~~drug~~ medication
345.17 repository program to other participating repositories for use pursuant to this program.

345.18 (b) A local repository that elects not to dispense donated drugs or supplies must transfer
345.19 all donated drugs and supplies to the central repository. A copy of the donor form that was
345.20 completed by the original donor under subdivision 6 must be provided to the central
345.21 repository at the time of transfer.

345.22 Subd. 11. **Forms and record-keeping requirements.** (a) The following forms developed
345.23 for the administration of this program shall be utilized by the participants of the program
345.24 and shall be available on the board's website:

345.25 (1) intake application form described under subdivision 5;

345.26 (2) local repository participation form described under subdivision 4;

345.27 (3) local repository withdrawal form described under subdivision 4;

345.28 (4) ~~drug~~ medication repository donor form described under subdivision 6;

345.29 (5) record of destruction form described under subdivision 7; and

345.30 (6) ~~drug~~ medication repository recipient form described under subdivision 8.

345.31 (b) All records, including drug inventory, inspection, and disposal of donated ~~prescription~~
345.32 drugs and medical supplies, must be maintained by a repository for a minimum of two years.

346.1 Records required as part of this program must be maintained pursuant to all applicable
346.2 practice acts.

346.3 (c) Data collected by the ~~drug~~ medication repository program from all local repositories
346.4 shall be submitted quarterly or upon request to the central repository. Data collected may
346.5 consist of the information, records, and forms required to be collected under this section.

346.6 (d) The central repository shall submit reports to the board as required by the contract
346.7 or upon request of the board.

346.8 Subd. 12. **Liability.** (a) The manufacturer of a drug or supply is not subject to criminal
346.9 or civil liability for injury, death, or loss to a person or to property for causes of action
346.10 described in clauses (1) and (2). A manufacturer is not liable for:

346.11 (1) the intentional or unintentional alteration of the drug or supply by a party not under
346.12 the control of the manufacturer; or

346.13 (2) the failure of a party not under the control of the manufacturer to transfer or
346.14 communicate product or consumer information or the expiration date of the donated drug
346.15 or supply.

346.16 (b) A health care facility participating in the program, a pharmacist dispensing a drug
346.17 or supply pursuant to the program, a practitioner dispensing or administering a drug or
346.18 supply pursuant to the program, or a donor of a drug or medical supply is immune from
346.19 civil liability for an act or omission that causes injury to or the death of an individual to
346.20 whom the drug or supply is dispensed and no disciplinary action by a health-related licensing
346.21 board shall be taken against a pharmacist or practitioner so long as the drug or supply is
346.22 donated, accepted, distributed, and dispensed according to the requirements of this section.
346.23 This immunity does not apply if the act or omission involves reckless, wanton, or intentional
346.24 misconduct, or malpractice unrelated to the quality of the drug or medical supply.

346.25 Subd. 13. **Drug returned for credit.** Nothing in this section allows a long-term care
346.26 facility to donate a drug to a central or local repository when federal or state law requires
346.27 the drug to be returned to the pharmacy that initially dispensed it, so that the pharmacy can
346.28 credit the payer for the amount of the drug returned.

346.29 Subd. 14. **Cooperation.** The central repository, as approved by the Board of Pharmacy,
346.30 may enter into an agreement with another state that has an established drug repository or
346.31 drug donation program if the other state's program includes regulations to ensure the purity,
346.32 integrity, and safety of the drugs and supplies donated, to permit the central repository to
346.33 offer to another state program inventory that is not needed by a Minnesota resident and to

347.1 accept inventory from another state program to be distributed to local repositories and
347.2 dispensed to Minnesota residents in accordance with this program.

347.3 Subd. 15. **Funding.** The central repository may seek grants and other money from
347.4 nonprofit charitable organizations, the federal government, and other sources to fund the
347.5 ongoing operations of the medication repository program.

347.6 Sec. 29. [245A.245] CHILDREN'S RESIDENTIAL FACILITY SUBSTANCE USE
347.7 DISORDER TREATMENT PROGRAMS.

347.8 Subdivision 1. **Applicability.** A license holder of a children's residential facility substance
347.9 use disorder treatment program license issued under this chapter and Minnesota Rules, parts
347.10 2960.0010 to 2960.0220 and 2960.0430 to 2960.0490, must comply with this section.

347.11 Subd. 2. **Former students.** (a) "Alcohol and drug counselor" means an individual
347.12 qualified according to Minnesota Rules, part 2960.0460, subpart 5.

347.13 (b) "Former student" means an individual that meets the requirements in section 148F.11,
347.14 subdivision 2a, to practice as a former student.

347.15 (c) An alcohol and drug counselor must supervise and be responsible for a treatment
347.16 service performed by a former student and must review and sign each assessment, individual
347.17 treatment plan, progress note, and treatment plan review prepared by a former student.

347.18 (d) A former student must receive the orientation and training required for permanent
347.19 staff members.

347.20 Sec. 30. Minnesota Statutes 2022, section 245G.01, is amended by adding a subdivision
347.21 to read:

347.22 Subd. 13c. **Former student.** "Former student" means a staff person that meets the
347.23 requirements in section 148F.11, subdivision 2a, to practice as a former student.

347.24 Sec. 31. Minnesota Statutes 2022, section 245G.11, subdivision 10, is amended to read:

347.25 Subd. 10. **Student interns and former students.** (a) A qualified staff member must
347.26 supervise and be responsible for a treatment service performed by a student intern and must
347.27 review and sign each assessment, individual treatment plan, and treatment plan review
347.28 prepared by a student intern.

347.29 (b) An alcohol and drug counselor must supervise and be responsible for a treatment
347.30 service performed by a former student and must review and sign each assessment, individual
347.31 treatment plan, and treatment plan review prepared by the former student.

348.1 (c) A student intern or former student must receive the orientation and training required
348.2 in section 245G.13, subdivisions 1, clause (7), and 2. No more than 50 percent of the
348.3 treatment staff may be students, former students, or licensing candidates with time
348.4 documented to be directly related to the provision of treatment services for which the staff
348.5 are authorized.

348.6 Sec. 32. **REPEALER.**

348.7 Minnesota Rules, parts 5610.0100; 5610.0200; and 5610.0300, are repealed.

348.8 **ARTICLE 6**
348.9 **BACKGROUND STUDIES**

348.10 Section 1. Minnesota Statutes 2022, section 245C.02, is amended by adding a subdivision
348.11 to read:

348.12 Subd. 7a. **Conservator.** "Conservator" has the meaning given under section 524.1-201,
348.13 clause (10), and includes proposed and current conservators.

348.14 Sec. 2. Minnesota Statutes 2022, section 245C.02, is amended by adding a subdivision to
348.15 read:

348.16 Subd. 11f. **Guardian.** "Guardian" has the meaning given under section 524.1-201, clause
348.17 (27), and includes proposed and current guardians.

348.18 Sec. 3. Minnesota Statutes 2022, section 245C.02, subdivision 13e, is amended to read:

348.19 Subd. 13e. **NETStudy 2.0.** "NETStudy 2.0" means the commissioner's system that
348.20 replaces both NETStudy and the department's internal background study processing system.
348.21 NETStudy 2.0 is designed to enhance protection of children and vulnerable adults by
348.22 improving the accuracy of background studies through fingerprint-based criminal record
348.23 checks and expanding the background studies to include a review of information from the
348.24 Minnesota Court Information System and the national crime information database. NETStudy
348.25 2.0 is also designed to increase efficiencies in and the speed of the hiring process by:

348.26 (1) providing access to and updates from public web-based data related to employment
348.27 eligibility;

348.28 (2) decreasing the need for repeat studies through electronic updates of background
348.29 study subjects' criminal records;

349.1 (3) supporting identity verification using subjects' Social Security numbers and
349.2 photographs;

349.3 (4) using electronic employer notifications; ~~and~~

349.4 (5) issuing immediate verification of subjects' eligibility to provide services as more
349.5 studies are completed under the NETStudy 2.0 system; and

349.6 (6) providing electronic access to certain notices for entities and background study
349.7 subjects.

349.8 Sec. 4. Minnesota Statutes 2022, section 245C.03, subdivision 1, is amended to read:

349.9 Subdivision 1. **Licensed programs.** (a) The commissioner shall conduct a background
349.10 study on:

349.11 (1) the person or persons applying for a license;

349.12 (2) an individual age 13 and over living in the household where the licensed program
349.13 will be provided who is not receiving licensed services from the program;

349.14 (3) current or prospective employees or contractors of the applicant who will have direct
349.15 contact with persons served by the facility, agency, or program;

349.16 (4) volunteers or student volunteers who will have direct contact with persons served
349.17 by the program to provide program services if the contact is not under the continuous, direct
349.18 supervision by an individual listed in clause (1) or (3);

349.19 (5) an individual age ten to 12 living in the household where the licensed services will
349.20 be provided when the commissioner has reasonable cause as defined in section 245C.02,
349.21 subdivision 15;

349.22 (6) an individual who, without providing direct contact services at a licensed program,
349.23 may have unsupervised access to children or vulnerable adults receiving services from a
349.24 program, when the commissioner has reasonable cause as defined in section 245C.02,
349.25 subdivision 15;

349.26 (7) all controlling individuals as defined in section 245A.02, subdivision 5a;

349.27 (8) notwithstanding the other requirements in this subdivision, child care background
349.28 study subjects as defined in section 245C.02, subdivision 6a; and

349.29 (9) notwithstanding clause (3), for children's residential facilities and foster residence
349.30 settings, any adult working in the facility, whether or not the individual will have direct
349.31 contact with persons served by the facility.

350.1 (b) For child foster care when the license holder resides in the home where foster care
 350.2 services are provided, a short-term substitute caregiver providing direct contact services for
 350.3 a child for less than 72 hours of continuous care is not required to receive a background
 350.4 study under this chapter.

350.5 (c) This subdivision applies to the following programs that must be licensed under
 350.6 chapter 245A:

350.7 (1) adult foster care;

350.8 (2) child foster care;

350.9 (3) children's residential facilities;

350.10 (4) family child care;

350.11 (5) licensed child care centers;

350.12 (6) licensed home and community-based services under chapter 245D;

350.13 (7) residential mental health programs for adults;

350.14 (8) substance use disorder treatment programs under chapter 245G;

350.15 (9) withdrawal management programs under chapter 245F;

350.16 (10) adult day care centers;

350.17 (11) family adult day services;

350.18 (12) independent living assistance for youth;

350.19 (13) detoxification programs;

350.20 (14) community residential settings; ~~and~~

350.21 (15) intensive residential treatment services and residential crisis stabilization under
 350.22 chapter 245I; and

350.23 (16) treatment programs for persons with sexual psychopathic personality or sexually
 350.24 dangerous persons, licensed under chapter 245A and according to Minnesota Rules, parts
 350.25 9515.3000 to 9515.3110.

350.26 **Sec. 5. [245C.033] GUARDIANS AND CONSERVATORS; MALTREATMENT**
 350.27 **AND STATE LICENSING AGENCY CHECKS.**

350.28 Subdivision 1. **Maltreatment data.** Requests for maltreatment data submitted pursuant
 350.29 to section 524.5-118 must include information regarding whether the guardian or conservator

352.1 individual's license, including a condition, suspension, revocation, or cancellation, is in the
352.2 licensing agency's database.

352.3 **Subd. 3. Procedure; maltreatment and state licensing agency data.** Requests for
352.4 maltreatment and state licensing agency data checks must be submitted by the guardian or
352.5 conservator to the commissioner on the form or in the manner prescribed by the
352.6 commissioner. Upon receipt of a signed informed consent and payment under section
352.7 245C.10, the commissioner shall complete the maltreatment and state licensing agency
352.8 checks. Upon completion of the checks, the commissioner shall provide the requested
352.9 information to the courts on the form or in the manner prescribed by the commissioner.

352.10 **Subd. 4. Classification of maltreatment and state licensing agency data; access to**
352.11 **information.** All data obtained by the commissioner for maltreatment and state licensing
352.12 agency checks completed under this section are classified as private data.

352.13 Sec. 6. Minnesota Statutes 2022, section 245C.05, subdivision 1, is amended to read:

352.14 Subdivision 1. **Individual studied.** (a) The individual who is the subject of the
352.15 background study must provide the applicant, license holder, or other entity under section
352.16 245C.04 with sufficient information to ensure an accurate study, including:

352.17 (1) the individual's first, middle, and last name and all other names by which the
352.18 individual has been known;

352.19 (2) current home address, city, and state of residence;

352.20 (3) current zip code;

352.21 (4) sex;

352.22 (5) date of birth;

352.23 (6) driver's license number or state identification number; and

352.24 (7) upon implementation of NETStudy 2.0, the home address, city, county, and state of
352.25 residence for the past five years.

352.26 (b) Every subject of a background study conducted or initiated by counties or private
352.27 agencies under this chapter must also provide the home address, city, county, and state of
352.28 residence for the past five years.

352.29 (c) Every subject of a background study related to private agency adoptions or related
352.30 to child foster care licensed through a private agency, who is 18 years of age or older, shall
352.31 also provide the commissioner a signed consent for the release of any information received

353.1 from national crime information databases to the private agency that initiated the background
353.2 study.

353.3 (d) The subject of a background study shall provide fingerprints and a photograph as
353.4 required in subdivision 5.

353.5 (e) The subject of a background study shall submit a completed criminal and maltreatment
353.6 history records check consent form for applicable national and state level record checks.

353.7 (f) A background study subject who has access to the NETStudy 2.0 applicant portal
353.8 must provide updated contact information to the commissioner via NETStudy 2.0 any time
353.9 their personal information changes for as long as they remain affiliated on any roster.

353.10 (g) An entity must update contact information in NETStudy 2.0 for a background study
353.11 subject on the entity's roster any time the entity receives new contact information from the
353.12 study subject.

353.13 Sec. 7. Minnesota Statutes 2022, section 245C.05, subdivision 4, is amended to read:

353.14 Subd. 4. **Electronic transmission.** (a) For background studies conducted by the
353.15 Department of Human Services, the commissioner shall implement a secure system for the
353.16 electronic transmission of:

353.17 (1) background study information to the commissioner;

353.18 (2) background study results to the license holder;

353.19 (3) background study information obtained under this section and section 245C.08 to
353.20 counties and private agencies for background studies conducted by the commissioner for
353.21 child foster care, including a summary of nondisqualifying results, except as prohibited by
353.22 law; and

353.23 (4) background study results to county agencies for background studies conducted by
353.24 the commissioner for adult foster care and family adult day services and, upon
353.25 implementation of NETStudy 2.0, family child care and legal nonlicensed child care
353.26 authorized under chapter 119B.

353.27 (b) Unless the commissioner has granted a hardship variance under paragraph (c), a
353.28 license holder or an applicant must use the electronic transmission system known as
353.29 NETStudy or NETStudy 2.0 to submit all requests for background studies to the
353.30 commissioner as required by this chapter.

354.1 (c) A license holder or applicant whose program is located in an area in which high-speed
354.2 Internet is inaccessible may request the commissioner to grant a variance to the electronic
354.3 transmission requirement.

354.4 (d) Section 245C.08, subdivision 3, paragraph (c), applies to results transmitted under
354.5 this subdivision.

354.6 (e) The background study subject shall access background study-related documents
354.7 electronically in the applicant portal. A background study subject may request the
354.8 commissioner to grant a variance to the requirement to access documents electronically in
354.9 the NETStudy 2.0 applicant portal, and maintains the ability to request paper documentation
354.10 of their background studies.

354.11 Sec. 8. Minnesota Statutes 2022, section 245C.08, subdivision 1, is amended to read:

354.12 Subdivision 1. **Background studies conducted by Department of Human Services.** (a)
354.13 For a background study conducted by the Department of Human Services, the commissioner
354.14 shall review:

354.15 (1) information related to names of substantiated perpetrators of maltreatment of
354.16 vulnerable adults that has been received by the commissioner as required under section
354.17 626.557, subdivision 9c, paragraph (j);

354.18 (2) the commissioner's records relating to the maltreatment of minors in licensed
354.19 programs, and from findings of maltreatment of minors as indicated through the social
354.20 service information system;

354.21 (3) information from juvenile courts as required in subdivision 4 for individuals listed
354.22 in section 245C.03, subdivision 1, paragraph (a), when there is reasonable cause;

354.23 (4) information from the Bureau of Criminal Apprehension, including information
354.24 regarding a background study subject's registration in Minnesota as a predatory offender
354.25 under section 243.166;

354.26 (5) except as provided in clause (6), information received as a result of submission of
354.27 fingerprints for a national criminal history record check, as defined in section 245C.02,
354.28 subdivision 13c, when the commissioner has reasonable cause for a national criminal history
354.29 record check as defined under section 245C.02, subdivision 15a, or as required under section
354.30 144.057, subdivision 1, clause (2);

354.31 (6) for a background study related to a child foster family setting application for licensure,
354.32 foster residence settings, children's residential facilities, a transfer of permanent legal and

355.1 physical custody of a child under sections 260C.503 to 260C.515, or adoptions, and for a
355.2 background study required for family child care, certified license-exempt child care, child
355.3 care centers, and legal nonlicensed child care authorized under chapter 119B, the
355.4 commissioner shall also review:

355.5 (i) information from the child abuse and neglect registry for any state in which the
355.6 background study subject has resided for the past five years;

355.7 (ii) when the background study subject is 18 years of age or older, or a minor under
355.8 section 245C.05, subdivision 5a, paragraph (c), information received following submission
355.9 of fingerprints for a national criminal history record check; and

355.10 (iii) when the background study subject is 18 years of age or older or a minor under
355.11 section 245C.05, subdivision 5a, paragraph (d), for licensed family child care, certified
355.12 license-exempt child care, licensed child care centers, and legal nonlicensed child care
355.13 authorized under chapter 119B, information obtained using non-fingerprint-based data
355.14 including information from the criminal and sex offender registries for any state in which
355.15 the background study subject resided for the past five years and information from the national
355.16 crime information database and the national sex offender registry; and

355.17 (7) for a background study required for family child care, certified license-exempt child
355.18 care centers, licensed child care centers, and legal nonlicensed child care authorized under
355.19 chapter 119B, the background study shall also include, to the extent practicable, a name
355.20 and date-of-birth search of the National Sex Offender Public website.

355.21 (b) Notwithstanding expungement by a court, the commissioner may consider information
355.22 obtained under paragraph (a), clauses (3) and (4), unless the commissioner received notice
355.23 of the petition for expungement and the court order for expungement is directed specifically
355.24 to the commissioner.

355.25 (c) The commissioner shall also review criminal case information received according
355.26 to section 245C.04, subdivision 4a, from the Minnesota court information system that relates
355.27 to individuals who have already been studied under this chapter and who remain affiliated
355.28 with the agency that initiated the background study.

355.29 (d) When the commissioner has reasonable cause to believe that the identity of a
355.30 background study subject is uncertain, the commissioner may require the subject to provide
355.31 a set of classifiable fingerprints for purposes of completing a fingerprint-based record check
355.32 with the Bureau of Criminal Apprehension. Fingerprints collected under this paragraph
355.33 shall not be saved by the commissioner after they have been used to verify the identity of
355.34 the background study subject against the particular criminal record in question.

356.1 (e) The commissioner may inform the entity that initiated a background study under
356.2 NETStudy 2.0 of the status of processing of the subject's fingerprints.

356.3 (f) For a background study required for treatment programs for sexual psychopathic
356.4 personality or sexually dangerous persons, the background study shall only include a review
356.5 of the information required under paragraph (a), clauses (1), (2), (3), and (4).

356.6 Sec. 9. Minnesota Statutes 2022, section 245C.10, subdivision 1d, is amended to read:

356.7 Subd. 1d. **State; national criminal history record check fees.** The commissioner may
356.8 increase background study fees as necessary, commensurate with an increase in state Bureau
356.9 of Criminal Apprehension or the national criminal history record check fee fees. The
356.10 ~~commissioner shall report any fee increase under this subdivision to the legislature during~~
356.11 ~~the legislative session following the fee increase, so that the legislature may consider adoption~~
356.12 ~~of the fee increase into statute. By July 1 of every year, background study fees shall be set~~
356.13 ~~at the amount adopted by the legislature under this section.~~

356.14 Sec. 10. Minnesota Statutes 2022, section 245C.10, subdivision 2, is amended to read:

356.15 Subd. 2. **Supplemental nursing services agencies.** The commissioner shall recover the
356.16 cost of the background studies initiated by supplemental nursing services agencies registered
356.17 under section 144A.71, subdivision 1, through a fee of no more than ~~\$42~~ \$44 per study
356.18 charged to the agency. The fees collected under this subdivision are appropriated to the
356.19 commissioner for the purpose of conducting background studies.

356.20 Sec. 11. Minnesota Statutes 2022, section 245C.10, subdivision 2a, is amended to read:

356.21 Subd. 2a. **Occupations regulated by commissioner of health.** The commissioner shall
356.22 set fees to recover the cost of combined background studies and criminal background checks
356.23 initiated by applicants, licensees, and certified practitioners regulated under sections 148.511
356.24 to 148.5198 and chapter 153A through a fee of no more than \$44 per study charged to the
356.25 entity. The fees collected under this subdivision shall be deposited in the special revenue
356.26 fund and are appropriated to the commissioner for the purpose of conducting background
356.27 studies and criminal background checks.

356.28 Sec. 12. Minnesota Statutes 2022, section 245C.10, subdivision 3, is amended to read:

356.29 Subd. 3. **Personal care provider organizations.** The commissioner shall recover the
356.30 cost of background studies initiated by a personal care provider organization under sections
356.31 256B.0651 to 256B.0654 and 256B.0659 through a fee of no more than ~~\$42~~ \$44 per study

357.1 charged to the organization responsible for submitting the background study form. The fees
357.2 collected under this subdivision are appropriated to the commissioner for the purpose of
357.3 conducting background studies.

357.4 Sec. 13. Minnesota Statutes 2022, section 245C.10, subdivision 4, is amended to read:

357.5 Subd. 4. **Temporary personnel agencies, educational programs, and professional**
357.6 **services agencies.** The commissioner shall recover the cost of the background studies
357.7 initiated by temporary personnel agencies, educational programs, and professional services
357.8 agencies that initiate background studies under section 245C.03, subdivision 4, through a
357.9 fee of no more than ~~\$42~~ \$44 per study charged to the agency. The fees collected under this
357.10 subdivision are appropriated to the commissioner for the purpose of conducting background
357.11 studies.

357.12 Sec. 14. Minnesota Statutes 2022, section 245C.10, subdivision 5, is amended to read:

357.13 Subd. 5. **Adult foster care and family adult day services.** The commissioner shall
357.14 recover the cost of background studies required under section 245C.03, subdivision 1, for
357.15 the purposes of adult foster care and family adult day services licensing, through a fee of
357.16 no more than ~~\$42~~ \$44 per study charged to the license holder. The fees collected under this
357.17 subdivision are appropriated to the commissioner for the purpose of conducting background
357.18 studies.

357.19 Sec. 15. Minnesota Statutes 2022, section 245C.10, subdivision 6, is amended to read:

357.20 Subd. 6. **Unlicensed home and community-based waiver providers of service to**
357.21 **seniors and individuals with disabilities.** The commissioner shall recover the cost of
357.22 background studies initiated by unlicensed home and community-based waiver providers
357.23 of service to seniors and individuals with disabilities under section 256B.4912 through a
357.24 fee of no more than ~~\$42~~ \$44 per study.

357.25 Sec. 16. Minnesota Statutes 2022, section 245C.10, subdivision 8, is amended to read:

357.26 Subd. 8. **Children's therapeutic services and supports providers.** The commissioner
357.27 shall recover the cost of background studies required under section 245C.03, subdivision
357.28 7, for the purposes of children's therapeutic services and supports under section 256B.0943,
357.29 through a fee of no more than ~~\$42~~ \$44 per study charged to the license holder. The fees
357.30 collected under this subdivision are appropriated to the commissioner for the purpose of
357.31 conducting background studies.

358.1 Sec. 17. Minnesota Statutes 2022, section 245C.10, subdivision 9, is amended to read:

358.2 Subd. 9. **Human services licensed programs.** The commissioner shall recover the cost
358.3 of background studies required under section 245C.03, subdivision 1, for all programs that
358.4 are licensed by the commissioner, except child foster care when the applicant or license
358.5 holder resides in the home where child foster care services are provided, family child care,
358.6 child care centers, certified license-exempt child care centers, and legal nonlicensed child
358.7 care authorized under chapter 119B, through a fee of no more than ~~\$42~~ \$44 per study charged
358.8 to the license holder. The fees collected under this subdivision are appropriated to the
358.9 commissioner for the purpose of conducting background studies.

358.10 Sec. 18. Minnesota Statutes 2022, section 245C.10, subdivision 9a, is amended to read:

358.11 Subd. 9a. **Child care programs.** The commissioner shall recover the cost of a background
358.12 study required for family child care, certified license-exempt child care centers, licensed
358.13 child care centers, and legal nonlicensed child care providers authorized under chapter 119B
358.14 through a fee of no more than ~~\$40~~ \$44 per study charged to the license holder. A fee of no
358.15 more than ~~\$42~~ \$44 per study shall be charged for studies conducted under section 245C.05,
358.16 subdivision 5a, paragraph (a). The fees collected under this subdivision are appropriated to
358.17 the commissioner to conduct background studies.

358.18 Sec. 19. Minnesota Statutes 2022, section 245C.10, subdivision 10, is amended to read:

358.19 Subd. 10. **Community first services and supports organizations.** The commissioner
358.20 shall recover the cost of background studies initiated by an agency-provider delivering
358.21 services under section 256B.85, subdivision 11, or a financial management services provider
358.22 providing service functions under section 256B.85, subdivision 13, through a fee of no more
358.23 than ~~\$42~~ \$44 per study, charged to the organization responsible for submitting the background
358.24 study form. The fees collected under this subdivision are appropriated to the commissioner
358.25 for the purpose of conducting background studies.

358.26 Sec. 20. Minnesota Statutes 2022, section 245C.10, subdivision 11, is amended to read:

358.27 Subd. 11. **Providers of housing support.** The commissioner shall recover the cost of
358.28 background studies initiated by providers of housing support under section 256I.04 through
358.29 a fee of no more than ~~\$42~~ \$44 per study. The fees collected under this subdivision are
358.30 appropriated to the commissioner for the purpose of conducting background studies.

401.1 to individuals with mental illness. An individual who does not meet these qualifications
401.2 may also serve as the vocational specialist upon completing a training plan approved by the
401.3 commissioner;

401.4 (ii) shall provide or facilitate the provision of vocational services to clients. The vocational
401.5 specialist serves as a consultant and educator to fellow ACT team members on these services;
401.6 and

401.7 (iii) must not refer individuals to receive any type of vocational services or linkage by
401.8 providers outside of the ACT team;

401.9 (6) the mental health certified peer specialist:

401.10 (i) shall be a full-time equivalent. No more than two individuals can share this position.
401.11 The mental health certified peer specialist is a fully integrated team member who provides
401.12 highly individualized services in the community and promotes the self-determination and
401.13 shared decision-making abilities of clients. This requirement may be waived due to workforce
401.14 shortages upon approval of the commissioner;

401.15 (ii) must provide coaching, mentoring, and consultation to the clients to promote recovery,
401.16 self-advocacy, and self-direction, promote wellness management strategies, and assist clients
401.17 in developing advance directives; and

401.18 (iii) must model recovery values, attitudes, beliefs, and personal action to encourage
401.19 wellness and resilience, provide consultation to team members, promote a culture where
401.20 the clients' points of view and preferences are recognized, understood, respected, and
401.21 integrated into treatment, and serve in a manner equivalent to other team members;

401.22 (7) the program administrative assistant shall be a full-time office-based program
401.23 administrative assistant position assigned to solely work with the ACT team, providing a
401.24 range of supports to the team, clients, and families; and

401.25 (8) additional staff:

401.26 (i) shall be based on team size. Additional treatment team staff may include mental
401.27 health professionals; clinical trainees; certified rehabilitation specialists; mental health
401.28 practitioners; or mental health rehabilitation workers. These individuals shall have the
401.29 knowledge, skills, and abilities required by the population served to carry out rehabilitation
401.30 and support functions; and

401.31 (ii) shall be selected based on specific program needs or the population served.

401.32 (b) Each ACT team must clearly document schedules for all ACT team members.

402.1 (c) Each ACT team member must serve as a primary team member for clients assigned
402.2 by the team leader and are responsible for facilitating the individual treatment plan process
402.3 for those clients. The primary team member for a client is the responsible team member
402.4 knowledgeable about the client's life and circumstances and writes the individual treatment
402.5 plan. The primary team member provides individual supportive therapy or counseling, and
402.6 provides primary support and education to the client's family and support system.

402.7 (d) Members of the ACT team must have strong clinical skills, professional qualifications,
402.8 experience, and competency to provide a full breadth of rehabilitation services. Each staff
402.9 member shall be proficient in their respective discipline and be able to work collaboratively
402.10 as a member of a multidisciplinary team to deliver the majority of the treatment,
402.11 rehabilitation, and support services clients require to fully benefit from receiving assertive
402.12 community treatment.

402.13 (e) Each ACT team member must fulfill training requirements established by the
402.14 commissioner.

402.15 Sec. 47. Minnesota Statutes 2022, section 256B.0622, subdivision 7b, is amended to read:

402.16 Subd. 7b. **Assertive community treatment program size and opportunities.** (a) Each
402.17 ACT team shall maintain an annual average caseload that does not exceed 100 clients.
402.18 Staff-to-client ratios shall be based on team size as follows:

402.19 (1) a small ACT team must:

402.20 (i) employ at least six but no more than seven full-time treatment team staff, excluding
402.21 the program assistant and the psychiatric care provider;

402.22 (ii) serve an annual average maximum of no more than 50 clients;

402.23 (iii) ensure at least one full-time equivalent position for every eight clients served;

402.24 (iv) schedule ACT team staff ~~for at least eight-hour shift coverage~~ on weekdays and
402.25 on-call duty to provide crisis services and deliver services after hours when staff are not
402.26 working;

402.27 (v) provide crisis services during business hours if the small ACT team does not have
402.28 sufficient staff numbers to operate an after-hours on-call system. During all other hours,
402.29 the ACT team may arrange for coverage for crisis assessment and intervention services
402.30 through a reliable crisis-intervention provider as long as there is a mechanism by which the
402.31 ACT team communicates routinely with the crisis-intervention provider and the on-call

403.1 ACT team staff are available to see clients face-to-face when necessary or if requested by
403.2 the crisis-intervention services provider;

403.3 (vi) adjust schedules and provide staff to carry out the needed service activities in the
403.4 evenings or on weekend days or holidays, when necessary;

403.5 (vii) arrange for and provide psychiatric backup during all hours the psychiatric care
403.6 provider is not regularly scheduled to work. If availability of the ACT team's psychiatric
403.7 care provider during all hours is not feasible, alternative psychiatric prescriber backup must
403.8 be arranged and a mechanism of timely communication and coordination established in
403.9 writing; and

403.10 (viii) be composed of, at minimum, one full-time team leader, at least 16 hours each
403.11 week per 50 clients of psychiatric provider time, or equivalent if fewer clients, one full-time
403.12 equivalent nursing, one full-time co-occurring disorder specialist, one full-time equivalent
403.13 mental health certified peer specialist, one full-time vocational specialist, one full-time
403.14 program assistant, and at least one additional full-time ACT team member who has mental
403.15 health professional, certified rehabilitation specialist, clinical trainee, or mental health
403.16 practitioner status; and

403.17 (2) a midsize ACT team shall:

403.18 (i) be composed of, at minimum, one full-time team leader, at least 16 hours of psychiatry
403.19 time for 51 clients, with an additional two hours for every six clients added to the team, 1.5
403.20 to two full-time equivalent nursing staff, one full-time co-occurring disorder specialist, one
403.21 full-time equivalent mental health certified peer specialist, one full-time vocational specialist,
403.22 one full-time program assistant, and at least 1.5 to two additional full-time equivalent ACT
403.23 members, with at least one dedicated full-time staff member with mental health professional
403.24 status. Remaining team members may have mental health professional, certified rehabilitation
403.25 specialist, clinical trainee, or mental health practitioner status;

403.26 (ii) employ seven or more treatment team full-time equivalents, excluding the program
403.27 assistant and the psychiatric care provider;

403.28 (iii) serve an annual average maximum caseload of 51 to 74 clients;

403.29 (iv) ensure at least one full-time equivalent position for every nine clients served;

403.30 (v) schedule ACT team staff for a minimum of ten-hour shift coverage on weekdays
403.31 and six- to eight-hour shift coverage on weekends and holidays. In addition to these minimum
403.32 specifications, staff are regularly scheduled to provide the necessary services on a
403.33 client-by-client basis in the evenings and on weekends and holidays;

404.1 (vi) schedule ACT team staff on-call duty to provide crisis services and deliver services
404.2 when staff are not working;

404.3 (vii) have the authority to arrange for coverage for crisis assessment and intervention
404.4 services through a reliable crisis-intervention provider as long as there is a mechanism by
404.5 which the ACT team communicates routinely with the crisis-intervention provider and the
404.6 on-call ACT team staff are available to see clients face-to-face when necessary or if requested
404.7 by the crisis-intervention services provider; and

404.8 (viii) arrange for and provide psychiatric backup during all hours the psychiatric care
404.9 provider is not regularly scheduled to work. If availability of the psychiatric care provider
404.10 during all hours is not feasible, alternative psychiatric prescriber backup must be arranged
404.11 and a mechanism of timely communication and coordination established in writing;

404.12 (3) a large ACT team must:

404.13 (i) be composed of, at minimum, one full-time team leader, at least 32 hours each week
404.14 per 100 clients, or equivalent of psychiatry time, three full-time equivalent nursing staff,
404.15 one full-time co-occurring disorder specialist, one full-time equivalent mental health certified
404.16 peer specialist, one full-time vocational specialist, one full-time program assistant, and at
404.17 least two additional full-time equivalent ACT team members, with at least one dedicated
404.18 full-time staff member with mental health professional status. Remaining team members
404.19 may have mental health professional or mental health practitioner status;

404.20 (ii) employ nine or more treatment team full-time equivalents, excluding the program
404.21 assistant and psychiatric care provider;

404.22 (iii) serve an annual average maximum caseload of 75 to 100 clients;

404.23 (iv) ensure at least one full-time equivalent position for every nine individuals served;

404.24 (v) schedule staff to work two eight-hour shifts, with a minimum of two staff on the
404.25 second shift providing services at least 12 hours per day weekdays. For weekends and
404.26 holidays, the team must operate and schedule ACT team staff to work one eight-hour shift,
404.27 with a minimum of two staff each weekend day and every holiday;

404.28 (vi) schedule ACT team staff on-call duty to provide crisis services and deliver services
404.29 when staff are not working; and

404.30 (vii) arrange for and provide psychiatric backup during all hours the psychiatric care
404.31 provider is not regularly scheduled to work. If availability of the ACT team psychiatric care
404.32 provider during all hours is not feasible, alternative psychiatric backup must be arranged
404.33 and a mechanism of timely communication and coordination established in writing.

405.1 (b) An ACT team of any size may have a staff-to-client ratio that is lower than the
405.2 requirements described in paragraph (a) upon approval by the commissioner, but may not
405.3 exceed a one-to-ten staff-to-client ratio.

405.4 Sec. 48. Minnesota Statutes 2022, section 256B.0622, subdivision 7c, is amended to read:

405.5 Subd. 7c. **Assertive community treatment program organization and communication**
405.6 **requirements.** (a) An ACT team shall provide at least 75 percent of all services in the
405.7 community in non-office-based or non-facility-based settings.

405.8 (b) ACT team members must know all clients receiving services, and interventions must
405.9 be carried out with consistency and follow empirically supported practice.

405.10 (c) Each ACT team client shall be assigned an individual treatment team that is
405.11 determined by a variety of factors, including team members' expertise and skills, rapport,
405.12 and other factors specific to the individual's preferences. The majority of clients shall see
405.13 at least three ACT team members in a given month.

405.14 (d) The ACT team shall have the capacity to rapidly increase service intensity to a client
405.15 when the client's status requires it, regardless of geography, and provide flexible service in
405.16 an individualized manner, and see clients on average three times per week for at least 120
405.17 minutes per week at a frequency that meets the client's needs. Services must be available
405.18 at times that meet client needs.

405.19 (e) ACT teams shall make deliberate efforts to assertively engage clients in services.
405.20 Input of family members, natural supports, and previous and subsequent treatment providers
405.21 is required in developing engagement strategies. ACT teams shall include the client, identified
405.22 family, and other support persons in the admission, initial assessment, and planning process
405.23 as primary stakeholders, meet with the client in the client's environment at times of the day
405.24 and week that honor the client's preferences, and meet clients at home and in jails or prisons,
405.25 streets, homeless shelters, or hospitals.

405.26 (f) ACT teams shall ensure that a process is in place for identifying individuals in need
405.27 of more or less assertive engagement. Interventions are monitored to determine the success
405.28 of these techniques and the need to adapt the techniques or approach accordingly.

405.29 (g) ACT teams shall conduct daily team meetings to systematically update clinically
405.30 relevant information, briefly discuss the status of assertive community treatment clients
405.31 over the past 24 hours, problem solve emerging issues, plan approaches to address and
405.32 prevent crises, and plan the service contacts for the following 24-hour period or weekend.
405.33 All team members scheduled to work shall attend this meeting.

406.1 (h) ACT teams shall maintain a clinical log that succinctly documents important clinical
406.2 information and develop a daily team schedule for the day's contacts based on a central file
406.3 of the clients' weekly or monthly schedules, which are derived from interventions specified
406.4 within the individual treatment plan. The team leader must have a record to ensure that all
406.5 assigned contacts are completed.

406.6 Sec. 49. Minnesota Statutes 2022, section 256B.0622, subdivision 8, is amended to read:

406.7 Subd. 8. **Medical assistance payment for assertive community treatment and**
406.8 **intensive residential treatment services.** (a) Payment for intensive residential treatment
406.9 services and assertive community treatment in this section shall be based on one daily rate
406.10 per provider inclusive of the following services received by an eligible client in a given
406.11 calendar day: all rehabilitative services under this section, staff travel time to provide
406.12 rehabilitative services under this section, and nonresidential crisis stabilization services
406.13 under section 256B.0624.

406.14 (b) Except as indicated in paragraph (c), payment will not be made to more than one
406.15 entity for each client for services provided under this section on a given day. If services
406.16 under this section are provided by a team that includes staff from more than one entity, the
406.17 team must determine how to distribute the payment among the members.

406.18 (c) The commissioner shall determine one rate for each provider that will bill medical
406.19 assistance for residential services under this section and one rate for each assertive community
406.20 treatment provider. If a single entity provides both services, one rate is established for the
406.21 entity's residential services and another rate for the entity's nonresidential services under
406.22 this section. A provider is not eligible for payment under this section without authorization
406.23 from the commissioner. The commissioner shall develop rates using the following criteria:

406.24 (1) the provider's cost for services shall include direct services costs, other program
406.25 costs, and other costs determined as follows:

406.26 (i) the direct services costs must be determined using actual costs of salaries, benefits,
406.27 payroll taxes, and training of direct service staff and service-related transportation;

406.28 (ii) other program costs not included in item (i) must be determined as a specified
406.29 percentage of the direct services costs as determined by item (i). The percentage used shall
406.30 be determined by the commissioner based upon the average of percentages that represent
406.31 the relationship of other program costs to direct services costs among the entities that provide
406.32 similar services;

407.1 (iii) physical plant costs calculated based on the percentage of space within the program
407.2 that is entirely devoted to treatment and programming. This does not include administrative
407.3 or residential space;

407.4 (iv) assertive community treatment physical plant costs must be reimbursed as part of
407.5 the costs described in item (ii); ~~and~~

407.6 (v) subject to federal approval, up to an additional five percent of the total rate may be
407.7 added to the program rate as a quality incentive based upon the entity meeting performance
407.8 criteria specified by the commissioner;

407.9 (vi) for assertive community treatment, intensive residential treatment services, and
407.10 residential crisis services, providers may include in their prospective cost-based rate-setting
407.11 methodology a line item reflecting estimated additional staffing compensation costs.

407.12 Estimated additional staffing compensation costs are subject to review by the commissioner;
407.13 and

407.14 (vii) for intensive residential treatment services and residential crisis services, providers
407.15 may include in their prospective cost-based rate-setting methodology a line item reflecting
407.16 estimated new capital costs. Estimated new capital costs are subject to review by the
407.17 commissioner;

407.18 (2) actual cost is defined as costs which are allowable, allocable, and reasonable, and
407.19 consistent with federal reimbursement requirements under Code of Federal Regulations,
407.20 title 48, chapter 1, part 31, relating to for-profit entities, and Office of Management and
407.21 Budget Circular Number A-122, relating to nonprofit entities;

407.22 (3) the number of service units;

407.23 (4) the degree to which clients will receive services other than services under this section;
407.24 and

407.25 (5) the costs of other services that will be separately reimbursed.

407.26 (d) The rate for intensive residential treatment services and assertive community treatment
407.27 must exclude room and board, as defined in section 256I.03, subdivision 6, and services
407.28 not covered under this section, such as partial hospitalization, home care, and inpatient
407.29 services.

407.30 (e) Physician services that are not separately billed may be included in the rate to the
407.31 extent that a psychiatrist, or other health care professional providing physician services
407.32 within their scope of practice, is a member of the intensive residential treatment services
407.33 treatment team. Physician services, whether billed separately or included in the rate, may

408.1 be delivered by telehealth. For purposes of this paragraph, "telehealth" has the meaning
408.2 given to "mental health telehealth" in section 256B.0625, subdivision 46, when telehealth
408.3 is used to provide intensive residential treatment services.

408.4 (f) When services under this section are provided by an assertive community treatment
408.5 provider, case management functions must be an integral part of the team.

408.6 (g) The rate for a provider must not exceed the rate charged by that provider for the
408.7 same service to other payors.

408.8 (h) The rates for existing programs must be established prospectively based upon the
408.9 expenditures and utilization over a prior 12-month period using the criteria established in
408.10 paragraph (c). The rates for new programs must be established based upon estimated
408.11 expenditures and estimated utilization using the criteria established in paragraph (c).

408.12 (i) Entities who discontinue providing services must be subject to a settle-up process
408.13 whereby actual costs and reimbursement for the previous 12 months are compared. In the
408.14 event that the entity was paid more than the entity's actual costs plus any applicable
408.15 performance-related funding due the provider, the excess payment must be reimbursed to
408.16 the department. If a provider's revenue is less than actual allowed costs due to lower
408.17 utilization than projected, the commissioner may reimburse the provider to recover its actual
408.18 allowable costs. The resulting adjustments by the commissioner must be proportional to the
408.19 percent of total units of service reimbursed by the commissioner and must reflect a difference
408.20 of greater than five percent.

408.21 (j) A provider may request of the commissioner a review of any rate-setting decision
408.22 made under this subdivision.

408.23 Sec. 50. Minnesota Statutes 2022, section 256B.0623, subdivision 4, is amended to read:

408.24 Subd. 4. **Provider entity standards.** (a) The provider entity must be certified by the
408.25 state following the certification process and procedures developed by the commissioner.

408.26 (b) The certification process is a determination as to whether the entity meets the standards
408.27 in this section and chapter 245I, as required in section 245I.011, subdivision 5. The
408.28 certification must specify which adult rehabilitative mental health services the entity is
408.29 qualified to provide.

408.30 ~~(c) A noncounty provider entity must obtain additional certification from each county~~
408.31 ~~in which it will provide services. The additional certification must be based on the adequacy~~
408.32 ~~of the entity's knowledge of that county's local health and human service system, and the~~
408.33 ~~ability of the entity to coordinate its services with the other services available in that county.~~

409.1 ~~A county-operated entity must obtain this additional certification from any other county in~~
409.2 ~~which it will provide services.~~

409.3 ~~(d)~~ (c) State-level recertification must occur at least every three years.

409.4 ~~(e)~~ (d) The commissioner may intervene at any time and decertify providers with cause.
409.5 The decertification is subject to appeal to the state. A county board may recommend that
409.6 the state decertify a provider for cause.

409.7 ~~(f)~~ (e) The adult rehabilitative mental health services provider entity must meet the
409.8 following standards:

409.9 (1) have capacity to recruit, hire, manage, and train qualified staff;

409.10 (2) have adequate administrative ability to ensure availability of services;

409.11 (3) ensure that staff are skilled in the delivery of the specific adult rehabilitative mental
409.12 health services provided to the individual eligible recipient;

409.13 (4) ensure enough flexibility in service delivery to respond to the changing and
409.14 intermittent care needs of a recipient as identified by the recipient and the individual treatment
409.15 plan;

409.16 (5) assist the recipient in arranging needed crisis assessment, intervention, and
409.17 stabilization services;

409.18 (6) ensure that services are coordinated with other recipient mental health services
409.19 providers and the county mental health authority and the federally recognized American
409.20 Indian authority and necessary others after obtaining the consent of the recipient. Services
409.21 must also be coordinated with the recipient's case manager or care coordinator if the recipient
409.22 is receiving case management or care coordination services;

409.23 (7) keep all necessary records required by law;

409.24 (8) deliver services as required by section 245.461;

409.25 (9) be an enrolled Medicaid provider; and

409.26 (10) maintain a quality assurance plan to determine specific service outcomes and the
409.27 recipient's satisfaction with services.

409.28 Sec. 51. Minnesota Statutes 2022, section 256B.0757, subdivision 4c, is amended to read:

409.29 Subd. 4c. **Behavioral health home services staff qualifications.** (a) A behavioral health
409.30 home services provider must maintain staff with required professional qualifications
409.31 appropriate to the setting.

410.1 (b) If behavioral health home services are offered in a mental health setting, the
410.2 integration specialist must be a ~~registered~~ licensed nurse ~~licensed under the Minnesota Nurse~~
410.3 ~~Practice Act, sections 148.171 to 148.285,~~ as defined in section 148.171, subdivision 9.

410.4 (c) If behavioral health home services are offered in a primary care setting, the integration
410.5 specialist must be a mental health professional who is qualified according to section 245I.04,
410.6 subdivision 2.

410.7 (d) If behavioral health home services are offered in either a primary care setting or
410.8 mental health setting, the systems navigator must be a mental health practitioner who is
410.9 qualified according to section 245I.04, subdivision 4, or a community health worker as
410.10 defined in section 256B.0625, subdivision 49.

410.11 (e) If behavioral health home services are offered in either a primary care setting or
410.12 mental health setting, the qualified health home specialist must be one of the following:

410.13 (1) a mental health certified peer specialist who is qualified according to section 245I.04,
410.14 subdivision 10;

410.15 (2) a mental health certified family peer specialist who is qualified according to section
410.16 245I.04, subdivision 12;

410.17 (3) a case management associate as defined in section 245.462, subdivision 4, paragraph
410.18 (g), or 245.4871, subdivision 4, paragraph (j);

410.19 (4) a mental health rehabilitation worker who is qualified according to section 245I.04,
410.20 subdivision 14;

410.21 (5) a community paramedic as defined in section 144E.28, subdivision 9;

410.22 (6) a peer recovery specialist as defined in section 245G.07, subdivision 1, clause (5);
410.23 or

410.24 (7) a community health worker as defined in section 256B.0625, subdivision 49.

410.25 Sec. 52. Minnesota Statutes 2022, section 256B.0941, subdivision 2a, is amended to read:

410.26 Subd. 2a. **Sleeping hours.** During normal sleeping hours, a psychiatric residential
410.27 treatment facility provider must provide at least one staff person for every six residents
410.28 present within a living unit. A provider must adjust sleeping-hour staffing levels based on
410.29 the clinical needs of the residents in the facility. Sleeping hours must include at least one
410.30 staff trained and certified to provide emergency medical response. During normal sleeping
410.31 hours, a registered nurse must be available on call to assess a child's needs and must be
410.32 available within 60 minutes.

411.1 Sec. 53. Minnesota Statutes 2022, section 256B.0624, subdivision 5, is amended to read:

411.2 Subd. 5. **Crisis assessment and intervention staff qualifications.** (a) Qualified
411.3 individual staff of a qualified provider entity must provide crisis assessment and intervention
411.4 services to a recipient. A staff member providing crisis assessment and intervention services
411.5 to a recipient must be qualified as a:

411.6 (1) mental health professional;

411.7 (2) clinical trainee;

411.8 (3) mental health practitioner;

411.9 (4) mental health certified family peer specialist; or

411.10 (5) mental health certified peer specialist.

411.11 (b) When crisis assessment and intervention services are provided to a recipient in the
411.12 community, a mental health professional, clinical trainee, or mental health practitioner must
411.13 lead the response.

411.14 (c) The 30 hours of ongoing training required by section 245I.05, subdivision 4, paragraph
411.15 (b), must be specific to providing crisis services to children and adults and include training
411.16 about evidence-based practices identified by the commissioner of health to reduce the
411.17 recipient's risk of suicide and self-injurious behavior.

411.18 (d) At least six hours of the ongoing training under paragraph (c) must be specific to
411.19 working with families and providing crisis stabilization services to children and include the
411.20 following topics:

411.21 (1) developmental tasks of childhood and adolescence;

411.22 (2) family relationships;

411.23 (3) child and youth engagement and motivation, including motivational interviewing;

411.24 (4) culturally responsive care, including care for lesbian, gay, bisexual, transgender, and
411.25 queer youth;

411.26 (5) positive behavior support;

411.27 (6) crisis intervention for youth with developmental disabilities;

411.28 (7) child traumatic stress, trauma-informed care, and trauma-focused cognitive behavioral
411.29 therapy; and

411.30 (8) youth substance use.

412.1 ~~(d)~~ (e) Team members must be experienced in crisis assessment, crisis intervention
412.2 techniques, treatment engagement strategies, working with families, and clinical
412.3 decision-making under emergency conditions and have knowledge of local services and
412.4 resources.

412.5 Sec. 54. Minnesota Statutes 2022, section 256B.0624, subdivision 8, is amended to read:

412.6 Subd. 8. **Crisis stabilization staff qualifications.** (a) Mental health crisis stabilization
412.7 services must be provided by qualified individual staff of a qualified provider entity. A staff
412.8 member providing crisis stabilization services to a recipient must be qualified as a:

412.9 (1) mental health professional;

412.10 (2) certified rehabilitation specialist;

412.11 (3) clinical trainee;

412.12 (4) mental health practitioner;

412.13 (5) mental health certified family peer specialist;

412.14 (6) mental health certified peer specialist; or

412.15 (7) mental health rehabilitation worker.

412.16 (b) The 30 hours of ongoing training required in section 245I.05, subdivision 4, paragraph
412.17 (b), must be specific to providing crisis services to children and adults and include training
412.18 about evidence-based practices identified by the commissioner of health to reduce a recipient's
412.19 risk of suicide and self-injurious behavior.

412.20 (c) For providers who deliver care to children 21 years of age and younger, at least six
412.21 hours of the ongoing training under this subdivision must be specific to working with families
412.22 and providing crisis stabilization services to children and include the following topics:

412.23 (1) developmental tasks of childhood and adolescence;

412.24 (2) family relationships;

412.25 (3) child and youth engagement and motivation, including motivational interviewing;

412.26 (4) culturally responsive care, including care for lesbian, gay, bisexual, transgender, and
412.27 queer youth;

412.28 (5) positive behavior support;

412.29 (6) crisis intervention for youth with developmental disabilities;

413.1 (7) child traumatic stress, trauma-informed care, and trauma-focused cognitive behavioral
413.2 therapy; and

413.3 (8) youth substance use.

413.4 This paragraph does not apply to adult residential crisis stabilization service providers
413.5 licensed according to section 245I.23.

413.6 Sec. 55. Minnesota Statutes 2022, section 256B.0625, subdivision 5m, is amended to read:

413.7 Subd. 5m. **Certified community behavioral health clinic services.** (a) Medical
413.8 assistance covers services provided by a not-for-profit certified community behavioral health
413.9 clinic (CCBHC) that meets the requirements of section 245.735, subdivision 3.

413.10 (b) The commissioner shall reimburse CCBHCs on a per-day basis for each day that an
413.11 eligible service is delivered using the CCBHC daily bundled rate system for medical
413.12 assistance payments as described in paragraph (c). The commissioner shall include a quality
413.13 incentive payment in the CCBHC daily bundled rate system as described in paragraph (e).
413.14 There is no county share for medical assistance services when reimbursed through the
413.15 CCBHC daily bundled rate system.

413.16 (c) The commissioner shall ensure that the CCBHC daily bundled rate system for CCBHC
413.17 payments under medical assistance meets the following requirements:

413.18 (1) the CCBHC daily bundled rate shall be a provider-specific rate calculated for each
413.19 CCBHC, based on the daily cost of providing CCBHC services and the total annual allowable
413.20 CCBHC costs divided by the total annual number of CCBHC visits. For calculating the
413.21 payment rate, total annual visits include visits covered by medical assistance and visits not
413.22 covered by medical assistance. Allowable costs include but are not limited to the salaries
413.23 and benefits of medical assistance providers; the cost of CCBHC services provided under
413.24 section 245.735, subdivision 3, paragraph (a), clauses (6) and (7); and other costs such as
413.25 insurance or supplies needed to provide CCBHC services;

413.26 (2) payment shall be limited to one payment per day per medical assistance enrollee
413.27 when an eligible CCBHC service is provided. A CCBHC visit is eligible for reimbursement
413.28 if at least one of the CCBHC services listed under section 245.735, subdivision 3, paragraph
413.29 (a), clause (6), is furnished to a medical assistance enrollee by a health care practitioner or
413.30 licensed agency employed by or under contract with a CCBHC;

413.31 (3) initial CCBHC daily bundled rates for newly certified CCBHCs under section 245.735,
413.32 subdivision 3, shall be established by the commissioner using a provider-specific rate based
413.33 on the newly certified CCBHC's audited historical cost report data adjusted for the expected

414.1 cost of delivering CCBHC services. Estimates are subject to review by the commissioner
414.2 and must include the expected cost of providing the full scope of CCBHC services and the
414.3 expected number of visits for the rate period;

414.4 (4) the commissioner shall rebase CCBHC rates once every ~~three~~ two years following
414.5 the last rebasing and no less than 12 months following an initial rate or a rate change due
414.6 to a change in the scope of services;

414.7 (5) the commissioner shall provide for a 60-day appeals process after notice of the results
414.8 of the rebasing;

414.9 ~~(6) the CCBHC daily bundled rate under this section does not apply to services rendered~~
414.10 ~~by CCBHCs to individuals who are dually eligible for Medicare and medical assistance~~
414.11 ~~when Medicare is the primary payer for the service. An entity that receives a CCBHC daily~~
414.12 ~~bundled rate system that overlaps with the CCBHC rate is not eligible for the CCBHC rate~~
414.13 if the commissioner has not reentered the CCBHC demonstration program by July 1, 2023,
414.14 CCBHCs shall be paid the daily bundled rate under this section for services rendered to
414.15 individuals who are duly eligible for Medicare and medical assistance;

414.16 (7) payments for CCBHC services to individuals enrolled in managed care shall be
414.17 coordinated with the state's phase-out of CCBHC wrap payments. The commissioner shall
414.18 complete the phase-out of CCBHC wrap payments within 60 days of the implementation
414.19 of the CCBHC daily bundled rate system in the Medicaid Management Information System
414.20 (MMIS), for CCBHCs reimbursed under this chapter, with a final settlement of payments
414.21 due made payable to CCBHCs no later than 18 months thereafter;

414.22 (8) the CCBHC daily bundled rate for each CCBHC shall be updated by trending each
414.23 provider-specific rate by the Medicare Economic Index for primary care services. This
414.24 update shall occur each year in between rebasing periods determined by the commissioner
414.25 in accordance with clause (4). CCBHCs must provide data on costs and visits to the state
414.26 annually using the CCBHC cost report established by the commissioner; and

414.27 (9) a CCBHC may request a rate adjustment for changes in the CCBHC's scope of
414.28 services when such changes are expected to result in an adjustment to the CCBHC payment
414.29 rate by 2.5 percent or more. The CCBHC must provide the commissioner with information
414.30 regarding the changes in the scope of services, including the estimated cost of providing
414.31 the new or modified services and any projected increase or decrease in the number of visits
414.32 resulting from the change. Estimated costs are subject to review by the commissioner. Rate
414.33 adjustments for changes in scope shall occur no more than once per year in between rebasing
414.34 periods per CCBHC and are effective on the date of the annual CCBHC rate update.

415.1 (d) Managed care plans and county-based purchasing plans shall reimburse CCBHC
415.2 providers at the CCBHC daily bundled rate. The commissioner shall monitor the effect of
415.3 this requirement on the rate of access to the services delivered by CCBHC providers. If, for
415.4 any contract year, federal approval is not received for this paragraph, the commissioner
415.5 must adjust the capitation rates paid to managed care plans and county-based purchasing
415.6 plans for that contract year to reflect the removal of this provision. Contracts between
415.7 managed care plans and county-based purchasing plans and providers to whom this paragraph
415.8 applies must allow recovery of payments from those providers if capitation rates are adjusted
415.9 in accordance with this paragraph. Payment recoveries must not exceed the amount equal
415.10 to any increase in rates that results from this provision. This paragraph expires if federal
415.11 approval is not received for this paragraph at any time.

415.12 (e) The commissioner shall implement a quality incentive payment program for CCBHCs
415.13 that meets the following requirements:

415.14 (1) a CCBHC shall receive a quality incentive payment upon meeting specific numeric
415.15 thresholds for performance metrics established by the commissioner, in addition to payments
415.16 for which the CCBHC is eligible under the CCBHC daily bundled rate system described in
415.17 paragraph (c);

415.18 (2) a CCBHC must be certified and enrolled as a CCBHC for the entire measurement
415.19 year to be eligible for incentive payments;

415.20 (3) each CCBHC shall receive written notice of the criteria that must be met in order to
415.21 receive quality incentive payments at least 90 days prior to the measurement year; and

415.22 (4) a CCBHC must provide the commissioner with data needed to determine incentive
415.23 payment eligibility within six months following the measurement year. The commissioner
415.24 shall notify CCBHC providers of their performance on the required measures and the
415.25 incentive payment amount within 12 months following the measurement year.

415.26 (f) All claims to managed care plans for CCBHC services as provided under this section
415.27 shall be submitted directly to, and paid by, the commissioner on the dates specified no later
415.28 than January 1 of the following calendar year, if:

415.29 (1) one or more managed care plans does not comply with the federal requirement for
415.30 payment of clean claims to CCBHCs, as defined in Code of Federal Regulations, title 42,
415.31 section 447.45(b), and the managed care plan does not resolve the payment issue within 30
415.32 days of noncompliance; and

416.1 (2) the total amount of clean claims not paid in accordance with federal requirements
416.2 by one or more managed care plans is 50 percent of, or greater than, the total CCBHC claims
416.3 eligible for payment by managed care plans.

416.4 If the conditions in this paragraph are met between January 1 and June 30 of a calendar
416.5 year, claims shall be submitted to and paid by the commissioner beginning on January 1 of
416.6 the following year. If the conditions in this paragraph are met between July 1 and December
416.7 31 of a calendar year, claims shall be submitted to and paid by the commissioner beginning
416.8 on July 1 of the following year.

416.9 (g) Peer services provided by a CCBHC certified under section 245.735 are a covered
416.10 service under medical assistance when a licensed mental health professional or alcohol and
416.11 drug counselor determines that peer services are medically necessary. Eligibility under this
416.12 subdivision for peer services provided by a CCBHC supersede eligibility standards under
416.13 sections 256B.0615, 256B.0616, and 245G. 07, subdivision 2, clause (8).

416.14 **EFFECTIVE DATE.** This section is effective July 1, 2023, or upon federal approval,
416.15 whichever is later. The commissioner of human services shall inform the revisor of statutes
416.16 when federal approval is obtained.

416.17 Sec. 56. Minnesota Statutes 2022, section 256B.0941, is amended by adding a subdivision
416.18 to read:

416.19 Subd. 2b. **Shared site.** Related services that have a bright-line separation from psychiatric
416.20 residential treatment facility service operations may be delivered in the same facility,
416.21 including under the same structural roof. In shared site settings, staff must provide services
416.22 only to programs they are affiliated to through NETStudy 2.0.

416.23 Sec. 57. Minnesota Statutes 2022, section 256B.0941, is amended by adding a subdivision
416.24 to read:

416.25 Subd. 5. **Start-up and capacity-building grants.** (a) The commissioner shall establish
416.26 start-up and capacity-building grants for psychiatric residential treatment facility sites.
416.27 Start-up grants to prospective psychiatric residential treatment facility sites may be used
416.28 for:

416.29 (1) administrative expenses;

416.30 (2) consulting services;

416.31 (3) Health Insurance Portability and Accountability Act of 1996 compliance;

417.1 (4) therapeutic resources, including evidence-based, culturally appropriate curriculums
417.2 and training programs for staff and clients;

417.3 (5) allowable physical renovations to the property; and

417.4 (6) emergency workforce shortage uses, as determined by the commissioner.

417.5 (b) Start-up and capacity-building grants to prospective and current psychiatric residential
417.6 treatment facilities may be used to support providers who treat and accept individuals with
417.7 complex support needs, including but not limited to:

417.8 (1) neurocognitive disorders;

417.9 (2) co-occurring intellectual developmental disabilities;

417.10 (3) schizophrenia spectrum disorders;

417.11 (4) manifested or labeled aggressive behaviors; and

417.12 (5) manifested sexually inappropriate behaviors.

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

417.14 Sec. 58. Minnesota Statutes 2022, section 256B.0947, is amended by adding a subdivision
417.15 to read:

417.16 Subd. 10. **Young adult continuity of care.** A client who received services under this
417.17 section or section 256B.0946 and aged out of eligibility may continue to receive services
417.18 from the same providers under this section until the client is 27 years old.

417.19 Sec. 59. Minnesota Statutes 2022, section 256B.69, subdivision 5a, is amended to read:

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

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

417.29 (c) The commissioner shall withhold five percent of managed care plan payments under
417.30 this section and county-based purchasing plan payments under section 256B.692 for the

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

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

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

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

418.31 (e) Effective for services rendered on or after January 1, 2012, the commissioner shall
418.32 include as part of the performance targets described in paragraph (c) a reduction in the health
418.33 plan's emergency department utilization rate for medical assistance and MinnesotaCare
418.34 enrollees, as determined by the commissioner. For 2012, the reduction shall be based on
418.35 the health plan's utilization in 2009. To earn the return of the withhold each subsequent

419.1 year, the managed care plan or county-based purchasing plan must achieve a qualifying
419.2 reduction of no less than ten percent of the plan's emergency department utilization rate for
419.3 medical assistance and MinnesotaCare enrollees, excluding enrollees in programs described
419.4 in subdivisions 23 and 28, compared to the previous measurement year until the final
419.5 performance target is reached. When measuring performance, the commissioner must
419.6 consider the difference in health risk in a managed care or county-based purchasing plan's
419.7 membership in the baseline year compared to the measurement year, and work with the
419.8 managed care or county-based purchasing plan to account for differences that they agree
419.9 are significant.

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

419.16 The withhold described in this paragraph shall continue for each consecutive contract
419.17 period until the plan's emergency room utilization rate for state health care program enrollees
419.18 is reduced by 25 percent of the plan's emergency room utilization rate for medical assistance
419.19 and MinnesotaCare enrollees for calendar year 2009. Hospitals shall cooperate with the
419.20 health plans in meeting this performance target and shall accept payment withholds that
419.21 may be returned to the hospitals if the performance target is achieved.

419.22 (f) Effective for services rendered on or after January 1, 2012, the commissioner shall
419.23 include as part of the performance targets described in paragraph (c) a reduction in the plan's
419.24 hospitalization admission rate for medical assistance and MinnesotaCare enrollees, as
419.25 determined by the commissioner. To earn the return of the withhold each year, the managed
419.26 care plan or county-based purchasing plan must achieve a qualifying reduction of no less
419.27 than five percent of the plan's hospital admission rate for medical assistance and
419.28 MinnesotaCare enrollees, excluding enrollees in programs described in subdivisions 23 and
419.29 28, compared to the previous calendar year until the final performance target is reached.
419.30 When measuring performance, the commissioner must consider the difference in health risk
419.31 in a managed care or county-based purchasing plan's membership in the baseline year
419.32 compared to the measurement year, and work with the managed care or county-based
419.33 purchasing plan to account for differences that they agree are significant.

419.34 The withheld funds must be returned no sooner than July 1 and no later than July 31 of
419.35 the following calendar year if the managed care plan or county-based purchasing plan

420.1 demonstrates to the satisfaction of the commissioner that this reduction in the hospitalization
420.2 rate was achieved. The commissioner shall structure the withhold so that the commissioner
420.3 returns a portion of the withheld funds in amounts commensurate with achieved reductions
420.4 in utilization less than the targeted amount.

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

420.12 (g) Effective for services rendered on or after January 1, 2012, the commissioner shall
420.13 include as part of the performance targets described in paragraph (c) a reduction in the plan's
420.14 hospitalization admission rates for subsequent hospitalizations within 30 days of a previous
420.15 hospitalization of a patient regardless of the reason, for medical assistance and MinnesotaCare
420.16 enrollees, as determined by the commissioner. To earn the return of the withhold each year,
420.17 the managed care plan or county-based purchasing plan must achieve a qualifying reduction
420.18 of the subsequent hospitalization rate for medical assistance and MinnesotaCare enrollees,
420.19 excluding enrollees in programs described in subdivisions 23 and 28, of no less than five
420.20 percent compared to the previous calendar year until the final performance target is reached.

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

420.27 The withhold described in this paragraph must continue for each consecutive contract
420.28 period until the plan's subsequent hospitalization rate for medical assistance and
420.29 MinnesotaCare enrollees, excluding enrollees in programs described in subdivisions 23 and
420.30 28, is reduced by 25 percent of the plan's subsequent hospitalization rate for calendar year
420.31 2011. Hospitals shall cooperate with the plans in meeting this performance target and shall
420.32 accept payment withholds that must be returned to the hospitals if the performance target
420.33 is achieved.

421.1 (h) Effective for services rendered on or after January 1, 2013, through December 31,
421.2 2013, the commissioner shall withhold 4.5 percent of managed care plan payments under
421.3 this section and county-based purchasing plan payments under section 256B.692 for the
421.4 prepaid medical assistance program. The withheld funds must be returned no sooner than
421.5 July 1 and no later than July 31 of the following year. The commissioner may exclude
421.6 special demonstration projects under subdivision 23.

421.7 (i) Effective for services rendered on or after January 1, 2014, the commissioner shall
421.8 withhold three percent of managed care plan payments under this section and county-based
421.9 purchasing plan payments under section 256B.692 for the prepaid medical assistance
421.10 program. The withheld funds must be returned no sooner than July 1 and no later than July
421.11 31 of the following year. The commissioner may exclude special demonstration projects
421.12 under subdivision 23.

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

421.16 (k) Contracts between the commissioner and a prepaid health plan are exempt from the
421.17 set-aside and preference provisions of section 16C.16, subdivisions 6, paragraph (a), and
421.18 7.

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

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

421.32 (n) Effective for services rendered on or after January 1, 2024, the commissioner shall
421.33 require, as part of a contract, that all managed care plans use timely claim filing timelines
421.34 of 12 months and use remittance advice and prior authorizations timelines consistent with

422.1 those used under medical assistance fee-for-service for mental health and substance use
422.2 disorder treatment services. A managed care plan under this section may not take back funds
422.3 the managed care plan paid to a mental health and substance use disorder treatment provider
422.4 once six months have elapsed from the date the funds were paid.

422.5 Sec. 60. Minnesota Statutes 2022, section 260C.007, subdivision 26d, is amended to read:

422.6 Subd. 26d. **Qualified residential treatment program.** "Qualified residential treatment
422.7 program" means a children's residential treatment program licensed under chapter 245A or
422.8 licensed or approved by a tribe that is approved to receive foster care maintenance payments
422.9 under section 256.82 that:

422.10 (1) has a trauma-informed treatment model designed to address the needs of children
422.11 with serious emotional or behavioral disorders or disturbances;

422.12 (2) has registered or licensed nursing staff and other licensed clinical staff who:

422.13 (i) provide care within the scope of their practice; and

422.14 (ii) are available 24 hours per day and seven days per week;

422.15 (3) is accredited by any of the following independent, nonprofit organizations: the
422.16 Commission on Accreditation of Rehabilitation Facilities (CARF), the Joint Commission
422.17 on Accreditation of Healthcare Organizations (JCAHO), and the Council on Accreditation
422.18 (COA), or any other nonprofit accrediting organization approved by the United States
422.19 Department of Health and Human Services;

422.20 (4) if it is in the child's best interests, facilitates participation of the child's family members
422.21 in the child's treatment programming consistent with the child's out-of-home placement
422.22 plan under sections 260C.212, subdivision 1, and 260C.708;

422.23 (5) facilitates outreach to family members of the child, including siblings;

422.24 (6) documents how the facility facilitates outreach to the child's parents and relatives,
422.25 as well as documents the child's parents' and other relatives' contact information;

422.26 (7) documents how the facility includes family members in the child's treatment process,
422.27 including after the child's discharge, and how the facility maintains the child's sibling
422.28 connections; and

422.29 (8) provides the child and child's family with discharge planning and family-based
422.30 aftercare support for at least six months after the child's discharge. Aftercare support may
422.31 include mental health certified family and youth peer specialist services, as defined under
422.32 section 256B.0616.

423.1 **Sec. 61. LOCAL AGENCY SUBSTANCE USE DISORDER ALLOCATION.**

423.2 The commissioner of human services shall evaluate the ongoing need for local agency
423.3 substance use disorder allocations under Minnesota Statutes, section 254B.02. The evaluation
423.4 must include recommendations on whether local agency allocations should continue, and
423.5 if so, the commissioner must recommend what the purpose of the allocations should be and
423.6 propose an updated allocation methodology that aligns with the purpose and person-centered
423.7 outcomes for people experiencing substance use disorders and behavioral health conditions.
423.8 The commissioner may contract with a vendor to support this evaluation through research
423.9 and actuarial analysis.

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

423.11 **Sec. 62. RATE INCREASE FOR MENTAL HEALTH ADULT DAY TREATMENT.**

423.12 The commissioner of human services must increase the reimbursement rate for adult
423.13 day treatment under Minnesota Statutes, section 256B.0671, subdivision 3, by 50 percent
423.14 over the reimbursement rate in effect as of June 30, 2023.

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

423.18 **Sec. 63. ROOM AND BOARD COSTS IN CHILDREN'S RESIDENTIAL**
423.19 **FACILITIES.**

423.20 The commissioner of human services must update the behavioral health fund room and
423.21 board rate schedule to include services provided under Minnesota Statutes, section 245.4882,
423.22 for individuals who do not have a placement under Minnesota Statutes, chapter 260C or
423.23 260D. The commissioner must establish room and board rates commensurate with current
423.24 room and board rates for adolescent programs licensed under Minnesota Statutes, section
423.25 245G.18.

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

423.27 **Sec. 64. DIRECTION TO THE COMMISSIONER; EARLY INTERVENTION AND**
423.28 **PREVENTION SERVICES.**

423.29 The commissioner of human services must make the International Classification of
423.30 Diseases, Tenth Revision V and Z codes available to medical assistance and MinnesotaCare
423.31 enrolled professionals to provide early intervention and prevention services. Services must

424.1 be delivered under the supervision of a mental health professional, as defined in Minnesota
 424.2 Statutes, section 245I.02, subdivision 27, and must only be provided for a period of up to
 424.3 six months after the first contact with a client who is enrolled in medical assistance or
 424.4 MinnesotaCare.

424.5 **ARTICLE 8**

424.6 **DEPARTMENT OF HUMAN SERVICES POLICY**

424.7 Section 1. Minnesota Statutes 2022, section 245.4661, subdivision 9, is amended to read:

424.8 **Subd. 9. Services and programs.** (a) The following three distinct grant programs are
 424.9 funded under this section:

424.10 (1) mental health crisis services;

424.11 (2) housing with supports for adults with serious mental illness; and

424.12 (3) projects for assistance in transitioning from homelessness (PATH program).

424.13 (b) In addition, the following are eligible for grant funds:

424.14 (1) community education and prevention;

424.15 (2) client outreach;

424.16 (3) early identification and intervention;

424.17 (4) adult outpatient diagnostic assessment and psychological testing;

424.18 (5) peer support services;

424.19 (6) community support program services (CSP);

424.20 (7) adult residential crisis stabilization;

424.21 (8) supported employment;

424.22 (9) assertive community treatment (ACT);

424.23 (10) housing subsidies;

424.24 (11) basic living, social skills, and community intervention;

424.25 (12) emergency response services;

424.26 (13) adult outpatient psychotherapy;

424.27 (14) adult outpatient medication management;

424.28 (15) adult mobile crisis services;

- 425.1 (16) adult day treatment;
- 425.2 (17) partial hospitalization;
- 425.3 (18) adult residential treatment;
- 425.4 (19) adult mental health targeted case management; and
- 425.5 ~~(20) intensive community rehabilitative services (ICRS); and~~
- 425.6 ~~(21)~~ (20) transportation.

425.7 Sec. 2. Minnesota Statutes 2022, section 245.469, subdivision 3, is amended to read:

425.8 Subd. 3. **Mental health crisis services.** The commissioner of human services shall

425.9 increase access to mental health crisis services for children and adults. In order to increase

425.10 access, the commissioner must:

- 425.11 (1) develop a central phone number where calls can be routed to the appropriate crisis
- 425.12 services;
- 425.13 (2) provide telephone consultation 24 hours a day to mobile crisis teams who are serving
- 425.14 people with traumatic brain injury or intellectual disabilities who are experiencing a mental
- 425.15 health crisis;
- 425.16 (3) expand crisis services across the state, including rural areas of the state and examining
- 425.17 access per population;
- 425.18 (4) establish and implement state standards and requirements for crisis services as outlined
- 425.19 in section 256B.0624; and
- 425.20 (5) provide grants to adult mental health initiatives, counties, tribes, or community mental
- 425.21 health providers to establish new mental health crisis residential service capacity.
- 425.22 Priority will be given to regions that do not have a mental health crisis residential services
- 425.23 program, do not have an inpatient psychiatric unit within the region, do not have an inpatient
- 425.24 psychiatric unit within 90 miles, or have a demonstrated need based on the number of crisis
- 425.25 residential or intensive residential treatment beds available to meet the needs of the residents
- 425.26 in the region. At least 50 percent of the funds must be distributed to programs in rural
- 425.27 Minnesota. Grant funds may be used for start-up costs, including but not limited to
- 425.28 renovations, furnishings, and staff training. Grant applications shall provide details on how
- 425.29 the intended service will address identified needs and shall demonstrate collaboration with
- 425.30 crisis teams, other mental health providers, hospitals, and police.

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

- 439.1 (5) inform a person that the person may submit the application before an interview;
- 439.2 (6) explain the information that will be verified during the application process by the
- 439.3 county agency as provided in section 256J.32;
- 439.4 (7) inform a person about the county agency's average application processing time and
- 439.5 explain how the application will be processed under subdivision 5;
- 439.6 (8) explain how to contact the county agency if a person's application information changes
- 439.7 and how to withdraw the application;
- 439.8 (9) inform a person that the next step in the application process is an interview and what
- 439.9 a person must do if the application is approved including, but not limited to, attending
- 439.10 orientation under section 256J.45 and complying with employment and training services
- 439.11 requirements in sections 256J.515 to 256J.57;
- 439.12 (10) inform the person that an interview must be conducted. The interview may be
- 439.13 conducted face-to-face in the county office or at a location mutually agreed upon, through
- 439.14 Internet telepresence, or by telephone;
- 439.15 (11) explain the child care and transportation services that are available under paragraph
- 439.16 (c) to enable caregivers to attend the interview, screening, and orientation; and
- 439.17 (12) identify any language barriers and arrange for translation assistance during
- 439.18 appointments, including, but not limited to, screening under subdivision 3a, orientation
- 439.19 under section 256J.45, and assessment under section 256J.521.
- 439.20 (b) Upon receipt of a signed application, the county agency must stamp the date of receipt
- 439.21 on the face of the application. The county agency must process the application within the
- 439.22 time period required under subdivision 5. An applicant may withdraw the application at
- 439.23 any time by giving written or oral notice to the county agency. The county agency must
- 439.24 issue a written notice confirming the withdrawal. The notice must inform the applicant of
- 439.25 the county agency's understanding that the applicant has withdrawn the application and no
- 439.26 longer wants to pursue it. When, within ten days of the date of the agency's notice, an
- 439.27 applicant informs a county agency, in writing, that the applicant does not wish to withdraw
- 439.28 the application, the county agency must reinstate the application and finish processing the
- 439.29 application.
- 439.30 (c) Upon a participant's request, the county agency must arrange for transportation and
- 439.31 child care or reimburse the participant for transportation and child care expenses necessary
- 439.32 to enable participants to attend the screening under subdivision 3a and orientation under
- 439.33 section 256J.45.

443.1 (3) the individual designated as the compliance officer under section 256B.04, subdivision
443.2 21, paragraph (g);

443.3 (4) each managerial official whose responsibilities include the direction of the
443.4 management or policies of a program; ~~and~~

443.5 (5) the individual designated as the primary provider of care for a special family child
443.6 care program under section 245A.14, subdivision 4, paragraph (i); and

443.7 (6) the president and treasurer of the board of directors of a nonprofit corporation.

443.8 (b) Controlling individual does not include:

443.9 (1) a bank, savings bank, trust company, savings association, credit union, industrial
443.10 loan and thrift company, investment banking firm, or insurance company unless the entity
443.11 operates a program directly or through a subsidiary;

443.12 (2) an individual who is a state or federal official, or state or federal employee, or a
443.13 member or employee of the governing body of a political subdivision of the state or federal
443.14 government that operates one or more programs, unless the individual is also an officer,
443.15 owner, or managerial official of the program, receives remuneration from the program, or
443.16 owns any of the beneficial interests not excluded in this subdivision;

443.17 (3) an individual who owns less than five percent of the outstanding common shares of
443.18 a corporation:

443.19 (i) whose securities are exempt under section 80A.45, clause (6); or

443.20 (ii) whose transactions are exempt under section 80A.46, clause (2);

443.21 (4) an individual who is a member of an organization exempt from taxation under section
443.22 290.05, unless the individual is also an officer, owner, or managerial official of the program
443.23 or owns any of the beneficial interests not excluded in this subdivision. This clause does
443.24 not exclude from the definition of controlling individual an organization that is exempt from
443.25 taxation; or

443.26 (5) an employee stock ownership plan trust, or a participant or board member of an
443.27 employee stock ownership plan, unless the participant or board member is a controlling
443.28 individual according to paragraph (a).

443.29 (c) For purposes of this subdivision, "managerial official" means an individual who has
443.30 the decision-making authority related to the operation of the program, and the responsibility
443.31 for the ongoing management of or direction of the policies, services, or employees of the

451.1 actions or failure to comply with applicable law or rule poses, or the actions of other
451.2 individuals or conditions in the program poses an imminent risk of harm to the health, safety,
451.3 or rights of persons served by the program. "Reasonable cause" means there exist specific
451.4 articulable facts or circumstances which provide the commissioner with a reasonable
451.5 suspicion that there is an imminent risk of harm to the health, safety, or rights of persons
451.6 served by the program. When the commissioner has determined there is reasonable cause
451.7 to order the temporary immediate suspension of a license based on a violation of safe sleep
451.8 requirements, as defined in section 245A.1435, the commissioner is not required to
451.9 demonstrate that an infant died or was injured as a result of the safe sleep violations. For
451.10 suspensions under subdivision 2, paragraph (a), clause (2), the burden of proof in expedited
451.11 hearings under this subdivision shall be limited to the commissioner's demonstration by a
451.12 preponderance of the evidence that, since the license was revoked, the license holder
451.13 committed additional violations of law or rule which may adversely affect the health or
451.14 safety of persons served by the program.

451.15 (b) The administrative law judge shall issue findings of fact, conclusions, and a
451.16 recommendation within ten working days from the date of hearing. The parties shall have
451.17 ten calendar days to submit exceptions to the administrative law judge's report. The record
451.18 shall close at the end of the ten-day period for submission of exceptions. The commissioner's
451.19 final order shall be issued within ten working days from the close of the record. When an
451.20 appeal of a temporary immediate suspension is withdrawn or dismissed, the commissioner
451.21 shall issue a final order affirming the temporary immediate suspension within ten calendar
451.22 days of the commissioner's receipt of the withdrawal or dismissal. Within 90 calendar days
451.23 after an immediate suspension has been issued and the license holder has not submitted a
451.24 timely appeal under subdivision 2, paragraph (b), or within 90 calendar days after a final
451.25 order affirming an immediate suspension, the commissioner shall ~~make a determination~~
451.26 regarding determine:

451.27 (1) whether a final licensing sanction shall be issued under subdivision 3, paragraph (a),
451.28 clauses (1) to (5). The license holder shall continue to be prohibited from operation of the
451.29 program during this 90-day period; or

451.30 (2) whether the outcome of related, ongoing investigations or judicial proceedings are
451.31 necessary to determine if a final licensing sanction under subdivision 3, paragraph (a),
451.32 clauses (1) to (5), will be issued, and persons served by the program remain at an imminent
451.33 risk of harm during the investigation period or proceedings. If so, the commissioner shall
451.34 issue a suspension order under subdivision 3, paragraph (a), clause (6).

452.1 (c) When the final order under paragraph (b) affirms an immediate suspension or the
452.2 license holder does not submit a timely appeal of the immediate suspension, and a final
452.3 licensing sanction is issued under subdivision 3 and the license holder appeals that sanction,
452.4 the license holder continues to be prohibited from operation of the program pending a final
452.5 commissioner's order under section 245A.08, subdivision 5, regarding the final licensing
452.6 sanction.

452.7 (d) The license holder shall continue to be prohibited from operation of the program
452.8 while a suspension order issued under paragraph (b), clause (2), remains in effect.

452.9 ~~(d)~~ (e) For suspensions under subdivision 2, paragraph (a), clause (3), the burden of
452.10 proof in expedited hearings under this subdivision shall be limited to the commissioner's
452.11 demonstration by a preponderance of the evidence that a criminal complaint and warrant
452.12 or summons was issued for the license holder that was not dismissed, and that the criminal
452.13 charge is an offense that involves fraud or theft against a program administered by the
452.14 commissioner.

452.15 Sec. 9. Minnesota Statutes 2022, section 245A.07, subdivision 3, is amended to read:

452.16 Subd. 3. **License suspension, revocation, or fine.** (a) The commissioner may suspend
452.17 or revoke a license, or impose a fine if:

452.18 (1) a license holder fails to comply fully with applicable laws or rules including but not
452.19 limited to the requirements of this chapter and chapter 245C;

452.20 (2) a license holder, a controlling individual, or an individual living in the household
452.21 where the licensed services are provided or is otherwise subject to a background study has
452.22 been disqualified and the disqualification was not set aside and no variance has been granted;

452.23 (3) a license holder knowingly withholds relevant information from or gives false or
452.24 misleading information to the commissioner in connection with an application for a license,
452.25 in connection with the background study status of an individual, during an investigation,
452.26 or regarding compliance with applicable laws or rules;

452.27 (4) a license holder is excluded from any program administered by the commissioner
452.28 under section 245.095; ~~or~~

452.29 (5) revocation is required under section 245A.04, subdivision 7, paragraph (d); or

452.30 (6) suspension is necessary under subdivision 2a, paragraph (b), clause (2).

452.31 A license holder who has had a license issued under this chapter suspended, revoked,
452.32 or has been ordered to pay a fine must be given notice of the action by certified mail or

453.1 personal service. If mailed, the notice must be mailed to the address shown on the application
453.2 or the last known address of the license holder. The notice must state in plain language the
453.3 reasons the license was suspended or revoked, or a fine was ordered.

453.4 (b) If the license was suspended or revoked, the notice must inform the license holder
453.5 of the right to a contested case hearing under chapter 14 and Minnesota Rules, parts
453.6 1400.8505 to 1400.8612. The license holder may appeal an order suspending or revoking
453.7 a license. The appeal of an order suspending or revoking a license must be made in writing
453.8 by certified mail or personal service. If mailed, the appeal must be postmarked and sent to
453.9 the commissioner within ten calendar days after the license holder receives notice that the
453.10 license has been suspended or revoked. If a request is made by personal service, it must be
453.11 received by the commissioner within ten calendar days after the license holder received the
453.12 order. Except as provided in subdivision 2a, paragraph (c), if a license holder submits a
453.13 timely appeal of an order suspending or revoking a license, the license holder may continue
453.14 to operate the program as provided in section 245A.04, subdivision 7, paragraphs (f) and
453.15 (g), until the commissioner issues a final order on the suspension or revocation.

453.16 (c)(1) If the license holder was ordered to pay a fine, the notice must inform the license
453.17 holder of the responsibility for payment of fines and the right to a contested case hearing
453.18 under chapter 14 and Minnesota Rules, parts 1400.8505 to 1400.8612. The appeal of an
453.19 order to pay a fine must be made in writing by certified mail or personal service. If mailed,
453.20 the appeal must be postmarked and sent to the commissioner within ten calendar days after
453.21 the license holder receives notice that the fine has been ordered. If a request is made by
453.22 personal service, it must be received by the commissioner within ten calendar days after
453.23 the license holder received the order.

453.24 (2) The license holder shall pay the fines assessed on or before the payment date specified.
453.25 If the license holder fails to fully comply with the order, the commissioner may issue a
453.26 second fine or suspend the license until the license holder complies. If the license holder
453.27 receives state funds, the state, county, or municipal agencies or departments responsible for
453.28 administering the funds shall withhold payments and recover any payments made while the
453.29 license is suspended for failure to pay a fine. A timely appeal shall stay payment of the fine
453.30 until the commissioner issues a final order.

453.31 (3) A license holder shall promptly notify the commissioner of human services, in writing,
453.32 when a violation specified in the order to forfeit a fine is corrected. If upon reinspection the
453.33 commissioner determines that a violation has not been corrected as indicated by the order
453.34 to forfeit a fine, the commissioner may issue a second fine. The commissioner shall notify

454.1 the license holder by certified mail or personal service that a second fine has been assessed.

454.2 The license holder may appeal the second fine as provided under this subdivision.

454.3 (4) Fines shall be assessed as follows:

454.4 (i) the license holder shall forfeit \$1,000 for each determination of maltreatment of a
454.5 child under chapter 260E or the maltreatment of a vulnerable adult under section 626.557
454.6 for which the license holder is determined responsible for the maltreatment under section
454.7 260E.30, subdivision 4, paragraphs (a) and (b), or 626.557, subdivision 9c, paragraph (c);

454.8 (ii) if the commissioner determines that a determination of maltreatment for which the
454.9 license holder is responsible is the result of maltreatment that meets the definition of serious
454.10 maltreatment as defined in section 245C.02, subdivision 18, the license holder shall forfeit
454.11 \$5,000;

454.12 (iii) for a program that operates out of the license holder's home and a program licensed
454.13 under Minnesota Rules, parts 9502.0300 to 9502.0445, the fine assessed against the license
454.14 holder shall not exceed \$1,000 for each determination of maltreatment;

454.15 (iv) the license holder shall forfeit \$200 for each occurrence of a violation of law or rule
454.16 governing matters of health, safety, or supervision, including but not limited to the provision
454.17 of adequate staff-to-child or adult ratios, and failure to comply with background study
454.18 requirements under chapter 245C; and

454.19 (v) the license holder shall forfeit \$100 for each occurrence of a violation of law or rule
454.20 other than those subject to a \$5,000, \$1,000, or \$200 fine in items (i) to (iv).

454.21 For purposes of this section, "occurrence" means each violation identified in the
454.22 commissioner's fine order. Fines assessed against a license holder that holds a license to
454.23 provide home and community-based services, as identified in section 245D.03, subdivision
454.24 1, and a community residential setting or day services facility license under chapter 245D
454.25 where the services are provided, may be assessed against both licenses for the same
454.26 occurrence, but the combined amount of the fines shall not exceed the amount specified in
454.27 this clause for that occurrence.

454.28 (5) When a fine has been assessed, the license holder may not avoid payment by closing,
454.29 selling, or otherwise transferring the licensed program to a third party. In such an event, the
454.30 license holder will be personally liable for payment. In the case of a corporation, each
454.31 controlling individual is personally and jointly liable for payment.

454.32 (d) Except for background study violations involving the failure to comply with an order
454.33 to immediately remove an individual or an order to provide continuous, direct supervision,

455.1 the commissioner shall not issue a fine under paragraph (c) relating to a background study
455.2 violation to a license holder who self-corrects a background study violation before the
455.3 commissioner discovers the violation. A license holder who has previously exercised the
455.4 provisions of this paragraph to avoid a fine for a background study violation may not avoid
455.5 a fine for a subsequent background study violation unless at least 365 days have passed
455.6 since the license holder self-corrected the earlier background study violation.

455.7 Sec. 10. Minnesota Statutes 2022, section 245A.10, subdivision 3, is amended to read:

455.8 Subd. 3. **Application fee for initial license or certification.** (a) For fees required under
455.9 subdivision 1, an applicant for an initial license or certification issued by the commissioner
455.10 shall submit a \$500 application fee with each new application required under this subdivision.
455.11 An applicant for an initial day services facility license under chapter 245D shall submit a
455.12 \$250 application fee with each new application. The application fee shall not be prorated,
455.13 is nonrefundable, and is in lieu of the annual license or certification fee that expires on
455.14 December 31. The commissioner shall not process an application until the application fee
455.15 is paid.

455.16 (b) Except as provided in clauses (1) ~~to (3)~~ and (2), an applicant shall apply for a license
455.17 to provide services at a specific location.

455.18 (1) For a license to provide home and community-based services to persons with
455.19 disabilities or age 65 and older under chapter 245D, an applicant shall submit an application
455.20 to provide services statewide. Notwithstanding paragraph (a), applications received by the
455.21 commissioner between July 1, 2013, and December 31, 2013, for licensure of services
455.22 provided under chapter 245D must include an application fee that is equal to the annual
455.23 license renewal fee under subdivision 4, paragraph (b), or \$500, whichever is less.
455.24 Applications received by the commissioner after January 1, 2014, must include the application
455.25 fee required under paragraph (a). Applicants who meet the modified application criteria
455.26 identified in section 245A.042, subdivision 2, are exempt from paying an application fee.

455.27 ~~(2) For a license to provide independent living assistance for youth under section 245A.22,~~
455.28 ~~an applicant shall submit a single application to provide services statewide.~~

455.29 ~~(3)~~(2) For a license for a private agency to provide foster care or adoption services under
455.30 Minnesota Rules, parts 9545.0755 to 9545.0845, an applicant shall submit a single application
455.31 to provide services statewide.

455.32 (c) The initial application fee charged under this subdivision does not include the
455.33 temporary license surcharge under section 16E.22.

457.1	greater than \$300,000 but less than or	
457.2	equal to \$350,000	\$1,400
457.3	greater than \$350,000 but less than or	
457.4	equal to \$400,000	\$1,600
457.5	greater than \$400,000 but less than or	
457.6	equal to \$450,000	\$1,800
457.7	greater than \$450,000 but less than or	
457.8	equal to \$500,000	\$2,000
457.9	greater than \$500,000 but less than or	
457.10	equal to \$600,000	\$2,250
457.11	greater than \$600,000 but less than or	
457.12	equal to \$700,000	\$2,500
457.13	greater than \$700,000 but less than or	
457.14	equal to \$800,000	\$2,750
457.15	greater than \$800,000 but less than or	
457.16	equal to \$900,000	\$3,000
457.17	greater than \$900,000 but less than or	
457.18	equal to \$1,000,000	\$3,250
457.19	greater than \$1,000,000 but less than or	
457.20	equal to \$1,250,000	\$3,500
457.21	greater than \$1,250,000 but less than or	
457.22	equal to \$1,500,000	\$3,750
457.23	greater than \$1,500,000 but less than or	
457.24	equal to \$1,750,000	\$4,000
457.25	greater than \$1,750,000 but less than or	
457.26	equal to \$2,000,000	\$4,250
457.27	greater than \$2,000,000 but less than or	
457.28	equal to \$2,500,000	\$4,500
457.29	greater than \$2,500,000 but less than or	
457.30	equal to \$3,000,000	\$4,750
457.31	greater than \$3,000,000 but less than or	
457.32	equal to \$3,500,000	\$5,000
457.33	greater than \$3,500,000 but less than or	
457.34	equal to \$4,000,000	\$5,500
457.35	greater than \$4,000,000 but less than or	
457.36	equal to \$4,500,000	\$6,000
457.37	greater than \$4,500,000 but less than or	
457.38	equal to \$5,000,000	\$6,500
457.39	greater than \$5,000,000 but less than or	
457.40	equal to \$7,500,000	\$7,000
457.41	greater than \$7,500,000 but less than or	
457.42	equal to \$10,000,000	\$8,500
457.43	greater than \$10,000,000 but less than or	
457.44	equal to \$12,500,000	\$10,000

458.1	greater than \$12,500,000 but less than or	
458.2	equal to \$15,000,000	\$14,000
458.3	greater than \$15,000,000	\$18,000

458.4 (2) If requested, the license holder shall provide the commissioner information to verify
458.5 the license holder's annual revenues or other information as needed, including copies of
458.6 documents submitted to the Department of Revenue.

458.7 (3) At each annual renewal, a license holder may elect to pay the highest renewal fee,
458.8 and not provide annual revenue information to the commissioner.

458.9 (4) A license holder that knowingly provides the commissioner incorrect revenue amounts
458.10 for the purpose of paying a lower license fee shall be subject to a civil penalty in the amount
458.11 of double the fee the provider should have paid.

458.12 (5) Notwithstanding clause (1), a license holder providing services under one or more
458.13 licenses under chapter 245B that are in effect on May 15, 2013, shall pay an annual license
458.14 fee for calendar years 2014, 2015, and 2016, equal to the total license fees paid by the license
458.15 holder for all licenses held under chapter 245B for calendar year 2013. For calendar year
458.16 2017 and thereafter, the license holder shall pay an annual license fee according to clause
458.17 (1).

458.18 (c) A substance use disorder treatment program licensed under chapter 245G, to provide
458.19 substance use disorder treatment shall pay an annual nonrefundable license fee based on
458.20 the following schedule:

458.21	Licensed Capacity	License Fee
458.22	1 to 24 persons	\$600
458.23	25 to 49 persons	\$800
458.24	50 to 74 persons	\$1,000
458.25	75 to 99 persons	\$1,200
458.26	100 or more persons	\$1,400

458.27 (d) A detoxification program licensed under Minnesota Rules, parts 9530.6510 to
458.28 9530.6590, or a withdrawal management program licensed under chapter 245F shall pay
458.29 an annual nonrefundable license fee based on the following schedule:

458.30	Licensed Capacity	License Fee
458.31	1 to 24 persons	\$760
458.32	25 to 49 persons	\$960
458.33	50 or more persons	\$1,160

459.1 A detoxification program that also operates a withdrawal management program at the same
 459.2 location shall only pay one fee based upon the licensed capacity of the program with the
 459.3 higher overall capacity.

459.4 (e) Except for child foster care, a residential facility licensed under Minnesota Rules,
 459.5 chapter 2960, to serve children shall pay an annual nonrefundable license fee based on the
 459.6 following schedule:

459.7	Licensed Capacity	License Fee
459.8	1 to 24 persons	\$1,000
459.9	25 to 49 persons	\$1,100
459.10	50 to 74 persons	\$1,200
459.11	75 to 99 persons	\$1,300
459.12	100 or more persons	\$1,400

459.13 (f) A residential facility licensed under section 245I.23 or Minnesota Rules, parts
 459.14 9520.0500 to 9520.0670, to serve persons with mental illness shall pay an annual
 459.15 nonrefundable license fee based on the following schedule:

459.16	Licensed Capacity	License Fee
459.17	1 to 24 persons	\$2,525
459.18	25 or more persons	\$2,725

459.19 (g) A residential facility licensed under Minnesota Rules, parts 9570.2000 to 9570.3400,
 459.20 to serve persons with physical disabilities shall pay an annual nonrefundable license fee
 459.21 based on the following schedule:

459.22	Licensed Capacity	License Fee
459.23	1 to 24 persons	\$450
459.24	25 to 49 persons	\$650
459.25	50 to 74 persons	\$850
459.26	75 to 99 persons	\$1,050
459.27	100 or more persons	\$1,250

459.28 ~~(h) A program licensed to provide independent living assistance for youth under section~~
 459.29 ~~245A.22 shall pay an annual nonrefundable license fee of \$1,500.~~

459.30 ~~(i)~~ (h) A private agency licensed to provide foster care and adoption services under
 459.31 Minnesota Rules, parts 9545.0755 to 9545.0845, shall pay an annual nonrefundable license
 459.32 fee of \$875.

460.1 ~~(j)~~ (i) A program licensed as an adult day care center licensed under Minnesota Rules,
 460.2 parts 9555.9600 to 9555.9730, shall pay an annual nonrefundable license fee based on the
 460.3 following schedule:

460.4	Licensed Capacity	License Fee
460.5	1 to 24 persons	\$500
460.6	25 to 49 persons	\$700
460.7	50 to 74 persons	\$900
460.8	75 to 99 persons	\$1,100
460.9	100 or more persons	\$1,300

460.10 ~~(k)~~ (j) A program licensed to provide treatment services to persons with sexual
 460.11 psychopathic personalities or sexually dangerous persons under Minnesota Rules, parts
 460.12 9515.3000 to 9515.3110, shall pay an annual nonrefundable license fee of \$20,000.

460.13 ~~(l)~~ (k) A mental health clinic certified under section 245I.20 shall pay an annual
 460.14 nonrefundable certification fee of \$1,550. If the mental health clinic provides services at a
 460.15 primary location with satellite facilities, the satellite facilities shall be certified with the
 460.16 primary location without an additional charge.

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

460.18 Sec. 12. Minnesota Statutes 2022, section 245A.16, subdivision 1, is amended to read:

460.19 Subdivision 1. **Delegation of authority to agencies.** (a) County agencies and private
 460.20 agencies that have been designated or licensed by the commissioner to perform licensing
 460.21 functions and activities under section 245A.04 ~~and background studies for family child care~~
 460.22 ~~under chapter 245C~~; to recommend denial of applicants under section 245A.05; to issue
 460.23 correction orders, to issue variances, and recommend a conditional license under section
 460.24 245A.06; or to recommend suspending or revoking a license or issuing a fine under section
 460.25 245A.07, shall comply with rules and directives of the commissioner governing those
 460.26 functions and with this section. The following variances are excluded from the delegation
 460.27 of variance authority and may be issued only by the commissioner:

- 460.28 (1) dual licensure of family child care and child foster care, dual licensure of child and
 460.29 adult foster care, and adult foster care and family child care;
- 460.30 (2) adult foster care maximum capacity;
- 460.31 (3) adult foster care minimum age requirement;
- 460.32 (4) child foster care maximum age requirement;

461.1 (5) variances regarding disqualified individuals ~~except that, before the implementation~~
461.2 ~~of NETStudy 2.0, county agencies may issue variances under section 245C.30 regarding~~
461.3 ~~disqualified individuals when the county is responsible for conducting a consolidated~~
461.4 ~~reconsideration according to sections 245C.25 and 245C.27, subdivision 2, clauses (a) and~~
461.5 ~~(b), of a county maltreatment determination and a disqualification based on serious or~~
461.6 ~~recurring maltreatment;~~

461.7 (6) the required presence of a caregiver in the adult foster care residence during normal
461.8 sleeping hours;

461.9 (7) variances to requirements relating to chemical use problems of a license holder or a
461.10 household member of a license holder; and

461.11 (8) variances to section 245A.53 for a time-limited period. If the commissioner grants
461.12 a variance under this clause, the license holder must provide notice of the variance to all
461.13 parents and guardians of the children in care.

461.14 Except as provided in section 245A.14, subdivision 4, paragraph (e), a county agency must
461.15 not grant a license holder a variance to exceed the maximum allowable family child care
461.16 license capacity of 14 children.

461.17 (b) A county agency that has been designated by the commissioner to issue family child
461.18 care variances must:

461.19 (1) publish the county agency's policies and criteria for issuing variances on the county's
461.20 public website and update the policies as necessary; and

461.21 (2) annually distribute the county agency's policies and criteria for issuing variances to
461.22 all family child care license holders in the county.

461.23 ~~(e) Before the implementation of NETStudy 2.0, county agencies must report information~~
461.24 ~~about disqualification reconsiderations under sections 245C.25 and 245C.27, subdivision~~
461.25 ~~2, paragraphs (a) and (b), and variances granted under paragraph (a), clause (5), to the~~
461.26 ~~commissioner at least monthly in a format prescribed by the commissioner.~~

461.27 ~~(d)~~ (c) For family child care programs, the commissioner shall require a county agency
461.28 to conduct one unannounced licensing review at least annually.

461.29 ~~(e)~~ (d) For family adult day services programs, the commissioner may authorize licensing
461.30 reviews every two years after a licensee has had at least one annual review.

461.31 ~~(f)~~ (e) A license issued under this section may be issued for up to two years.

461.32 ~~(g)~~ (f) During implementation of chapter 245D, the commissioner shall consider:

462.1 (1) the role of counties in quality assurance;

462.2 (2) the duties of county licensing staff; and

462.3 (3) the possible use of joint powers agreements, according to section 471.59, with counties
 462.4 through which some licensing duties under chapter 245D may be delegated by the
 462.5 commissioner to the counties.

462.6 Any consideration related to this paragraph must meet all of the requirements of the corrective
 462.7 action plan ordered by the federal Centers for Medicare and Medicaid Services.

462.8 ~~(h)~~ (g) Licensing authority specific to section 245D.06, subdivisions 5, 6, 7, and 8, or
 462.9 successor provisions; and section 245D.061 or successor provisions, for family child foster
 462.10 care programs providing out-of-home respite, as identified in section 245D.03, subdivision
 462.11 1, paragraph (b), clause (1), is excluded from the delegation of authority to county and
 462.12 private agencies.

462.13 ~~(h)~~ (h) A county agency shall report to the commissioner, in a manner prescribed by the
 462.14 commissioner, the following information for a licensed family child care program:

462.15 (1) the results of each licensing review completed, including the date of the review, and
 462.16 any licensing correction order issued;

462.17 (2) any death, serious injury, or determination of substantiated maltreatment; and

462.18 (3) any fires that require the service of a fire department within 48 hours of the fire. The
 462.19 information under this clause must also be reported to the state fire marshal within two
 462.20 business days of receiving notice from a licensed family child care provider.

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

462.22 Sec. 13. **[245A.211] PRONE RESTRAINT PROHIBITION.**

462.23 Subdivision 1. **Applicability.** This section applies to all programs licensed or certified
 462.24 under this chapter, chapters 245D, 245F, 245G, 245H, and sections 245I.20 and 245I.23.

462.25 The requirements in this section are in addition to any applicable requirements for the use
 462.26 of holds or restraints for each license or certification type.

462.27 Subd. 2. **Definitions.** (a) "Mechanical restraint" means a restraint device that limits the
 462.28 voluntary movement of a person or the person's limbs.

462.29 (b) "Prone restraint" means a restraint that places a person in a face-down position with
 462.30 the person's chest in contact with the floor or other surface.

463.1 (c) "Restraint" means a physical hold, physical restraint, manual restraint, restraint
463.2 equipment, or mechanical restraint that holds a person immobile or limits the voluntary
463.3 movement of a person or the person's limbs.

463.4 Subd. 3. **Prone restraint prohibition.** (a) A license or certification holder must not use
463.5 a prone restraint on any person receiving services in a program, except in the instances
463.6 allowed by paragraphs (b) to (d).

463.7 (b) If a person rolls into a prone position during the use of a restraint, the person must
463.8 be restored to a nonprone position as quickly as possible.

463.9 (c) If the applicable licensing requirements allow a program to use mechanical restraints,
463.10 a person may be briefly held in a prone restraint for the purpose of applying mechanical
463.11 restraints if the person is restored to a nonprone position as quickly as possible.

463.12 (d) If the applicable licensing requirements allow a program to use seclusion, a person
463.13 may be briefly held in a prone restraint to allow staff to safely exit a seclusion room.

463.14 Subd. 4. **Contraindicated physical restraints.** A license or certification holder must
463.15 not implement a restraint on a person receiving services in a program in a way that is
463.16 contraindicated for any of the person's known medical or psychological conditions. Prior
463.17 to using restraints on a person, the license or certification holder must assess and document
463.18 a determination of any medical or psychological conditions that restraints are contraindicated
463.19 for and the type of restraints that will not be used on the person based on this determination.

463.20 Sec. 14. Minnesota Statutes 2022, section 245C.02, subdivision 6a, is amended to read:

463.21 **Subd. 6a. Child care background study subject.** (a) "Child care background study
463.22 subject" means an individual who is affiliated with a licensed child care center, certified
463.23 license-exempt child care center, licensed family child care program, or legal nonlicensed
463.24 child care provider authorized under chapter 119B, and who is:

463.25 (1) employed by a child care provider for compensation;

463.26 (2) assisting in the care of a child for a child care provider;

463.27 (3) a person applying for licensure, certification, or enrollment;

463.28 (4) a controlling individual as defined in section 245A.02, subdivision 5a;

463.29 (5) an individual 13 years of age or older who lives in the household where the licensed
463.30 program will be provided and who is not receiving licensed services from the program;

464.1 (6) an individual ten to 12 years of age who lives in the household where the licensed
464.2 services will be provided when the commissioner has reasonable cause as defined in section
464.3 245C.02, subdivision 15;

464.4 (7) an individual who, without providing direct contact services at a licensed program,
464.5 certified program, or program authorized under chapter 119B, may have unsupervised access
464.6 to a child receiving services from a program when the commissioner has reasonable cause
464.7 as defined in section 245C.02, subdivision 15; or

464.8 (8) a volunteer, contractor providing services for hire in the program, prospective
464.9 employee, or other individual who has unsupervised physical access to a child served by a
464.10 program and who is not under supervision by an individual listed in clause (1) or (5),
464.11 regardless of whether the individual provides program services.

464.12 (b) Notwithstanding paragraph (a), an individual who is providing services that are not
464.13 part of the child care program is not required to have a background study if:

464.14 (1) the child receiving services is signed out of the child care program for the duration
464.15 that the services are provided;

464.16 (2) the licensed child care center, certified license-exempt child care center, licensed
464.17 family child care program, or legal nonlicensed child care provider authorized under chapter
464.18 119B has obtained advanced written permission from the parent authorizing the child to
464.19 receive the services, which is maintained in the child's record;

464.20 (3) the licensed child care center, certified license-exempt child care center, licensed
464.21 family child care program, or legal nonlicensed child care provider authorized under chapter
464.22 119B maintains documentation on site that identifies the individual service provider and
464.23 the services being provided; and

464.24 (4) the licensed child care center, certified license-exempt child care center, licensed
464.25 family child care program, or legal nonlicensed child care provider authorized under chapter
464.26 119B ensures that the service provider does not have unsupervised access to a child not
464.27 receiving the provider's services.

464.28 (c) The definition of employee under subdivision 11f and the definition of volunteer
464.29 under subdivision 22 do not apply for child care background study subjects.

464.30 Sec. 15. Minnesota Statutes 2022, section 245C.02, subdivision 11c, is amended to read:

464.31 Subd. 11c. **Entity.** "Entity" means any program, organization, license holder, or agency
464.32 initiating required to initiate or submit a background study.

465.1 Sec. 16. Minnesota Statutes 2022, section 245C.02, is amended by adding a subdivision
465.2 to read:

465.3 Subd. 11f. **Employee.** "Employee" means an individual who provides services or seeks
465.4 to provide services for or through the entity with which they are required to be affiliated in
465.5 NETStudy 2.0 and who is subject to oversight by the entity, which includes but is not limited
465.6 to continuous, direct supervision by the entity and being subject to immediate removal from
465.7 providing direct contact services by the entity when required.

465.8 Sec. 17. Minnesota Statutes 2022, section 245C.02, is amended by adding a subdivision
465.9 to read:

465.10 Subd. 22. **Volunteer.** "Volunteer" means an individual who provides or seeks to provide
465.11 services for or through an entity without direct compensation for services provided, is
465.12 required to be affiliated in NETStudy 2.0 and is subject to oversight by the entity, including
465.13 but not limited to continuous, direct supervision and immediate removal from providing
465.14 direct contact services when required.

465.15 Sec. 18. Minnesota Statutes 2022, section 245C.03, subdivision 1, is amended to read:

465.16 Subdivision 1. **Licensed programs.** (a) The commissioner shall conduct a background
465.17 study on:

465.18 (1) the person or persons applying for a license;

465.19 (2) an individual age 13 and over living in the household where the licensed program
465.20 will be provided who is not receiving licensed services from the program;

465.21 (3) current or prospective employees ~~or contractors~~ of the applicant or license holder
465.22 who will have direct contact with persons served by the facility, agency, or program;

465.23 (4) volunteers or student volunteers who will have direct contact with persons served
465.24 by the program to provide program services if the contact is not under the continuous, direct
465.25 supervision by an individual listed in clause (1) or (3);

465.26 (5) an individual age ten to 12 living in the household where the licensed services will
465.27 be provided when the commissioner has reasonable cause as defined in section 245C.02,
465.28 subdivision 15;

465.29 (6) an individual who, without providing direct contact services at a licensed program,
465.30 may have unsupervised access to children or vulnerable adults receiving services from a

466.1 program, when the commissioner has reasonable cause as defined in section 245C.02,
466.2 subdivision 15;

466.3 (7) all controlling individuals as defined in section 245A.02, subdivision 5a;

466.4 (8) notwithstanding the other requirements in this subdivision, child care background
466.5 study subjects as defined in section 245C.02, subdivision 6a; and

466.6 (9) notwithstanding clause (3), for children's residential facilities and foster residence
466.7 settings, any adult working in the facility, whether or not the individual will have direct
466.8 contact with persons served by the facility.

466.9 (b) For child foster care when the license holder resides in the home where foster care
466.10 services are provided, a short-term substitute caregiver providing direct contact services for
466.11 a child for less than 72 hours of continuous care is not required to receive a background
466.12 study under this chapter.

466.13 (c) This subdivision applies to the following programs that must be licensed under
466.14 chapter 245A:

466.15 (1) adult foster care;

466.16 (2) child foster care;

466.17 (3) children's residential facilities;

466.18 (4) family child care;

466.19 (5) licensed child care centers;

466.20 (6) licensed home and community-based services under chapter 245D;

466.21 (7) residential mental health programs for adults;

466.22 (8) substance use disorder treatment programs under chapter 245G;

466.23 (9) withdrawal management programs under chapter 245F;

466.24 (10) adult day care centers;

466.25 (11) family adult day services;

466.26 ~~(12) independent living assistance for youth;~~

466.27 ~~(13)~~ (12) detoxification programs;

466.28 ~~(14)~~ (13) community residential settings; and

467.1 (15) ~~(14)~~ intensive residential treatment services and residential crisis stabilization under
467.2 chapter 245I.

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

467.4 Sec. 19. Minnesota Statutes 2022, section 245C.03, subdivision 1a, is amended to read:

467.5 Subd. 1a. **Procedure.** (a) Individuals and organizations that are required under this
467.6 section to have or initiate background studies shall comply with the requirements of this
467.7 chapter.

467.8 (b) All studies conducted under this section shall be conducted according to sections
467.9 299C.60 to 299C.64, including the consent and self-disclosure required in section 299C.62,
467.10 subdivision 2. This requirement does not apply to subdivisions 1, paragraph (c), clauses (2)
467.11 to (5), and 6a.

467.12 Sec. 20. Minnesota Statutes 2022, section 245C.03, subdivision 4, is amended to read:

467.13 Subd. 4. **Personnel pool agencies; temporary personnel agencies; educational**
467.14 **programs; professional services agencies.** (a) The commissioner also may conduct studies
467.15 on individuals specified in subdivision 1, paragraph (a), clauses (3) and (4), when the studies
467.16 are initiated by:

467.17 (1) personnel pool agencies;

467.18 (2) temporary personnel agencies;

467.19 (3) educational programs that train individuals by providing direct contact services in
467.20 licensed programs; and

467.21 (4) professional services agencies that are not licensed and ~~which contract~~ that work
467.22 with licensed programs to provide direct contact services or individuals who provide direct
467.23 contact services.

467.24 (b) Personnel pool agencies, temporary personnel agencies, and professional services
467.25 agencies must employ the individuals providing direct care services for children, people
467.26 with disabilities, or the elderly. Individuals must be affiliated in NETStudy 2.0 and subject
467.27 to oversight by the entity, which includes but is not limited to continuous, direct supervision
467.28 by the entity and being subject to immediate removal from providing direct care services
467.29 when required.

468.1 Sec. 21. Minnesota Statutes 2022, section 245C.03, subdivision 5, is amended to read:

468.2 Subd. 5. **Other state agencies.** The commissioner shall conduct background studies on
468.3 applicants and license holders under the jurisdiction of other state agencies who are required
468.4 in other statutory sections to initiate background studies under this chapter, including the
468.5 applicant's or license holder's employees,~~contractors~~, and volunteers when required under
468.6 other statutory sections.

468.7 Sec. 22. Minnesota Statutes 2022, section 245C.03, subdivision 5a, is amended to read:

468.8 Subd. 5a. **Facilities serving children or adults licensed or regulated by the**
468.9 **Department of Health.** (a) Except as specified in paragraph (b), the commissioner shall
468.10 conduct background studies of:

468.11 (1) individuals providing services who have direct contact, as defined under section
468.12 245C.02, subdivision 11, with patients and residents in hospitals, boarding care homes,
468.13 outpatient surgical centers licensed under sections 144.50 to 144.58; nursing homes and
468.14 home care agencies licensed under chapter 144A; assisted living facilities and assisted living
468.15 facilities with dementia care licensed under chapter 144G; and board and lodging
468.16 establishments that are registered to provide supportive or health supervision services under
468.17 section 157.17;

468.18 (2) individuals specified in subdivision 2 who provide direct contact services in a nursing
468.19 home or a home care agency licensed under chapter 144A; an assisted living facility or
468.20 assisted living facility with dementia care licensed under chapter 144G; or a boarding care
468.21 home licensed under sections 144.50 to 144.58. If the individual undergoing a study resides
468.22 outside of Minnesota, the study must include a check for substantiated findings of
468.23 maltreatment of adults and children in the individual's state of residence when the state
468.24 makes the information available;

468.25 (3) all other employees in assisted living facilities or assisted living facilities with
468.26 dementia care licensed under chapter 144G, nursing homes licensed under chapter 144A,
468.27 and boarding care homes licensed under sections 144.50 to 144.58. A disqualification of
468.28 an individual in this section shall disqualify the individual from positions allowing direct
468.29 contact with or access to patients or residents receiving services. "Access" means physical
468.30 access to a client or the client's personal property without continuous, direct supervision as
468.31 defined in section 245C.02, subdivision 8, when the employee's employment responsibilities
468.32 do not include providing direct contact services;

469.1 (4) individuals employed by a supplemental nursing services agency, as defined under
469.2 section 144A.70, who are providing services in health care facilities;

469.3 (5) controlling persons of a supplemental nursing services agency, as defined by section
469.4 144A.70; and

469.5 (6) license applicants, owners, managerial officials, and controlling individuals who are
469.6 required under section 144A.476, subdivision 1, or 144G.13, subdivision 1, to undergo a
469.7 background study under this chapter, regardless of the licensure status of the license applicant,
469.8 owner, managerial official, or controlling individual.

469.9 (b) ~~The commissioner of human services shall not conduct~~ An entity shall not initiate a
469.10 background study on any individual identified in paragraph (a), clauses (1) to (5), if the
469.11 individual has a valid license issued by a health-related licensing board as defined in section
469.12 214.01, subdivision 2, and has completed the criminal background check as required in
469.13 section 214.075. An entity that is affiliated with individuals who meet the requirements of
469.14 this paragraph must separate those individuals from the entity's roster for NETStudy 2.0.
469.15 The Department of Human Services is not liable for conducting background studies that
469.16 have been submitted or not removed from the roster in violation of this provision.

469.17 (c) If a facility or program is licensed by the Department of Human Services and the
469.18 Department of Health and is subject to the background study provisions of this chapter, the
469.19 Department of Human Services is solely responsible for the background studies of individuals
469.20 in the jointly licensed program.

469.21 (d) The commissioner of health shall review and make decisions regarding reconsideration
469.22 requests, including whether to grant variances, according to the procedures and criteria in
469.23 this chapter. The commissioner of health shall inform the requesting individual and the
469.24 Department of Human Services of the commissioner of health's decision regarding the
469.25 reconsideration. The commissioner of health's decision to grant or deny a reconsideration
469.26 of a disqualification is a final administrative agency action.

469.27 Sec. 23. Minnesota Statutes 2022, section 245C.031, subdivision 1, is amended to read:

469.28 Subdivision 1. **Alternative background studies.** (a) The commissioner shall conduct
469.29 an alternative background study of individuals listed in this section.

469.30 (b) Notwithstanding other sections of this chapter, all alternative background studies
469.31 except subdivision 12 shall be conducted according to this section and with sections 299C.60
469.32 to 299C.64, including the consent and self-disclosure required in section 299C.62, subdivision
469.33 2.

470.1 (c) All terms in this section shall have the definitions provided in section 245C.02.

470.2 (d) The entity that submits an alternative background study request under this section
470.3 shall submit the request to the commissioner according to section 245C.05.

470.4 (e) The commissioner shall comply with the destruction requirements in section 245C.051.

470.5 (f) Background studies conducted under this section are subject to the provisions of
470.6 section 245C.32.

470.7 (g) The commissioner shall forward all information that the commissioner receives under
470.8 section 245C.08 to the entity that submitted the alternative background study request under
470.9 subdivision 2. The commissioner shall not make any eligibility determinations regarding
470.10 background studies conducted under this section.

470.11 Sec. 24. Minnesota Statutes 2022, section 245C.031, subdivision 4, is amended to read:

470.12 Subd. 4. **Applicants, licensees, and other occupations regulated by the commissioner**
470.13 **of health.** The commissioner shall conduct an alternative background study, including a
470.14 check of state data, and a national criminal history records check of the following individuals.
470.15 For studies under this section, the following persons shall complete a consent form and
470.16 criminal history disclosure form:

470.17 (1) An applicant for initial licensure, temporary licensure, or relicensure after a lapse in
470.18 licensure as an audiologist or speech-language pathologist or an applicant for initial
470.19 certification as a hearing instrument dispenser who must submit to a background study
470.20 under section 144.0572.

470.21 (2) An applicant for a renewal license or certificate as an audiologist, speech-language
470.22 pathologist, or hearing instrument dispenser who was licensed or obtained a certificate
470.23 before January 1, 2018.

470.24 Sec. 25. Minnesota Statutes 2022, section 245C.05, subdivision 1, is amended to read:

470.25 Subdivision 1. **Individual studied.** (a) The individual who is the subject of the
470.26 background study must provide the applicant, license holder, or other entity under section
470.27 245C.04 with sufficient information to ensure an accurate study, including:

470.28 (1) the individual's first, middle, and last name and all other names by which the
470.29 individual has been known;

470.30 (2) current home address, city, and state of residence;

470.31 (3) current zip code;

471.1 (4) sex;

471.2 (5) date of birth;

471.3 (6) driver's license number or state identification number or, for those without a driver's
471.4 license or state identification card, an acceptable form of identification as determined by
471.5 the commissioner; and

471.6 (7) upon implementation of NETStudy 2.0, the home address, city, county, and state of
471.7 residence for the past five years.

471.8 (b) Every subject of a background study conducted or initiated by counties or private
471.9 agencies under this chapter must also provide the home address, city, county, and state of
471.10 residence for the past five years.

471.11 (c) Every subject of a background study related to private agency adoptions or related
471.12 to child foster care licensed through a private agency, who is 18 years of age or older, shall
471.13 also provide the commissioner a signed consent for the release of any information received
471.14 from national crime information databases to the private agency that initiated the background
471.15 study.

471.16 (d) The subject of a background study shall provide fingerprints and a photograph as
471.17 required in subdivision 5.

471.18 (e) The subject of a background study shall submit a completed criminal and maltreatment
471.19 history records check consent form and criminal history disclosure form for applicable
471.20 national and state level record checks.

471.21 Sec. 26. Minnesota Statutes 2022, section 245C.05, is amended by adding a subdivision
471.22 to read:

471.23 Subd. 8. Study submitted. The entity with which the background study subject is seeking
471.24 affiliation shall initiate the background study in the NETStudy 2.0 system.

471.25 Sec. 27. Minnesota Statutes 2022, section 245C.07, is amended to read:

471.26 **245C.07 STUDY SUBJECT AFFILIATED WITH MULTIPLE FACILITIES.**

471.27 (a) Subject to the conditions in paragraph (d), when a license holder, applicant, or other
471.28 entity owns multiple programs or services that are licensed by the Department of Human
471.29 Services, Department of Health, or Department of Corrections, only one background study
471.30 is required for an individual who provides direct contact services in one or more of the
471.31 licensed programs or services if:

472.1 (1) the license holder designates one individual with one address and telephone number
472.2 as the person to receive sensitive background study information for the multiple licensed
472.3 programs or services that depend on the same background study; and

472.4 (2) the individual designated to receive the sensitive background study information is
472.5 capable of determining, upon request of the department, whether a background study subject
472.6 is providing direct contact services in one or more of the license holder's programs or services
472.7 and, if so, at which location or locations.

472.8 (b) When a license holder maintains background study compliance for multiple licensed
472.9 programs according to paragraph (a), and one or more of the licensed programs closes, the
472.10 license holder shall immediately notify the commissioner which staff must be transferred
472.11 to an active license so that the background studies can be electronically paired with the
472.12 license holder's active program.

472.13 (c) When a background study is being initiated by a licensed program or service or a
472.14 foster care provider that is also licensed under chapter 144G, a study subject affiliated with
472.15 multiple licensed programs or services may attach to the background study form a cover
472.16 letter indicating the additional names of the programs or services, addresses, and background
472.17 study identification numbers.

472.18 When the commissioner receives a notice, the commissioner shall notify each program
472.19 or service identified by the background study subject of the study results.

472.20 The background study notice the commissioner sends to the subsequent agencies shall
472.21 satisfy those programs' or services' responsibilities for initiating a background study on that
472.22 individual.

472.23 (d) If a background study was conducted on an individual related to child foster care
472.24 and the requirements under paragraph (a) are met, the background study is transferable
472.25 across all licensed programs. If a background study was conducted on an individual under
472.26 a license other than child foster care and the requirements under paragraph (a) are met, the
472.27 background study is transferable to all licensed programs except child foster care.

472.28 (e) The provisions of this section that allow a single background study in one or more
472.29 licensed programs or services do not apply to background studies submitted by adoption
472.30 agencies, supplemental nursing services agencies, personnel pool agencies, educational
472.31 programs, professional services agencies, temporary personnel agencies, and unlicensed
472.32 personal care provider organizations.

473.1 (f) For an entity operating under NETStudy 2.0, the entity's active roster must be the
473.2 system used to document when a background study subject is affiliated with multiple entities.
473.3 For a background study to be transferable:

473.4 (1) the background study subject must be on and moving to a roster for which the person
473.5 designated to receive sensitive background study information is the same; and

473.6 (2) the same entity must own or legally control both the roster from which the transfer
473.7 is occurring and the roster to which the transfer is occurring. For an entity that holds or
473.8 controls multiple licenses, or unlicensed personal care provider organizations, there must
473.9 be a common highest level entity that has a legally identifiable structure that can be verified
473.10 through records available from the secretary of state.

473.11 Sec. 28. Minnesota Statutes 2022, section 245C.10, subdivision 4, is amended to read:

473.12 Subd. 4. **Temporary personnel agencies, personnel pool agencies, educational**
473.13 **programs, and professional services agencies.** The commissioner shall recover the cost
473.14 of the background studies initiated by temporary personnel agencies, personnel pool agencies,
473.15 educational programs, and professional services agencies that initiate background studies
473.16 under section 245C.03, subdivision 4, through a fee of no more than \$42 per study charged
473.17 to the agency. The fees collected under this subdivision are appropriated to the commissioner
473.18 for the purpose of conducting background studies.

473.19 Sec. 29. Minnesota Statutes 2022, section 245C.31, subdivision 1, is amended to read:

473.20 Subdivision 1. **Board determines disciplinary or corrective action.** ~~(a)~~ The
473.21 commissioner shall notify a health-related licensing board as defined in section 214.01,
473.22 subdivision 2, if the commissioner determines that an individual who is licensed by the
473.23 health-related licensing board and who is included on the board's roster list provided in
473.24 accordance with subdivision 3a is responsible for substantiated maltreatment under section
473.25 626.557 or chapter 260E, in accordance with subdivision 2. Upon receiving notification,
473.26 the health-related licensing board shall make a determination as to whether to impose
473.27 disciplinary or corrective action under chapter 214.

473.28 ~~(b) This section does not apply to a background study of an individual regulated by a~~
473.29 ~~health-related licensing board if the individual's study is related to child foster care, adult~~
473.30 ~~foster care, or family child care licensure.~~

474.1 Sec. 30. Minnesota Statutes 2022, section 245C.33, subdivision 4, is amended to read:

474.2 Subd. 4. **Information commissioner reviews.** (a) The commissioner shall review the
474.3 following information regarding the background study subject:

474.4 (1) the information under section 245C.08, subdivisions 1, 3, and 4;

474.5 (2) information from the child abuse and neglect registry for any state in which the
474.6 subject has resided for the past five years; and

474.7 (3) information from national crime information databases, when required under section
474.8 245C.08.

474.9 (b) The commissioner shall provide any information collected under this subdivision to
474.10 the county or private agency that initiated the background study. The commissioner shall
474.11 also provide the agency:

474.12 ~~(1) with a notice~~ whether the information collected shows that the subject of the
474.13 background study has a conviction listed in United States Code, title 42, section
474.14 671(a)(20)(A); ~~and~~

474.15 ~~(2) for background studies conducted under subdivision 1, paragraph (a), the date of all~~
474.16 ~~adoption-related background studies completed on the subject by the commissioner after~~
474.17 ~~June 30, 2007, and the name of the county or private agency that initiated the adoption-related~~
474.18 ~~background study.~~

474.19 Sec. 31. Minnesota Statutes 2022, section 245H.13, subdivision 9, is amended to read:

474.20 Subd. 9. **Behavior guidance.** The certified center must ensure that staff and volunteers
474.21 use positive behavior guidance and do not subject children to:

474.22 (1) corporal punishment, including but not limited to rough handling, shoving, hair
474.23 pulling, ear pulling, shaking, slapping, kicking, biting, pinching, hitting, and spanking;

474.24 (2) humiliation;

474.25 (3) abusive language;

474.26 (4) the use of mechanical restraints, including tying;

474.27 (5) the use of physical restraints other than to physically hold a child when containment
474.28 is necessary to protect a child or others from harm; ~~or~~

474.29 (6) prone restraints, as prohibited by section 245A.211; or

474.30 ~~(6)~~ (7) the withholding or forcing of food and other basic needs.

475.1 Sec. 32. Minnesota Statutes 2022, section 245I.20, subdivision 10, is amended to read:

475.2 Subd. 10. **Application procedures.** (a) The applicant for certification must submit any
475.3 documents that the commissioner requires on forms approved by the commissioner.

475.4 (b) Upon submitting an application for certification, an applicant must pay the application
475.5 fee required by section 245A.10, subdivision 3.

475.6 (c) The commissioner must act on an application within 90 working days of receiving
475.7 a completed application.

475.8 (d) When the commissioner receives an application for initial certification that is
475.9 incomplete because the applicant failed to submit required documents or is deficient because
475.10 the submitted documents do not meet certification requirements, the commissioner must
475.11 provide the applicant with written notice that the application is incomplete or deficient. In
475.12 the notice, the commissioner must identify the particular documents that are missing or
475.13 deficient and give the applicant 45 days to submit a second application that is complete. An
475.14 applicant's failure to submit a complete application within 45 days after receiving notice
475.15 from the commissioner is a basis for certification denial.

475.16 (e) The commissioner must give notice of a denial to an applicant when the commissioner
475.17 has made the decision to deny the certification application. In the notice of denial, the
475.18 commissioner must state the reasons for the denial in plain language. The commissioner
475.19 must send or deliver the notice of denial to an applicant by certified mail or personal service.
475.20 In the notice of denial, the commissioner must state the reasons that the commissioner denied
475.21 the application and must inform the applicant of the applicant's right to request a contested
475.22 case hearing under chapter 14 and Minnesota Rules, parts 1400.8505 to 1400.8612. The
475.23 applicant may appeal the denial by notifying the commissioner in writing by certified mail
475.24 or personal service. If mailed, the appeal must be postmarked and sent to the commissioner
475.25 within 20 calendar days after the applicant received the notice of denial. If an applicant
475.26 delivers an appeal by personal service, the commissioner must receive the appeal within 20
475.27 calendar days after the applicant received the notice of denial.

475.28 (f) The commissioner may require the applicant or certification holder to provide an
475.29 email address for the certification holder that will be made public subject to the requirements
475.30 under section 13.46, subdivision 4, paragraph (b), clause (1), item (i).

475.31 Sec. 33. Minnesota Statutes 2022, section 256.9685, subdivision 1a, is amended to read:

475.32 Subd. 1a. **Administrative reconsideration.** Notwithstanding section 256B.04,
475.33 subdivision 15, the commissioner shall establish an administrative reconsideration process

476.1 for appeals of inpatient hospital services determined to be medically unnecessary. A
476.2 physician, advanced practice registered nurse, physician assistant, or hospital may request
476.3 a reconsideration of the decision that inpatient hospital services are not medically necessary
476.4 by submitting a written request for review to the commissioner within ~~30~~ 45 calendar days
476.5 after ~~receiving~~ the date of the notice of the decision was mailed. The request for
476.6 reconsideration process shall take place prior to the procedures of subdivision 1b and shall
476.7 be conducted be reviewed by the at least one medical review agent that is independent of
476.8 the case under reconsideration. The medical review agent shall make a recommendation to
476.9 the commissioner. The commissioner's decision on reconsideration is final and not subject
476.10 to appeal under chapter 14.

476.11 Sec. 34. Minnesota Statutes 2022, section 256.9685, subdivision 1b, is amended to read:

476.12 Subd. 1b. **Appeal of reconsideration.** ~~Notwithstanding section 256B.72, the~~
476.13 ~~commissioner may recover inpatient hospital payments for services that have been determined~~
476.14 ~~to be medically unnecessary after the reconsideration and determinations. A physician,~~
476.15 ~~advanced practice registered nurse, physician assistant, or hospital may appeal the result of~~
476.16 ~~the reconsideration process by submitting a written request for review to the commissioner~~
476.17 ~~within 30 days after receiving notice of the action. The commissioner shall review the~~
476.18 ~~medical record and information submitted during the reconsideration process and the medical~~
476.19 ~~review agent's basis for the determination that the services were not medically necessary~~
476.20 ~~for inpatient hospital services. The commissioner shall issue an order upholding or reversing~~
476.21 ~~the decision of the reconsideration process based on the review. The commissioner's decision~~
476.22 under subdivision 1a is appealable by petition for writ of certiorari under chapter 606.

476.23 Sec. 35. Minnesota Statutes 2022, section 256.9686, is amended by adding a subdivision
476.24 to read:

476.25 Subd. 7a. **Medical review agent.** "Medical review agent" means the representative of
476.26 the commissioner who is authorized by the commissioner to administer medical record
476.27 reviews; conduct administrative reconsiderations as defined by section 256.9685, subdivision
476.28 1a; and perform other functions as stipulated in the terms of the agent's contract with the
476.29 department. Medical records reviews and administrative reconsiderations will be performed
476.30 by medical professionals within their scope of expertise, including but not limited to
476.31 physicians, physician assistants, advanced practice registered nurses, and registered nurses.
476.32 The medical professional performing the review or reconsideration must be on staff with
476.33 the medical review agent, in good standing, and licensed to practice in the state where the
476.34 medical professional resides.

477.1 Sec. 36. Minnesota Statutes 2022, section 256B.04, subdivision 15, is amended to read:

477.2 Subd. 15. **Utilization review.** (a) Establish on a statewide basis a new program to
477.3 safeguard against unnecessary or inappropriate use of medical assistance services, against
477.4 excess payments, against unnecessary or inappropriate hospital admissions or lengths of
477.5 stay, and against underutilization of services in prepaid health plans, long-term care facilities
477.6 or any health care delivery system subject to fixed rate reimbursement. In implementing
477.7 the program, the state agency shall utilize both prepayment and postpayment review systems
477.8 to determine if utilization is reasonable and necessary. The determination of whether services
477.9 are reasonable and necessary shall be made by the commissioner in consultation with a
477.10 professional services advisory group or health care consultant appointed by the commissioner.

477.11 (b) Contracts entered into for purposes of meeting the requirements of this subdivision
477.12 shall not be subject to the set-aside provisions of chapter 16C.

477.13 (c) A recipient aggrieved by the commissioner's termination of services or denial of
477.14 future services may appeal pursuant to section 256.045. Unless otherwise provided by law,
477.15 a vendor aggrieved by the commissioner's determination that services provided were not
477.16 reasonable or necessary may appeal pursuant to the contested case procedures of chapter
477.17 14. To appeal, the vendor shall notify the commissioner in writing within 30 days of receiving
477.18 the commissioner's notice. The appeal request shall specify each disputed item, the reason
477.19 for the dispute, an estimate of the dollar amount involved for each disputed item, the
477.20 computation that the vendor believes is correct, the authority in statute or rule upon which
477.21 the vendor relies for each disputed item, the name and address of the person or firm with
477.22 whom contacts may be made regarding the appeal, and other information required by the
477.23 commissioner.

477.24 (d) The commissioner may select providers to provide case management services to
477.25 recipients who use health care services inappropriately or to recipients who are eligible for
477.26 other managed care projects. The providers shall be selected based upon criteria that may
477.27 include a comparison with a peer group of providers related to the quality, quantity, or cost
477.28 of health care services delivered or a review of sanctions previously imposed by health care
477.29 services programs or the provider's professional licensing board.

477.30 Sec. 37. Minnesota Statutes 2022, section 256B.064, is amended to read:

477.31 **256B.064 SANCTIONS; MONETARY RECOVERY.**

477.32 Subdivision 1. **Terminating payments to ineligible vendors individuals or entities.** The
477.33 commissioner may terminate payments under this chapter to any person or facility that,

478.1 under applicable federal law or regulation, has been determined to be ineligible for payments
 478.2 under title XIX of the Social Security Act.

478.3 Subd. 1a. **Grounds for sanctions against vendors.** (a) The commissioner may impose
 478.4 sanctions against ~~a vendor of medical care~~ any individual or entity that receives payments
 478.5 from medical assistance or provides goods or services for which payment is made from
 478.6 medical assistance for any of the following: (1) fraud, theft, or abuse in connection with the
 478.7 provision of ~~medical care~~ goods and services to recipients of public assistance for which
 478.8 payment is made from medical assistance; (2) a pattern of presentment of false or duplicate
 478.9 claims or claims for services not medically necessary; (3) a pattern of making false statements
 478.10 of material facts for the purpose of obtaining greater compensation than that to which the
 478.11 ~~vendor~~ individual or entity is legally entitled; (4) suspension or termination as a Medicare
 478.12 vendor; (5) refusal to grant the state agency access during regular business hours to examine
 478.13 all records necessary to disclose the extent of services provided to program recipients and
 478.14 appropriateness of claims for payment; (6) failure to repay an overpayment or a fine finally
 478.15 established under this section; (7) failure to correct errors in the maintenance of health
 478.16 service or financial records for which a fine was imposed or after issuance of a warning by
 478.17 the commissioner; and (8) any reason for which ~~a vendor~~ an individual or entity could be
 478.18 excluded from participation in the Medicare program under section 1128, 1128A, or
 478.19 1866(b)(2) of the Social Security Act. For the purposes of this section, goods or services
 478.20 for which payment is made from medical assistance includes but is not limited to care and
 478.21 services identified in section 256B.0625 or provided pursuant to any federally approved
 478.22 waiver.

478.23 (b) The commissioner may impose sanctions against a pharmacy provider for failure to
 478.24 respond to a cost of dispensing survey under section 256B.0625, subdivision 13e, paragraph
 478.25 (h).

478.26 Subd. 1b. **Sanctions available.** The commissioner may impose the following sanctions
 478.27 for the conduct described in subdivision 1a: suspension or withholding of payments to a
 478.28 ~~vendor~~ an individual or entity and suspending or terminating participation in the program,
 478.29 or imposition of a fine under subdivision 2, paragraph (f). When imposing sanctions under
 478.30 this section, the commissioner shall consider the nature, chronicity, or severity of the conduct
 478.31 and the effect of the conduct on the health and safety of persons served by the ~~vendor~~
 478.32 individual or entity. The commissioner shall suspend ~~a vendor's~~ an individual's or entity's
 478.33 participation in the program for a minimum of five years if the ~~vendor~~ individual or entity
 478.34 is convicted of a crime, received a stay of adjudication, or entered a court-ordered diversion
 478.35 program for an offense related to a provision of a health service under medical assistance,

479.1 including a federally approved waiver, or health care fraud. Regardless of imposition of
479.2 sanctions, the commissioner may make a referral to the appropriate state licensing board.

479.3 Subd. 1c. **Grounds for and methods of monetary recovery.** (a) The commissioner
479.4 may obtain monetary recovery from ~~a vendor who~~ an individual or entity that has been
479.5 improperly paid by the department either as a result of conduct described in subdivision 1a
479.6 or as a result of ~~a vendor or department~~ an error by the individual or entity submitting the
479.7 claim or by the department, regardless of whether the error was intentional. Patterns need
479.8 not be proven as a precondition to monetary recovery of erroneous or false claims, duplicate
479.9 claims, claims for services not medically necessary, or claims based on false statements.

479.10 (b) The commissioner may obtain monetary recovery using methods including but not
479.11 limited to the following: assessing and recovering money improperly paid and debiting from
479.12 future payments any money improperly paid. The commissioner shall charge interest on
479.13 money to be recovered if the recovery is to be made by installment payments or debits,
479.14 except when the monetary recovery is of an overpayment that resulted from a department
479.15 error. The interest charged shall be the rate established by the commissioner of revenue
479.16 under section 270C.40.

479.17 Subd. 1d. **Investigative costs.** The commissioner may seek recovery of investigative
479.18 costs from any ~~vendor of medical care or services who~~ individual or entity that willfully
479.19 submits a claim for reimbursement for services that the ~~vendor~~ individual or entity knows,
479.20 or reasonably should have known, is a false representation and that results in the payment
479.21 of public funds for which the ~~vendor~~ individual or entity is ineligible. Billing errors that
479.22 result in unintentional overcharges shall not be grounds for investigative cost recoupment.

479.23 Subd. 2. **Imposition of monetary recovery and sanctions.** (a) The commissioner shall
479.24 determine any monetary amounts to be recovered and sanctions to be imposed upon ~~a vendor~~
479.25 ~~of medical care~~ an individual or entity under this section. Except as provided in paragraphs
479.26 (b) and (d), neither a monetary recovery nor a sanction will be imposed by the commissioner
479.27 without prior notice and an opportunity for a hearing, according to chapter 14, on the
479.28 commissioner's proposed action, provided that the commissioner may suspend or reduce
479.29 payment to ~~a vendor of medical care~~ an individual or entity, except a nursing home or
479.30 convalescent care facility, after notice and prior to the hearing if in the commissioner's
479.31 opinion that action is necessary to protect the public welfare and the interests of the program.

479.32 (b) Except when the commissioner finds good cause not to suspend payments under
479.33 Code of Federal Regulations, title 42, section 455.23 (e) or (f), the commissioner shall

480.1 withhold or reduce payments to ~~a vendor of medical care~~ an individual or entity without
480.2 providing advance notice of such withholding or reduction if either of the following occurs:

480.3 (1) the ~~vendor~~ individual or entity is convicted of a crime involving the conduct described
480.4 in subdivision 1a; or

480.5 (2) the commissioner determines there is a credible allegation of fraud for which an
480.6 investigation is pending under the program. Allegations are considered credible when they
480.7 have an indicium of reliability and the state agency has reviewed all allegations, facts, and
480.8 evidence carefully and acts judiciously on a case-by-case basis. A credible allegation of
480.9 fraud is an allegation which has been verified by the state, from any source, including but
480.10 not limited to:

480.11 (i) fraud hotline complaints;

480.12 (ii) claims data mining; and

480.13 (iii) patterns identified through provider audits, civil false claims cases, and law
480.14 enforcement investigations.

480.15 ~~Allegations are considered to be credible when they have an indicia of reliability and~~
480.16 ~~the state agency has reviewed all allegations, facts, and evidence carefully and acts~~
480.17 ~~judiciously on a case-by-case basis.~~

480.18 (c) The commissioner must send notice of the withholding or reduction of payments
480.19 under paragraph (b) within five days of taking such action unless requested in writing by a
480.20 law enforcement agency to temporarily withhold the notice. The notice must:

480.21 (1) state that payments are being withheld according to paragraph (b);

480.22 (2) set forth the general allegations as to the nature of the withholding action, but need
480.23 not disclose any specific information concerning an ongoing investigation;

480.24 (3) except in the case of a conviction for conduct described in subdivision 1a, state that
480.25 the withholding is for a temporary period and cite the circumstances under which withholding
480.26 will be terminated;

480.27 (4) identify the types of claims to which the withholding applies; and

480.28 (5) inform the ~~vendor~~ individual or entity of the right to submit written evidence for
480.29 consideration by the commissioner.

480.30 (d) The withholding or reduction of payments will not continue after the commissioner
480.31 determines there is insufficient evidence of fraud by the ~~vendor~~ individual or entity, or after
480.32 legal proceedings relating to the alleged fraud are completed, unless the commissioner has

481.1 sent notice of intention to impose monetary recovery or sanctions under paragraph (a). Upon
481.2 conviction for a crime related to the provision, management, or administration of a health
481.3 service under medical assistance, a payment held pursuant to this section by the commissioner
481.4 or a managed care organization that contracts with the commissioner under section 256B.035
481.5 is forfeited to the commissioner or managed care organization, regardless of the amount
481.6 charged in the criminal complaint or the amount of criminal restitution ordered.

481.7 ~~(d)~~ (e) The commissioner shall suspend or terminate a ~~vendor's~~ an individual's or entity's
481.8 participation in the program without providing advance notice and an opportunity for a
481.9 hearing when the suspension or termination is required because of the ~~vendor's~~ individual's
481.10 or entity's exclusion from participation in Medicare. Within five days of taking such action,
481.11 the commissioner must send notice of the suspension or termination. The notice must:

481.12 (1) state that suspension or termination is the result of the ~~vendor's~~ individual's or entity's
481.13 exclusion from Medicare;

481.14 (2) identify the effective date of the suspension or termination; and

481.15 (3) inform the ~~vendor~~ individual or entity of the need to be reinstated to Medicare before
481.16 reapplying for participation in the program.

481.17 ~~(e)~~ (f) Upon receipt of a notice under paragraph (a) that a monetary recovery or sanction
481.18 is to be imposed, a ~~vendor~~ an individual or entity may request a contested case, as defined
481.19 in section 14.02, subdivision 3, by filing with the commissioner a written request of appeal.
481.20 The appeal request must be received by the commissioner no later than 30 days after the
481.21 date the notification of monetary recovery or sanction was mailed to the ~~vendor~~ individual
481.22 or entity. The appeal request must specify:

481.23 (1) each disputed item, the reason for the dispute, and an estimate of the dollar amount
481.24 involved for each disputed item;

481.25 (2) the computation that the ~~vendor~~ individual or entity believes is correct;

481.26 (3) the authority in statute or rule upon which the ~~vendor~~ individual or entity relies for
481.27 each disputed item;

481.28 (4) the name and address of the person or entity with whom contacts may be made
481.29 regarding the appeal; and

481.30 (5) other information required by the commissioner.

481.31 ~~(f)~~ (g) The commissioner may order a ~~vendor~~ an individual or entity to forfeit a fine for
481.32 failure to fully document services according to standards in this chapter and Minnesota

482.1 Rules, chapter 9505. The commissioner may assess fines if specific required components
482.2 of documentation are missing. The fine for incomplete documentation shall equal 20 percent
482.3 of the amount paid on the claims for reimbursement submitted by the ~~vendor~~ individual or
482.4 entity, or up to \$5,000, whichever is less. If the commissioner determines that a ~~vendor~~ an
482.5 individual or entity repeatedly violated this chapter, chapter 254B or 245G, or Minnesota
482.6 Rules, chapter 9505, related to the provision of services to program recipients and the
482.7 submission of claims for payment, the commissioner may order a ~~vendor~~ an individual or
482.8 entity to forfeit a fine based on the nature, severity, and chronicity of the violations, in an
482.9 amount of up to \$5,000 or 20 percent of the value of the claims, whichever is greater. The
482.10 commissioner may issue fines under this paragraph in place of or in addition to full monetary
482.11 recovery of the value of the claims submitted under subdivision 1c.

482.12 ~~(g)~~ (h) The ~~vendor~~ individual or entity shall pay the fine assessed on or before the
482.13 payment date specified. If the ~~vendor~~ individual or entity fails to pay the fine, the
482.14 commissioner may withhold or reduce payments and recover the amount of the fine. A
482.15 timely appeal shall stay payment of the fine until the commissioner issues a final order.

482.16 Subd. 3. **~~Vendor~~ Mandates on prohibited payments.** (a) The commissioner shall
482.17 maintain and publish a list of each excluded individual and entity that was convicted of a
482.18 crime related to the provision, management, or administration of a medical assistance health
482.19 service, or suspended or terminated under subdivision 2. Medical assistance payments cannot
482.20 be made by a ~~vendor~~ an individual or entity for items or services furnished either directly
482.21 or indirectly by an excluded individual or entity, or at the direction of excluded individuals
482.22 or entities.

482.23 (b) The ~~vendor~~ entity must check the exclusion list on a monthly basis and document
482.24 the date and time the exclusion list was checked and the name and title of the person who
482.25 checked the exclusion list. The ~~vendor~~ entity must immediately terminate payments to an
482.26 individual or entity on the exclusion list.

482.27 (c) ~~A vendor's~~ An entity's requirement to check the exclusion list and to terminate
482.28 payments to individuals or entities on the exclusion list applies to each individual or entity
482.29 on the exclusion list, even if the named individual or entity is not responsible for direct
482.30 patient care or direct submission of a claim to medical assistance.

482.31 (d) ~~A vendor~~ An entity that pays medical assistance program funds to an individual or
482.32 entity on the exclusion list must refund any payment related to either items or services
482.33 rendered by an individual or entity on the exclusion list from the date the individual or entity

483.1 is first paid or the date the individual or entity is placed on the exclusion list, whichever is
483.2 later, and ~~a vendor~~ an entity may be subject to:

483.3 (1) sanctions under subdivision 2;

483.4 (2) a civil monetary penalty of up to \$25,000 for each determination by the department
483.5 that the vendor employed or contracted with an individual or entity on the exclusion list;
483.6 and

483.7 (3) other fines or penalties allowed by law.

483.8 Subd. 4. **Notice.** (a) The department shall serve the notice required under subdivision 2
483.9 ~~shall be served~~ by certified mail at the address submitted to the department by the ~~vendor~~
483.10 individual or entity. Service is complete upon mailing. ~~The commissioner shall place an~~
483.11 ~~affidavit of the certified mailing in the vendor's file as an indication of the address and the~~
483.12 ~~date of mailing.~~

483.13 (b) The department shall give notice in writing to a recipient placed in the Minnesota
483.14 restricted recipient program under section 256B.0646 and Minnesota Rules, part 9505.2200.
483.15 The department shall send the notice ~~shall be sent~~ by first class mail to the recipient's current
483.16 address on file with the department. A recipient placed in the Minnesota restricted recipient
483.17 program may contest the placement by submitting a written request for a hearing to the
483.18 department within 90 days of the notice being mailed.

483.19 Subd. 5. **Immunity; good faith reporters.** (a) A person who makes a good faith report
483.20 is immune from any civil or criminal liability that might otherwise arise from reporting or
483.21 participating in the investigation. Nothing in this subdivision affects ~~a vendor's~~ an individual's
483.22 or entity's responsibility for an overpayment established under this subdivision.

483.23 (b) A person employed by a lead investigative agency who is conducting or supervising
483.24 an investigation or enforcing the law according to the applicable law or rule is immune from
483.25 any civil or criminal liability that might otherwise arise from the person's actions, if the
483.26 person is acting in good faith and exercising due care.

483.27 (c) For purposes of this subdivision, "person" includes a natural person or any form of
483.28 a business or legal entity.

483.29 (d) After an investigation is complete, the reporter's name must be kept confidential.
483.30 The subject of the report may compel disclosure of the reporter's name only with the consent
483.31 of the reporter or upon a written finding by a district court that the report was false and there
483.32 is evidence that the report was made in bad faith. This subdivision does not alter disclosure
483.33 responsibilities or obligations under the Rules of Criminal Procedure, except that when the

484.1 identity of the reporter is relevant to a criminal prosecution the district court shall conduct
484.2 an in-camera review before determining whether to order disclosure of the reporter's identity.

484.3 Sec. 38. Minnesota Statutes 2022, section 256B.27, subdivision 3, is amended to read:

484.4 Subd. 3. **Access to medical records.** The commissioner of human services, with the
484.5 written consent of the recipient, on file with the local welfare agency, shall be allowed
484.6 access in the manner and within the time prescribed by the commissioner to all personal
484.7 medical records of medical assistance recipients solely for the purposes of investigating
484.8 whether or not: (a) a vendor of medical care has submitted a claim for reimbursement, a
484.9 cost report or a rate application which is duplicative, erroneous, or false in whole or in part,
484.10 or which results in the vendor obtaining greater compensation than the vendor is legally
484.11 entitled to; or (b) the medical care was medically necessary. When the commissioner is
484.12 investigating a possible overpayment of Medicaid funds, the commissioner must be given
484.13 immediate access without prior notice to the vendor's office during regular business hours
484.14 and to documentation and records related to services provided and submission of claims
484.15 for services provided. The department shall document in writing the need for immediate
484.16 access to records related to a specific investigation. Denying the commissioner access to
484.17 records is cause for the vendor's immediate suspension of payment or termination according
484.18 to section 256B.064. Any records not provided to the commissioner at the date and time of
484.19 the request are inadmissible if offered as evidence by the provider in any proceeding to
484.20 contest sanctions against or monetary recovery from the provider. The determination of
484.21 provision of services not medically necessary shall be made by the commissioner.
484.22 Notwithstanding any other law to the contrary, a vendor of medical care shall not be subject
484.23 to any civil or criminal liability for providing access to medical records to the commissioner
484.24 of human services pursuant to this section.

484.25 Sec. 39. Minnesota Statutes 2022, section 524.5-118, subdivision 2a, is amended to read:

484.26 Subd. 2a. **Procedure; state licensing agency data.** (a) The court shall request the
484.27 commissioner of human services to provide the court within 25 working days of receipt of
484.28 the request with licensing agency data for licenses directly related to the responsibilities of
484.29 a professional fiduciary if the study subject indicates current or prior affiliation from the
484.30 following agencies in Minnesota:

484.31 (1) Lawyers Responsibility Board;

484.32 (2) State Board of Accountancy;

484.33 (3) Board of Social Work;

- 485.1 (4) Board of Psychology;
- 485.2 (5) Board of Nursing;
- 485.3 (6) Board of Medical Practice;
- 485.4 ~~(7) Department of Education;~~
- 485.5 ~~(8)~~ (7) Department of Commerce;
- 485.6 ~~(9)~~ (8) Board of Chiropractic Examiners;
- 485.7 ~~(10)~~ (9) Board of Dentistry;
- 485.8 ~~(11)~~ (10) Board of Marriage and Family Therapy;
- 485.9 ~~(12)~~ (11) Department of Human Services;
- 485.10 ~~(13)~~ (12) Peace Officer Standards and Training (POST) Board; and
- 485.11 ~~(14)~~ (13) Professional Educator Licensing and Standards Board.
- 485.12 (b) The commissioner shall enter into agreements with these agencies to provide the
- 485.13 commissioner with electronic access to the relevant licensing data, and to provide the
- 485.14 commissioner with a quarterly list of new sanctions issued by the agency.
- 485.15 (c) The commissioner shall provide to the court the electronically available data
- 485.16 maintained in the agency's database, including whether the proposed guardian or conservator
- 485.17 is or has been licensed by the agency, and if the licensing agency database indicates a
- 485.18 disciplinary action or a sanction against the individual's license, including a condition,
- 485.19 suspension, revocation, or cancellation.
- 485.20 (d) If the proposed guardian or conservator has resided in a state other than Minnesota
- 485.21 in the previous ten years, licensing agency data under this section shall also include the
- 485.22 licensing agency data from any other state where the proposed guardian or conservator
- 485.23 reported to have resided during the previous ten years if the study subject indicates current
- 485.24 or prior affiliation. If the proposed guardian or conservator has or has had a professional
- 485.25 license in another state that is directly related to the responsibilities of a professional fiduciary
- 485.26 from one of the agencies listed under paragraph (a), state licensing agency data shall also
- 485.27 include data from the relevant licensing agency of that state.
- 485.28 (e) The commissioner is not required to repeat a search for Minnesota or out-of-state
- 485.29 licensing data on an individual if the commissioner has provided this information to the
- 485.30 court within the prior five years.

486.1 (f) The commissioner shall review the information in paragraph (c) at least once every
486.2 four months to determine if an individual who has been studied within the previous five
486.3 years:

486.4 (1) has new disciplinary action or sanction against the individual's license; or

486.5 (2) did not disclose a prior or current affiliation with a Minnesota licensing agency.

486.6 (g) If the commissioner's review in paragraph (f) identifies new information, the
486.7 commissioner shall provide any new information to the court.

486.8 Sec. 40. **REVISOR INSTRUCTION.**

486.9 The revisor of statutes shall renumber the subdivisions in Minnesota Statutes, section
486.10 245C.02, in alphabetical order and correct any cross-reference changes that result.

486.11 Sec. 41. **REPEALER.**

486.12 (a) Minnesota Statutes 2022, sections 245A.22; 245C.02, subdivision 9; 245C.301; and
486.13 256.9685, subdivisions 1c and 1d, are repealed.

486.14 (b) Minnesota Rules, parts 9505.0505, subpart 18; and 9505.0520, subpart 9b, are
486.15 repealed.

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

486.17 **ARTICLE 10**
486.18 **ECONOMIC ASSISTANCE**

486.19 Section 1. Minnesota Statutes 2022, section 256D.01, subdivision 1a, is amended to read:

486.20 Subd. 1a. **Standards.** (a) A principal objective in providing general assistance is to
486.21 provide for single adults, childless couples, or children as defined in section 256D.02,
486.22 subdivision 6, ineligible for federal programs who are unable to provide for themselves.

486.23 The minimum standard of assistance determines the total amount of the general assistance
486.24 grant without separate standards for shelter, utilities, or other needs.

486.25 (b) ~~The commissioner shall set the standard of assistance for an assistance unit consisting~~
486.26 ~~of an adult~~ a recipient who is childless and unmarried or living apart from children and
486.27 spouse and who does not live with a parent or parents or a legal custodian is the cash portion
486.28 of the MFIP transitional standard for a single adult under section 256J.24, subdivision 5.

486.29 ~~When the other standards specified in this subdivision increase, this standard must also be~~
486.30 ~~increased by the same percentage.~~

487.1 (c) For an assistance unit consisting of a single adult who lives with a parent or parents,
 487.2 the general assistance standard of assistance ~~is the amount that the aid to families with~~
 487.3 ~~dependent children standard of assistance, in effect on July 16, 1996, would increase if the~~
 487.4 ~~recipient were added as an additional minor child to an assistance unit consisting of the~~
 487.5 ~~recipient's parent and all of that parent's family members, except that the standard may not~~
 487.6 ~~exceed the standard for a general assistance recipient living alone~~ is the cash portion of the
 487.7 MFIP transitional standard for a single adult under section 256J.24, subdivision 5. Benefits
 487.8 received by a responsible relative of the assistance unit under the Supplemental Security
 487.9 Income program, a workers' compensation program, the Minnesota supplemental aid program,
 487.10 or any other program based on the responsible relative's disability, and any benefits received
 487.11 by a responsible relative of the assistance unit under the Social Security retirement program,
 487.12 may not be counted in the determination of eligibility or benefit level for the assistance unit.
 487.13 Except as provided below, the assistance unit is ineligible for general assistance if the
 487.14 available resources or the countable income of the assistance unit and the parent or parents
 487.15 with whom the assistance unit lives are such that a family consisting of the assistance unit's
 487.16 parent or parents, the parent or parents' other family members and the assistance unit as the
 487.17 only or additional minor child would be financially ineligible for general assistance. For
 487.18 the purposes of calculating the countable income of the assistance unit's parent or parents,
 487.19 the calculation methods must follow the provisions under section 256P.06.

487.20 (d) For an assistance unit consisting of a childless couple, the standards of assistance
 487.21 are the same as the first and second adult standards of the aid to families with dependent
 487.22 children program in effect on July 16, 1996. If one member of the couple is not included in
 487.23 the general assistance grant, the standard of assistance for the other is the second adult
 487.24 standard of the aid to families with dependent children program as of July 16, 1996.

487.25 **EFFECTIVE DATE.** This section is effective October 1, 2024.

487.26 Sec. 2. Minnesota Statutes 2022, section 256D.024, subdivision 1, is amended to read:

487.27 Subdivision 1. **Person convicted of drug offenses.** (a) ~~If An applicant or recipient~~
 487.28 ~~individual who~~ has been convicted of a felony-level drug offense after July 1, 1997, the
 487.29 ~~assistance unit is ineligible for benefits under this chapter until five years after the applicant~~
 487.30 ~~has completed terms of the court-ordered sentence, unless the person is participating in a~~
 487.31 ~~drug treatment program, has successfully completed a drug treatment program, or has been~~
 487.32 ~~assessed by the county and determined not to be in need of a drug treatment program. Persons~~
 487.33 ~~subject to the limitations of this subdivision who become eligible for assistance under this~~
 487.34 ~~chapter shall~~ during the previous ten years from the date of application or recertification

488.1 ~~may be subject to random drug testing as a condition of continued eligibility and shall lose~~
 488.2 ~~eligibility for benefits for five years beginning the month following.~~ The county must
 488.3 provide information about substance use disorder treatment programs to a person who tests
 488.4 positive for an illegal controlled substance.

488.5 ~~(1) Any positive test result for an illegal controlled substance; or~~

488.6 ~~(2) discharge of sentence after conviction for another drug felony.~~

488.7 (b) For the purposes of this subdivision, "drug offense" means a conviction that occurred
 488.8 after July 1, 1997, during the previous ten years from the date of application or recertification
 488.9 of sections 152.021 to 152.025, 152.0261, 152.0262, or 152.096. Drug offense also means
 488.10 a conviction in another jurisdiction of the possession, use, or distribution of a controlled
 488.11 substance, or conspiracy to commit any of these offenses, if the ~~offense~~ conviction occurred
 488.12 after July 1, 1997, during the previous ten years from the date of application or recertification
 488.13 and the conviction is a felony offense in that jurisdiction, or in the case of New Jersey, a
 488.14 high misdemeanor.

488.15 **EFFECTIVE DATE.** This section is effective August 1, 2023.

488.16 Sec. 3. Minnesota Statutes 2022, section 256D.06, subdivision 5, is amended to read:

488.17 Subd. 5. **Eligibility; requirements.** (a) Any applicant, otherwise eligible for general
 488.18 assistance and possibly eligible for maintenance benefits from any other source shall (1)
 488.19 make application for those benefits within ~~30~~ 90 days of the general assistance application;
 488.20 and (2) execute an interim assistance agreement on a form as directed by the commissioner.

488.21 (b) The commissioner shall review a denial of an application for other maintenance
 488.22 benefits and may require a recipient of general assistance to file an appeal of the denial if
 488.23 appropriate. If found eligible for benefits from other sources, and a payment received from
 488.24 another source relates to the period during which general assistance was also being received,
 488.25 the recipient shall be required to reimburse the county agency for the interim assistance
 488.26 paid. Reimbursement shall not exceed the amount of general assistance paid during the time
 488.27 period to which the other maintenance benefits apply and shall not exceed the state standard
 488.28 applicable to that time period.

488.29 (c) The commissioner may contract with the county agencies, qualified agencies,
 488.30 organizations, or persons to provide advocacy and support services to process claims for
 488.31 federal disability benefits for applicants or recipients of services or benefits supervised by
 488.32 the commissioner using money retained under this section.

489.1 (d) The commissioner may provide methods by which county agencies shall identify,
489.2 refer, and assist recipients who may be eligible for benefits under federal programs for
489.3 people with a disability.

489.4 (e) The total amount of interim assistance recoveries retained under this section for
489.5 advocacy, support, and claim processing services shall not exceed 35 percent of the interim
489.6 assistance recoveries in the prior fiscal year.

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

489.8 Sec. 4. Minnesota Statutes 2022, section 256J.26, subdivision 1, is amended to read:

489.9 Subdivision 1. **Person convicted of drug offenses.** (a) An individual who has been
489.10 convicted of a felony level drug offense committed during the previous ten years from the
489.11 date of application or recertification is subject to the following:

489.12 (1) Benefits for the entire assistance unit must be paid in vendor form for shelter and
489.13 utilities during any time the applicant is part of the assistance unit.

489.14 (2) The convicted applicant or participant shall may be subject to random drug testing
489.15 ~~as a condition of continued eligibility and.~~ Following any positive test for an illegal controlled
489.16 ~~substance is subject to the following sanctions:~~ the county must provide information about
489.17 substance use disorder treatment programs to the applicant or participant.

489.18 ~~(i) for failing a drug test the first time, the residual amount of the participant's grant after~~
489.19 ~~making vendor payments for shelter and utility costs, if any, must be reduced by an amount~~
489.20 ~~equal to 30 percent of the MFIP standard of need for an assistance unit of the same size.~~
489.21 ~~When a sanction under this subdivision is in effect, the job counselor must attempt to meet~~
489.22 ~~with the person face-to-face. During the face-to-face meeting, the job counselor must explain~~
489.23 ~~the consequences of a subsequent drug test failure and inform the participant of the right to~~
489.24 ~~appeal the sanction under section 256J.40. If a face-to-face meeting is not possible, the~~
489.25 ~~county agency must send the participant a notice of adverse action as provided in section~~
489.26 ~~256J.31, subdivisions 4 and 5, and must include the information required in the face-to-face~~
489.27 ~~meeting; or~~

489.28 ~~(ii) for failing a drug test two times, the participant is permanently disqualified from~~
489.29 ~~receiving MFIP assistance, both the cash and food portions. The assistance unit's MFIP~~
489.30 ~~grant must be reduced by the amount which would have otherwise been made available to~~
489.31 ~~the disqualified participant. Disqualification under this item does not make a participant~~
489.32 ~~ineligible for the Supplemental Nutrition Assistance Program (SNAP). Before a~~
489.33 ~~disqualification under this provision is imposed, the job counselor must attempt to meet~~

490.1 ~~with the participant face-to-face. During the face-to-face meeting, the job counselor must~~
490.2 ~~identify other resources that may be available to the participant to meet the needs of the~~
490.3 ~~family and inform the participant of the right to appeal the disqualification under section~~
490.4 ~~256J.40. If a face-to-face meeting is not possible, the county agency must send the participant~~
490.5 ~~a notice of adverse action as provided in section 256J.31, subdivisions 4 and 5, and must~~
490.6 ~~include the information required in the face-to-face meeting.~~

490.7 ~~(3) A participant who fails a drug test the first time and is under a sanction due to other~~
490.8 ~~MFIP program requirements is considered to have more than one occurrence of~~
490.9 ~~noncompliance and is subject to the applicable level of sanction as specified under section~~
490.10 ~~256J.46, subdivision 1, paragraph (d).~~

490.11 ~~(b) Applicants requesting only SNAP benefits or participants receiving only SNAP~~
490.12 ~~benefits, who have been convicted of a felony-level drug offense that occurred after July~~
490.13 ~~1, 1997, during the previous ten years from the date of application or recertification may,~~
490.14 ~~if otherwise eligible, receive SNAP benefits if. The convicted applicant or participant is~~
490.15 ~~may be subject to random drug testing as a condition of continued eligibility. Following a~~
490.16 ~~positive test for an illegal controlled substance, the applicant is subject to the following~~
490.17 ~~sanctions: county must provide information about substance use disorder treatment programs~~
490.18 ~~to the applicant or participant.~~

490.19 ~~(1) for failing a drug test the first time, SNAP benefits shall be reduced by an amount~~
490.20 ~~equal to 30 percent of the applicable SNAP benefit allotment. When a sanction under this~~
490.21 ~~clause is in effect, a job counselor must attempt to meet with the person face-to-face. During~~
490.22 ~~the face-to-face meeting, a job counselor must explain the consequences of a subsequent~~
490.23 ~~drug test failure and inform the participant of the right to appeal the sanction under section~~
490.24 ~~256J.40. If a face-to-face meeting is not possible, a county agency must send the participant~~
490.25 ~~a notice of adverse action as provided in section 256J.31, subdivisions 4 and 5, and must~~
490.26 ~~include the information required in the face-to-face meeting; and~~

490.27 ~~(2) for failing a drug test two times, the participant is permanently disqualified from~~
490.28 ~~receiving SNAP benefits. Before a disqualification under this provision is imposed, a job~~
490.29 ~~counselor must attempt to meet with the participant face-to-face. During the face-to-face~~
490.30 ~~meeting, the job counselor must identify other resources that may be available to the~~
490.31 ~~participant to meet the needs of the family and inform the participant of the right to appeal~~
490.32 ~~the disqualification under section 256J.40. If a face-to-face meeting is not possible, a county~~
490.33 ~~agency must send the participant a notice of adverse action as provided in section 256J.31,~~
490.34 ~~subdivisions 4 and 5, and must include the information required in the face-to-face meeting.~~

491.1 (c) For the purposes of this subdivision, "drug offense" means ~~an offense~~ a conviction
491.2 that occurred during the previous ten years from the date of application or recertification
491.3 of sections 152.021 to 152.025, 152.0261, 152.0262, 152.096, or 152.137. Drug offense
491.4 also means a conviction in another jurisdiction of the possession, use, or distribution of a
491.5 controlled substance, or conspiracy to commit any of these offenses, if the ~~offense~~ conviction
491.6 occurred during the previous ten years from the date of application or recertification and
491.7 the conviction is a felony offense in that jurisdiction, or in the case of New Jersey, a high
491.8 misdemeanor.

491.9 **EFFECTIVE DATE.** This section is effective August 1, 2023.

491.10 Sec. 5. Minnesota Statutes 2022, section 256P.01, is amended by adding a subdivision to
491.11 read:

491.12 **Subd. 2b. Census income.** "Census income" means income earned working as a census
491.13 enumerator or decennial census worker responsible for recording the housing units and
491.14 residents in a specific geographic area.

491.15 Sec. 6. Minnesota Statutes 2022, section 256P.01, is amended by adding a subdivision to
491.16 read:

491.17 **Subd. 5a. Lived-experience engagement.** "Lived-experience engagement" means an
491.18 intentional engagement of people with lived experience by a federal, Tribal, state, county,
491.19 municipal, or nonprofit human services agency funded in part or in whole by federal, state,
491.20 local government, Tribal Nation, public, private, or philanthropic funds to gather and share
491.21 feedback on the impact of human services programs.

491.22 Sec. 7. Minnesota Statutes 2022, section 256P.02, subdivision 1a, is amended to read:

491.23 **Subd. 1a. Exemption.** Participants who qualify for child care assistance programs under
491.24 chapter 119B are exempt from this section, except that the personal property identified in
491.25 subdivision 2 is counted toward the asset limit of the child care assistance program under
491.26 chapter 119B. Census income is not counted toward the asset limit of the child care assistance
491.27 program under chapter 119B.

491.28 Sec. 8. Minnesota Statutes 2022, section 256P.02, subdivision 2, is amended to read:

491.29 **Subd. 2. Personal property limitations.** The equity value of an assistance unit's personal
491.30 property listed in clauses (1) to (5) must not exceed \$10,000 for applicants and participants.
491.31 For purposes of this subdivision, personal property is limited to:

- 492.1 (1) cash not excluded under subdivisions 4 and 5;
- 492.2 (2) bank accounts;
- 492.3 (3) liquid stocks and bonds that can be readily accessed without a financial penalty;
- 492.4 (4) vehicles not excluded under subdivision 3; and
- 492.5 (5) the full value of business accounts used to pay expenses not related to the business.

492.6 Sec. 9. Minnesota Statutes 2022, section 256P.02, is amended by adding a subdivision to
492.7 read:

492.8 Subd. 4. **Health and human services recipient engagement income.** Income received
492.9 from lived-experience engagement, as defined in section 256P.01, subdivision 6, shall be
492.10 excluded when determining the equity value of personal property.

492.11 Sec. 10. Minnesota Statutes 2022, section 256P.02, is amended by adding a subdivision
492.12 to read:

492.13 Subd. 5. **Census income.** Census income is excluded when determining the equity value
492.14 of personal property.

492.15 Sec. 11. Minnesota Statutes 2022, section 256P.06, subdivision 3, is amended to read:

492.16 Subd. 3. **Income inclusions.** The following must be included in determining the income
492.17 of an assistance unit:

- 492.18 (1) earned income; and
- 492.19 (2) unearned income, which includes:
- 492.20 (i) interest and dividends from investments and savings;
- 492.21 (ii) capital gains as defined by the Internal Revenue Service from any sale of real property;
- 492.22 (iii) proceeds from rent and contract for deed payments in excess of the principal and
492.23 interest portion owed on property;
- 492.24 (iv) income from trusts, excluding special needs and supplemental needs trusts;
- 492.25 (v) interest income from loans made by the participant or household;
- 492.26 (vi) cash prizes and winnings;
- 492.27 (vii) unemployment insurance income that is received by an adult member of the
492.28 assistance unit unless the individual receiving unemployment insurance income is:

- 493.1 (A) 18 years of age and enrolled in a secondary school; or
- 493.2 (B) 18 or 19 years of age, a caregiver, and is enrolled in school at least half-time;
- 493.3 (viii) retirement, survivors, and disability insurance payments;
- 493.4 (ix) nonrecurring income over \$60 per quarter unless the nonrecurring income is: (A)
- 493.5 from tax refunds, tax rebates, or tax credits; (B) a reimbursement, rebate, award, grant, or
- 493.6 refund of personal or real property or costs or losses incurred when these payments are
- 493.7 made by: a public agency; a court; solicitations through public appeal; a federal, state, or
- 493.8 local unit of government; or a disaster assistance organization; (C) provided as an in-kind
- 493.9 benefit; or (D) earmarked and used for the purpose for which it was intended, subject to
- 493.10 verification requirements under section 256P.04;
- 493.11 (x) retirement benefits;
- 493.12 (xi) cash assistance benefits, as defined by each program in chapters 119B, 256D, 256I,
- 493.13 and 256J;
- 493.14 ~~(xii) Tribal per capita payments unless excluded by federal and state law;~~
- 493.15 ~~(xiii)~~ (xii) income from members of the United States armed forces unless excluded
- 493.16 from income taxes according to federal or state law;
- 493.17 ~~(xiv)~~ (xiii) all child support payments for programs under chapters 119B, 256D, and
- 493.18 256I;
- 493.19 ~~(xv)~~ (xiv) the amount of child support received that exceeds \$100 for assistance units
- 493.20 with one child and \$200 for assistance units with two or more children for programs under
- 493.21 chapter 256J;
- 493.22 ~~(xvi)~~ (xv) spousal support; and
- 493.23 ~~(xvii)~~ (xvi) workers' compensation.
- 493.24 Sec. 12. Minnesota Statutes 2022, section 256P.06, is amended by adding a subdivision
- 493.25 to read:
- 493.26 Subd. 4. Recipient engagement income. Income received from lived-experience
- 493.27 engagement, as defined in section 256P.01, subdivision 5a, must not be counted as income
- 493.28 for purposes of determining or redetermining eligibility or benefits.
- 493.29 EFFECTIVE DATE. This section is effective August 1, 2024.

494.1 Sec. 13. Minnesota Statutes 2022, section 256P.06, is amended by adding a subdivision
494.2 to read:

494.3 Subd. 5. **Census income.** Census income does not count as income for purposes of
494.4 determining or redetermining eligibility or benefits.

494.5 Sec. 14. Minnesota Statutes 2022, section 609B.425, subdivision 2, is amended to read:

494.6 Subd. 2. **Benefit eligibility.** (a) For general assistance benefits and Minnesota
494.7 supplemental aid under chapter 256D, a person convicted of a felony-level drug offense
494.8 after July 1, 1997, is ineligible for general assistance benefits and Supplemental Security
494.9 Income under chapter 256D until: during the previous ten years from the date of application
494.10 or recertification may be subject to random drug testing. The county must provide information
494.11 about substance use disorder treatment programs to a person who tests positive for an illegal
494.12 controlled substance.

494.13 ~~(1) five years after completing the terms of a court-ordered sentence; or~~

494.14 ~~(2) unless the person is participating in a drug treatment program, has successfully~~
494.15 ~~completed a program, or has been determined not to be in need of a drug treatment program.~~

494.16 ~~(b) A person who becomes eligible for assistance under chapter 256D is subject to~~
494.17 ~~random drug testing and shall lose eligibility for benefits for five years beginning the month~~
494.18 ~~following:~~

494.19 ~~(1) any positive test for an illegal controlled substance; or~~

494.20 ~~(2) discharge of sentence for conviction of another drug felony.~~

494.21 ~~(e)~~ (b) Parole violators and fleeing felons are ineligible for benefits and persons
494.22 fraudulently misrepresenting eligibility are also ineligible to receive benefits for ten years.

494.23 **EFFECTIVE DATE.** This section is effective August 1, 2023.

494.24 Sec. 15. Minnesota Statutes 2022, section 609B.435, subdivision 2, is amended to read:

494.25 Subd. 2. **Drug offenders; random testing; sanctions.** A person who is an applicant for
494.26 benefits from the Minnesota family investment program or MFIP, the vehicle for temporary
494.27 assistance for needy families or TANF, and who has been convicted of a felony-level drug
494.28 offense shall ~~may~~ be subject to ~~certain conditions, including random drug testing, in order~~
494.29 ~~to receive MFIP benefits.~~ Following any positive test for a controlled substance, the ~~convicted~~
494.30 ~~applicant or participant is subject to the following sanctions:~~ county must provide information
494.31 about substance use disorder treatment programs to the applicant or participant.

495.1 ~~(1) a first time drug test failure results in a reduction of benefits in an amount equal to~~
 495.2 ~~30 percent of the MFIP standard of need; and~~

495.3 ~~(2) a second time drug test failure results in permanent disqualification from receiving~~
 495.4 ~~MFIP assistance.~~

495.5 ~~A similar disqualification sequence occurs if the applicant is receiving Supplemental Nutrition~~
 495.6 ~~Assistance Program (SNAP) benefits.~~

495.7 **EFFECTIVE DATE.** This section is effective August 1, 2023.

495.8 **ARTICLE 11**

495.9 **HOUSING SUPPORTS**

495.10 Section 1. Minnesota Statutes 2022, section 256I.03, subdivision 7, is amended to read:

495.11 Subd. 7. **Countable income.** (a) "Countable income" means all income received by an
 495.12 applicant or recipient as described under section 256P.06, less any applicable exclusions or
 495.13 disregards. For a recipient of any cash benefit from the SSI program, countable income
 495.14 means the SSI benefit limit in effect at the time the person is a recipient of housing support,
 495.15 less the medical assistance personal needs allowance under section 256B.35. If the SSI limit
 495.16 or benefit is reduced for a person due to events other than receipt of additional income,
 495.17 countable income means actual income less any applicable exclusions and disregards.

495.18 (b) For a recipient of any cash benefit from the SSI program who does not live in a
 495.19 setting described in section 256I.04, subdivision 2a, paragraph (b), clause (2), countable
 495.20 income equals the SSI benefit limit in effect at the time the person is a recipient of housing
 495.21 support, less the personal needs allowance under section 256B.35. If the SSI limit or benefit
 495.22 is reduced for a person due to events other than receipt of additional income, countable
 495.23 income equals actual income less any applicable exclusions and disregards.

495.24 (c) For a recipient of any cash benefit from the SSI program who lives in a setting as
 495.25 described in section 256I.04, subdivision 2a, paragraph (b), clause (2), countable income
 495.26 equals 30 percent of the SSI benefit limit in effect at the time a person is a recipient of
 495.27 housing support. If the SSI limit or benefit is reduced for a person due to events other than
 495.28 receipt of additional income, countable income equals 30 percent of the actual income less
 495.29 any applicable exclusions and disregards. For recipients under this paragraph, the personal
 495.30 needs allowance described in section 256B.35 does not apply.

495.31 (d) Notwithstanding the earned income disregard described in section 256P.03, for a
 495.32 recipient of unearned income as defined in section 256P.06, subdivision 3, clause (2), other

496.1 than SSI and the general assistance personal needs allowance who lives in a setting described
496.2 in section 256I.04, subdivision 2a, paragraph (b), clause (2), countable income equals 30
496.3 percent of the recipient's total income after applicable exclusions and disregards. Total
496.4 income includes any unearned income as defined in section 256P.06 and any earned income
496.5 in the month the person is a recipient of housing support. For recipients under this paragraph,
496.6 the personal needs allowance described in section 256B.35 does not apply.

496.7 (e) For a recipient who lives in a setting as described in section 256I.04, subdivision 2a,
496.8 paragraph (b), clause (2), and receives general assistance, the personal needs allowance
496.9 described in section 256B.35 is not countable unearned income.

496.10 **EFFECTIVE DATE.** This section is effective October 1, 2024.

496.11 Sec. 2. Minnesota Statutes 2022, section 256I.04, subdivision 1, is amended to read:

496.12 Subdivision 1. **Individual eligibility requirements.** An individual is eligible for and
496.13 entitled to a housing support payment to be made on the individual's behalf if the agency
496.14 has approved the setting where the individual will receive housing support and the individual
496.15 meets the requirements in paragraph (a), (b), ~~(c)~~, or (d).

496.16 (a) The individual is aged, blind, or is over 18 years of age with a disability as determined
496.17 under the criteria used by the title II program of the Social Security Act, and meets the
496.18 resource restrictions and standards of section 256P.02, and the individual's countable income
496.19 after deducting the (1) exclusions and disregards of the SSI program, (2) the medical
496.20 assistance personal needs allowance under section 256B.35, and (3) an amount equal to the
496.21 income actually made available to a community spouse by an elderly waiver participant
496.22 under the provisions of sections 256B.0575, paragraph (a), clause (4), and 256B.058,
496.23 subdivision 2, is less than the monthly rate specified in the agency's agreement with the
496.24 provider of housing support in which the individual resides.

496.25 (b) The individual meets a category of eligibility under section 256D.05, subdivision 1,
496.26 paragraph (a), clauses (1), (3), (4) to (8), and (13), and paragraph (b), if applicable, and the
496.27 individual's resources are less than the standards specified by section 256P.02, and the
496.28 individual's countable income as determined under section 256P.06, less the medical
496.29 assistance personal needs allowance under section 256B.35 is less than the monthly rate
496.30 specified in the agency's agreement with the provider of housing support in which the
496.31 individual resides.

496.32 (c) The individual lacks a fixed, adequate, nighttime residence upon discharge from a
496.33 residential behavioral health treatment program, as determined by treatment staff from the

497.1 residential behavioral health treatment program. An individual is eligible under this paragraph
497.2 for up to three months, including a full or partial month from the individual's move-in date
497.3 at a setting approved for housing support following discharge from treatment, plus two full
497.4 months.

497.5 (d) The individual meets the criteria related to establishing a certified disability or
497.6 disabling condition in paragraph (a) or (b) and lacks a fixed, adequate, nighttime residence
497.7 upon discharge from a correctional facility, as determined by an authorized representative
497.8 from a Minnesota-based correctional facility. An individual is eligible under this paragraph
497.9 for up to three months, including a full or partial month from the individual's move-in date
497.10 at a setting approved for housing support following release, plus two full months. People
497.11 who meet the disabling condition criteria established in paragraph (a) or (b) will not have
497.12 any countable income for the duration of eligibility under this paragraph.

497.13 **EFFECTIVE DATE.** This section is effective November 1, 2024.

497.14 Sec. 3. Minnesota Statutes 2022, section 256I.04, subdivision 3, is amended to read:

497.15 Subd. 3. **Moratorium on development of housing support beds.** (a) Agencies shall
497.16 not enter into agreements for new housing support beds with total rates in excess of the
497.17 MSA equivalent rate except:

497.18 (1) for establishments licensed under chapter 245D provided the facility is needed to
497.19 meet the census reduction targets for persons with developmental disabilities at regional
497.20 treatment centers;

497.21 (2) up to 80 beds in a single, specialized facility located in Hennepin County that will
497.22 provide housing for chronic inebriates who are repetitive users of detoxification centers and
497.23 are refused placement in emergency shelters because of their state of intoxication, and
497.24 planning for the specialized facility must have been initiated before July 1, 1991, in
497.25 anticipation of receiving a grant from the Housing Finance Agency under section 462A.05,
497.26 subdivision 20a, paragraph (b);

497.27 (3) notwithstanding the provisions of subdivision 2a, for up to 226 supportive housing
497.28 units in Anoka, Carver, Dakota, Hennepin, ~~or~~ Ramsey, Scott, or Washington County for
497.29 homeless adults with a mental illness, a history of substance abuse, or human
497.30 immunodeficiency virus or acquired immunodeficiency syndrome. For purposes of this
497.31 section, "homeless adult" means a person who is living on the street or in a shelter or
497.32 discharged from a regional treatment center, community hospital, or residential treatment
497.33 program and has no appropriate housing available and lacks the resources and support

498.1 necessary to access appropriate housing. At least 70 percent of the supportive housing units
498.2 must serve homeless adults with mental illness, substance abuse problems, or human
498.3 immunodeficiency virus or acquired immunodeficiency syndrome who are about to be or,
498.4 within the previous six months, have been discharged from a regional treatment center, or
498.5 a state-contracted psychiatric bed in a community hospital, or a residential mental health
498.6 or substance use disorder treatment program. If a person meets the requirements of
498.7 subdivision 1, paragraph (a), and receives a federal or state housing subsidy, the housing
498.8 support rate for that person is limited to the supplementary rate under section 256I.05,
498.9 subdivision 1a, and is determined by subtracting the amount of the person's countable income
498.10 that exceeds the MSA equivalent rate from the housing support supplementary service rate.
498.11 A resident in a demonstration project site who no longer participates in the demonstration
498.12 program shall retain eligibility for a housing support payment in an amount determined
498.13 under section 256I.06, subdivision 8, using the MSA equivalent rate. Service funding under
498.14 section 256I.05, subdivision 1a, will end June 30, 1997, if federal matching funds are
498.15 available and the services can be provided through a managed care entity. If federal matching
498.16 funds are not available, then service funding will continue under section 256I.05, subdivision
498.17 1a;

498.18 (4) for an additional two beds, resulting in a total of 32 beds, for a facility located in
498.19 Hennepin County providing services for men with and recovering from substance use
498.20 disorder that has had a housing support contract with the county and has been licensed as
498.21 a board and lodge facility with special services since 1980;

498.22 (5) for a housing support provider located in the city of St. Cloud, or a county contiguous
498.23 to the city of St. Cloud, that operates a 40-bed facility, that received financing through the
498.24 Minnesota Housing Finance Agency Ending Long-Term Homelessness Initiative and serves
498.25 clientele with substance use disorder, providing 24-hour-a-day supervision;

498.26 (6) for a new 65-bed facility in Crow Wing County that will serve persons with substance
498.27 use disorder, operated by a housing support provider that currently operates a 304-bed
498.28 facility in Minneapolis, and a 44-bed facility in Duluth;

498.29 (7) for a housing support provider that operates two ten-bed facilities, one located in
498.30 Hennepin County and one located in Ramsey County, that provide community support and
498.31 24-hour-a-day supervision to serve the mental health needs of individuals who have
498.32 chronically lived unsheltered; and

498.33 (8) for a facility authorized for recipients of housing support in Hennepin County with
498.34 a capacity of up to 48 beds that has been licensed since 1978 as a board and lodging facility

499.1 and that until August 1, 2007, operated as a licensed substance use disorder treatment
499.2 program.

499.3 (b) An agency may enter into a housing support agreement for beds with rates in excess
499.4 of the MSA equivalent rate in addition to those currently covered under a housing support
499.5 agreement if the additional beds are only a replacement of beds with rates in excess of the
499.6 MSA equivalent rate which have been made available due to closure of a setting, a change
499.7 of licensure or certification which removes the beds from housing support payment, or as
499.8 a result of the downsizing of a setting authorized for recipients of housing support. The
499.9 transfer of available beds from one agency to another can only occur by the agreement of
499.10 both agencies.

499.11 **Sec. 4. HOUSING STABILIZATION SERVICES INFLATIONARY ADJUSTMENT.**

499.12 The commissioner of human services shall seek federal approval to apply biennial
499.13 inflationary updates to housing stabilization services rates based on the consumer price
499.14 index. Beginning January 1, 2024, the commissioner must update rates using the most
499.15 recently available data from the consumer price index.

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

499.19 **ARTICLE 12**

499.20 **LICENSING**

499.21 Section 1. Minnesota Statutes 2022, section 245A.04, subdivision 1, is amended to read:

499.22 Subdivision 1. **Application for licensure.** (a) An individual, organization, or government
499.23 entity that is subject to licensure under section 245A.03 must apply for a license. The
499.24 application must be made on the forms and in the manner prescribed by the commissioner.
499.25 The commissioner shall provide the applicant with instruction in completing the application
499.26 and provide information about the rules and requirements of other state agencies that affect
499.27 the applicant. An applicant seeking licensure in Minnesota with headquarters outside of
499.28 Minnesota must have a program office located within 30 miles of the Minnesota border.
499.29 An applicant who intends to buy or otherwise acquire a program or services licensed under
499.30 this chapter that is owned by another license holder must apply for a license under this
499.31 chapter and comply with the application procedures in this section and section 245A.03.

500.1 The commissioner shall act on the application within 90 working days after a complete
500.2 application and any required reports have been received from other state agencies or
500.3 departments, counties, municipalities, or other political subdivisions. The commissioner
500.4 shall not consider an application to be complete until the commissioner receives all of the
500.5 required information.

500.6 When the commissioner receives an application for initial licensure that is incomplete
500.7 because the applicant failed to submit required documents or that is substantially deficient
500.8 because the documents submitted do not meet licensing requirements, the commissioner
500.9 shall provide the applicant written notice that the application is incomplete or substantially
500.10 deficient. In the written notice to the applicant the commissioner shall identify documents
500.11 that are missing or deficient and give the applicant 45 days to resubmit a second application
500.12 that is substantially complete. An applicant's failure to submit a substantially complete
500.13 application after receiving notice from the commissioner is a basis for license denial under
500.14 section 245A.05.

500.15 (b) An application for licensure must identify all controlling individuals as defined in
500.16 section 245A.02, subdivision 5a, and must designate one individual to be the authorized
500.17 agent. The application must be signed by the authorized agent and must include the authorized
500.18 agent's first, middle, and last name; mailing address; and email address. By submitting an
500.19 application for licensure, the authorized agent consents to electronic communication with
500.20 the commissioner throughout the application process. The authorized agent must be
500.21 authorized to accept service on behalf of all of the controlling individuals. A government
500.22 entity that holds multiple licenses under this chapter may designate one authorized agent
500.23 for all licenses issued under this chapter or may designate a different authorized agent for
500.24 each license. Service on the authorized agent is service on all of the controlling individuals.
500.25 It is not a defense to any action arising under this chapter that service was not made on each
500.26 controlling individual. The designation of a controlling individual as the authorized agent
500.27 under this paragraph does not affect the legal responsibility of any other controlling individual
500.28 under this chapter.

500.29 (c) An applicant or license holder must have a policy that prohibits license holders,
500.30 employees, subcontractors, and volunteers, when directly responsible for persons served
500.31 by the program, from abusing prescription medication or being in any manner under the
500.32 influence of a chemical that impairs the individual's ability to provide services or care. The
500.33 license holder must train employees, subcontractors, and volunteers about the program's
500.34 drug and alcohol policy.

501.1 (d) An applicant and license holder must have a program grievance procedure that permits
501.2 persons served by the program and their authorized representatives to bring a grievance to
501.3 the highest level of authority in the program.

501.4 (e) The commissioner may limit communication during the application process to the
501.5 authorized agent or the controlling individuals identified on the license application and for
501.6 whom a background study was initiated under chapter 245C. Upon implementation of the
501.7 provider licensing and reporting hub, applicants and license holders must use the hub in the
501.8 manner prescribed by the commissioner. The commissioner may require the applicant,
501.9 except for child foster care, to demonstrate competence in the applicable licensing
501.10 requirements by successfully completing a written examination. The commissioner may
501.11 develop a prescribed written examination format.

501.12 (f) When an applicant is an individual, the applicant must provide:

501.13 (1) the applicant's taxpayer identification numbers including the Social Security number
501.14 or Minnesota tax identification number, and federal employer identification number if the
501.15 applicant has employees;

501.16 (2) at the request of the commissioner, a copy of the most recent filing with the secretary
501.17 of state that includes the complete business name, if any;

501.18 (3) if doing business under a different name, the doing business as (DBA) name, as
501.19 registered with the secretary of state;

501.20 (4) if applicable, the applicant's National Provider Identifier (NPI) number and Unique
501.21 Minnesota Provider Identifier (UMPI) number; and

501.22 (5) at the request of the commissioner, the notarized signature of the applicant or
501.23 authorized agent.

501.24 (g) When an applicant is an organization, the applicant must provide:

501.25 (1) the applicant's taxpayer identification numbers including the Minnesota tax
501.26 identification number and federal employer identification number;

501.27 (2) at the request of the commissioner, a copy of the most recent filing with the secretary
501.28 of state that includes the complete business name, and if doing business under a different
501.29 name, the doing business as (DBA) name, as registered with the secretary of state;

501.30 (3) the first, middle, and last name, and address for all individuals who will be controlling
501.31 individuals, including all officers, owners, and managerial officials as defined in section

502.1 245A.02, subdivision 5a, and the date that the background study was initiated by the applicant
502.2 for each controlling individual;

502.3 (4) if applicable, the applicant's NPI number and UMPI number;

502.4 (5) the documents that created the organization and that determine the organization's
502.5 internal governance and the relations among the persons that own the organization, have
502.6 an interest in the organization, or are members of the organization, in each case as provided
502.7 or authorized by the organization's governing statute, which may include a partnership
502.8 agreement, bylaws, articles of organization, organizational chart, and operating agreement,
502.9 or comparable documents as provided in the organization's governing statute; and

502.10 (6) the notarized signature of the applicant or authorized agent.

502.11 (h) When the applicant is a government entity, the applicant must provide:

502.12 (1) the name of the government agency, political subdivision, or other unit of government
502.13 seeking the license and the name of the program or services that will be licensed;

502.14 (2) the applicant's taxpayer identification numbers including the Minnesota tax
502.15 identification number and federal employer identification number;

502.16 (3) a letter signed by the manager, administrator, or other executive of the government
502.17 entity authorizing the submission of the license application; and

502.18 (4) if applicable, the applicant's NPI number and UMPI number.

502.19 (i) At the time of application for licensure or renewal of a license under this chapter, the
502.20 applicant or license holder must acknowledge on the form provided by the commissioner
502.21 if the applicant or license holder elects to receive any public funding reimbursement from
502.22 the commissioner for services provided under the license that:

502.23 (1) the applicant's or license holder's compliance with the provider enrollment agreement
502.24 or registration requirements for receipt of public funding may be monitored by the
502.25 commissioner as part of a licensing investigation or licensing inspection; and

502.26 (2) noncompliance with the provider enrollment agreement or registration requirements
502.27 for receipt of public funding that is identified through a licensing investigation or licensing
502.28 inspection, or noncompliance with a licensing requirement that is a basis of enrollment for
502.29 reimbursement for a service, may result in:

502.30 (i) a correction order or a conditional license under section 245A.06, or sanctions under
502.31 section 245A.07;

503.1 (ii) nonpayment of claims submitted by the license holder for public program
503.2 reimbursement;

503.3 (iii) recovery of payments made for the service;

503.4 (iv) disenrollment in the public payment program; or

503.5 (v) other administrative, civil, or criminal penalties as provided by law.

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

503.7 Sec. 2. Minnesota Statutes 2022, section 245A.04, subdivision 7a, is amended to read:

503.8 Subd. 7a. **Notification required.** (a) A license holder must notify the commissioner, in
503.9 a manner prescribed by the commissioner, and obtain the commissioner's approval before
503.10 making any change that would alter the license information listed under subdivision 7,
503.11 paragraph (a).

503.12 (b) A license holder must also notify the commissioner, in a manner prescribed by the
503.13 commissioner, before making any change:

503.14 (1) to the license holder's authorized agent as defined in section 245A.02, subdivision
503.15 3b;

503.16 (2) to the license holder's controlling individual as defined in section 245A.02, subdivision
503.17 5a;

503.18 (3) to the license holder information on file with the secretary of state;

503.19 (4) in the location of the program or service licensed under this chapter; and

503.20 (5) to the federal or state tax identification number associated with the license holder.

503.21 (c) When, for reasons beyond the license holder's control, a license holder cannot provide
503.22 the commissioner with prior notice of the changes in paragraph (b), clauses (1) to (3), the
503.23 license holder must notify the commissioner by the tenth business day after the change and
503.24 must provide any additional information requested by the commissioner.

503.25 (d) When a license holder notifies the commissioner of a change to the license holder
503.26 information on file with the secretary of state, the license holder must provide amended
503.27 articles of incorporation and other documentation of the change.

503.28 (e) Upon implementation of the provider licensing and reporting hub, license holders
503.29 must enter and update information in the hub in a manner prescribed by the commissioner.

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

504.1 Sec. 3. Minnesota Statutes 2022, section 245A.05, is amended to read:

504.2 **245A.05 DENIAL OF APPLICATION.**

504.3 (a) The commissioner may deny a license if an applicant or controlling individual:

504.4 (1) fails to submit a substantially complete application after receiving notice from the
504.5 commissioner under section 245A.04, subdivision 1;

504.6 (2) fails to comply with applicable laws or rules;

504.7 (3) knowingly withholds relevant information from or gives false or misleading
504.8 information to the commissioner in connection with an application for a license or during
504.9 an investigation;

504.10 (4) has a disqualification that has not been set aside under section 245C.22 and no
504.11 variance has been granted;

504.12 (5) has an individual living in the household who received a background study under
504.13 section 245C.03, subdivision 1, paragraph (a), clause (2), who has a disqualification that
504.14 has not been set aside under section 245C.22, and no variance has been granted;

504.15 (6) is associated with an individual who received a background study under section
504.16 245C.03, subdivision 1, paragraph (a), clause (6), who may have unsupervised access to
504.17 children or vulnerable adults, and who has a disqualification that has not been set aside
504.18 under section 245C.22, and no variance has been granted;

504.19 (7) fails to comply with section 245A.04, subdivision 1, paragraph (f) or (g);

504.20 (8) fails to demonstrate competent knowledge as required by section 245A.04, subdivision
504.21 6;

504.22 (9) has a history of noncompliance as a license holder or controlling individual with
504.23 applicable laws or rules, including but not limited to this chapter and chapters 119B and
504.24 245C;

504.25 (10) is prohibited from holding a license according to section 245.095; or

504.26 (11) for a family foster setting, has nondisqualifying background study information, as
504.27 described in section 245C.05, subdivision 4, that reflects on the individual's ability to safely
504.28 provide care to foster children.

504.29 (b) An applicant whose application has been denied by the commissioner must be given
504.30 notice of the denial, which must state the reasons for the denial in plain language. Notice
504.31 must be given by certified mail ~~or~~, by personal service, or through the provider licensing

505.1 and reporting hub. The notice must state the reasons the application was denied and must
505.2 inform the applicant of the right to a contested case hearing under chapter 14 and Minnesota
505.3 Rules, parts 1400.8505 to 1400.8612. The applicant may appeal the denial by notifying the
505.4 commissioner in writing by certified mail ~~or~~, by personal service, or through the provider
505.5 licensing and reporting hub. If mailed, the appeal must be postmarked and sent to the
505.6 commissioner within 20 calendar days after the applicant received the notice of denial. If
505.7 an appeal request is made by personal service, it must be received by the commissioner
505.8 within 20 calendar days after the applicant received the notice of denial. If the order is issued
505.9 through the provider hub, the appeal must be received by the commissioner within 20
505.10 calendar days from the date the commissioner issued the order through the hub. Section
505.11 245A.08 applies to hearings held to appeal the commissioner's denial of an application.

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

505.13 Sec. 4. Minnesota Statutes 2022, section 245A.055, subdivision 2, is amended to read:

505.14 Subd. 2. **Reconsideration of closure.** If a license is closed, the commissioner must
505.15 notify the license holder of closure by certified mail ~~or~~, by personal service, or through the
505.16 provider licensing and reporting hub. If mailed, the notice of closure must be mailed to the
505.17 last known address of the license holder and must inform the license holder why the license
505.18 was closed and that the license holder has the right to request reconsideration of the closure.
505.19 If the license holder believes that the license was closed in error, the license holder may ask
505.20 the commissioner to reconsider the closure. The license holder's request for reconsideration
505.21 must be made in writing and must include documentation that the licensed program has
505.22 served a client in the previous 12 months. The request for reconsideration must be postmarked
505.23 and sent to the commissioner or submitted through the provider licensing and reporting hub
505.24 within 20 calendar days after the license holder receives the notice of closure. Upon
505.25 implementation of the provider licensing and reporting hub, the provider must use the hub
505.26 to request reconsideration. If the order is issued through the provider hub, the reconsideration
505.27 must be received by the commissioner within 20 calendar days from the date the
505.28 commissioner issued the order through the hub. A timely request for reconsideration stays
505.29 imposition of the license closure until the commissioner issues a decision on the request for
505.30 reconsideration.

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

506.1 Sec. 5. Minnesota Statutes 2022, section 245A.06, subdivision 1, is amended to read:

506.2 Subdivision 1. **Contents of correction orders and conditional licenses.** (a) If the
 506.3 commissioner finds that the applicant or license holder has failed to comply with an
 506.4 applicable law or rule and this failure does not imminently endanger the health, safety, or
 506.5 rights of the persons served by the program, the commissioner may issue a correction order
 506.6 and an order of conditional license to the applicant or license holder. When issuing a
 506.7 conditional license, the commissioner shall consider the nature, chronicity, or severity of
 506.8 the violation of law or rule and the effect of the violation on the health, safety, or rights of
 506.9 persons served by the program. The correction order or conditional license must state the
 506.10 following in plain language:

506.11 (1) the conditions that constitute a violation of the law or rule;

506.12 (2) the specific law or rule violated;

506.13 (3) the time allowed to correct each violation; and

506.14 (4) if a license is made conditional, the length and terms of the conditional license, and
 506.15 the reasons for making the license conditional.

506.16 (b) Nothing in this section prohibits the commissioner from proposing a sanction as
 506.17 specified in section 245A.07, prior to issuing a correction order or conditional license.

506.18 (c) The commissioner may issue a correction order and an order of conditional license
 506.19 to the applicant or license holder through the provider licensing and reporting hub.

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

506.21 Sec. 6. Minnesota Statutes 2022, section 245A.06, subdivision 2, is amended to read:

506.22 Subd. 2. **Reconsideration of correction orders.** (a) If the applicant or license holder
 506.23 believes that the contents of the commissioner's correction order are in error, the applicant
 506.24 or license holder may ask the Department of Human Services to reconsider the parts of the
 506.25 correction order that are alleged to be in error. The request for reconsideration must be made
 506.26 in writing and must be postmarked and sent to the commissioner within 20 calendar days
 506.27 after receipt of the correction order by the applicant or license holder or submitted in the
 506.28 provider licensing and reporting hub within 20 calendar days from the date the commissioner
 506.29 issued the order through the hub, and:

506.30 (1) specify the parts of the correction order that are alleged to be in error;

506.31 (2) explain why they are in error; and

507.1 (3) include documentation to support the allegation of error.

507.2 Upon implementation of the provider licensing and reporting hub, the provider must use
507.3 the hub to request reconsideration. A request for reconsideration does not stay any provisions
507.4 or requirements of the correction order. The commissioner's disposition of a request for
507.5 reconsideration is final and not subject to appeal under chapter 14.

507.6 (b) This paragraph applies only to licensed family child care providers. A licensed family
507.7 child care provider who requests reconsideration of a correction order under paragraph (a)
507.8 may also request, on a form and in the manner prescribed by the commissioner, that the
507.9 commissioner expedite the review if:

507.10 (1) the provider is challenging a violation and provides a description of how complying
507.11 with the corrective action for that violation would require the substantial expenditure of
507.12 funds or a significant change to their program; and

507.13 (2) describes what actions the provider will take in lieu of the corrective action ordered
507.14 to ensure the health and safety of children in care pending the commissioner's review of the
507.15 correction order.

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

507.17 Sec. 7. Minnesota Statutes 2022, section 245A.06, subdivision 4, is amended to read:

507.18 Subd. 4. **Notice of conditional license; reconsideration of conditional license.** (a) If
507.19 a license is made conditional, the license holder must be notified of the order by certified
507.20 mail ~~or~~, by personal service, or through the provider licensing and reporting hub. If mailed,
507.21 the notice must be mailed to the address shown on the application or the last known address
507.22 of the license holder. The notice must state the reasons the conditional license was ordered
507.23 and must inform the license holder of the right to request reconsideration of the conditional
507.24 license by the commissioner. The license holder may request reconsideration of the order
507.25 of conditional license by notifying the commissioner by certified mail ~~or~~, by personal service,
507.26 or through the provider licensing and reporting hub. The request must be made in writing.
507.27 If sent by certified mail, the request must be postmarked and sent to the commissioner within
507.28 ten calendar days after the license holder received the order. If a request is made by personal
507.29 service, it must be received by the commissioner within ten calendar days after the license
507.30 holder received the order. If the order is issued through the provider hub, the request must
507.31 be received by the commissioner within ten calendar days from the date the commissioner
507.32 issued the order through the hub. The license holder may submit with the request for
507.33 reconsideration written argument or evidence in support of the request for reconsideration.

508.1 A timely request for reconsideration shall stay imposition of the terms of the conditional
 508.2 license until the commissioner issues a decision on the request for reconsideration. If the
 508.3 commissioner issues a dual order of conditional license under this section and an order to
 508.4 pay a fine under section 245A.07, subdivision 3, the license holder has a right to a contested
 508.5 case hearing under chapter 14 and Minnesota Rules, parts 1400.8505 to 1400.8612. The
 508.6 scope of the contested case hearing shall include the fine and the conditional license. In this
 508.7 case, a reconsideration of the conditional license will not be conducted under this section.
 508.8 If the license holder does not appeal the fine, the license holder does not have a right to a
 508.9 contested case hearing and a reconsideration of the conditional license must be conducted
 508.10 under this subdivision.

508.11 (b) The commissioner's disposition of a request for reconsideration is final and not
 508.12 subject to appeal under chapter 14.

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

508.14 Sec. 8. Minnesota Statutes 2022, section 245A.07, subdivision 3, is amended to read:

508.15 Subd. 3. **License suspension, revocation, or fine.** (a) The commissioner may suspend
 508.16 or revoke a license, or impose a fine if:

508.17 (1) a license holder fails to comply fully with applicable laws or rules including but not
 508.18 limited to the requirements of this chapter and chapter 245C;

508.19 (2) a license holder, a controlling individual, or an individual living in the household
 508.20 where the licensed services are provided or is otherwise subject to a background study has
 508.21 been disqualified and the disqualification was not set aside and no variance has been granted;

508.22 (3) a license holder knowingly withholds relevant information from or gives false or
 508.23 misleading information to the commissioner in connection with an application for a license,
 508.24 in connection with the background study status of an individual, during an investigation,
 508.25 or regarding compliance with applicable laws or rules;

508.26 (4) a license holder is excluded from any program administered by the commissioner
 508.27 under section 245.095; or

508.28 (5) revocation is required under section 245A.04, subdivision 7, paragraph (d).

508.29 A license holder who has had a license issued under this chapter suspended, revoked,
 508.30 or has been ordered to pay a fine must be given notice of the action by certified mail ~~or~~, by
 508.31 personal service, or through the provider licensing and reporting hub. If mailed, the notice
 508.32 must be mailed to the address shown on the application or the last known address of the

509.1 license holder. The notice must state in plain language the reasons the license was suspended
509.2 or revoked, or a fine was ordered.

509.3 (b) If the license was suspended or revoked, the notice must inform the license holder
509.4 of the right to a contested case hearing under chapter 14 and Minnesota Rules, parts
509.5 1400.8505 to 1400.8612. The license holder may appeal an order suspending or revoking
509.6 a license. The appeal of an order suspending or revoking a license must be made in writing
509.7 by certified mail ~~or~~, by personal service, or through the provider licensing and reporting
509.8 hub. If mailed, the appeal must be postmarked and sent to the commissioner within ten
509.9 calendar days after the license holder receives notice that the license has been suspended
509.10 or revoked. If a request is made by personal service, it must be received by the commissioner
509.11 within ten calendar days after the license holder received the order. If the order is issued
509.12 through the provider hub, the appeal must be received by the commissioner within ten
509.13 calendar days from the date the commissioner issued the order through the hub. Except as
509.14 provided in subdivision 2a, paragraph (c), if a license holder submits a timely appeal of an
509.15 order suspending or revoking a license, the license holder may continue to operate the
509.16 program as provided in section 245A.04, subdivision 7, paragraphs (f) and (g), until the
509.17 commissioner issues a final order on the suspension or revocation.

509.18 (c)(1) If the license holder was ordered to pay a fine, the notice must inform the license
509.19 holder of the responsibility for payment of fines and the right to a contested case hearing
509.20 under chapter 14 and Minnesota Rules, parts 1400.8505 to 1400.8612. The appeal of an
509.21 order to pay a fine must be made in writing by certified mail ~~or~~, by personal service, or
509.22 through the provider licensing and reporting hub. If mailed, the appeal must be postmarked
509.23 and sent to the commissioner within ten calendar days after the license holder receives
509.24 notice that the fine has been ordered. If a request is made by personal service, it must be
509.25 received by the commissioner within ten calendar days after the license holder received the
509.26 order. If the order is issued through the provider hub, the appeal must be received by the
509.27 commissioner within ten calendar days from the date the commissioner issued the order
509.28 through the hub.

509.29 (2) The license holder shall pay the fines assessed on or before the payment date specified.
509.30 If the license holder fails to fully comply with the order, the commissioner may issue a
509.31 second fine or suspend the license until the license holder complies. If the license holder
509.32 receives state funds, the state, county, or municipal agencies or departments responsible for
509.33 administering the funds shall withhold payments and recover any payments made while the
509.34 license is suspended for failure to pay a fine. A timely appeal shall stay payment of the fine
509.35 until the commissioner issues a final order.

510.1 (3) A license holder shall promptly notify the commissioner of human services, in writing,
 510.2 when a violation specified in the order to forfeit a fine is corrected. If upon reinspection the
 510.3 commissioner determines that a violation has not been corrected as indicated by the order
 510.4 to forfeit a fine, the commissioner may issue a second fine. The commissioner shall notify
 510.5 the license holder by certified mail ~~or~~, by personal service, or through the provider licensing
 510.6 and reporting hub that a second fine has been assessed. The license holder may appeal the
 510.7 second fine as provided under this subdivision.

510.8 (4) Fines shall be assessed as follows:

510.9 (i) the license holder shall forfeit \$1,000 for each determination of maltreatment of a
 510.10 child under chapter 260E or the maltreatment of a vulnerable adult under section 626.557
 510.11 for which the license holder is determined responsible for the maltreatment under section
 510.12 260E.30, subdivision 4, paragraphs (a) and (b), or 626.557, subdivision 9c, paragraph (c);

510.13 (ii) if the commissioner determines that a determination of maltreatment for which the
 510.14 license holder is responsible is the result of maltreatment that meets the definition of serious
 510.15 maltreatment as defined in section 245C.02, subdivision 18, the license holder shall forfeit
 510.16 \$5,000;

510.17 (iii) for a program that operates out of the license holder's home and a program licensed
 510.18 under Minnesota Rules, parts 9502.0300 to 9502.0445, the fine assessed against the license
 510.19 holder shall not exceed \$1,000 for each determination of maltreatment;

510.20 (iv) the license holder shall forfeit \$200 for each occurrence of a violation of law or rule
 510.21 governing matters of health, safety, or supervision, including but not limited to the provision
 510.22 of adequate staff-to-child or adult ratios, and failure to comply with background study
 510.23 requirements under chapter 245C; and

510.24 (v) the license holder shall forfeit \$100 for each occurrence of a violation of law or rule
 510.25 other than those subject to a \$5,000, \$1,000, or \$200 fine in items (i) to (iv).

510.26 For purposes of this section, "occurrence" means each violation identified in the
 510.27 commissioner's fine order. Fines assessed against a license holder that holds a license to
 510.28 provide home and community-based services, as identified in section 245D.03, subdivision
 510.29 1, and a community residential setting or day services facility license under chapter 245D
 510.30 where the services are provided, may be assessed against both licenses for the same
 510.31 occurrence, but the combined amount of the fines shall not exceed the amount specified in
 510.32 this clause for that occurrence.

511.1 (5) When a fine has been assessed, the license holder may not avoid payment by closing,
511.2 selling, or otherwise transferring the licensed program to a third party. In such an event, the
511.3 license holder will be personally liable for payment. In the case of a corporation, each
511.4 controlling individual is personally and jointly liable for payment.

511.5 (d) Except for background study violations involving the failure to comply with an order
511.6 to immediately remove an individual or an order to provide continuous, direct supervision,
511.7 the commissioner shall not issue a fine under paragraph (c) relating to a background study
511.8 violation to a license holder who self-corrects a background study violation before the
511.9 commissioner discovers the violation. A license holder who has previously exercised the
511.10 provisions of this paragraph to avoid a fine for a background study violation may not avoid
511.11 a fine for a subsequent background study violation unless at least 365 days have passed
511.12 since the license holder self-corrected the earlier background study violation.

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

511.14 Sec. 9. Minnesota Statutes 2022, section 245A.16, is amended by adding a subdivision to
511.15 read:

511.16 **Subd. 10. Licensing and reporting hub.** Upon implementation of the provider licensing
511.17 and reporting hub, county staff who perform licensing functions must use the hub in the
511.18 manner prescribed by the commissioner.

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

511.20 Sec. 10. Minnesota Statutes 2022, section 245H.01, subdivision 3, is amended to read:

511.21 **Subd. 3. Center operator or program operator.** "Center operator" or "program operator"
511.22 means the person exercising supervision or control over the center's or program's operations,
511.23 planning, and functioning. ~~There may be more than one designated center operator or~~
511.24 ~~program operator.~~

511.25 Sec. 11. Minnesota Statutes 2022, section 245H.01, is amended by adding a subdivision
511.26 to read:

511.27 **Subd. 4a. Authorized agent.** "Authorized agent" means the individual designated by
511.28 the certification holder that is responsible for communicating with the commissioner
511.29 regarding all items pursuant to this chapter.

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

512.1 Sec. 12. Minnesota Statutes 2022, section 245H.03, subdivision 2, is amended to read:

512.2 Subd. 2. **Application submission.** The commissioner shall provide application
 512.3 instructions and information about the rules and requirements of other state agencies that
 512.4 affect the applicant. The certification application must be submitted in a manner prescribed
 512.5 by the commissioner. Upon implementation of the provider licensing and reporting hub,
 512.6 applicants must use the hub in the manner prescribed by the commissioner. The commissioner
 512.7 shall act on the application within 90 working days of receiving a completed application.

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

512.9 Sec. 13. Minnesota Statutes 2022, section 245H.03, subdivision 3, is amended to read:

512.10 Subd. 3. **Incomplete applications.** When the commissioner receives an application for
 512.11 initial certification that is incomplete because the applicant failed to submit required
 512.12 documents or is deficient because the documents submitted do not meet certification
 512.13 requirements, the commissioner shall provide the applicant written notice that the application
 512.14 is incomplete or deficient. In the notice, the commissioner shall identify documents that are
 512.15 missing or deficient and give the applicant 45 days to resubmit a second application that is
 512.16 complete. An applicant's failure to submit a complete application after receiving notice from
 512.17 the commissioner is basis for certification denial.

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

512.19 Sec. 14. Minnesota Statutes 2022, section 245H.03, subdivision 4, is amended to read:

512.20 Subd. 4. **Reconsideration of certification denial.** (a) The applicant may request
 512.21 reconsideration of the denial by notifying the commissioner by certified mail ~~or~~ by personal
 512.22 service, or through the provider licensing and reporting hub. The request must be made in
 512.23 writing. If sent by certified mail, the request must be postmarked and sent to the
 512.24 commissioner within 20 calendar days after the applicant received the order. If a request is
 512.25 made by personal service, it must be received by the commissioner within 20 calendar days
 512.26 after the applicant received the order. If the order is issued through the provider hub, the
 512.27 request must be received by the commissioner within 20 calendar days from the date the
 512.28 commissioner issued the order through the hub. The applicant may submit with the request
 512.29 for reconsideration a written argument or evidence in support of the request for
 512.30 reconsideration.

512.31 (b) The commissioner's disposition of a request for reconsideration is final and not
 512.32 subject to appeal under chapter 14.

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

513.2 Sec. 15. Minnesota Statutes 2022, section 245H.06, subdivision 1, is amended to read:

513.3 Subdivision 1. **Correction order requirements.** (a) If the applicant or certification
513.4 holder failed to comply with a law or rule, the commissioner may issue a correction order.
513.5 The correction order must state:

513.6 (1) the condition that constitutes a violation of the law or rule;

513.7 (2) the specific law or rule violated; and

513.8 (3) the time allowed to correct each violation.

513.9 (b) The commissioner may issue a correction order to the applicant or certification holder
513.10 through the provider licensing and reporting hub.

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

513.12 Sec. 16. Minnesota Statutes 2022, section 245H.06, subdivision 2, is amended to read:

513.13 Subd. 2. **Reconsideration request.** (a) If the applicant or certification holder believes
513.14 that the commissioner's correction order is erroneous, the applicant or certification holder
513.15 may ask the commissioner to reconsider the part of the correction order that is allegedly
513.16 erroneous. A request for reconsideration must be made in writing, and postmarked, or
513.17 submitted through the provider licensing and reporting hub and sent to the commissioner
513.18 within 20 calendar days after the applicant or certification holder received the correction
513.19 order, and must:

513.20 (1) specify the part of the correction order that is allegedly erroneous;

513.21 (2) explain why the specified part is erroneous; and

513.22 (3) include documentation to support the allegation of error.

513.23 (b) A request for reconsideration does not stay any provision or requirement of the
513.24 correction order. The commissioner's disposition of a request for reconsideration is final
513.25 and not subject to appeal.

513.26 (c) Upon implementation of the provider licensing and reporting hub, the provider must
513.27 use the hub to request reconsideration. If the order is issued through the provider hub, the
513.28 request must be received by the commissioner within 20 calendar days from the date the
513.29 commissioner issued the order through the hub.

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

514.1 Sec. 17. Minnesota Statutes 2022, section 245H.07, subdivision 1, is amended to read:

514.2 Subdivision 1. **Generally.** (a) The commissioner may decertify a center if a certification
514.3 holder:

514.4 (1) failed to comply with an applicable law or rule;

514.5 (2) knowingly withheld relevant information from or gave false or misleading information
514.6 to the commissioner in connection with an application for certification, in connection with
514.7 the background study status of an individual, during an investigation, or regarding compliance
514.8 with applicable laws or rules; or

514.9 (3) has authorization to receive child care assistance payments revoked pursuant to
514.10 chapter 119B.

514.11 (b) When considering decertification, the commissioner shall consider the nature,
514.12 chronicity, or severity of the violation of law or rule.

514.13 (c) When a center is decertified, the center is ineligible to receive a child care assistance
514.14 payment under chapter 119B.

514.15 (d) The commissioner may issue a decertification order to a certification holder through
514.16 the provider licensing and reporting hub.

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

514.18 Sec. 18. Minnesota Statutes 2022, section 245H.07, subdivision 2, is amended to read:

514.19 Subd. 2. **Reconsideration of decertification.** (a) The certification holder may request
514.20 reconsideration of the decertification by notifying the commissioner by certified mail ~~or~~
514.21 by personal service, or through the provider licensing and reporting hub. The request must
514.22 be made in writing. If sent by certified mail, the request must be postmarked and sent to the
514.23 commissioner within 20 calendar days after the certification holder received the order. If a
514.24 request is made by personal service, it must be received by the commissioner within 20
514.25 calendar days after the certification holder received the order. If the order is issued through
514.26 the provider hub, the request must be received by the commissioner within 20 calendar days
514.27 from the date the commissioner issued the order through the hub. With the request for
514.28 reconsideration, the certification holder may submit a written argument or evidence in
514.29 support of the request for reconsideration.

514.30 (b) The commissioner's disposition of a request for reconsideration is final and not
514.31 subject to appeal under chapter 14.

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

515.1 Sec. 19. Minnesota Statutes 2022, section 245I.20, subdivision 10, is amended to read:

515.2 Subd. 10. **Application procedures.** (a) The applicant for certification must submit any
515.3 documents that the commissioner requires on forms approved by the commissioner. Upon
515.4 implementation of the provider licensing and reporting hub, applicants must use the hub in
515.5 the manner prescribed by the commissioner.

515.6 (b) Upon submitting an application for certification, an applicant must pay the application
515.7 fee required by section 245A.10, subdivision 3.

515.8 (c) The commissioner must act on an application within 90 working days of receiving
515.9 a completed application.

515.10 (d) When the commissioner receives an application for initial certification that is
515.11 incomplete because the applicant failed to submit required documents or is deficient because
515.12 the submitted documents do not meet certification requirements, the commissioner must
515.13 provide the applicant with written notice that the application is incomplete or deficient. In
515.14 the notice, the commissioner must identify the particular documents that are missing or
515.15 deficient and give the applicant 45 days to submit a second application that is complete. An
515.16 applicant's failure to submit a complete application within 45 days after receiving notice
515.17 from the commissioner is a basis for certification denial.

515.18 (e) The commissioner must give notice of a denial to an applicant when the commissioner
515.19 has made the decision to deny the certification application. In the notice of denial, the
515.20 commissioner must state the reasons for the denial in plain language. The commissioner
515.21 must send or deliver the notice of denial to an applicant by certified mail ~~or~~, by personal
515.22 service. In the notice of denial, the commissioner must state the reasons that the commissioner
515.23 denied the application and must inform the applicant of the applicant's right to request a
515.24 contested case hearing under chapter 14 and Minnesota Rules, parts 1400.8505 to 1400.8612.
515.25 The applicant may appeal the denial by notifying the commissioner in writing by certified
515.26 mail ~~or~~, by personal service, or through the provider licensing and reporting hub. If mailed,
515.27 the appeal must be postmarked and sent to the commissioner within 20 calendar days after
515.28 the applicant received the notice of denial. If an applicant delivers an appeal by personal
515.29 service, the commissioner must receive the appeal within 20 calendar days after the applicant
515.30 received the notice of denial. If the order is issued through the provider hub, the request
515.31 must be received by the commissioner within 20 calendar days from the date the
515.32 commissioner issued the order through the hub.

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

516.1 Sec. 20. Minnesota Statutes 2022, section 245I.20, subdivision 13, is amended to read:

516.2 Subd. 13. **Correction orders.** (a) If the applicant or certification holder fails to comply
516.3 with a law or rule, the commissioner may issue a correction order. The correction order
516.4 must state:

516.5 (1) the condition that constitutes a violation of the law or rule;

516.6 (2) the specific law or rule that the applicant or certification holder has violated; and

516.7 (3) the time that the applicant or certification holder is allowed to correct each violation.

516.8 (b) If the applicant or certification holder believes that the commissioner's correction
516.9 order is erroneous, the applicant or certification holder may ask the commissioner to
516.10 reconsider the part of the correction order that is allegedly erroneous. An applicant or
516.11 certification holder must make a request for reconsideration in writing. The request must
516.12 be postmarked and sent to the commissioner or submitted in the provider licensing and
516.13 reporting hub within 20 calendar days after the applicant or certification holder received
516.14 the correction order; and the request must:

516.15 (1) specify the part of the correction order that is allegedly erroneous;

516.16 (2) explain why the specified part is erroneous; and

516.17 (3) include documentation to support the allegation of error.

516.18 (c) A request for reconsideration does not stay any provision or requirement of the
516.19 correction order. The commissioner's disposition of a request for reconsideration is final
516.20 and not subject to appeal.

516.21 (d) If the commissioner finds that the applicant or certification holder failed to correct
516.22 the violation specified in the correction order, the commissioner may decertify the certified
516.23 mental health clinic according to subdivision 14.

516.24 (e) Nothing in this subdivision prohibits the commissioner from decertifying a mental
516.25 health clinic according to subdivision 14.

516.26 (f) The commissioner may issue a correction order to the applicant or certification holder
516.27 through the provider licensing and reporting hub. If the order is issued through the provider
516.28 hub, the request must be received by the commissioner within 20 calendar days from the
516.29 date the commissioner issued the order through the hub.

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

517.1 Sec. 21. Minnesota Statutes 2022, section 245I.20, subdivision 14, is amended to read:

517.2 Subd. 14. **Decertification.** (a) The commissioner may decertify a mental health clinic
517.3 if a certification holder:

517.4 (1) failed to comply with an applicable law or rule; or

517.5 (2) knowingly withheld relevant information from or gave false or misleading information
517.6 to the commissioner in connection with an application for certification, during an
517.7 investigation, or regarding compliance with applicable laws or rules.

517.8 (b) When considering decertification of a mental health clinic, the commissioner must
517.9 consider the nature, chronicity, or severity of the violation of law or rule and the effect of
517.10 the violation on the health, safety, or rights of clients.

517.11 (c) If the commissioner decertifies a mental health clinic, the order of decertification
517.12 must inform the certification holder of the right to have a contested case hearing under
517.13 chapter 14 and Minnesota Rules, parts 1400.8505 to 1400.8612. The commissioner may
517.14 issue the order through the provider licensing and reporting hub. The certification holder
517.15 may appeal the decertification. The certification holder must appeal a decertification in
517.16 writing and send or deliver the appeal to the commissioner by certified mail ~~or~~, by personal
517.17 service, or through the provider licensing and reporting hub. If the certification holder mails
517.18 the appeal, the appeal must be postmarked and sent to the commissioner within ten calendar
517.19 days after the certification holder receives the order of decertification. If the certification
517.20 holder delivers an appeal by personal service, the commissioner must receive the appeal
517.21 within ten calendar days after the certification holder received the order. If the order is
517.22 issued through the provider hub, the request must be received by the commissioner within
517.23 20 calendar days from the date the commissioner issued the order through the hub. If a
517.24 certification holder submits a timely appeal of an order of decertification, the certification
517.25 holder may continue to operate the program until the commissioner issues a final order on
517.26 the decertification.

517.27 (d) If the commissioner decertifies a mental health clinic pursuant to paragraph (a),
517.28 clause (1), based on a determination that the mental health clinic was responsible for
517.29 maltreatment, and if the certification holder appeals the decertification according to paragraph
517.30 (c), and appeals the maltreatment determination under section 260E.33, the final
517.31 decertification determination is stayed until the commissioner issues a final decision regarding
517.32 the maltreatment appeal.

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

518.1 Sec. 22. Minnesota Statutes 2022, section 245I.20, subdivision 16, is amended to read:

518.2 Subd. 16. **Notifications required and noncompliance.** (a) A certification holder must
518.3 notify the commissioner, in a manner prescribed by the commissioner, and obtain the
518.4 commissioner's approval before making any change to the name of the certification holder
518.5 or the location of the mental health clinic. Upon implementation of the provider licensing
518.6 and reporting hub, certification holders must enter and update information in the hub in a
518.7 manner prescribed by the commissioner.

518.8 (b) Changes in mental health clinic organization, staffing, treatment, or quality assurance
518.9 procedures that affect the ability of the certification holder to comply with the minimum
518.10 standards of this section must be reported in writing by the certification holder to the
518.11 commissioner within 15 days of the occurrence. Review of the change must be conducted
518.12 by the commissioner. A certification holder with changes resulting in noncompliance in
518.13 minimum standards must receive written notice and may have up to 180 days to correct the
518.14 areas of noncompliance before being decertified. Interim procedures to resolve the
518.15 noncompliance on a temporary basis must be developed and submitted in writing to the
518.16 commissioner for approval within 30 days of the commissioner's determination of the
518.17 noncompliance. Not reporting an occurrence of a change that results in noncompliance
518.18 within 15 days, failure to develop an approved interim procedure within 30 days of the
518.19 determination of the noncompliance, or nonresolution of the noncompliance within 180
518.20 days will result in immediate decertification.

518.21 (c) The mental health clinic may be required to submit written information to the
518.22 department to document that the mental health clinic has maintained compliance with this
518.23 section and mental health clinic procedures.

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

518.25 Sec. 23. Minnesota Statutes 2022, section 260E.09, is amended to read:

518.26 **260E.09 REPORTING REQUIREMENTS.**

518.27 (a) An oral report shall be made immediately by telephone or otherwise. An oral report
518.28 made by a person required under section 260E.06, subdivision 1, to report shall be followed
518.29 within 72 hours, exclusive of weekends and holidays, by a report in writing to the appropriate
518.30 police department, the county sheriff, the agency responsible for assessing or investigating
518.31 the report, or the local welfare agency.

518.32 (b) Any report shall be of sufficient content to identify the child, any person believed
518.33 to be responsible for the maltreatment of the child if the person is known, the nature and

519.1 extent of the maltreatment, and the name and address of the reporter. The local welfare
519.2 agency or agency responsible for assessing or investigating the report shall accept a report
519.3 made under section 260E.06 notwithstanding refusal by a reporter to provide the reporter's
519.4 name or address as long as the report is otherwise sufficient under this paragraph.

519.5 (c) Notwithstanding paragraph (a), upon implementation of the provider licensing and
519.6 reporting hub, an individual who has an account with the provider licensing and reporting
519.7 hub and is required to report suspected maltreatment as a licensed program under section
519.8 260E.06, subdivision 1, may submit a written report in the hub in a manner prescribed by
519.9 the commissioner and is not required to make an oral report. A report submitted through
519.10 the provider licensing and reporting hub must be made immediately.

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

519.12 Sec. 24. Minnesota Statutes 2022, section 270B.14, subdivision 1, is amended to read:

519.13 Subdivision 1. **Disclosure to commissioner of human services.** (a) On the request of
519.14 the commissioner of human services, the commissioner shall disclose return information
519.15 regarding taxes imposed by chapter 290, and claims for refunds under chapter 290A, to the
519.16 extent provided in paragraph (b) and for the purposes set forth in paragraph (c).

519.17 (b) Data that may be disclosed are limited to data relating to the identity, whereabouts,
519.18 employment, income, and property of a person owing or alleged to be owing an obligation
519.19 of child support.

519.20 (c) The commissioner of human services may request data only for the purposes of
519.21 carrying out the child support enforcement program and to assist in the location of parents
519.22 who have, or appear to have, deserted their children. Data received may be used only as set
519.23 forth in section 256.978.

519.24 (d) The commissioner shall provide the records and information necessary to administer
519.25 the supplemental housing allowance to the commissioner of human services.

519.26 (e) At the request of the commissioner of human services, the commissioner of revenue
519.27 shall electronically match the Social Security numbers and names of participants in the
519.28 telephone assistance plan operated under sections 237.69 to 237.71, with those of property
519.29 tax refund filers, and determine whether each participant's household income is within the
519.30 eligibility standards for the telephone assistance plan.

519.31 (f) The commissioner may provide records and information collected under sections
519.32 295.50 to 295.59 to the commissioner of human services for purposes of the Medicaid
519.33 Voluntary Contribution and Provider-Specific Tax Amendments of 1991, Public Law

520.1 102-234. Upon the written agreement by the United States Department of Health and Human
 520.2 Services to maintain the confidentiality of the data, the commissioner may provide records
 520.3 and information collected under sections 295.50 to 295.59 to the Centers for Medicare and
 520.4 Medicaid Services section of the United States Department of Health and Human Services
 520.5 for purposes of meeting federal reporting requirements.

520.6 (g) The commissioner may provide records and information to the commissioner of
 520.7 human services as necessary to administer the early refund of refundable tax credits.

520.8 (h) The commissioner may disclose information to the commissioner of human services
 520.9 as necessary for income verification for eligibility and premium payment under the
 520.10 MinnesotaCare program, under section 256L.05, subdivision 2, as well as the medical
 520.11 assistance program under chapter 256B.

520.12 (i) The commissioner may disclose information to the commissioner of human services
 520.13 necessary to verify whether applicants or recipients for the Minnesota family investment
 520.14 program, general assistance, the Supplemental Nutrition Assistance Program (SNAP),
 520.15 Minnesota supplemental aid program, and child care assistance have claimed refundable
 520.16 tax credits under chapter 290 and the property tax refund under chapter 290A, and the
 520.17 amounts of the credits.

520.18 (j) The commissioner may disclose information to the commissioner of human services
 520.19 necessary to verify income for purposes of calculating parental contribution amounts under
 520.20 section 252.27, subdivision 2a.

520.21 (k) The commissioner shall disclose information to the commissioner of human services
 520.22 to verify the income and tax identification information of:

520.23 (1) an applicant under section 245A.04, subdivision 1;

520.24 (2) an applicant under section 245H.03;

520.25 (3) an applicant under section 245I.20;

520.26 (4) a license holder; or

520.27 (5) a certification holder.

ARTICLE 13

MISCELLANEOUS

521.1

521.2

521.3 Section 1. Minnesota Statutes 2022, section 62A.30, is amended by adding a subdivision
521.4 to read:

521.5 Subd. 5. **Mammogram; diagnostic services and testing.** If a health care provider
521.6 determines an enrollee requires additional diagnostic services or testing after a mammogram,
521.7 a health plan must provide coverage for the additional diagnostic services or testing with
521.8 no cost-sharing, including co-pay, deductible, or coinsurance.

521.9 **EFFECTIVE DATE.** This section is effective January 1, 2024, and applies to health
521.10 plans offered, issued, or sold on or after that date.

521.11 Sec. 2. Minnesota Statutes 2022, section 62A.30, is amended by adding a subdivision to
521.12 read:

521.13 Subd. 6. **Application.** If the application of subdivision 5 before an enrollee has met their
521.14 health plan's deductible would result in: (1) health savings account ineligibility under United
521.15 States Code, title 26, section 223; or (2) catastrophic health plan ineligibility under United
521.16 States Code, title 42, section 18022(e), then subdivision 5 shall apply to diagnostic services
521.17 or testing only after the enrollee has met their health plan's deductible.

521.18 **EFFECTIVE DATE.** This section is effective January 1, 2024, and applies to health
521.19 plans offered, issued, or sold on or after that date.

521.20 Sec. 3. **[62Q.481] COST-SHARING FOR PRESCRIPTION DRUGS AND RELATED**
521.21 **MEDICAL SUPPLIES TO TREAT CHRONIC DISEASE.**

521.22 Subdivision 1. **Cost-sharing limits.** (a) A health plan must limit the amount of any
521.23 enrollee cost-sharing for prescription drugs prescribed to treat a chronic disease to no more
521.24 than \$25 per one-month supply for each prescription drug regardless of the amount or type
521.25 of medication required to fill the prescription and to no more than \$50 per month in total
521.26 for all related medical supplies. The cost-sharing limit for related medical supplies does not
521.27 increase with the number of chronic diseases for which an enrollee is treated. Coverage
521.28 under this section shall not be subject to any deductible.

521.29 (b) If application of this section before an enrollee has met their plan's deductible would
521.30 result in: (1) health savings account ineligibility under United States Code, title 26, section
521.31 223; or (2) catastrophic health plan ineligibility under United States Code, title 42, section

522.1 18022(e), then this section shall apply to that specific prescription drug or related medical
522.2 supply only after the enrollee has met their plan's deductible.

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

522.4 (b) "Chronic disease" means diabetes, asthma, and allergies requiring the use of
522.5 epinephrine auto-injectors.

522.6 (c) "Cost-sharing" means co-payments and coinsurance.

522.7 (d) "Related medical supplies" means syringes, insulin pens, insulin pumps, test strips,
522.8 glucometers, continuous glucose monitors, epinephrine auto-injectors, asthma inhalers, and
522.9 other medical supply items necessary to effectively and appropriately treat a chronic disease
522.10 or administer a prescription drug prescribed to treat a chronic disease.

522.11 **EFFECTIVE DATE.** This section is effective January 1, 2024, and applies to health
522.12 plans offered, issued, or renewed on or after that date.

522.13 Sec. 4. Minnesota Statutes 2022, section 121A.28, is amended to read:

522.14 **121A.28 LAW ENFORCEMENT RECORDS.**

522.15 A law enforcement agency shall provide notice of any drug incident occurring within
522.16 the agency's jurisdiction, in which the agency has probable cause to believe a student violated
522.17 section 152.021, 152.022, 152.023, 152.024, 152.025, 152.0262, 152.027, ~~152.092~~, 152.097,
522.18 or 340A.503, subdivision 1, 2, or 3. The notice shall be in writing and shall be provided,
522.19 within two weeks after an incident occurs, to the chemical abuse preassessment team in the
522.20 school where the student is enrolled.

522.21 Sec. 5. Minnesota Statutes 2022, section 151.01, is amended by adding a subdivision to
522.22 read:

522.23 Subd. 43. **Syringe services provider.** "Syringe services provider" means a
522.24 community-based public health program that offers cost-free comprehensive harm reduction
522.25 services which may include: providing sterile needles, syringes, and other injection
522.26 equipment; making safe disposal containers for needles and syringes available; educating
522.27 participants and others about overdose prevention, safer injection practices, and infectious
522.28 disease prevention; providing blood-borne pathogen testing or referrals to blood-borne
522.29 pathogen testing; offering referrals to substance use disorder treatment, including substance
522.30 use disorder treatment with medications for opioid use disorder; and providing referrals to
522.31 medical treatment and services, mental health programs and services, and other social
522.32 services.

523.1 Sec. 6. Minnesota Statutes 2022, section 151.40, subdivision 1, is amended to read:

523.2 Subdivision 1. **Generally.** It is unlawful for any person to ~~possess, control,~~ manufacture,
523.3 sell, furnish, dispense, or otherwise dispose of hypodermic syringes or needles or any
523.4 instrument or implement which can be adapted for subcutaneous injections, except for:

523.5 (1) the following persons when acting in the course of their practice or employment:

523.6 (i) licensed practitioners and their employees, agents, or delegates;

523.7 (ii) licensed pharmacies and their employees or agents;

523.8 (iii) licensed pharmacists;

523.9 (iv) registered nurses and licensed practical nurses;

523.10 (v) registered medical technologists;

523.11 (vi) medical interns and residents;

523.12 (vii) licensed drug wholesalers and their employees or agents;

523.13 (viii) licensed hospitals;

523.14 (ix) bona fide hospitals in which animals are treated;

523.15 (x) licensed nursing homes;

523.16 (xi) licensed morticians;

523.17 (xii) syringe and needle manufacturers and their dealers and agents;

523.18 (xiii) persons engaged in animal husbandry;

523.19 (xiv) clinical laboratories and their employees;

523.20 (xv) persons engaged in bona fide research or education or industrial use of hypodermic
523.21 syringes and needles provided such persons cannot use hypodermic syringes and needles
523.22 for the administration of drugs to human beings unless such drugs are prescribed, dispensed,
523.23 and administered by a person lawfully authorized to do so; ~~and~~

523.24 (xvi) persons who administer drugs pursuant to an order or direction of a licensed
523.25 practitioner; and

523.26 (xvii) syringe services providers and their employees and agents;

523.27 (2) a person who self-administers drugs pursuant to either the prescription or the direction
523.28 of a practitioner, or a family member, caregiver, or other individual who is designated by

524.1 such person to assist the person in obtaining and using needles and syringes for the
524.2 administration of such drugs;

524.3 (3) a person who is disposing of hypodermic syringes and needles through an activity
524.4 or program developed under section 325F.785; ~~or~~

524.5 (4) a person who sells, ~~possesses~~, or handles hypodermic syringes and needles pursuant
524.6 to subdivision 2; or

524.7 (5) a participant receiving services from a syringe services provider who accesses or
524.8 receives new syringes or needles from a syringe services provider or returns used syringes
524.9 or needles to a syringe services provider.

524.10 **EFFECTIVE DATE.** This section is effective August 1, 2023.

524.11 Sec. 7. Minnesota Statutes 2022, section 151.40, subdivision 2, is amended to read:

524.12 Subd. 2. **Sales of limited quantities of clean needles and syringes.** (a) A registered
524.13 pharmacy or a licensed pharmacist may sell, without the prescription or direction of a
524.14 practitioner, unused hypodermic needles and syringes ~~in quantities of ten or fewer~~, provided
524.15 the pharmacy or pharmacist complies with all of the requirements of this subdivision.

524.16 (b) At any location where hypodermic needles and syringes are kept for retail sale under
524.17 this subdivision, the needles and syringes shall be stored in a manner that makes them
524.18 available only to authorized personnel and not openly available to customers.

524.19 (c) A registered pharmacy or licensed pharmacist that sells hypodermic needles or
524.20 syringes under this subdivision may give the purchaser the materials developed by the
524.21 commissioner of health under section 325F.785.

524.22 (d) A registered pharmacy or licensed pharmacist that sells hypodermic needles or
524.23 syringes under this subdivision must certify to the commissioner of health participation in
524.24 an activity, including but not limited to those developed under section 325F.785, that supports
524.25 proper disposal of used hypodermic needles or syringes.

524.26 Sec. 8. Minnesota Statutes 2022, section 151.74, subdivision 3, is amended to read:

524.27 Subd. 3. **Access to urgent-need insulin.** (a) MNsure shall develop an application form
524.28 to be used by an individual who is in urgent need of insulin. The application must ask the
524.29 individual to attest to the eligibility requirements described in subdivision 2. The form shall
524.30 be accessible through MNsure's website. MNsure shall also make the form available to
524.31 pharmacies and health care providers who prescribe or dispense insulin, hospital emergency

525.1 departments, urgent care clinics, and community health clinics. By submitting a completed,
525.2 signed, and dated application to a pharmacy, the individual attests that the information
525.3 contained in the application is correct.

525.4 (b) If the individual is in urgent need of insulin, the individual may present a completed,
525.5 signed, and dated application form to a pharmacy. The individual must also:

525.6 (1) have a valid insulin prescription; and

525.7 (2) present the pharmacist with identification indicating Minnesota residency in the form
525.8 of a valid Minnesota identification card, driver's license or permit, individual taxpayer
525.9 identification number, or Tribal identification card as defined in section 171.072, paragraph

525.10 (b). If the individual in urgent need of insulin is under the age of 18, the individual's parent
525.11 or legal guardian must provide the pharmacist with proof of residency.

525.12 (c) Upon receipt of a completed and signed application, the pharmacist shall dispense
525.13 the prescribed insulin in an amount that will provide the individual with a 30-day supply.
525.14 The pharmacy must notify the health care practitioner who issued the prescription order no
525.15 later than 72 hours after the insulin is dispensed.

525.16 (d) The pharmacy may submit to the manufacturer of the dispensed insulin product or
525.17 to the manufacturer's vendor a claim for payment that is in accordance with the National
525.18 Council for Prescription Drug Program standards for electronic claims processing, unless
525.19 the manufacturer agrees to send to the pharmacy a replacement supply of the same insulin
525.20 as dispensed in the amount dispensed. If the pharmacy submits an electronic claim to the
525.21 manufacturer or the manufacturer's vendor, the manufacturer or vendor shall reimburse the
525.22 pharmacy in an amount that covers the pharmacy's acquisition cost.

525.23 (e) The pharmacy may collect an insulin co-payment from the individual to cover the
525.24 pharmacy's costs of processing and dispensing in an amount not to exceed \$35 for the 30-day
525.25 supply of insulin dispensed.

525.26 (f) The pharmacy shall also provide each eligible individual with the information sheet
525.27 described in subdivision 7 and a list of trained navigators provided by the Board of Pharmacy
525.28 for the individual to contact if the individual is in need of accessing ongoing insulin coverage
525.29 options, including assistance in:

525.30 (1) applying for medical assistance or MinnesotaCare;

525.31 (2) applying for a qualified health plan offered through MNsure, subject to open and
525.32 special enrollment periods;

526.1 (3) accessing information on providers who participate in prescription drug discount
526.2 programs, including providers who are authorized to participate in the 340B program under
526.3 section 340b of the federal Public Health Services Act, United States Code, title 42, section
526.4 256b; and

526.5 (4) accessing insulin manufacturers' patient assistance programs, co-payment assistance
526.6 programs, and other foundation-based programs.

526.7 (g) The pharmacist shall retain a copy of the application form submitted by the individual
526.8 to the pharmacy for reporting and auditing purposes.

526.9 Sec. 9. Minnesota Statutes 2022, section 151.74, subdivision 4, is amended to read:

526.10 Subd. 4. **Continuing safety net program; general.** (a) Each manufacturer shall make
526.11 a patient assistance program available to any individual who meets the requirements of this
526.12 subdivision. Each manufacturer's patient assistance programs must meet the requirements
526.13 of this section. Each manufacturer shall provide the Board of Pharmacy with information
526.14 regarding the manufacturer's patient assistance program, including contact information for
526.15 individuals to call for assistance in accessing their patient assistance program.

526.16 (b) To be eligible to participate in a manufacturer's patient assistance program, the
526.17 individual must:

526.18 (1) be a Minnesota resident with a valid Minnesota identification card that indicates
526.19 Minnesota residency in the form of a Minnesota identification card, driver's license or
526.20 permit, individual taxpayer identification number, or Tribal identification card as defined
526.21 in section 171.072, paragraph (b). If the individual is under the age of 18, the individual's
526.22 parent or legal guardian must provide proof of residency;

526.23 (2) have a family income that is equal to or less than 400 percent of the federal poverty
526.24 guidelines;

526.25 (3) not be enrolled in medical assistance or MinnesotaCare;

526.26 (4) not be eligible to receive health care through a federally funded program or receive
526.27 prescription drug benefits through the Department of Veterans Affairs; and

526.28 (5) not be enrolled in prescription drug coverage through an individual or group health
526.29 plan that limits the total amount of cost-sharing that an enrollee is required to pay for a
526.30 30-day supply of insulin, including co-payments, deductibles, or coinsurance to \$75 or less,
526.31 regardless of the type or amount of insulin needed.

527.1 (c) Notwithstanding the requirement in paragraph (b), clause (4), an individual who is
527.2 enrolled in Medicare Part D is eligible for a manufacturer's patient assistance program if
527.3 the individual has spent \$1,000 on prescription drugs in the current calendar year and meets
527.4 the eligibility requirements in paragraph (b), clauses (1) to (3).

527.5 (d) An individual who is interested in participating in a manufacturer's patient assistance
527.6 program may apply directly to the manufacturer; apply through the individual's health care
527.7 practitioner, if the practitioner participates; or contact a trained navigator for assistance in
527.8 finding a long-term insulin supply solution, including assistance in applying to a
527.9 manufacturer's patient assistance program.

527.10 Sec. 10. Minnesota Statutes 2022, section 152.01, subdivision 18, is amended to read:

527.11 Subd. 18. **Drug paraphernalia.** (a) Except as otherwise provided in paragraph (b), "drug
527.12 paraphernalia" means all equipment, products, and materials of any kind, except those items
527.13 used in conjunction with permitted uses of controlled substances under this chapter or the
527.14 Uniform Controlled Substances Act, which are knowingly or intentionally used primarily
527.15 in (1) manufacturing a controlled substance, (2) injecting, ingesting, inhaling, or otherwise
527.16 introducing into the human body a controlled substance, or (3) testing the strength,
527.17 ~~effectiveness, or purity of a controlled substance, or (4) enhancing the effect of a controlled~~
527.18 substance.

527.19 (b) "Drug paraphernalia" does not include the possession, manufacture, delivery, or sale
527.20 of: (1) ~~hypodermic needles or syringes in accordance with section 151.40, subdivision 2.~~
527.21 hypodermic syringes or needles or any instrument or implement that can be adapted for
527.22 subcutaneous injections; or (2) products that detect the presence of fentanyl or a fentanyl
527.23 analog in a controlled substance.

527.24 **EFFECTIVE DATE.** This section is effective August 1, 2023, and applies to crimes
527.25 committed on or after that date.

527.26 Sec. 11. Minnesota Statutes 2022, section 152.205, is amended to read:

527.27 **152.205 LOCAL REGULATIONS.**

527.28 Sections 152.01, subdivision 18, and ~~152.092~~ 152.093 to 152.095 do not preempt
527.29 enforcement or preclude adoption of municipal or county ordinances prohibiting or otherwise
527.30 regulating the manufacture, delivery, possession, or advertisement of drug paraphernalia.

528.1 Sec. 12. Minnesota Statutes 2022, section 256L.03, subdivision 5, is amended to read:

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

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

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

528.13 (d) Cost-sharing for prescription drugs and related medical supplies to treat chronic
528.14 disease must comply with the requirements of section 62Q.481.

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

528.16 Sec. 13. Minnesota Statutes 2022, section 256L.03, subdivision 5, is amended to read:

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

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

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

528.28 (d) Co-payments, coinsurance, and deductibles do not apply to additional diagnostic
528.29 services or testing that a health care provider determines an enrollee requires after a
528.30 mammogram, as specified under section 62A.30, subdivision 5.

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

529.1 Sec. 14. **REPEALER.**

529.2 Minnesota Statutes 2022, section 152.092, is repealed.

529.3 **ARTICLE 14**

529.4 **FORECAST ADJUSTMENTS**

529.5 Section 1. **DEPARTMENT OF HUMAN SERVICES FORECAST ADJUSTMENT.**

529.6 The dollar amounts shown in the columns marked "Appropriations" are added to or, if
 529.7 shown in parentheses, are subtracted from the appropriations in Laws 2021, First Special
 529.8 Session chapter 7, article 15, and Laws 2021, First Special Session chapter 7, article 16,
 529.9 from the general fund, or any other fund named, to the commissioner of human services for
 529.10 the purposes specified in this article, to be available for the fiscal year indicated for each
 529.11 purpose. The figure "2023" used in this article means that the appropriations listed are
 529.12 available for the fiscal year ending June 30, 2023.

529.13 **APPROPRIATIONS**
 529.14 **Available for the Year**
 529.15 **Ending June 30**
 529.16 **2023**

529.17 Sec. 2. **COMMISSIONER OF HUMAN**
 529.18 **SERVICES**

529.19 **Subdivision 1. Total Appropriation** **\$ (1,453,441,000)**

529.20 **Appropriations by Fund**

529.21 **2023**
 529.22 **General** **(1,228,684,000)**

529.23 **Health Care Access** **(203,530,000)**

529.24 **Federal TANF** **(21,227,000)**

529.25 **Subd. 2. Forecasted Programs**

529.26 **(a) Minnesota Family**
 529.27 **Investment Program**
 529.28 **(MFIP)/Diversionary Work**
 529.29 **Program (DWP)**

529.30 **Appropriations by Fund**

529.31 **2023**
 529.32 **General** **(99,000)**

529.33 **Federal TANF** **(21,227,000)**

529.34 **(b) MFIP Child Care Assistance** **(36,957,000)**

530.1	<u>(c) General Assistance</u>	<u>(1,632,000)</u>
530.2	<u>(d) Minnesota Supplemental Aid</u>	<u>783,000</u>
530.3	<u>(e) Housing Support</u>	<u>180,000</u>
530.4	<u>(f) Northstar Care for Children</u>	<u>(18,038,000)</u>
530.5	<u>(g) MinnesotaCare</u>	<u>(203,530,000)</u>

530.6 This appropriation is from the health care
 530.7 access fund.

530.8 (h) Medical Assistance

530.9 Appropriations by Fund

530.10		<u>2023</u>
530.11	<u>General</u>	<u>(1,172,921,000)</u>
530.12	<u>Health Care Access</u>	<u>0</u>

530.13 (i) Behavioral Health Fund (6,404,000)

530.14 Sec. 3. EFFECTIVE DATE.

530.15 Sections 1 and 2 are effective the day following final enactment.

530.16 **ARTICLE 15**
 530.17 **APPROPRIATIONS**

530.18 Section 1. HEALTH AND HUMAN SERVICES APPROPRIATIONS.

530.19 The sums shown in the columns marked "Appropriations" are appropriated to the agencies
 530.20 and for the purposes specified in this article. The appropriations are from the general fund,
 530.21 or another named fund, and are available for the fiscal years indicated for each purpose.
 530.22 The figures "2024" and "2025" used in this article mean that the appropriations listed under
 530.23 them are available for the fiscal year ending June 30, 2024, or June 30, 2025, respectively.
 530.24 "The first year" is fiscal year 2024. "The second year" is fiscal year 2025. "The biennium"
 530.25 is fiscal years 2024 and 2025.

530.26	<u>APPROPRIATIONS</u>
530.27	<u>Available for the Year</u>
530.28	<u>Ending June 30</u>
530.29	<u>2024</u> <u>2025</u>

- 532.1 (3) state and county MFIP administrative costs
532.2 under Minnesota Statutes, chapters 256J and
532.3 256K;
- 532.4 (4) state, county, and Tribal MFIP
532.5 employment services under Minnesota
532.6 Statutes, chapters 256J and 256K;
- 532.7 (5) expenditures made on behalf of legal
532.8 noncitizen MFIP recipients who qualify for
532.9 the MinnesotaCare program under Minnesota
532.10 Statutes, chapter 256L;
- 532.11 (6) qualifying working family credit
532.12 expenditures under Minnesota Statutes, section
532.13 290.0671;
- 532.14 (7) qualifying Minnesota education credit
532.15 expenditures under Minnesota Statutes, section
532.16 290.0674; and
- 532.17 (8) qualifying Head Start expenditures under
532.18 Minnesota Statutes, section 119A.50.
- 532.19 **(b) Nonfederal Expenditures; Reporting.**
532.20 For the activities listed in paragraph (a),
532.21 clauses (2) to (8), the commissioner may
532.22 report only expenditures that are excluded
532.23 from the definition of assistance under Code
532.24 of Federal Regulations, title 45, section
532.25 260.31.
- 532.26 **(c) Limitations; Exceptions.** The
532.27 commissioner must not claim an amount of
532.28 TANF maintenance of effort in excess of the
532.29 75 percent standard in Code of Federal
532.30 Regulations, title 45, section 263.1(a)(2),
532.31 except:
- 532.32 (1) to the extent necessary to meet the 80
532.33 percent standard under Code of Federal

533.1 Regulations, title 45, section 263.1(a)(1), if it
533.2 is determined by the commissioner that the
533.3 state will not meet the TANF work
533.4 participation target rate for the current year;
533.5 (2) to provide any additional amounts under
533.6 Code of Federal Regulations, title 45, section
533.7 264.5, that relate to replacement of TANF
533.8 funds due to the operation of TANF penalties;
533.9 and
533.10 (3) to provide any additional amounts that may
533.11 contribute to avoiding or reducing TANF work
533.12 participation penalties through the operation
533.13 of the excess maintenance of effort provisions
533.14 of Code of Federal Regulations, title 45,
533.15 section 261.43(a)(2).

533.16 **(d) Supplemental Expenditures.** For the
533.17 purposes of paragraph (c), the commissioner
533.18 may supplement the maintenance of effort
533.19 claim with working family credit expenditures
533.20 or other qualified expenditures to the extent
533.21 such expenditures are otherwise available after
533.22 considering the expenditures allowed in this
533.23 subdivision.

533.24 **(e) Reduction of Appropriations; Exception.**
533.25 The requirement in Minnesota Statutes, section
533.26 256.011, subdivision 3, that federal grants or
533.27 aids secured or obtained under that subdivision
533.28 be used to reduce any direct appropriations
533.29 provided by law does not apply if the grants
533.30 or aids are federal TANF funds.

533.31 **(f) IT Appropriations Generally.** This
533.32 appropriation includes funds for information
533.33 technology projects, services, and support.
533.34 Notwithstanding Minnesota Statutes, section

534.1 16E.0466, funding for information technology
534.2 project costs must be incorporated into the
534.3 service level agreement and paid to the
534.4 Minnesota IT Services by the Department of
534.5 Human Services under the rates and
534.6 mechanism specified in that agreement.

534.7 **(g) Receipts for Systems Project.**
534.8 Appropriations and federal receipts for
534.9 information technology systems projects for
534.10 MAXIS, PRISM, MMIS, ISDS, METS, and
534.11 SSIS must be deposited in the state systems
534.12 account authorized in Minnesota Statutes,
534.13 section 256.014. Money appropriated for
534.14 information technology projects approved by
534.15 the commissioner of the Minnesota IT
534.16 Services funded by the legislature and
534.17 approved by the commissioner of management
534.18 and budget may be transferred from one
534.19 project to another and from development to
534.20 operations as the commissioner of human
534.21 services considers necessary. Any unexpended
534.22 balance in the appropriation for these projects
534.23 does not cancel and is available for ongoing
534.24 development and operations.

534.25 **(h) Federal SNAP Education and Training**
534.26 **Grants.** Federal funds available during fiscal
534.27 years 2024 and 2025 for Supplemental
534.28 Nutrition Assistance Program Education and
534.29 Training and SNAP Quality Control
534.30 Performance Bonus grants are appropriated
534.31 to the commissioner of human services for the
534.32 purposes allowable under the terms of the
534.33 federal award. This paragraph is effective the
534.34 day following final enactment.

534.35 **Subd. 3. Central Office; Operations**

535.1	<u>Appropriations by Fund</u>		
535.2	<u>General</u>	<u>286,688,000</u>	<u>249,734,000</u>
535.3	<u>State Government</u>		
535.4	<u>Special Revenue</u>	<u>4,721,000</u>	<u>5,169,000</u>
535.5	<u>Health Care Access</u>	<u>9,347,000</u>	<u>11,244,000</u>
535.6	<u>Federal TANF</u>	<u>1,090,000</u>	<u>1,194,000</u>

535.7 (a) Administrative Recovery; Set-Aside. The
 535.8 commissioner may invoice local entities
 535.9 through the SWIFT accounting system as an
 535.10 alternative means to recover the actual cost of
 535.11 administering the following provisions:

535.12 (1) the statewide data management system
 535.13 authorized in Minnesota Statutes, section
 535.14 125A.744, subdivision 3;

535.15 (2) repayment of the special revenue
 535.16 maximization account as provided under
 535.17 Minnesota Statutes, section 245.495,
 535.18 paragraph (b);

535.19 (3) repayment of the special revenue
 535.20 maximization account as provided under
 535.21 Minnesota Statutes, section 256B.0625,
 535.22 subdivision 20, paragraph (k);

535.23 (4) targeted case management under
 535.24 Minnesota Statutes, section 256B.0924,
 535.25 subdivision 6, paragraph (g);

535.26 (5) residential services for children with severe
 535.27 emotional disturbance under Minnesota
 535.28 Statutes, section 256B.0945, subdivision 4,
 535.29 paragraph (d); and

535.30 (6) repayment of the special revenue
 535.31 maximization account as provided under
 535.32 Minnesota Statutes, section 256F.10,
 535.33 subdivision 6, paragraph (b).

536.1 **(b) Tribal Nations Fraud Prevention**
 536.2 **Program Grants.** \$400,000 in fiscal year
 536.3 2024 is from the general fund for start-up
 536.4 grants to the Red Lake Nation, White Earth
 536.5 Nation, and Mille Lacs Band of Ojibwe to
 536.6 develop a fraud prevention program. This
 536.7 appropriation is available until June 30, 2025.

536.8 **(c) Base Level Adjustment.** The general fund
 536.9 base is \$221,875,000 in fiscal year 2026 and
 536.10 \$238,783,000 in fiscal year 2027. The state
 536.11 government special revenue base is \$4,765,000
 536.12 in fiscal year 2026 and \$4,765,000 in fiscal
 536.13 year 2027.

536.14 **Subd. 4. Central Office; Children and Families**

536.15	<u>Appropriations by Fund</u>		
536.16	<u>General</u>	<u>18,791,000</u>	<u>18,797,000</u>
536.17	<u>Federal TANF</u>	<u>2,582,000</u>	<u>2,582,000</u>

536.18 **Subd. 5. Central Office; Health Care**

536.19	<u>Appropriations by Fund</u>		
536.20	<u>General</u>	<u>36,477,000</u>	<u>36,316,000</u>
536.21	<u>Health Care Access</u>	<u>28,168,000</u>	<u>28,168,000</u>

536.22 **(a) Improved Accessibility.** \$1,350,000 in
 536.23 fiscal year 2024 is from the general fund to
 536.24 improve the accessibility of Minnesota health
 536.25 care programs applications, forms, and other
 536.26 consumer support resources and services to
 536.27 enrollees with limited English proficiency.

536.28 **(b) Improvements to Application,**
 536.29 **Enrollment, Service Delivery.** \$510,000 in
 536.30 fiscal year 2024 and \$1,020,000 in fiscal year
 536.31 2025 are from the general fund for contracts
 536.32 with community-based organizations to
 536.33 facilitate conversations with applicants and
 536.34 enrollees in Minnesota health care programs

537.1 to improve the application, enrollment, and
 537.2 service delivery experience in medical
 537.3 assistance and MinnesotaCare.

537.4 **(c) Base Level Adjustment.** The general fund
 537.5 base is \$50,462,000 in fiscal year 2026 and
 537.6 \$64,939,000 in fiscal year 2027.

537.7 **Subd. 6. Central Office; Continuing Care for**
 537.8 **Older Adults**

537.9 Appropriations by Fund

537.10	<u>General</u>	<u>38,726,000</u>	<u>34,688,000</u>
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537.11	<u>State Government</u>		
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537.12	<u>Special Revenue</u>	<u>125,000</u>	<u>125,000</u>
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537.13 **Subd. 7. Central Office; Behavioral Health,**
 537.14 **Housing, and Deaf and Hard-of-Hearing**
 537.15 **Services**

		<u>27,739,000</u>	<u>27,862,000</u>
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537.16 **(a) Evaluation of Outcomes; PATH Grants.**

537.17 \$150,000 in fiscal year 2025 is for evaluating
 537.18 outcomes for the additional grant funding for
 537.19 the expansion of base funding for the PATH
 537.20 grants. This is a onetime appropriation.

537.21 **(b) Online Locator.** \$1,720,000 in fiscal year

537.22 2024 and \$1,720,000 in fiscal year 2025 are
 537.23 for an online behavioral health program
 537.24 locator with continued expansion of the
 537.25 provider database allowing people to research
 537.26 and access mental health and substance use
 537.27 disorder treatment options.

537.28 **(c) Base Level Adjustment.** The general fund

537.29 base is \$26,107,000 in fiscal year 2026 and
 537.30 \$25,746,000 in fiscal year 2027.

537.31 **Subd. 8. Forecasted Programs; MFIP/DWP**

	<u>77,000</u>	<u>108,000</u>
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537.32 **Subd. 9. Forecasted Programs; General**

537.33 **Assistance**

	<u>52,018,000</u>	<u>74,455,000</u>
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537.34 **Emergency General Assistance.** The amount

537.35 appropriated for emergency general assistance

538.1 is limited to no more than \$6,729,812 in fiscal
 538.2 year 2024 and \$6,729,812 in fiscal year 2025.
 538.3 Funds to counties shall be allocated by the
 538.4 commissioner using the allocation method
 538.5 under Minnesota Statutes, section 256D.06.

538.6	<u>Subd. 10. Forecasted Programs; Minnesota</u>		
538.7	<u>Supplemental Aid</u>	<u>58,320,000</u>	<u>59,865,000</u>

538.8	<u>Subd. 11. Forecasted Programs; Housing</u>		
538.9	<u>Support</u>	<u>211,692,000</u>	<u>224,225,000</u>

538.10	<u>Subd. 12. Forecasted Programs; MinnesotaCare</u>	<u>89,306,000</u>	<u>60,533,000</u>
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538.11 These appropriations are from the health care
 538.12 access fund.

538.13 Subd. 13. Forecasted Programs; Medical
 538.14 Assistance

538.15	<u>Appropriations by Fund</u>		
538.16	<u>General</u>	<u>1,078,348,000</u>	<u>791,406,000</u>
538.17	<u>Health Care Access</u>	<u>869,524,000</u>	<u>1,194,975,000</u>

538.18 Base Level Adjustment. The health care
 538.19 access fund base is \$589,959,000 in fiscal year
 538.20 2026, \$1,147,261,000 in fiscal year 2027, and
 538.21 \$612,099,000 in fiscal year 2028.

538.22	<u>Subd. 14. Forecasted Programs; Behavioral</u>		
538.23	<u>Health Fund</u>	<u>351,000</u>	<u>350,000</u>

538.24 Subd. 15. Grant Programs; Health Care Grants

538.25	<u>Appropriations by Fund</u>		
538.26	<u>General</u>	<u>7,311,000</u>	<u>7,311,000</u>
538.27	<u>Health Care Access</u>	<u>3,465,000</u>	<u>3,465,000</u>

538.28 (a) Indian Health Board. \$2,500,000 in fiscal
 538.29 year 2024 and \$2,500,000 in fiscal year 2025
 538.30 are from the general fund for funding to the
 538.31 Indian Health Board of Minneapolis to support
 538.32 continued access to health care coverage
 538.33 through Minnesota health care programs,
 538.34 improve access to quality care, and increase

539.1 vaccination rates among urban American
 539.2 Indians. The general fund base for this
 539.3 appropriation is \$2,500,000 in fiscal year 2026
 539.4 and \$0 in fiscal year 2027.

539.5 (b) Base Level Adjustment. The general fund
 539.6 base is \$7,311,000 in fiscal year 2026 and
 539.7 \$4,811,000 in fiscal year 2027.

539.8 <u>Subd. 16. Grant Programs; Disabilities Grants</u>	<u>500,000</u>	<u>1,000,000</u>
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539.9 (a) Transition to Community Initiative.
 539.10 \$500,000 in fiscal year 2024 and \$1,000,000
 539.11 in fiscal year 2025 are for the transition to
 539.12 community initiative grant funding under
 539.13 Laws 2021, First Special Session chapter 7,
 539.14 article 17, section 6.

539.15 (b) Base Level Adjustment. The general fund
 539.16 base is \$1,000,000 in fiscal year 2026 and
 539.17 \$100,000 in fiscal year 2027.

539.18 <u>Subd. 17. Grant Programs; Housing Support</u>		
539.19 <u>Grants</u>	<u>19,464,000</u>	<u>11,464,000</u>

539.20 Heading Home Corps. \$1,100,000 in fiscal
 539.21 year 2024 and \$1,100,000 in fiscal year 2025
 539.22 are for the AmeriCorps Heading Home Corps
 539.23 program.

539.24 <u>Subd. 18. Grant Programs; Adult Mental Health</u>		
539.25 <u>Grants</u>	<u>127,912,000</u>	<u>137,925,000</u>

539.26 (a) White Earth Nation; Adult Mental
 539.27 Health Initiative. \$300,000 in fiscal year
 539.28 2024 and \$300,000 in fiscal year 2025 are for
 539.29 adult mental health initiative grants to the
 539.30 White Earth Nation. This is a onetime
 539.31 appropriation.

539.32 (b) Transition to Community Initiative.
 539.33 \$750,000 in fiscal year 2024 and \$750,000 in
 539.34 fiscal year 2025 are for the transition to

540.1 community initiative grant funding under
 540.2 Laws 2021, First Special Session chapter 7,
 540.3 article 17, section 6.

540.4 **(c) Mobile Crisis Grants.** \$4,000,000 in fiscal
 540.5 year 2024 and \$8,000,000 in fiscal year 2025
 540.6 are for the mobile crisis grants under Laws
 540.7 2021, First Special Session chapter 7, article
 540.8 17, section 11. The base for this appropriation
 540.9 is \$5,000,000 in fiscal year 2026 and
 540.10 \$5,000,000 in fiscal year 2027.

540.11 **(d) Mobile Crisis Funds to Tribal Nations.**
 540.12 \$1,000,000 in fiscal year 2024 and \$1,000,000
 540.13 in fiscal year 2025 are for mobile crisis funds
 540.14 to Tribal Nations. This is a onetime
 540.15 appropriation.

540.16 **(e) Engagement Services Pilot Grants.**
 540.17 \$250,000 in fiscal year 2024 is for grants to
 540.18 counties to establish pilot projects to provide
 540.19 engagement services under Minnesota
 540.20 Statutes, section 253B.041. Counties receiving
 540.21 grants must develop a system to respond to
 540.22 individual requests for engagement services,
 540.23 conduct outreach to families and engagement
 540.24 services providers, and evaluate the impact of
 540.25 engagement services in decreasing civil
 540.26 commitments, increasing engagement in
 540.27 treatment, decreasing police involvement with
 540.28 individuals exhibiting symptoms of serious
 540.29 mental illness, and other measures.

540.30 **(f) Base Level Adjustment.** The general fund
 540.31 base is \$132,297,000 in fiscal year 2026 and
 540.32 \$132,297,000 in fiscal year 2027.

540.33 **Subd. 19. Grant Programs; Child Mental Health**
 540.34 **Grants**

50,128,000

43,426,000

541.1 **(a) School-Linked Behavioral Health**
 541.2 **Services.** \$11,248,000 in fiscal year 2024 and
 541.3 \$8,400,000 in fiscal year 2025 are for
 541.4 school-linked behavioral health services and
 541.5 for school-linked behavioral health services
 541.6 in intermediate school districts. The base for
 541.7 this appropriation is \$2,500,000 in fiscal year
 541.8 2026 and \$2,500,000 in fiscal year 2027.

541.9 **(b) Psychiatric Residential Treatment**
 541.10 **Facility Specialization Grants.** \$1,050,000
 541.11 in fiscal year 2024 and \$1,050,000 in fiscal
 541.12 year 2025 are for psychiatric residential
 541.13 treatment facilities specialization grants for
 541.14 staffing costs to treat and support behavioral
 541.15 health conditions and support children and
 541.16 families.

541.17 **(c) Base Level Adjustment.** The general fund
 541.18 base is \$37,526,000 in fiscal year 2026 and
 541.19 \$37,526,000 in fiscal year 2027.

541.20 **Subd. 20. Grant Programs; Chemical**
 541.21 **Dependency Treatment Support Grants**

541.22		<u>Appropriations by Fund</u>	
541.23	<u>General</u>	<u>1,350,000</u>	<u>1,350,000</u>

541.24	<u>Subd. 21. Technical Activities</u>		<u>71,493,000</u>	<u>71,493,000</u>
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541.25 This appropriation is from the federal TANF
 541.26 fund.

541.27 **Sec. 3. COMMISSIONER OF HEALTH**

541.28	<u>Subdivision 1. Total Appropriation</u>		<u>\$ 473,085,000</u>	<u>\$ 435,666,000</u>
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541.29		<u>Appropriations by Fund</u>	
541.30		<u>2024</u>	<u>2025</u>
541.31	<u>General</u>	<u>326,653,000</u>	<u>279,093,000</u>
541.32	<u>State Government</u>		
541.33	<u>Special Revenue</u>	<u>83,373,000</u>	<u>85,902,000</u>

542.1	<u>Health Care Access</u>	<u>38,857,000</u>	<u>41,557,000</u>
542.2	<u>Federal TANF</u>	<u>11,713,000</u>	<u>11,713,000</u>

542.3 The amounts that may be spent for each
 542.4 purpose are specified in the following
 542.5 subdivisions.

542.6 **Subd. 2. Health Improvement**

542.7 Appropriations by Fund

542.8	<u>General</u>	<u>268,786,000</u>	<u>225,336,000</u>
542.9	<u>State Government</u>		
542.10	<u>Special Revenue</u>	<u>12,392,000</u>	<u>12,682,000</u>
542.11	<u>Health Care Access</u>	<u>38,857,000</u>	<u>41,557,000</u>
542.12	<u>Federal TANF</u>	<u>11,713,000</u>	<u>11,713,000</u>

542.13 **(a) Telehealth; Payment Parity. Of the**
 542.14 amount appropriated in Laws 2021, First
 542.15 Special Session chapter 7, article 16, section
 542.16 3, subdivision 2, \$1,200,000 from the general
 542.17 fund in fiscal year 2023 is for the studies of
 542.18 telehealth expansion and payment parity and
 542.19 is available until June 30, 2024.

542.20 **(b) Adolescent Mental Health Promotion.**
 542.21 \$2,790,000 in fiscal year 2024 and \$2,790,000
 542.22 in fiscal year 2025 are from the general fund
 542.23 for adolescent mental health promotion. Of
 542.24 this appropriation each year, \$2,250,000 is for
 542.25 grants and \$540,000 is for administration. This
 542.26 is a onetime appropriation.

542.27 **(c) Advancing Equity Through Capacity**
 542.28 **Building and Resource Allocation.**
 542.29 \$1,986,000 in fiscal year 2024 and \$1,986,000
 542.30 in fiscal year 2025 are from the general fund
 542.31 to advance equity in procurement and
 542.32 grantmaking. Of this appropriation each year,
 542.33 \$1,000,000 is for grants and \$986,000 is for
 542.34 administration. This is a onetime
 542.35 appropriation.

543.1 **(d) Community Solutions for Healthy Child**
543.2 **Development Grants.** \$4,980,000 in fiscal
543.3 year 2024 and \$5,055,000 in fiscal year 2025
543.4 are from the general fund to improve child
543.5 development outcomes and well-being of
543.6 children of color and American Indian children
543.7 and their families under Minnesota Statutes,
543.8 section 145.9257. Of this appropriation in
543.9 fiscal year 2024, \$4,000,000 is for grants and
543.10 \$980,000 is for administration and in fiscal
543.11 year 2025, \$4,000,000 is for grants and
543.12 \$1,055,000 is for administration.

543.13 **(e) Comprehensive Overdose and Morbidity**
543.14 **Prevention Act.** \$8,164,000 in fiscal year
543.15 2024 and \$8,164,000 in fiscal year 2025 are
543.16 from the general fund for comprehensive
543.17 overdose and morbidity prevention strategies
543.18 under Minnesota Statutes, section 144.0528.
543.19 Of this appropriation each year, \$6,250,000
543.20 is for grants and \$1,644,000 is for
543.21 administration.

543.22 **(f) Emergency Preparedness and Response.**
543.23 \$12,400,000 in fiscal year 2024 and
543.24 \$12,400,000 in fiscal year 2025 are from the
543.25 general fund for public health emergency
543.26 preparedness and response, the sustainability
543.27 of the strategic stockpile, and COVID-19
543.28 pandemic response transition. Of this
543.29 appropriation each year, \$8,400,000 is for
543.30 grants and \$4,000,000 is for administration.
543.31 The general fund base for this appropriation
543.32 is \$11,400,000 in fiscal year 2026, of which
543.33 \$8,400,000 is for grants and \$3,000,000 is for
543.34 administration, and \$11,400,000 in fiscal year

544.1 2027, of which \$8,400,000 is for grants and
544.2 \$3,000,000 is for administration.

544.3 **(g) Healthy Beginnings, Healthy Families.**
544.4 \$12,052,000 in fiscal year 2024 and
544.5 \$11,853,000 in fiscal year 2025 are from the
544.6 general fund for a comprehensive approach to
544.7 ensure healthy outcomes for children and
544.8 families. Of this appropriation in fiscal year
544.9 2024, \$8,750,000 is for grants and \$2,339,000
544.10 is for administration and in fiscal year 2025,
544.11 \$8,750,000 is for grants and \$1,682,000 is for
544.12 administration. This is a onetime
544.13 appropriation.

544.14 **(h) No Surprises Act Enforcement.**
544.15 \$1,210,000 in fiscal year 2024 and \$1,090,000
544.16 in fiscal year 2025 are from the general fund
544.17 for implementation of the federal No Surprises
544.18 Act portion of the Consolidated
544.19 Appropriations Act, 2021, under Minnesota
544.20 Statutes, section 62Q.021, and assessment of
544.21 feasibility of a statewide provider directory.
544.22 The general fund base for this appropriation
544.23 is \$855,000 in fiscal year 2026 and \$855,000
544.24 in fiscal year 2027.

544.25 **(i) African American Health. \$2,182,000 in**
544.26 fiscal year 2024 and \$2,182,000 in fiscal year
544.27 2025 are from the general fund to establish an
544.28 Office of African American Health at the
544.29 Minnesota Department of Health under
544.30 Minnesota Statutes, section 144.0755, and for
544.31 grants under Minnesota Statutes, section
544.32 144.0756. Of this appropriation each year,
544.33 \$1,000,000 is for grants and \$1,182,000 is for
544.34 administration. The general fund base for this
544.35 appropriation is \$2,182,000 in fiscal year

545.1 2026, of which \$1,000,000 is for grants and
545.2 \$1,182,000 is for administration, and
545.3 \$2,117,000 in fiscal year 2027, of which
545.4 \$1,000,000 is for grants and \$1,117,000 is for
545.5 administration.

545.6 **(j) American Indian Health.** \$2,089,000 in
545.7 fiscal year 2024 and \$2,089,000 in fiscal year
545.8 2025 are from the general fund for the Office
545.9 of American Indian Health at the Minnesota
545.10 Department of Health under Minnesota
545.11 Statutes, section 144.0757. Of this
545.12 appropriation each year, \$1,000,000 is for
545.13 grants and \$1,089,000 is for administration.

545.14 **(k) Public Health System Transformation.**
545.15 \$17,120,000 in fiscal year 2024 and
545.16 \$17,120,000 in fiscal year 2025 are from the
545.17 general fund for public health system
545.18 transformation. Of this appropriation each
545.19 year:

545.20 (1) \$15,000,000 is for grants to community
545.21 health boards under Minnesota Statutes,
545.22 section 145A.131, subdivision 1, paragraph
545.23 (f);

545.24 (2) \$750,000 is for grants to Tribal
545.25 governments under Minnesota Statutes, section
545.26 145A.14, subdivision 2b;

545.27 (3) \$500,000 is for a public health AmeriCorps
545.28 program grant under Minnesota Statutes,
545.29 section 144.0759; and

545.30 (4) \$870,000 is for oversight and
545.31 administration of activities under this
545.32 paragraph.

546.1 The base for this appropriation is \$8,000,000
546.2 in fiscal year 2026 and \$8,000,000 in fiscal
546.3 year 2027.

546.4 (1) **Health Care Workforce.** \$6,120,000 in
546.5 fiscal year 2024 and \$7,400,000 in fiscal year
546.6 2025 are from the general fund to revitalize
546.7 the Minnesota health care workforce. The
546.8 general fund base for this appropriation is
546.9 \$6,850,000 in fiscal year 2026 and \$7,100,000
546.10 in fiscal year 2027. Of this appropriation:

546.11 (1) \$750,000 in fiscal year 2024 and
546.12 \$2,000,000 in fiscal year 2025 are for rural
546.13 training tracks and rural clinicals grants under
546.14 Minnesota Statutes, section 144.1508;

546.15 (2) \$220,000 in fiscal year 2024 and \$200,000
546.16 in fiscal year 2025 are for immigrant
546.17 international medical graduate training grants
546.18 under Minnesota Statutes, section 144.1911;

546.19 (3) \$3,250,000 in fiscal year 2024 and
546.20 \$3,300,000 in fiscal year 2025 are for
546.21 site-based clinical training grants under
546.22 Minnesota Statutes, section 144.1505. The
546.23 base for this appropriation is \$3,000,000 in
546.24 fiscal year 2026 and \$3,000,000 in fiscal year
546.25 2027;

546.26 (4) \$500,000 in fiscal year 2024 and \$500,000
546.27 in fiscal year 2025 are for mental health for
546.28 health care professionals grants. These
546.29 appropriations are available until June 30,
546.30 2027, and are onetime appropriations;

546.31 (5) \$400,000 in fiscal year 2024 and \$400,000
546.32 in fiscal year 2025 are for primary care
546.33 employee recruitment education loan

547.1 forgiveness under Minnesota Statutes, section
547.2 144.1504;

547.3 (6) \$750,000 in fiscal year 2024 and \$750,000
547.4 in fiscal year 2025 are for administration of
547.5 the grant programs and loan forgiveness
547.6 programs under this paragraph; and

547.7 (7) \$250,000 in fiscal year 2024 and \$250,000
547.8 in fiscal year 2025 are for workforce research
547.9 and data on shortages, maldistribution of
547.10 health care providers in Minnesota, and
547.11 determinants of practicing in rural areas.

547.12 (m) **School Health.** \$1,432,000 in fiscal year
547.13 2024 and \$1,932,000 in fiscal year 2025 are
547.14 from the general fund for school-based health
547.15 centers under Minnesota Statutes, section
547.16 145.903. Of this appropriation each year,
547.17 \$800,000 is for grants and \$632,000 is for
547.18 administration. The general fund base for this
547.19 appropriation is \$2,983,000 in fiscal year
547.20 2026, of which \$2,300,000 is for grants and
547.21 \$683,000 is for administration, and \$2,983,000
547.22 in fiscal year 2027, of which \$2,300,000 is for
547.23 grants and \$683,000 is for administration.

547.24 (n) **Long COVID.** \$3,146,000 in fiscal year
547.25 2024 and \$3,146,000 in fiscal year 2025 are
547.26 from the general fund to address long COVID
547.27 and post-COVID conditions. Of this
547.28 appropriation each year, \$900,000 is for grants
547.29 and \$2,246,000 is for administration. This is
547.30 a onetime appropriation.

547.31 (o) **Home Visiting for Priority Populations.**
547.32 \$2,500,000 in fiscal year 2024 and \$2,500,000
547.33 in fiscal year 2025 are from the general fund
547.34 to expand home visiting for priority

548.1 populations under Minnesota Statutes, section
548.2 145.87. Of this appropriation each year,
548.3 \$2,250,000 is for grants to promising practices
548.4 home visiting programs as defined in
548.5 Minnesota Statutes, section 145.87,
548.6 subdivision 1, paragraph (e), and \$250,000 is
548.7 for administration.

548.8 **(p) Clinical Dental Education Innovation**
548.9 **Grants.** \$1,182,000 in fiscal year 2024 and
548.10 \$1,182,000 in fiscal year 2025 are from the
548.11 general fund for clinical dental education
548.12 innovation grants under Minnesota Statutes,
548.13 section 144.1913. Of this appropriation each
548.14 year, \$1,122,000 is for grants and \$60,000 is
548.15 for administration.

548.16 **(q) Medical Education and Research Costs.**
548.17 \$300,000 in fiscal year 2024 and \$300,000 in
548.18 fiscal year 2025 are from the general fund for
548.19 administration of the medical education and
548.20 research costs program under Minnesota
548.21 Statutes, section 62J.692.

548.22 **(r) Health Care Affordability Commission**
548.23 **and Advisory Council.** \$4,131,000 in fiscal
548.24 year 2024 and \$4,773,000 in fiscal year 2025
548.25 are from the general fund for the costs of the
548.26 Health Care Affordability Commission and
548.27 the Health Care Affordability Advisory
548.28 Council, including the costs to the
548.29 commissioner to provide technical and
548.30 administrative support. The general fund base
548.31 for this appropriation is \$4,787,000 in fiscal
548.32 year 2026 and \$4,784,000 in fiscal year 2027.

548.33 **(s) Economic Analysis; Analytic Tool.**
548.34 \$4,020,000 in fiscal year 2024 and \$580,000
548.35 in fiscal year 2025 are from the general fund

549.1 to contract for and conduct an economic
549.2 analysis of the benefits and costs of universal
549.3 health care system reform models and to
549.4 develop a related analytic tool. The general
549.5 fund base for this appropriation is \$580,000
549.6 in fiscal year 2026 and \$0 in fiscal year 2027.
549.7 This appropriation is available until June 30,
549.8 2027.

549.9 **(t) Keeping Nurses at the Bedside Act.**
549.10 \$11,553,000 in fiscal year 2024 and
549.11 \$11,558,000 in fiscal year 2025 are from the
549.12 general fund for the Keeping Nurses at the
549.13 Bedside Act. Of these appropriations:

549.14 (1) \$5,000,000 in fiscal year 2024 and
549.15 \$5,000,000 in fiscal year 2025 are for mental
549.16 health grants for health care professionals
549.17 under Laws 2022, chapter 99, article 1, section
549.18 46;

549.19 (2) notwithstanding the priorities and
549.20 distribution requirements under Minnesota
549.21 Statutes, section 144.1501, \$5,050,000 in
549.22 fiscal year 2024 and \$5,050,000 in fiscal year
549.23 2025 are for the health professional education
549.24 loan forgiveness program under Minnesota
549.25 Statutes, section 144.1501, of which:

549.26 (i) \$5,000,000 in fiscal year 2024 and
549.27 \$5,000,000 in fiscal year 2025 are for
549.28 distribution to eligible nurses who have agreed
549.29 to work as hospital nurses in accordance with
549.30 Minnesota Statutes, section 144.1501,
549.31 subdivision 2, paragraph (a), clause (7); and

549.32 (ii) \$50,000 in fiscal year 2024 and \$50,000
549.33 in fiscal year 2025 are for distribution to
549.34 eligible nurses who have agreed to teach in

550.1 accordance with Minnesota Statutes, section
550.2 144.1501, subdivision 2, paragraph (a), clause
550.3 (3); and
550.4 (3) \$1,503,000 in fiscal year 2024 and
550.5 \$1,508,000 in fiscal year 2025 are for the
550.6 commissioner of health to administer
550.7 Minnesota Statutes, section 144.7057; to
550.8 perform the grading duties described in
550.9 Minnesota Statutes, section 144.7058; to
550.10 continue the prevention of violence in health
550.11 care programs and to create violence
550.12 prevention resources for hospitals and other
550.13 health care providers to use to train their staff
550.14 on violence prevention; for work to identify
550.15 potential links between adverse events and
550.16 understaffing; and for a report on the current
550.17 status of the state's nursing workforce
550.18 employed by hospitals.
550.19 **(u) Supporting Healthy Development of**
550.20 **Babies During Pregnancy and Postpartum.**
550.21 \$260,000 in fiscal year 2024 is from the
550.22 general fund for a grant to the Amherst H.
550.23 Wilder Foundation for the African American
550.24 Babies Coalition initiative for
550.25 community-driven training and education on
550.26 best practices to support healthy development
550.27 of babies during pregnancy and postpartum.
550.28 The grant must be used to build capacity in,
550.29 train, educate, or improve practices among
550.30 individuals, from youth to elders, serving
550.31 families with members who are Black,
550.32 Indigenous, or People of Color during
550.33 pregnancy and postpartum. This appropriation
550.34 is available until June 30, 2025.

- 551.1 **(v) Critical Access Dental Infrastructure**
551.2 **Program.** \$20,000,000 in fiscal year 2024 is
551.3 from the general fund for the critical access
551.4 dental infrastructure program. This
551.5 appropriation is available until June 30, 2026.
- 551.6 **(w) Workplace Safety Grants Program.**
551.7 \$10,000,000 in fiscal year 2024 is from the
551.8 general fund for the workplace safety grants
551.9 program for health care entities and human
551.10 services providers. This appropriation is
551.11 available until June 30, 2025.
- 551.12 **(x) Analyses and Reports; Health Care**
551.13 **Transactions.** \$2,000,000 in fiscal year 2024
551.14 is from the general fund to conduct analyses
551.15 of the impacts of health care transactions on
551.16 health care cost, quality, and competition, and
551.17 to issue public reports on health care
551.18 transactions in Minnesota and their impacts.
551.19 This appropriation is available until June 30,
551.20 2025.
- 551.21 **(y) Provider Orders for Life-sustaining**
551.22 **Treatment Registry.** \$530,000 in fiscal year
551.23 2024 and \$1,655,000 in fiscal year 2025 are
551.24 from the general fund to study and implement
551.25 a statewide registry for provider orders for
551.26 life-sustaining treatment. The general fund
551.27 base for this appropriation is \$658,000 in fiscal
551.28 year 2026 and \$658,000 in fiscal year 2027.
- 551.29 **(z) Emmett Louis Till Victims Recovery**
551.30 **Program.** \$500,000 in fiscal year 2024 is from
551.31 the general fund for the Emmett Louis Till
551.32 victims recovery program. This appropriation
551.33 is available until June 30, 2025.

552.1 (aa) Task Force on Pregnancy Health and
552.2 Substance Use Disorders. \$100,000 in fiscal
552.3 year 2024 is from the general fund for the Task
552.4 Force on Pregnancy Health and Substance Use
552.5 Disorders. This appropriation is available until
552.6 December 1, 2024.

552.7 (bb) Labor Trafficking Services Programs.
552.8 \$546,000 in fiscal year 2024 and \$546,000 in
552.9 fiscal year 2025 are from the general fund for
552.10 grants for comprehensive, trauma-informed,
552.11 and culturally specific services for victims of
552.12 labor trafficking or labor exploitation. This is
552.13 a onetime appropriation.

552.14 (cc) Psychedelic Medicine Task Force.
552.15 \$200,000 in fiscal year 2024 and \$200,000 in
552.16 fiscal year 2025 are from the general fund for
552.17 the Psychedelic Medicine Task Force. This is
552.18 a onetime appropriation.

552.19 (dd) Help Me Connect. \$463,000 in fiscal
552.20 year 2024 and \$921,000 in fiscal year 2025
552.21 are from the general fund for the Help Me
552.22 Connect system. This is a onetime
552.23 appropriation.

552.24 (ee) TANF Appropriations. (1) TANF funds
552.25 must be used as follows:

552.26 (i) \$3,579,000 in fiscal year 2024 and
552.27 \$3,579,000 in fiscal year 2025 are from the
552.28 TANF fund for home visiting and nutritional
552.29 services listed under Minnesota Statutes,
552.30 section 145.882, subdivision 7, clauses (6) and
552.31 (7). Funds must be distributed to community
552.32 health boards according to Minnesota Statutes,
552.33 section 145A.131, subdivision 1;

553.1 (ii) \$2,000,000 in fiscal year 2024 and
553.2 \$2,000,000 in fiscal year 2025 are from the
553.3 TANF fund for decreasing racial and ethnic
553.4 disparities in infant mortality rates under
553.5 Minnesota Statutes, section 145.928,
553.6 subdivision 7;

553.7 (iii) \$4,978,000 in fiscal year 2024 and
553.8 \$4,978,000 in fiscal year 2025 are from the
553.9 TANF fund for the family home visiting grant
553.10 program under Minnesota Statutes, section
553.11 145A.17. \$4,000,000 in each fiscal year must
553.12 be distributed to community health boards
553.13 under Minnesota Statutes, section 145A.131,
553.14 subdivision 1. \$978,000 in each fiscal year
553.15 must be distributed to Tribal governments
553.16 under Minnesota Statutes, section 145A.14,
553.17 subdivision 2a;

553.18 (iv) \$1,156,000 in fiscal year 2024 and
553.19 \$1,156,000 in fiscal year 2025 are from the
553.20 TANF fund for family planning grants under
553.21 Minnesota Statutes, section 145.925; and

553.22 (v) the commissioner may use up to 6.23
553.23 percent of the funds appropriated from the
553.24 TANF fund each fiscal year to conduct the
553.25 ongoing evaluations required under Minnesota
553.26 Statutes, section 145A.17, subdivision 7, and
553.27 training and technical assistance as required
553.28 under Minnesota Statutes, section 145A.17,
553.29 subdivisions 4 and 5.

553.30 (2) TANF Carryforward. Any unexpended
553.31 balance of the TANF appropriation in the first
553.32 year does not cancel but is available in the
553.33 second year.

554.1 (ff) **Base Level Adjustments.** The general
 554.2 fund base is \$193,895,000 in fiscal year 2026
 554.3 and \$193,403,000 in fiscal year 2027. The
 554.4 health care access fund base is \$42,157,000
 554.5 in fiscal year 2026 and \$41,557,000 in fiscal
 554.6 year 2027.

554.7 **Subd. 3. Health Protection**

554.8	<u>Appropriations by Fund</u>		
554.9	<u>General</u>	<u>39,375,000</u>	<u>35,352,000</u>
554.10	<u>State Government</u>		
554.11	<u>Special Revenue</u>	<u>70,981,000</u>	<u>73,220,000</u>

554.12 **(a) Lead Remediation in Schools and Child**
 554.13 **Care Settings.** \$500,000 in fiscal year 2024
 554.14 and \$500,000 in fiscal year 2025 are from the
 554.15 general fund to reduce lead in drinking water
 554.16 in schools and child care facilities under
 554.17 Minnesota Statutes, section 145.9272. Of this
 554.18 appropriation in fiscal year 2024, \$146,000 is
 554.19 for grants and \$354,000 is for administration
 554.20 and in fiscal year 2025, \$239,000 is for grants
 554.21 and \$261,000 is for administration.

554.22 **(b) Antimicrobial Stewardship.** \$312,000 in
 554.23 fiscal year 2024 and \$312,000 in fiscal year
 554.24 2025 are from the general fund for the
 554.25 Minnesota One Health Antimicrobial
 554.26 Stewardship Collaborative under Minnesota
 554.27 Statutes, section 144.0526.

554.28 **(c) Comprehensive Overdose and Morbidity**
 554.29 **Prevention Act; Public Health Laboratory**
 554.30 **and Infectious Disease Prevention.**
 554.31 \$1,544,000 in fiscal year 2024 and \$1,544,000
 554.32 in fiscal year 2025 are from the general fund
 554.33 for comprehensive overdose and morbidity
 554.34 prevention strategies under Minnesota
 554.35 Statutes, section 144.0528. Of this

555.1 appropriation in fiscal year 2024, \$960,000 is
555.2 for grants and \$584,000 is for administration
555.3 and in fiscal year 2025, \$960,000 is for grants
555.4 and \$584,000 is for administration.

555.5 **(d) HIV Prevention Health Equity.**
555.6 \$2,267,000 in fiscal year 2024 and \$2,267,000
555.7 in fiscal year 2025 are from the general fund
555.8 for equity in HIV prevention. Of this
555.9 appropriation each year, \$1,264,000 is for
555.10 grants under Minnesota Statutes, section
555.11 145.924, and \$1,003,000 is for administration.
555.12 This is a onetime appropriation.

555.13 **(e) Uninsured and Underinsured Adult**
555.14 **Vaccine Program.** \$1,470,000 in fiscal year
555.15 2024 and \$1,470,000 in fiscal year 2025 are
555.16 from the general fund for the program for
555.17 vaccines for uninsured and underinsured
555.18 adults. This is a onetime appropriation.

555.19 **(f) Climate Resiliency.** \$500,000 in fiscal
555.20 year 2024 and \$500,000 in fiscal year 2025
555.21 are from the general fund for climate resiliency
555.22 actions. This is a onetime appropriation.

555.23 **(g) Transfer to Public Health Response**
555.24 **Contingency Account.** The commissioner
555.25 shall transfer \$4,804,000 in fiscal year 2024
555.26 from the general fund to the public health
555.27 response contingency account established in
555.28 Minnesota Statutes, section 144.4199. This is
555.29 a onetime transfer.

555.30 **(h) Base Level Adjustments.** The general
555.31 fund base is \$31,115,000 in fiscal year 2026
555.32 and \$31,115,000 in fiscal year 2027.

556.1 **Subd. 4. Health Operations**

556.2 Appropriations by Fund

556.3 General 18,492,000 18,405,000

556.4 **Sec. 4. HEALTH-RELATED BOARDS**

556.5 Subdivision 1. Total Appropriation **\$ 31,292,000 \$ 32,040,000**

556.6 Appropriations by Fund

556.7 General Fund 468,000 468,000

556.8 State Government

556.9 Special Revenue 30,748,000 31,534,000

556.10 Health Care Access 76,000 38,000

556.11 This appropriation is from the state
 556.12 government special revenue fund unless
 556.13 specified otherwise. The amounts that may be
 556.14 spent for each purpose are specified in the
 556.15 following subdivisions.

556.16 **Subd. 2. Board of Behavioral Health and**
 556.17 **Therapy**

1,022,000 1,044,000

556.18 **Subd. 3. Board of Chiropractic Examiners**

773,000 790,000

556.19 **Subd. 4. Board of Dentistry**

4,100,000 4,163,000

556.20 **(a) Administrative Services Unit; Operating**
 556.21 **Costs.** Of this appropriation, \$1,936,000 in
 556.22 fiscal year 2024 and \$1,960,000 in fiscal year
 556.23 2025 are for operating costs of the
 556.24 administrative services unit. The
 556.25 administrative services unit may receive and
 556.26 expend reimbursements for services it
 556.27 performs for other agencies.

556.28 **(b) Administrative Services Unit; Volunteer**
 556.29 **Health Care Provider Program.** Of this
 556.30 appropriation, \$150,000 in fiscal year 2024
 556.31 and \$150,000 in fiscal year 2025 are to pay
 556.32 for medical professional liability coverage
 556.33 required under Minnesota Statutes, section
 556.34 214.40.

557.1 **(c) Administrative Services Unit;**
557.2 **Retirement Costs.** Of this appropriation,
557.3 \$237,000 in fiscal year 2024 and \$237,000 in
557.4 fiscal year 2025 are for the administrative
557.5 services unit to pay for the retirement costs of
557.6 health-related board employees. This funding
557.7 may be transferred to the health board
557.8 incurring retirement costs. Any board that has
557.9 an unexpended balance for an amount
557.10 transferred under this paragraph shall transfer
557.11 the unexpended amount to the administrative
557.12 services unit. If the amount appropriated in
557.13 the first year of the biennium is not sufficient,
557.14 the amount from the second year of the
557.15 biennium is available.

557.16 **(d) Administrative Services Unit; Contested**
557.17 **Cases and Other Legal Proceedings.** Of this
557.18 appropriation, \$200,000 in fiscal year 2024
557.19 and \$200,000 in fiscal year 2025 are for costs
557.20 of contested case hearings and other
557.21 unanticipated costs of legal proceedings
557.22 involving health-related boards funded under
557.23 this section. Upon certification by a
557.24 health-related board to the administrative
557.25 services unit that costs will be incurred and
557.26 that there is insufficient money available to
557.27 pay for the costs out of money currently
557.28 available to that board, the administrative
557.29 services unit is authorized to transfer money
557.30 from this appropriation to the board for
557.31 payment of those costs with the approval of
557.32 the commissioner of management and budget.
557.33 The commissioner of management and budget
557.34 must require any board that has an unexpended
557.35 balance for an amount transferred under this
557.36 paragraph to transfer the unexpended amount

558.1 to the administrative services unit to be
 558.2 deposited in the state government special
 558.3 revenue fund.

558.4 **Subd. 5. Board of Dietetics and Nutrition**
 558.5 **Practice** 213,000 217,000

558.6 **Subd. 6. Board of Executives for Long-term**
 558.7 **Services and Supports** 705,000 736,000

558.8 **Subd. 7. Board of Marriage and Family Therapy** 443,000 456,000

558.9 **Subd. 8. Board of Medical Practice** 5,779,000 5,971,000

558.10 **Subd. 9. Board of Nursing** 6,039,000 6,275,000

558.11 **Subd. 10. Board of Occupational Therapy**
 558.12 **Practice** 468,000 480,000

558.13 **Subd. 11. Board of Optometry** 270,000 280,000

558.14 **Subd. 12. Board of Pharmacy**

558.15 Appropriations by Fund

558.16 General Fund 468,000 468,000

558.17 State Government
 558.18 Special Revenue 5,226,000 5,206,000

558.19 Health Care Access 76,000 38,000

558.20 **(a) Medication Repository Program.**
 558.21 \$468,000 in fiscal year 2024 and \$468,000 in
 558.22 fiscal year 2025 are from the general fund for
 558.23 transfer to the central repository to administer
 558.24 the medication repository program under
 558.25 Minnesota Statutes, section 151.555.

558.26 **(b) Base Level Adjustment.** The state
 558.27 government special revenue fund base is
 558.28 \$5,056,000 in fiscal year 2026 and \$5,056,000
 558.29 in fiscal year 2027. The health care access
 558.30 fund base is \$0 in fiscal year 2026 and \$0 in
 558.31 fiscal year 2027.

558.32 **Subd. 13. Board of Physical Therapy** 678,000 694,000

558.33 **Subd. 14. Board of Podiatric Medicine** 253,000 257,000

558.34 **Subd. 15. Board of Psychology** 2,618,000 2,734,000

559.1 **Health Professionals Service Program.** This
 559.2 appropriation includes \$1,234,000 in fiscal
 559.3 year 2024 and \$1,324,000 in fiscal year 2025
 559.4 for the health professional services program.

559.5 Subd. 16. **Board of Social Work** 1,779,000 1,839,000

559.6 Subd. 17. **Board of Veterinary Medicine** 382,000 392,000

559.7 Sec. 5. **EMERGENCY MEDICAL SERVICES**
 559.8 **REGULATORY BOARD** \$ 6,800,000 \$ 6,176,000

559.9 (a) **Cooper/Sams Volunteer Ambulance**
 559.10 **Program.** \$950,000 in fiscal year 2024 and
 559.11 \$950,000 in fiscal year 2025 are for the
 559.12 Cooper/Sams volunteer ambulance program
 559.13 under Minnesota Statutes, section 144E.40.

559.14 (1) Of this appropriation, \$861,000 in fiscal
 559.15 year 2024 and \$861,000 in fiscal year 2025
 559.16 are for the ambulance service personnel
 559.17 longevity award and incentive program under
 559.18 Minnesota Statutes, section 144E.40.

559.19 (2) Of this appropriation, \$89,000 in fiscal
 559.20 year 2024 and \$89,000 in fiscal year 2025 are
 559.21 for operations of the ambulance service
 559.22 personnel longevity award and incentive
 559.23 program under Minnesota Statutes, section
 559.24 144E.40.

559.25 (b) **EMSRB Operations.** \$2,421,000 in fiscal
 559.26 year 2024 and \$2,480,000 in fiscal year 2025
 559.27 are for board operations.

559.28 (c) **Regional Grants for Continuing**
 559.29 **Education.** \$585,000 in fiscal year 2024 and
 559.30 \$585,000 in fiscal year 2025 are for regional
 559.31 emergency medical services programs to be
 559.32 distributed equally to the eight emergency
 559.33 medical service regions under Minnesota
 559.34 Statutes, section 144E.52.

560.1 (d) Ambulance Training Grants. \$361,000
 560.2 in fiscal year 2024 and \$361,000 in fiscal year
 560.3 2025 are for training grants under Minnesota
 560.4 Statutes, section 144E.35.

560.5 (e) Medical Resource Communication
 560.6 Center Grants. \$1,683,000 in fiscal year 2024
 560.7 and \$1,000,000 in fiscal year 2025 are for
 560.8 medical resource communication center grants
 560.9 under Minnesota Statutes, section 144E.53.
 560.10 This is a onetime appropriation.

560.11 (f) Grants to Regional Emergency Medical
 560.12 Services Program. \$800,000 in fiscal year
 560.13 2024 and \$800,000 in fiscal year 2025 are for
 560.14 grants to regional emergency medical services
 560.15 programs, to be distributed among the eight
 560.16 emergency medical services regions according
 560.17 to Minnesota Statutes, section 144E.50.

560.18 (g) Base Level Adjustment. The general fund
 560.19 base is \$5,176,000 in fiscal year 2026 and
 560.20 \$5,176,000 in fiscal year 2027.

560.21 Sec. 6. MNSURE. \$ 22,373,000 \$ 34,810,000

560.22 (a) Transfer. The general fund appropriations
 560.23 must be transferred to the enterprise account
 560.24 established under Minnesota Statutes, section
 560.25 62V.07, for the purpose of establishing a
 560.26 single end-to-end IT system with seamless,
 560.27 real-time interoperability between qualified
 560.28 health plan eligibility and enrollment services.

560.29 (b) Base Level Adjustment. The general fund
 560.30 base is \$3,591,000 in fiscal year 2026,
 560.31 \$3,530,000 in fiscal year 2027, and \$7,055,000
 560.32 in fiscal year 2028.

560.33 Sec. 7. RARE DISEASE ADVISORY
 560.34 COUNCIL \$ 314,000 \$ 326,000

561.1 Sec. 8. Laws 2021, First Special Session chapter 7, article 16, section 2, subdivision 32,
 561.2 as amended by Laws 2022, chapter 98, article 15, section 7, is amended to read:

561.3 **Subd. 32. Grant Programs; Child Mental Health**
 561.4 **Grants** 30,167,000 30,182,000

561.5 **(a) Children's Residential Facilities.**
 561.6 \$1,964,000 in fiscal year 2022 and \$1,979,000
 561.7 in fiscal year 2023 are to reimburse counties
 561.8 and Tribal governments for a portion of the
 561.9 costs of treatment in children's residential
 561.10 facilities. The commissioner shall distribute
 561.11 the appropriation to counties and Tribal
 561.12 governments proportionally based on a
 561.13 methodology developed by the commissioner.
 561.14 ~~The fiscal year 2022 appropriation is available~~
 561.15 ~~until June 30, 2023~~ base for this activity is \$0
 561.16 in fiscal year 2025.

561.17 **(b) Base Level Adjustment.** The general fund
 561.18 base is \$29,580,000 in fiscal year 2024 and
 561.19 ~~\$27,705,000~~ \$25,726,000 in fiscal year 2025.

561.20 **Sec. 9. ASSET DISREGARDS.**
 561.21 \$351,000 in fiscal year 2023 is appropriated from the general fund to the commissioner
 561.22 of human services to implement a temporary asset disregard program in the medical
 561.23 assistance program. This is a onetime appropriation.

561.24 **Sec. 10. TRANSFERS.**
 561.25 Subdivision 1. **Grants.** The commissioner of human services, with the approval of the
 561.26 commissioner of management and budget, may transfer unencumbered appropriation balances
 561.27 for the biennium ending June 30, 2025, within fiscal years among MFIP; general assistance;
 561.28 medical assistance; MinnesotaCare; MFIP child care assistance under Minnesota Statutes,
 561.29 section 119B.05; Minnesota supplemental aid program; housing support program; the
 561.30 entitlement portion of Northstar Care for Children under Minnesota Statutes, chapter 256N;
 561.31 and the entitlement portion of the behavioral health fund between fiscal years of the biennium.
 561.32 The commissioner shall report to the chairs and ranking minority members of the legislative

562.1 committees with jurisdiction over health and human services quarterly about transfers made
562.2 under this subdivision.

562.3 Subd. 2. **Administration.** Positions, salary money, and nonsalary administrative money
562.4 may be transferred within the Department of Human Services as the commissioners consider
562.5 necessary, with the advance approval of the commissioner of management and budget. The
562.6 commissioners shall report to the chairs and ranking minority members of the legislative
562.7 committees with jurisdiction over health and human services finance quarterly about transfers
562.8 made under this section.

562.9 **Sec. 11. TRANSFERS; ADMINISTRATION.**

562.10 Positions, salary money, and nonsalary administrative money may be transferred within
562.11 the Department of Health as the commissioner considers necessary with the advance approval
562.12 of the commissioner of management and budget. The commissioner shall report to the chairs
562.13 and ranking minority members of the legislative committees with jurisdiction over health
562.14 finance quarterly about transfers made under this section.

562.15 **Sec. 12. INDIRECT COSTS NOT TO FUND PROGRAMS.**

562.16 The commissioner of health shall not use indirect cost allocations to pay for the
562.17 operational costs of any program for which they are responsible.

562.18 **Sec. 13. APPROPRIATIONS GIVEN EFFECT ONCE.**

562.19 If an appropriation or transfer in this article is enacted more than once during the 2023
562.20 regular session, the appropriation or transfer must be given effect once.

562.21 **Sec. 14. EXPIRATION OF UNCODIFIED LANGUAGE.**

562.22 All uncodified language contained in this article expires on June 30, 2025, unless a
562.23 different expiration date is explicit.

62J.692 MEDICAL EDUCATION.

Subd. 4a. **Alternative distribution.** If federal approval is not received for the formula described in subdivision 4, paragraphs (a) and (b), 100 percent of available medical education and research funds shall be distributed based on a distribution formula that reflects a summation of two factors:

(1) a public program volume factor, that is determined by the total volume of public program revenue received by each training site as a percentage of all public program revenue received by all training sites in the fund pool; and

(2) a supplemental public program volume factor, that is determined by providing a supplemental payment of 20 percent of each training site's grant to training sites whose public program revenue accounted for at least 0.98 percent of the total public program revenue received by all eligible training sites. Grants to training sites whose public program revenue accounted for less than 0.98 percent of the total public program revenue received by all eligible training sites shall be reduced by an amount equal to the total value of the supplemental payment.

Subd. 7. **Transfers from commissioner of human services.** Of the amount transferred according to section 256B.69, subdivision 5c, paragraph (a), clauses (1) to (4), \$21,714,000 shall be distributed as follows:

(1) \$2,157,000 shall be distributed by the commissioner to the University of Minnesota Board of Regents for the purposes described in sections 137.38 to 137.40;

(2) \$1,035,360 shall be distributed by the commissioner to the Hennepin County Medical Center for clinical medical education;

(3) \$17,400,000 shall be distributed by the commissioner to the University of Minnesota Board of Regents for purposes of medical education;

(4) \$1,121,640 shall be distributed by the commissioner to clinical medical education dental innovation grants in accordance with subdivision 7a; and

(5) the remainder of the amount transferred according to section 256B.69, subdivision 5c, clauses (1) to (4), shall be distributed by the commissioner annually to clinical medical education programs that meet the qualifications of subdivision 3 based on the formula in subdivision 4, paragraph (a).

Subd. 7a. **Clinical medical education innovations grants.** (a) The commissioner shall award grants to teaching institutions and clinical training sites for projects that increase dental access for underserved populations and promote innovative clinical training of dental professionals. In awarding the grants, the commissioner, in consultation with the commissioner of human services, shall consider the following:

(1) potential to successfully increase access to an underserved population;

(2) the long-term viability of the project to improve access beyond the period of initial funding;

(3) evidence of collaboration between the applicant and local communities;

(4) the efficiency in the use of the funding; and

(5) the priority level of the project in relation to state clinical education, access, and workforce goals.

(b) The commissioner shall periodically evaluate the priorities in awarding the innovations grants in order to ensure that the priorities meet the changing workforce needs of the state.

62J.84 PRESCRIPTION DRUG PRICE TRANSPARENCY.

Subd. 5. **Newly acquired prescription drug price reporting.** (a) Beginning January 1, 2022, the acquiring drug manufacturer must submit to the commissioner the information described in paragraph (b) for each newly acquired prescription drug for which the price was \$100 or greater for a 30-day supply or for a course of treatment lasting less than 30 days and:

(1) for a newly acquired brand name drug where there is an increase of ten percent or greater in the price over the previous 12-month period or an increase of 16 percent or greater in price over the previous 24-month period; and

(2) for a newly acquired generic drug where there is an increase of 50 percent or greater in the price over the previous 12-month period.

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(b) For each of the drugs described in paragraph (a), the acquiring manufacturer shall submit to the commissioner no later than 60 days after the acquiring manufacturer begins to sell the newly acquired drug, in the form and manner prescribed by the commissioner, the following information, if applicable:

(1) the price of the prescription drug at the time of acquisition and in the calendar year prior to acquisition;

(2) the name of the company from which the prescription drug was acquired, the date acquired, and the purchase price;

(3) the year the prescription drug was introduced to market and the price of the prescription drug at the time of introduction;

(4) the price of the prescription drug for the previous five years;

(5) any agreement between a manufacturer and another entity contingent upon any delay in offering to market a generic version of the manufacturer's drug; and

(6) the patent expiration date of the drug if it is under patent.

(c) The manufacturer may submit any documentation necessary to support the information reported under this subdivision.

62Q.145 ABORTION AND SCOPE OF PRACTICE.

Health plan company policies related to scope of practice for allied independent health providers, midlevel practitioners as defined in section 144.1501, subdivision 1, and other nonphysician health care professionals must comply with the requirements governing the performance of abortions in section 145.412, subdivision 1.

62U.10 HEALTH CARE TRANSFER, SAVINGS, AND REPAYMENT.

Subd. 6. **Projected spending baseline.** Beginning February 15, 2016, and each February 15 thereafter, the commissioner of health shall report the projected impact on spending from specified health indicators related to various preventable illnesses and death. The impacts shall be reported over a ten-year time frame using a baseline forecast of private and public health care and long-term care spending for residents of this state, beginning with calendar year 2009 projected estimates of costs, and updated annually for each of the following health indicators:

(1) costs related to rates of obesity, including obesity-related cancers, coronary heart disease, stroke, and arthritis;

(2) costs related to the utilization of tobacco products;

(3) costs related to hypertension;

(4) costs related to diabetes or prediabetes; and

(5) costs related to dementia and chronic disease among an elderly population over 60, including additional long-term care costs.

Subd. 7. **Outcomes reporting; savings determination.** (a) Beginning November 1, 2016, and each November 1 thereafter, the commissioner of health shall determine the actual total private and public health care and long-term care spending for Minnesota residents related to each health indicator projected in subdivision 6 for the most recent calendar year available. The commissioner shall determine the difference between the projected and actual spending for each health indicator and for each year, and determine the savings attributable to changes in these health indicators. The assumptions and research methods used to calculate actual spending must be determined to be appropriate by an independent actuarial consultant. If the actual spending is less than the projected spending, the commissioner, in consultation with the commissioners of human services and management and budget, shall use the proportion of spending for state-administered health care programs to total private and public health care spending for each health indicator for the calendar year two years before the current calendar year to determine the percentage of the calculated aggregate savings amount accruing to state-administered health care programs.

(b) The commissioner may use the data submitted under section 62U.04, subdivisions 4 and 5, to complete the activities required under this section, but may only report publicly on regional data aggregated to granularity of 25,000 lives or greater for this purpose.

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Subd. 8. **Transfers.** When accumulated annual savings accruing to state-administered health care programs, as calculated under subdivision 7, meet or exceed \$50,000,000 for all health indicators in aggregate statewide, the commissioner of health shall certify that event to the commissioner of management and budget, no later than December 15 of each year. In the next fiscal year following the certification, the commissioner of management and budget shall transfer \$50,000,000 from the general fund to the health care access fund. This transfer shall repeat in each fiscal year following subsequent certifications of additional cumulative savings, up to \$50,000,000 per year. The amount necessary to make the transfer is appropriated from the general fund to the commissioner of management and budget.

137.38 EDUCATION AND TRAINING OF PRIMARY CARE PHYSICIANS.

Subdivision 1. **Condition.** If the Board of Regents accepts the amount transferred under section 62J.692, subdivision 7, clause (1), to be used for the purposes described in sections 137.38 to 137.40, it shall comply with the duties for which the transfer is made.

144.059 PALLIATIVE CARE ADVISORY COUNCIL.

Subd. 10. **Sunset.** The council shall sunset January 1, 2025.

144.9505 CREDENTIALING OF LEAD FIRMS AND PROFESSIONALS.

Subd. 3. **Licensed building contractor; information.** The commissioner shall provide health and safety information on lead abatement and lead hazard reduction to all residential building contractors licensed under section 326B.805. The information must include the lead-safe practices and any other materials describing ways to protect the health and safety of both employees and residents.

145.1621 DISPOSITION OF ABORTED OR MISCARRIED FETUSES.

Subdivision 1. **Purpose.** The purpose of this section is to protect the public health and welfare by providing for the dignified and sanitary disposition of the remains of aborted or miscarried human fetuses in a uniform manner and to declare violations of this section to be a public nuisance.

Subd. 2. **Definition; remains of a human fetus.** For the purposes of this section, the term "remains of a human fetus" means the remains of the dead offspring of a human being that has reached a stage of development so that there are cartilaginous structures, fetal or skeletal parts after an abortion or miscarriage, whether or not the remains have been obtained by induced, spontaneous, or accidental means.

Subd. 3. **Regulation of disposal.** Remains of a human fetus resulting from an abortion or miscarriage, induced or occurring accidentally or spontaneously at a hospital, clinic, or medical facility must be deposited or disposed of in this state only at the place and in the manner provided by this section or, if not possible, as directed by the commissioner of health.

Subd. 4. **Disposition; tests.** Hospitals, clinics, and medical facilities in which abortions are induced or occur spontaneously or accidentally and laboratories to which the remains of human fetuses are delivered must provide for the disposal of the remains by cremation, interment by burial, or in a manner directed by the commissioner of health. The hospital, clinic, medical facility, or laboratory may complete laboratory tests necessary for the health of the woman or her future offspring or for purposes of a criminal investigation or determination of parentage prior to disposing of the remains.

Subd. 5. **Violation; penalty.** Failure to comply with this section constitutes a public nuisance. A person, firm, or corporation failing to comply with this section is guilty of a misdemeanor.

Subd. 6. **Exclusions.** To comply with this section, a religious service or ceremony is not required as part of the disposition of the remains of a human fetus, and no discussion of the method of disposition is required with the woman obtaining an induced abortion.

145.411 REGULATION OF ABORTIONS; DEFINITIONS.

Subd. 2. **Viable.** "Viable" means able to live outside the womb even though artificial aid may be required. During the second half of its gestation period a fetus shall be considered potentially "viable."

Subd. 4. **Abortion facility.** "Abortion facility" means those places properly recognized and licensed by the state commissioner of health under lawful rules promulgated by the commissioner for the performance of abortions.

145.412 CRIMINAL ACTS.

Subdivision 1. **Requirements.** It shall be unlawful to willfully perform an abortion unless the abortion is performed:

- (1) by a physician licensed to practice medicine pursuant to chapter 147, or a physician in training under the supervision of a licensed physician;
- (2) in a hospital or abortion facility if the abortion is performed after the first trimester;
- (3) in a manner consistent with the lawful rules promulgated by the state commissioner of health; and
- (4) with the consent of the woman submitting to the abortion after a full explanation of the procedure and effect of the abortion.

Subd. 2. **Unconsciousness; lifesaving.** It shall be unlawful to perform an abortion upon a woman who is unconscious except if the woman has been rendered unconscious for the purpose of having an abortion or if the abortion is necessary to save the life of the woman.

Subd. 3. **Viability.** It shall be unlawful to perform an abortion when the fetus is potentially viable unless:

- (1) the abortion is performed in a hospital;
- (2) the attending physician certifies in writing that in the physician's best medical judgment the abortion is necessary to preserve the life or health of the pregnant woman; and
- (3) to the extent consistent with sound medical practice the abortion is performed under circumstances which will reasonably assure the live birth and survival of the fetus.

Subd. 4. **Penalty.** A person who performs an abortion in violation of this section is guilty of a felony.

145.413 RECORDING AND REPORTING HEALTH DATA.

Subd. 2. **Death of woman.** If any woman who has had an abortion dies from any cause within 30 days of the abortion or from any cause potentially related to the abortion within 90 days of the abortion, that fact shall be reported to the state commissioner of health.

Subd. 3. **Penalty.** A physician who performs an abortion and who fails to comply with subdivision 1 and transmit the required information to the state commissioner of health within 30 days after the abortion is guilty of a misdemeanor.

145.4131 RECORDING AND REPORTING ABORTION DATA.

Subdivision 1. **Forms.** (a) Within 90 days of July 1, 1998, the commissioner shall prepare a reporting form for use by physicians or facilities performing abortions. A copy of this section shall be attached to the form. A physician or facility performing an abortion shall obtain a form from the commissioner.

(b) The form shall require the following information:

- (1) the number of abortions performed by the physician in the previous calendar year, reported by month;
- (2) the method used for each abortion;
- (3) the approximate gestational age expressed in one of the following increments:
 - (i) less than nine weeks;
 - (ii) nine to ten weeks;
 - (iii) 11 to 12 weeks;
 - (iv) 13 to 15 weeks;
 - (v) 16 to 20 weeks;
 - (vi) 21 to 24 weeks;
 - (vii) 25 to 30 weeks;
 - (viii) 31 to 36 weeks; or

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- (ix) 37 weeks to term;
- (4) the age of the woman at the time the abortion was performed;
- (5) the specific reason for the abortion, including, but not limited to, the following:
 - (i) the pregnancy was a result of rape;
 - (ii) the pregnancy was a result of incest;
 - (iii) economic reasons;
 - (iv) the woman does not want children at this time;
 - (v) the woman's emotional health is at stake;
 - (vi) the woman's physical health is at stake;
 - (vii) the woman will suffer substantial and irreversible impairment of a major bodily function if the pregnancy continues;
 - (viii) the pregnancy resulted in fetal anomalies; or
 - (ix) unknown or the woman refused to answer;
- (6) the number of prior induced abortions;
- (7) the number of prior spontaneous abortions;
- (8) whether the abortion was paid for by:
 - (i) private coverage;
 - (ii) public assistance health coverage; or
 - (iii) self-pay;
- (9) whether coverage was under:
 - (i) a fee-for-service plan;
 - (ii) a capitated private plan; or
 - (iii) other;
- (10) complications, if any, for each abortion and for the aftermath of each abortion. Space for a description of any complications shall be available on the form;
- (11) the medical specialty of the physician performing the abortion;
- (12) if the abortion was performed via telehealth, the facility code for the patient and the facility code for the physician; and
- (13) whether the abortion resulted in a born alive infant, as defined in section 145.423, subdivision 4, and:
 - (i) any medical actions taken to preserve the life of the born alive infant;
 - (ii) whether the born alive infant survived; and
 - (iii) the status of the born alive infant, should the infant survive, if known.

Subd. 2. **Submission.** A physician performing an abortion or a facility at which an abortion is performed shall complete and submit the form to the commissioner no later than April 1 for abortions performed in the previous calendar year. The annual report to the commissioner shall include the methods used to dispose of fetal tissue and remains.

Subd. 3. **Additional reporting.** Nothing in this section shall be construed to preclude the voluntary or required submission of other reports or forms regarding abortions.

145.4132 RECORDING AND REPORTING ABORTION COMPLICATION DATA.

Subdivision 1. **Forms.** (a) Within 90 days of July 1, 1998, the commissioner shall prepare an abortion complication reporting form for all physicians licensed and practicing in the state. A copy of this section shall be attached to the form.

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(b) The Board of Medical Practice shall ensure that the abortion complication reporting form is distributed:

(1) to all physicians licensed to practice in the state, within 120 days after July 1, 1998, and by December 1 of each subsequent year; and

(2) to a physician who is newly licensed to practice in the state, at the same time as official notification to the physician that the physician is so licensed.

Subd. 2. **Required reporting.** A physician licensed and practicing in the state who knowingly encounters an illness or injury that, in the physician's medical judgment, is related to an induced abortion or the facility where the illness or injury is encountered shall complete and submit an abortion complication reporting form to the commissioner.

Subd. 3. **Submission.** A physician or facility required to submit an abortion complication reporting form to the commissioner shall do so as soon as practicable after the encounter with the abortion-related illness or injury.

Subd. 4. **Additional reporting.** Nothing in this section shall be construed to preclude the voluntary or required submission of other reports or forms regarding abortion complications.

145.4133 REPORTING OUT-OF-STATE ABORTIONS.

The commissioner of human services shall report to the commissioner by April 1 each year the following information regarding abortions paid for with state funds and performed out of state in the previous calendar year:

(1) the total number of abortions performed out of state and partially or fully paid for with state funds through the medical assistance or MinnesotaCare program, or any other program;

(2) the total amount of state funds used to pay for the abortions and expenses incidental to the abortions; and

(3) the gestational age at the time of abortion.

145.4134 COMMISSIONER'S PUBLIC REPORT.

(a) By July 1 of each year, except for 1998 and 1999 information, the commissioner shall issue a public report providing statistics for the previous calendar year compiled from the data submitted under sections 145.4131 to 145.4133 and sections 145.4241 to 145.4249. For 1998 and 1999 information, the report shall be issued October 1, 2000. Each report shall provide the statistics for all previous calendar years, adjusted to reflect any additional information from late or corrected reports. The commissioner shall ensure that none of the information included in the public reports can reasonably lead to identification of an individual having performed or having had an abortion. All data included on the forms under sections 145.4131 to 145.4133 and sections 145.4241 to 145.4249 must be included in the public report, except that the commissioner shall maintain as confidential, data which alone or in combination may constitute information from which an individual having performed or having had an abortion may be identified using epidemiologic principles.

(b) The commissioner may, by rules adopted under chapter 14, alter the submission dates established under sections 145.4131 to 145.4133 for administrative convenience, fiscal savings, or other valid reason, provided that physicians or facilities and the commissioner of human services submit the required information once each year and the commissioner issues a report once each year.

145.4135 ENFORCEMENT; PENALTIES.

(a) If the commissioner finds that a physician or facility has failed to submit the required form under section 145.4131 within 60 days following the due date, the commissioner shall notify the physician or facility that the form is late. A physician or facility who fails to submit the required form under section 145.4131 within 30 days following notification from the commissioner that a report is late is subject to a late fee of \$500 for each 30-day period, or portion thereof, that the form is overdue. If a physician or facility required to report under this section does not submit a report, or submits only an incomplete report, more than one year following the due date, the commissioner may take action to fine the physician or facility or may bring an action to require that the physician or facility be directed by a court of competent jurisdiction to submit a complete report within a period stated by court order or be subject to sanctions for civil contempt. Notwithstanding section 13.39 to the contrary, action taken by the commissioner to enforce the provision of this section shall be treated as private if the data related to this action, alone or in combination, may constitute

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information from which an individual having performed or having had an abortion may be identified using epidemiologic principles.

(b) If the commissioner fails to issue the public report required under section 145.4134 or fails in any way to enforce this section, a group of 100 or more citizens of the state may seek an injunction in a court of competent jurisdiction against the commissioner requiring that a complete report be issued within a period stated by court order or requiring that enforcement action be taken.

(c) A physician or facility reporting in good faith and exercising due care shall have immunity from civil, criminal, or administrative liability that might otherwise result from reporting. A physician who knowingly or recklessly submits a false report under this section is guilty of a misdemeanor.

(d) The commissioner may take reasonable steps to ensure compliance with sections 145.4131 to 145.4133 and to verify data provided, including but not limited to, inspection of places where abortions are performed in accordance with chapter 14.

(e) The commissioner shall develop recommendations on appropriate penalties and methods of enforcement for physicians or facilities who fail to submit the report required under section 145.4132, submit an incomplete report, or submit a late report. The commissioner shall also assess the effectiveness of the enforcement methods and penalties provided in paragraph (a) and shall recommend appropriate changes, if any. These recommendations shall be reported to the chairs of the senate Health and Family Security Committee and the house of representatives Health and Human Services Committee by November 15, 1998.

145.4136 SEVERABILITY.

If any one or more provision, section, subdivision, sentence, clause, phrase, or word in sections 145.4131 to 145.4135, or the application thereof to any person or circumstance is found to be unconstitutional, the same is hereby declared to be severable and the balance of sections 145.4131 to 145.4135 shall remain effective notwithstanding such unconstitutionality. The legislature hereby declares that it would have passed sections 145.4131 to 145.4135, and each provision, section, subdivision, sentence, clause, phrase, or word thereof, irrespective of the fact that any one or more provision, section, subdivision, sentence, clause, phrase, or word be declared unconstitutional.

145.415 LIVE FETUS AFTER ABORTION, TREATMENT.

Subdivision 1. **Recognition.** A potentially viable fetus which is live born following an attempted abortion shall be fully recognized as a human person under the law.

Subd. 2. **Medical care.** If an abortion of a potentially viable fetus results in a live birth, the responsible medical personnel shall take all reasonable measures, in keeping with good medical practice, to preserve the life and health of the live born person.

Subd. 3. **Status.** (1) Unless the abortion is performed to save the life of the woman or child, or (2) unless one or both of the parents of the unborn child agrees within 30 days of the birth to accept the parental rights and responsibilities for the child if it survives the abortion, whenever an abortion of a potentially viable fetus results in a live birth, the child shall be an abandoned ward of the state and the parents shall have no parental rights or obligations as if the parental rights had been terminated pursuant to section 260C.301. The child shall be provided for pursuant to chapter 256J.

145.416 LICENSING AND REGULATION OF FACILITIES.

The state commissioner of health shall license and promulgate rules for facilities as defined in section 145.411, subdivision 4, which are organized for purposes of delivering abortion services.

145.423 ABORTION; LIVE BIRTHS.

Subd. 2. **Physician required.** When an abortion is performed after the 20th week of pregnancy, a physician, other than the physician performing the abortion, shall be immediately accessible to take all reasonable measures consistent with good medical practice, including the compilation of appropriate medical records, to preserve the life and health of any born alive infant that is the result of the abortion.

Subd. 3. **Death.** If a born alive infant described in subdivision 1 dies after birth, the body shall be disposed of in accordance with the provisions of section 145.1621.

Subd. 4. **Definition of born alive infant.** (a) In determining the meaning of any Minnesota statute, or of any ruling, regulation, or interpretation of the various administrative bureaus and agencies of Minnesota, the words "person," "human being," "child," and "individual" shall include every infant member of the species *Homo sapiens* who is born alive at any stage of development.

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(b) As used in this section, the term "born alive," with respect to a member of the species *Homo sapiens*, means the complete expulsion or extraction from his or her mother of that member, at any stage of development, who, after such expulsion or extraction, breathes or has a beating heart, pulsation of the umbilical cord, or definite movement of voluntary muscles, regardless of whether the umbilical cord has been cut, and regardless of whether the expulsion or extraction occurs as a result of a natural or induced labor, cesarean section, or induced abortion.

(c) Nothing in this section shall be construed to affirm, deny, expand, or contract any legal status or legal right applicable to any member of the species *Homo sapiens* at any point prior to being born alive, as defined in this section.

Subd. 5. Civil and disciplinary actions. (a) Any person upon whom an abortion has been performed, or the parent or guardian of the mother if the mother is a minor, and the abortion results in the infant having been born alive, may maintain an action for death of or injury to the born alive infant against the person who performed the abortion if the death or injury was a result of simple negligence, gross negligence, wantonness, willfulness, intentional conduct, or another violation of the legal standard of care.

(b) Any responsible medical personnel that does not take all reasonable measures consistent with good medical practice to preserve the life and health of the born alive infant, as required by subdivision 1, may be subject to the suspension or revocation of that person's professional license by the professional board with authority over that person. Any person who has performed an abortion and against whom judgment has been rendered pursuant to paragraph (a) shall be subject to an automatic suspension of the person's professional license for at least one year and said license shall be reinstated only after the person's professional board requires compliance with this section by all board licensees.

(c) Nothing in this subdivision shall be construed to hold the mother of the born alive infant criminally or civilly liable for the actions of a physician, nurse, or other licensed health care provider in violation of this section to which the mother did not give her consent.

Subd. 6. Protection of privacy in court proceedings. In every civil action brought under this section, the court shall rule whether the anonymity of any female upon whom an abortion has been performed or attempted shall be preserved from public disclosure if she does not give her consent to such disclosure. The court, upon motion or sua sponte, shall make such a ruling and, upon determining that her anonymity should be preserved, shall issue orders to the parties, witnesses, and counsel and shall direct the sealing of the record and exclusion of individuals from courtrooms or hearing rooms to the extent necessary to safeguard her identity from public disclosure. Each order must be accompanied by specific written findings explaining why the anonymity of the female should be preserved from public disclosure, why the order is essential to that end, how the order is narrowly tailored to serve that interest, and why no reasonable, less restrictive alternative exists. This section may not be construed to conceal the identity of the plaintiff or of witnesses from the defendant.

Subd. 7. Status of born alive infant. Unless the abortion is performed to save the life of the woman or fetus, or, unless one or both of the parents of the born alive infant agree within 30 days of the birth to accept the parental rights and responsibilities for the child, the child shall be an abandoned ward of the state and the parents shall have no parental rights or obligations as if the parental rights had been terminated pursuant to section 260C.301. The child shall be provided for pursuant to chapter 256J.

Subd. 8. Severability. If any one or more provision, section, subdivision, sentence, clause, phrase, or word of this section or the application of it to any person or circumstance is found to be unconstitutional, it is declared to be severable and the balance of this section shall remain effective notwithstanding such unconstitutionality. The legislature intends that it would have passed this section, and each provision, section, subdivision, sentence, clause, phrase, or word, regardless of the fact that any one provision, section, subdivision, sentence, clause, phrase, or word is declared unconstitutional.

Subd. 9. Short title. This section may be cited as the "Born Alive Infants Protection Act."

145.4235 POSITIVE ABORTION ALTERNATIVES.

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

(1) "abortion" means the use of any means to terminate the pregnancy of a woman known to be pregnant with knowledge that the termination with those means will, with reasonable likelihood,

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cause the death of the unborn child. For purposes of this section, abortion does not include an abortion necessary to prevent the death of the mother;

(2) "nondirective counseling" means providing clients with:

(i) a list of health care providers and social service providers that provide prenatal care, childbirth care, infant care, foster care, adoption services, alternatives to abortion, or abortion services; and

(ii) nondirective, nonmarketing information regarding such providers; and

(3) "unborn child" means a member of the species *Homo sapiens* from fertilization until birth.

Subd. 2. **Eligibility for grants.** (a) The commissioner shall award grants to eligible applicants under paragraph (c) for the reasonable expenses of alternatives to abortion programs to support, encourage, and assist women in carrying their pregnancies to term and caring for their babies after birth by providing information on, referral to, and assistance with securing necessary services that enable women to carry their pregnancies to term and care for their babies after birth. Necessary services must include, but are not limited to:

(1) medical care;

(2) nutritional services;

(3) housing assistance;

(4) adoption services;

(5) education and employment assistance, including services that support the continuation and completion of high school;

(6) child care assistance; and

(7) parenting education and support services.

An applicant may not provide or assist a woman to obtain adoption services from a provider of adoption services that is not licensed.

(b) In addition to providing information and referral under paragraph (a), an eligible program may provide one or more of the necessary services under paragraph (a) that assists women in carrying their pregnancies to term. To avoid duplication of efforts, grantees may refer to other public or private programs, rather than provide the care directly, if a woman meets eligibility criteria for the other programs.

(c) To be eligible for a grant, an agency or organization must:

(1) be a private, nonprofit organization;

(2) demonstrate that the program is conducted under appropriate supervision;

(3) not charge women for services provided under the program;

(4) provide each pregnant woman counseled with accurate information on the developmental characteristics of babies and of unborn children, including offering the printed information described in section 145.4243;

(5) ensure that its alternatives-to-abortion program's purpose is to assist and encourage women in carrying their pregnancies to term and to maximize their potentials thereafter;

(6) ensure that none of the money provided is used to encourage or affirmatively counsel a woman to have an abortion not necessary to prevent her death, to provide her an abortion, or to directly refer her to an abortion provider for an abortion. The agency or organization may provide nondirective counseling; and

(7) have had the alternatives to abortion program in existence for at least one year as of July 1, 2011; or incorporated an alternative to abortion program that has been in existence for at least one year as of July 1, 2011.

(d) The provisions, words, phrases, and clauses of paragraph (c) are inseverable from this subdivision, and if any provision, word, phrase, or clause of paragraph (c) or its application to any person or circumstance is held invalid, the invalidity applies to all of this subdivision.

(e) An organization that provides abortions, promotes abortions, or directly refers to an abortion provider for an abortion is ineligible to receive a grant under this program. An affiliate of an

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organization that provides abortions, promotes abortions, or directly refers to an abortion provider for an abortion is ineligible to receive a grant under this section unless the organizations are separately incorporated and independent from each other. To be independent, the organizations may not share any of the following:

- (1) the same or a similar name;
 - (2) medical facilities or nonmedical facilities, including but not limited to, business offices, treatment rooms, consultation rooms, examination rooms, and waiting rooms;
 - (3) expenses;
 - (4) employee wages or salaries; or
 - (5) equipment or supplies, including but not limited to, computers, telephone systems, telecommunications equipment, and office supplies.
- (f) An organization that receives a grant under this section and that is affiliated with an organization that provides abortion services must maintain financial records that demonstrate strict compliance with this subdivision and that demonstrate that its independent affiliate that provides abortion services receives no direct or indirect economic or marketing benefit from the grant under this section.
- (g) The commissioner shall approve any information provided by a grantee on the health risks associated with abortions to ensure that the information is medically accurate.

Subd. 3. Privacy protection. (a) Any program receiving a grant under this section must have a privacy policy and procedures in place to ensure that the name, address, telephone number, or any other information that might identify any woman seeking the services of the program is not made public or shared with any other agency or organization without the written consent of the woman. All communications between the program and the woman must remain confidential. For purposes of any medical care provided by the program, including, but not limited to, pregnancy tests or ultrasonic scanning, the program must adhere to the requirements in sections 144.291 to 144.298 that apply to providers before releasing any information relating to the medical care provided.

(b) Notwithstanding paragraph (a), the commissioner has access to any information necessary to monitor and review a grantee's program as required under subdivision 4.

Subd. 4. Duties of commissioner. The commissioner shall make grants under subdivision 2 beginning no later than July 1, 2006. In awarding grants, the commissioner shall consider the program's demonstrated capacity in providing services to assist a pregnant woman in carrying her pregnancy to term. The commissioner shall monitor and review the programs of each grantee to ensure that the grantee carefully adheres to the purposes and requirements of subdivision 2 and shall cease funding a grantee that fails to do so.

Subd. 5. Severability. Except as provided in subdivision 2, paragraph (d), if any provision, word, phrase, or clause of this section or its application to any person or circumstance is held invalid, such invalidity shall not affect the provisions, words, phrases, clauses, or applications of this section that can be given effect without the invalid provision, word, phrase, clause, or application and to this end, the provisions, words, phrases, and clauses of this section are severable.

Subd. 6. Minnesota Supreme Court jurisdiction. The Minnesota Supreme Court has original jurisdiction over an action challenging the constitutionality of this section and shall expedite the resolution of the action.

145.4241 DEFINITIONS.

Subdivision 1. **Applicability.** As used in sections 145.4241 to 145.4249, the following terms have the meanings given them.

Subd. 2. Abortion. "Abortion" means the use or prescription of any instrument, medicine, drug, or any other substance or device to intentionally terminate the pregnancy of a female known to be pregnant, with an intention other than to increase the probability of a live birth, to preserve the life or health of the child after live birth, or to remove a dead fetus.

Subd. 3. Attempt to perform an abortion. "Attempt to perform an abortion" means an act, or an omission of a statutorily required act, that, under the circumstances as the actor believes them to be, constitutes a substantial step in a course of conduct planned to culminate in the performance of an abortion in Minnesota in violation of sections 145.4241 to 145.4249.

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Subd. 3a. **Fetal anomaly incompatible with life.** "Fetal anomaly incompatible with life" means a fetal anomaly diagnosed before birth that will with reasonable certainty result in death of the unborn child within three months. Fetal anomaly incompatible with life does not include conditions which can be treated.

Subd. 4. **Medical emergency.** "Medical emergency" means any condition that, on the basis of the physician's good faith clinical judgment, so complicates the medical condition of a pregnant female as to necessitate the immediate abortion of her pregnancy to avert her death or for which a delay will create serious risk of substantial and irreversible impairment of a major bodily function.

Subd. 4a. **Perinatal hospice.** (a) "Perinatal hospice" means comprehensive support to the female and her family that includes support from the time of diagnosis through the time of birth and death of the infant and through the postpartum period. Supportive care may include maternal-fetal medical specialists, obstetricians, neonatologists, anesthesia specialists, clergy, social workers, and specialty nurses.

(b) The availability of perinatal hospice provides an alternative to families for whom elective pregnancy termination is not chosen.

Subd. 5. **Physician.** "Physician" means a person licensed as a physician or osteopathic physician under chapter 147.

Subd. 6. **Probable gestational age of the unborn child.** "Probable gestational age of the unborn child" means what will, in the judgment of the physician, with reasonable probability, be the gestational age of the unborn child at the time the abortion is planned to be performed.

Subd. 7. **Stable Internet website.** "Stable Internet website" means a website that, to the extent reasonably practicable, is safeguarded from having its content altered other than by the commissioner of health.

Subd. 8. **Unborn child.** "Unborn child" means a member of the species *Homo sapiens* from fertilization until birth.

145.4242 INFORMED CONSENT.

(a) No abortion shall be performed in this state except with the voluntary and informed consent of the female upon whom the abortion is to be performed. Except in the case of a medical emergency or if the fetus has an anomaly incompatible with life, and the female has declined perinatal hospice care, consent to an abortion is voluntary and informed only if:

(1) the female is told the following, by telephone or in person, by the physician who is to perform the abortion or by a referring physician, at least 24 hours before the abortion:

(i) the particular medical risks associated with the particular abortion procedure to be employed including, when medically accurate, the risks of infection, hemorrhage, breast cancer, danger to subsequent pregnancies, and infertility;

(ii) the probable gestational age of the unborn child at the time the abortion is to be performed;

(iii) the medical risks associated with carrying her child to term; and

(iv) for abortions after 20 weeks gestational, whether or not an anesthetic or analgesic would eliminate or alleviate organic pain to the unborn child caused by the particular method of abortion to be employed and the particular medical benefits and risks associated with the particular anesthetic or analgesic.

The information required by this clause may be provided by telephone without conducting a physical examination or tests of the patient, in which case the information required to be provided may be based on facts supplied to the physician by the female and whatever other relevant information is reasonably available to the physician. It may not be provided by a tape recording, but must be provided during a consultation in which the physician is able to ask questions of the female and the female is able to ask questions of the physician. If a physical examination, tests, or the availability of other information to the physician subsequently indicate, in the medical judgment of the physician, a revision of the information previously supplied to the patient, that revised information may be communicated to the patient at any time prior to the performance of the abortion. Nothing in this section may be construed to preclude provision of required information in a language understood by the patient through a translator;

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(2) the female is informed, by telephone or in person, by the physician who is to perform the abortion, by a referring physician, or by an agent of either physician at least 24 hours before the abortion:

(i) that medical assistance benefits may be available for prenatal care, childbirth, and neonatal care;

(ii) that the father is liable to assist in the support of her child, even in instances when the father has offered to pay for the abortion; and

(iii) that she has the right to review the printed materials described in section 145.4243, that these materials are available on a state-sponsored website, and what the website address is. The physician or the physician's agent shall orally inform the female that the materials have been provided by the state of Minnesota and that they describe the unborn child, list agencies that offer alternatives to abortion, and contain information on fetal pain. If the female chooses to view the materials other than on the website, they shall either be given to her at least 24 hours before the abortion or mailed to her at least 72 hours before the abortion by certified mail, restricted delivery to addressee, which means the postal employee can only deliver the mail to the addressee.

The information required by this clause may be provided by a tape recording if provision is made to record or otherwise register specifically whether the female does or does not choose to have the printed materials given or mailed to her;

(3) the female certifies in writing, prior to the abortion, that the information described in clauses (1) and (2) has been furnished to her and that she has been informed of her opportunity to review the information referred to in clause (2), item (iii); and

(4) prior to the performance of the abortion, the physician who is to perform the abortion or the physician's agent obtains a copy of the written certification prescribed by clause (3) and retains it on file with the female's medical record for at least three years following the date of receipt.

(b) Prior to administering the anesthetic or analgesic as described in paragraph (a), clause (1), item (iv), the physician must disclose to the woman any additional cost of the procedure for the administration of the anesthetic or analgesic. If the woman consents to the administration of the anesthetic or analgesic, the physician shall administer the anesthetic or analgesic or arrange to have the anesthetic or analgesic administered.

(c) A female seeking an abortion of her unborn child diagnosed with fetal anomaly incompatible with life must be informed of available perinatal hospice services and offered this care as an alternative to abortion. If perinatal hospice services are declined, voluntary and informed consent by the female seeking an abortion is given if the female receives the information required in paragraphs (a), clause (1), and (b). The female must comply with the requirements in paragraph (a), clauses (3) and (4).

145.4243 PRINTED INFORMATION.

(a) Within 90 days after July 1, 2003, the commissioner of health shall cause to be published, in English and in each language that is the primary language of two percent or more of the state's population, and shall cause to be available on the state website provided for under section 145.4244 the following printed materials in such a way as to ensure that the information is easily comprehensible:

(1) geographically indexed materials designed to inform the female of public and private agencies and services available to assist a female through pregnancy, upon childbirth, and while the child is dependent, including adoption agencies, which shall include a comprehensive list of the agencies available, a description of the services they offer, and a description of the manner, including telephone numbers, in which they might be contacted or, at the option of the commissioner of health, printed materials including a toll-free, 24-hours-a-day telephone number that may be called to obtain, orally or by a tape recorded message tailored to a zip code entered by the caller, such a list and description of agencies in the locality of the caller and of the services they offer;

(2) materials designed to inform the female of the probable anatomical and physiological characteristics of the unborn child at two-week gestational increments from the time when a female can be known to be pregnant to full term, including any relevant information on the possibility of the unborn child's survival and pictures or drawings representing the development of unborn children at two-week gestational increments, provided that any such pictures or drawings must contain the dimensions of the fetus and must be realistic and appropriate for the stage of pregnancy depicted. The materials shall be objective, nonjudgmental, and designed to convey only accurate scientific

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information about the unborn child at the various gestational ages. The material shall also contain objective information describing the methods of abortion procedures commonly employed, the medical risks commonly associated with each procedure, the possible detrimental psychological effects of abortion, and the medical risks commonly associated with carrying a child to term; and

(3) materials with the following information concerning an unborn child of 20 weeks gestational age and at two weeks gestational increments thereafter in such a way as to ensure that the information is easily comprehensible:

(i) the development of the nervous system of the unborn child;

(ii) fetal responsiveness to adverse stimuli and other indications of capacity to experience organic pain; and

(iii) the impact on fetal organic pain of each of the methods of abortion procedures commonly employed at this stage of pregnancy.

The material under this clause shall be objective, nonjudgmental, and designed to convey only accurate scientific information.

(b) The materials referred to in this section must be printed in a typeface large enough to be clearly legible. The website provided for under section 145.4244 shall be maintained at a minimum resolution of 70 DPI (dots per inch). All pictures appearing on the website shall be a minimum of 200x300 pixels. All letters on the website shall be a minimum of 11-point font. All information and pictures shall be accessible with an industry standard browser, requiring no additional plug-ins. The materials required under this section must be available at no cost from the commissioner of health upon request and in appropriate number to any person, facility, or hospital.

145.4244 INTERNET WEBSITE.

The commissioner of health shall develop and maintain a stable Internet website to provide the information described under section 145.4243. No information regarding who uses the website shall be collected or maintained. The commissioner of health shall monitor the website on a weekly basis to prevent and correct tampering.

145.4245 PROCEDURE IN CASE OF MEDICAL EMERGENCY.

When a medical emergency compels the performance of an abortion, the physician shall inform the female, prior to the abortion if possible, of the medical indications supporting the physician's judgment that an abortion is necessary to avert her death or that a 24-hour delay will create serious risk of substantial and irreversible impairment of a major bodily function.

145.4246 REPORTING REQUIREMENTS.

Subdivision 1. **Reporting form.** Within 90 days after July 1, 2003, the commissioner of health shall prepare a reporting form for physicians containing a reprint of sections 145.4241 to 145.4249 and listing:

(1) the number of females to whom the physician provided the information described in section 145.4242, clause (1); of that number, the number provided by telephone and the number provided in person; and of each of those numbers, the number provided in the capacity of a referring physician and the number provided in the capacity of a physician who is to perform the abortion;

(2) the number of females to whom the physician or an agent of the physician provided the information described in section 145.4242, clause (2); of that number, the number provided by telephone and the number provided in person; of each of those numbers, the number provided in the capacity of a referring physician and the number provided in the capacity of a physician who is to perform the abortion; and of each of those numbers, the number provided by the physician and the number provided by an agent of the physician;

(3) the number of females who availed themselves of the opportunity to obtain a copy of the printed information described in section 145.4243 other than on the website and the number who did not; and of each of those numbers, the number who, to the best of the reporting physician's information and belief, went on to obtain the abortion; and

(4) the number of abortions performed by the physician in which information otherwise required to be provided at least 24 hours before the abortion was not so provided because an immediate abortion was necessary to avert the female's death and the number of abortions in which such information was not so provided because a delay would create serious risk of substantial and irreversible impairment of a major bodily function.

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Subd. 2. **Distribution of forms.** The commissioner of health shall ensure that copies of the reporting forms described in subdivision 1 are provided:

(1) by December 1, 2003, and by December 1 of each subsequent year thereafter to all physicians licensed to practice in this state; and

(2) to each physician who subsequently becomes newly licensed to practice in this state, at the same time as official notification to that physician that the physician is so licensed.

Subd. 3. **Reporting requirement.** By April 1, 2005, and by April 1 of each subsequent year thereafter, each physician who provided, or whose agent provided, information to one or more females in accordance with section 145.4242 during the previous calendar year shall submit to the commissioner of health a copy of the form described in subdivision 1 with the requested data entered accurately and completely.

Subd. 4. **Additional reporting.** Nothing in this section shall be construed to preclude the voluntary or required submission of other reports or forms regarding abortions.

Subd. 5. **Failure to report as required.** Reports that are not submitted by the end of a grace period of 30 days following the due date shall be subject to a late fee of \$500 for each additional 30-day period or portion of a 30-day period they are overdue. Any physician required to report according to this section who has not submitted a report, or has submitted only an incomplete report, more than one year following the due date, may, in an action brought by the commissioner of health, be directed by a court of competent jurisdiction to submit a complete report within a period stated by court order or be subject to sanctions for civil contempt.

Subd. 6. **Public statistics.** By July 1, 2005, and by July 1 of each subsequent year thereafter, the commissioner of health shall issue a public report providing statistics for the previous calendar year compiled from all of the reports covering that year submitted according to this section for each of the items listed in subdivision 1. Each report shall also provide the statistics for all previous calendar years, adjusted to reflect any additional information from late or corrected reports. The commissioner of health shall take care to ensure that none of the information included in the public reports could reasonably lead to the identification of any individual providing or provided information according to section 145.4242.

Subd. 7. **Consolidation.** The commissioner of health may consolidate the forms or reports described in this section with other forms or reports to achieve administrative convenience or fiscal savings or to reduce the burden of reporting requirements.

145.4247 REMEDIES.

Subdivision 1. **Civil remedies.** Any person upon whom an abortion has been performed without complying with sections 145.4241 to 145.4249 may maintain an action against the person who performed the abortion in knowing or reckless violation of sections 145.4241 to 145.4249 for actual and punitive damages. Any person upon whom an abortion has been attempted without complying with sections 145.4241 to 145.4249 may maintain an action against the person who attempted to perform the abortion in knowing or reckless violation of sections 145.4241 to 145.4249 for actual and punitive damages. No civil liability may be assessed for failure to comply with section 145.4242, clause (2), item (iii), or that portion of section 145.4242, clause (2), requiring written certification that the female has been informed of her opportunity to review the information referred to in section 145.4242, clause (2), item (iii), unless the commissioner of health has made the printed materials or website address available at the time the physician or the physician's agent is required to inform the female of her right to review them.

Subd. 2. **Suit to compel statistical report.** If the commissioner of health fails to issue the public report required under section 145.4246, subdivision 6, or fails in any way to enforce Laws 2003, chapter 14, any group of ten or more citizens of this state may seek an injunction in a court of competent jurisdiction against the commissioner of health requiring that a complete report be issued within a period stated by court order. Failure to abide by such an injunction shall subject the commissioner to sanctions for civil contempt.

Subd. 3. **Attorney fees.** If judgment is rendered in favor of the plaintiff in any action described in this section, the court shall also render judgment for reasonable attorney fees in favor of the plaintiff against the defendant. If judgment is rendered in favor of the defendant and the court finds that the plaintiff's suit was frivolous and brought in bad faith, the court shall also render judgment for reasonable attorney fees in favor of the defendant against the plaintiff.

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Subd. 4. **Protection of privacy in court proceedings.** In every civil action brought under sections 145.4241 to 145.4249, the court shall rule whether the anonymity of any female upon whom an abortion has been performed or attempted shall be preserved from public disclosure if she does not give her consent to such disclosure. The court, upon motion or sua sponte, shall make such a ruling and, upon determining that her anonymity should be preserved, shall issue orders to the parties, witnesses, and counsel and shall direct the sealing of the record and exclusion of individuals from courtrooms or hearing rooms to the extent necessary to safeguard her identity from public disclosure. Each order must be accompanied by specific written findings explaining why the anonymity of the female should be preserved from public disclosure, why the order is essential to that end, how the order is narrowly tailored to serve that interest, and why no reasonable, less restrictive alternative exists. In the absence of written consent of the female upon whom an abortion has been performed or attempted, anyone, other than a public official, who brings an action under subdivision 1, shall do so under a pseudonym. This section may not be construed to conceal the identity of the plaintiff or of witnesses from the defendant.

145.4248 SEVERABILITY.

If any one or more provision, section, subsection, sentence, clause, phrase, or word of sections 145.4241 to 145.4249 or the application thereof to any person or circumstance is found to be unconstitutional, the same is hereby declared to be severable and the balance of sections 145.4241 to 145.4249 shall remain effective notwithstanding such unconstitutionality. The legislature hereby declares that it would have passed sections 145.4241 to 145.4249, and each provision, section, subsection, sentence, clause, phrase, or word thereof, irrespective of the fact that any one or more provision, section, subsection, sentence, clause, phrase, or word be declared unconstitutional.

145.4249 SUPREME COURT JURISDICTION.

The Minnesota Supreme Court has original jurisdiction over an action challenging the constitutionality of sections 145.4241 to 145.4249 and shall expedite the resolution of the action.

152.092 POSSESSION OF DRUG PARAPHERNALIA PROHIBITED.

(a) It is unlawful for any person knowingly or intentionally to use or to possess drug paraphernalia. Any violation of this section is a petty misdemeanor.

(b) A person who violates paragraph (a) and has previously violated paragraph (a) on two or more occasions has committed a crime and may be sentenced to imprisonment for up to 90 days or to payment of a fine up to \$1,000, or both.

153A.14 REGULATION.

Subd. 5. **Rulemaking authority.** The commissioner shall adopt rules under chapter 14 to implement this chapter. The rules may include procedures and standards relating to the certification requirement, the scope of authorized practice, fees, supervision required, continuing education, career progression, disciplinary matters, and examination procedures.

245A.22 INDEPENDENT LIVING ASSISTANCE FOR YOUTH.

Subdivision 1. **Independent living assistance for youth.** "Independent living assistance for youth" means a nonresidential program that provides a system of services that includes training, counseling, instruction, supervision, and assistance provided to youth according to the youth's independent living plan, when the placements in the program are made by the county agency. Services may include assistance in locating housing, budgeting, meal preparation, shopping, personal appearance, counseling, and related social support services needed to meet the youth's needs and improve the youth's ability to conduct such tasks independently. Such services shall not extend to youths needing 24-hour per day supervision and services. Youths needing a 24-hour per day program of supervision and services shall not be accepted or retained in an independent living assistance program.

Subd. 2. **Admission.** (a) The license holder shall accept as clients in the independent living assistance program only youth ages 16 to 21 who are in out-of-home placement, leaving out-of-home placement, at risk of becoming homeless, or homeless.

(b) Youth who have current drug or alcohol problems, a recent history of violent behaviors, or a mental health disorder or issue that is not being resolved through counseling or treatment are not eligible to receive the services described in subdivision 1.

(c) Youth who are not employed, participating in employment training, or enrolled in an academic program are not eligible to receive transitional housing or independent living assistance.

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(d) The commissioner may grant a variance under section 245A.04, subdivision 9, to requirements in this section.

Subd. 3. **Independent living plan.** (a) Unless an independent living plan has been developed by the local agency, the license holder shall develop a plan based on the client's individual needs that specifies objectives for the client. The services provided shall include those specified in this section. The plan shall identify the persons responsible for implementation of each part of the plan. The plan shall be reviewed as necessary, but at least annually.

(b) The following services, or adequate access to referrals for the following services, must be made available to the targeted youth participating in the programs described in subdivision 1:

(1) counseling services for the youth and their families, if appropriate, on site, to help with problems that contributed to the homelessness or could impede making the transition to independent living;

(2) educational, vocational, or employment services;

(3) health care;

(4) transportation services including, where appropriate, assisting the child in obtaining a driver's license;

(5) money management skills training;

(6) planning for ongoing housing;

(7) social and recreational skills training; and

(8) assistance establishing and maintaining connections with the child's family and community.

Subd. 4. **Records.** (a) The license holder shall maintain a record for each client.

(b) For each client the record maintained by the license holder shall document the following:

(1) admission information;

(2) the independent living plan;

(3) delivery of the services required of the license holder in the independent living plan;

(4) the client's progress toward obtaining the objectives identified in the independent living plan; and

(5) a termination summary after service is terminated.

(c) If the license holder manages the client's money, the record maintained by the license holder shall also include the following:

(1) written permission from the client or the client's legal guardian to manage the client's money;

(2) the reasons the license holder is to manage the client's money; and

(3) a complete record of the use of the client's money and reconciliation of the account.

Subd. 5. **Service termination plan.** The license holder, in conjunction with the county agency, shall establish a service termination plan that specifies how independent living assistance services will be terminated and the actions to be performed by the involved agencies, including necessary referrals for other ongoing services.

Subd. 6. **Place of residence provided by program.** When a client's place of residence is provided by the license holder as part of the independent living assistance program, the place of residence is not subject to separate licensure.

Subd. 7. **General licensing requirements apply.** In addition to the requirements of this section, providers of independent living assistance are subject to general licensing requirements of this chapter.

245C.02 DEFINITIONS.

Subd. 9. **Contractor.** "Contractor" means any individual, regardless of employer, who is providing program services for hire under the control of the provider.

Subd. 14b. **Public law background study.** "Public law background study" means a background study conducted by the commissioner pursuant to section 245C.032.

245C.031 BACKGROUND STUDY; ALTERNATIVE BACKGROUND STUDIES.

Subd. 5. **Guardians and conservators.** (a) The commissioner shall conduct an alternative background study of:

(1) every court-appointed guardian and conservator, unless a background study has been completed of the person under this section within the previous five years. The alternative background study shall be completed prior to the appointment of the guardian or conservator, unless a court determines that it would be in the best interests of the ward or protected person to appoint a guardian or conservator before the alternative background study can be completed. If the court appoints the guardian or conservator while the alternative background study is pending, the alternative background study must be completed as soon as reasonably possible after the guardian or conservator's appointment and no later than 30 days after the guardian or conservator's appointment; and

(2) a guardian and a conservator once every five years after the guardian or conservator's appointment if the person continues to serve as a guardian or conservator.

(b) An alternative background study is not required if the guardian or conservator is:

(1) a state agency or county;

(2) a parent or guardian of a proposed ward or protected person who has a developmental disability if the parent or guardian has raised the proposed ward or protected person in the family home until the time that the petition is filed, unless counsel appointed for the proposed ward or protected person under section 524.5-205, paragraph (d); 524.5-304, paragraph (b); 524.5-405, paragraph (a); or 524.5-406, paragraph (b), recommends a background study; or

(3) a bank with trust powers, a bank and trust company, or a trust company, organized under the laws of any state or of the United States and regulated by the commissioner of commerce or a federal regulator.

Subd. 6. **Guardians and conservators; required checks.** (a) An alternative background study for a guardian or conservator pursuant to subdivision 5 shall include:

(1) criminal history data from the Bureau of Criminal Apprehension and other criminal history data obtained by the commissioner of human services;

(2) data regarding whether the person has been a perpetrator of substantiated maltreatment of a vulnerable adult under section 626.557 or a minor under chapter 260E. If the subject of the study has been the perpetrator of substantiated maltreatment of a vulnerable adult or a minor, the commissioner must include a copy of the public portion of the investigation memorandum under section 626.557, subdivision 12b, or the public portion of the investigation memorandum under section 260E.30. The commissioner shall provide the court with information from a review of information according to subdivision 7 if the study subject provided information that the study subject has a current or prior affiliation with a state licensing agency;

(3) criminal history data from a national criminal history record check as defined in section 245C.02, subdivision 13c; and

(4) state licensing agency data if a search of the database or databases of the agencies listed in subdivision 7 shows that the proposed guardian or conservator has held a professional license directly related to the responsibilities of a professional fiduciary from an agency listed in subdivision 7 that was conditioned, suspended, revoked, or canceled.

(b) If the guardian or conservator is not an individual, the background study must be completed of all individuals who are currently employed by the proposed guardian or conservator who are responsible for exercising powers and duties under the guardianship or conservatorship.

Subd. 7. **Guardians and conservators; state licensing data.** (a) Within 25 working days of receiving the request for an alternative background study of a guardian or conservator, the commissioner shall provide the court with licensing agency data for licenses directly related to the responsibilities of a guardian or conservator if the study subject has a current or prior affiliation with the:

(1) Lawyers Responsibility Board;

(2) State Board of Accountancy;

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- (3) Board of Social Work;
- (4) Board of Psychology;
- (5) Board of Nursing;
- (6) Board of Medical Practice;
- (7) Department of Education;
- (8) Department of Commerce;
- (9) Board of Chiropractic Examiners;
- (10) Board of Dentistry;
- (11) Board of Marriage and Family Therapy;
- (12) Department of Human Services;
- (13) Peace Officer Standards and Training (POST) Board; and
- (14) Professional Educator Licensing and Standards Board.

(b) The commissioner and each of the agencies listed above, except for the Department of Human Services, shall enter into a written agreement to provide the commissioner with electronic access to the relevant licensing data and to provide the commissioner with a quarterly list of new sanctions issued by the agency.

(c) The commissioner shall provide to the court the electronically available data maintained in the agency's database, including whether the proposed guardian or conservator is or has been licensed by the agency and whether a disciplinary action or a sanction against the individual's license, including a condition, suspension, revocation, or cancellation, is in the licensing agency's database.

(d) If the proposed guardian or conservator has resided in a state other than Minnesota during the previous ten years, licensing agency data under this section shall also include licensing agency data from any other state where the proposed guardian or conservator reported to have resided during the previous ten years if the study subject has a current or prior affiliation to the licensing agency. If the proposed guardian or conservator has or has had a professional license in another state that is directly related to the responsibilities of a guardian or conservator from one of the agencies listed under paragraph (a), state licensing agency data shall also include data from the relevant licensing agency of the other state.

(e) The commissioner is not required to repeat a search for Minnesota or out-of-state licensing data on an individual if the commissioner has provided this information to the court within the prior five years.

(f) The commissioner shall review the information in paragraph (c) at least once every four months to determine whether an individual who has been studied within the previous five years:

- (1) has any new disciplinary action or sanction against the individual's license; or
- (2) did not disclose a prior or current affiliation with a Minnesota licensing agency.

(g) If the commissioner's review in paragraph (f) identifies new information, the commissioner shall provide any new information to the court.

245C.032 PUBLIC LAW BACKGROUND STUDIES.

Subdivision 1. **Public law background studies.** (a) Notwithstanding all other sections of chapter 245C, the commissioner shall conduct public law background studies exclusively in accordance with this section. The commissioner shall conduct a public law background study under this section for an individual having direct contact with persons served by a licensed sex offender treatment program under chapters 246B and 253D.

(b) All terms in this section shall have the definitions provided in section 245C.02.

(c) The commissioner shall conduct public law background studies according to the following:

(1) section 245C.04, subdivision 1, paragraphs (a), (b), (d), (g), (h), and (i), subdivision 4a, and subdivision 7;

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(2) section 245C.05, subdivision 1, paragraphs (a) and (d), subdivisions 2, 2c, and 2d, subdivision 4, paragraph (a), clauses (1) and (2), subdivision 5, paragraphs (b) to (f), and subdivisions 6 and 7;

(3) section 245C.051;

(4) section 245C.07, paragraphs (a), (b), (d), and (f);

(5) section 245C.08, subdivision 1, paragraph (a), clauses (1) to (5), paragraphs (b), (c), (d), and (e), subdivision 3, and subdivision 4, paragraphs (a), (c), (d), and (e);

(6) section 245C.09, subdivisions 1 and 2;

(7) section 245C.10, subdivision 9;

(8) section 245C.13, subdivision 1, and subdivision 2, paragraph (a), and paragraph (c), clauses (1) to (3);

(9) section 245C.14, subdivisions 1 and 2;

(10) section 245C.15;

(11) section 245C.16, subdivision 1, paragraphs (a), (b), (c), and (f), and subdivision 2, paragraphs (a) and (b);

(12) section 245C.17, subdivision 1, subdivision 2, paragraph (a), clauses (1) to (3), clause (6), item (ii), subdivision 3, paragraphs (a) and (b), paragraph (c), clauses (1) and (2), items (ii) and (iii), paragraph (d), clauses (1) and (2), item (ii), and paragraph (e);

(13) section 245C.18, paragraph (a);

(14) section 245C.19;

(15) section 245C.20;

(16) section 245C.21, subdivision 1, subdivision 1a, paragraph (c), and subdivisions 2, 3, and 4;

(17) section 245C.22, subdivisions 1, 2, and 3, subdivision 4, paragraphs (a) to (c), subdivision 5, paragraphs (a), (b), and (d), and subdivision 6;

(18) section 245C.23, subdivision 1, paragraphs (a) and (b), and subdivision 2, paragraphs (a) to (c);

(19) section 245C.24, subdivision 2, paragraph (a);

(20) section 245C.25;

(21) section 245C.27;

(22) section 245C.28;

(23) section 245C.29, subdivision 1, and subdivision 2, paragraphs (a) and (c);

(24) section 245C.30, subdivision 1, paragraphs (a) and (d), and subdivisions 3 to 5;

(25) section 245C.31; and

(26) section 245C.32.

Subd. 2. Classification of public law background study data; access to information. All data obtained by the commissioner for a background study completed under this section shall be classified as private data.

245C.30 VARIANCE FOR A DISQUALIFIED INDIVIDUAL.

Subd. 1a. Public law background study variances. For a variance related to a public law background study conducted under section 245C.032, the variance shall state the services that may be provided by the disqualified individual and state the conditions with which the license holder or applicant must comply for the variance to remain in effect. The variance shall not state the reason for the disqualification.

245C.301 NOTIFICATION OF SET-ASIDE OR VARIANCE.

(a) Except as provided under paragraphs (b) and (c), if required by the commissioner, family child care providers and child care centers must provide a written notification to parents considering

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enrollment of a child or parents of a child attending the family child care or child care center if the program employs or has living in the home any individual who is the subject of either a set-aside or variance.

(b) Notwithstanding paragraph (a), family child care license holders are not required to disclose that the program has an individual living in the home who is the subject of a set-aside or variance if:

(1) the household member resides in the residence where the family child care is provided;

(2) the subject of the set-aside or variance is under the age of 18 years; and

(3) the set-aside or variance relates to a disqualification under section 245C.15, subdivision 4, for a misdemeanor-level theft crime as defined in section 609.52.

(c) The notice specified in paragraph (a) is not required when the period of disqualification in section 245C.15, subdivisions 2 to 4, has been exceeded.

256.9685 ESTABLISHMENT OF INPATIENT HOSPITAL PAYMENT SYSTEM.

Subd. 1c. **Judicial review.** A hospital, physician, advanced practice registered nurse, or physician assistant aggrieved by an order of the commissioner under subdivision 1b may appeal the order to the district court of the county in which the physician, advanced practice registered nurse, physician assistant, or hospital is located by:

(1) serving a written copy of a notice of appeal upon the commissioner within 30 days after the date the commissioner issued the order; and

(2) filing the original notice of appeal and proof of service with the court administrator of the district court. The appeal shall be treated as a dispositive motion under the Minnesota General Rules of Practice, rule 115. The district court scope of review shall be as set forth in section 14.69.

Subd. 1d. **Transmittal of record.** Within 30 days after being served with the notice of appeal, the commissioner shall transmit to the district court the original or certified copy of the entire record considered by the commissioner in making the final agency decision. The district court shall not consider evidence that was not included in the record before the commissioner.

256B.011 POLICY FOR CHILDBIRTH AND ABORTION FUNDING.

Between normal childbirth and abortion it is the policy of the state of Minnesota that normal childbirth is to be given preference, encouragement and support by law and by state action, it being in the best interests of the well being and common good of Minnesota citizens.

256B.40 SUBSIDY FOR ABORTIONS PROHIBITED.

No medical assistance funds of this state or any agency, county, municipality or any other subdivision thereof and no federal funds passing through the state treasury or the state agency shall be authorized or paid pursuant to this chapter to any person or entity for or in connection with any abortion that is not eligible for funding pursuant to sections 256B.02, subdivision 8, and 256B.0625.

256B.69 PREPAID HEALTH PLANS.

Subd. 5c. **Medical education and research fund.** (a) The commissioner of human services shall transfer each year to the medical education and research fund established under section 62J.692, an amount specified in this subdivision. The commissioner shall calculate the following:

(1) an amount equal to the reduction in the prepaid medical assistance payments as specified in this clause. After January 1, 2002, the county medical assistance capitation base rate prior to plan specific adjustments is reduced 6.3 percent for Hennepin County, two percent for the remaining metropolitan counties, and 1.6 percent for nonmetropolitan Minnesota counties. Nursing facility and elderly waiver payments and demonstration project payments operating under subdivision 23 are excluded from this reduction. The amount calculated under this clause shall not be adjusted for periods already paid due to subsequent changes to the capitation payments;

(2) beginning July 1, 2003, \$4,314,000 from the capitation rates paid under this section;

(3) beginning July 1, 2002, an additional \$12,700,000 from the capitation rates paid under this section; and

(4) beginning July 1, 2003, an additional \$4,700,000 from the capitation rates paid under this section.

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(b) This subdivision shall be effective upon approval of a federal waiver which allows federal financial participation in the medical education and research fund. The amount specified under paragraph (a), clauses (1) to (4), shall not exceed the total amount transferred for fiscal year 2009. Any excess shall first reduce the amounts specified under paragraph (a), clauses (2) to (4). Any excess following this reduction shall proportionally reduce the amount specified under paragraph (a), clause (1).

(c) Beginning September 1, 2011, of the amount in paragraph (a), the commissioner shall transfer \$21,714,000 each fiscal year to the medical education and research fund.

(d) Beginning September 1, 2011, of the amount in paragraph (a), following the transfer under paragraph (c), the commissioner shall transfer to the medical education research fund \$23,936,000 in fiscal years 2012 and 2013 and \$49,552,000 in fiscal year 2014 and thereafter.

256L.03 DEFINITIONS.

Subd. 6. **Medical assistance room and board rate.** "Medical assistance room and board rate" means an amount equal to 81 percent of the federal poverty guideline for a single individual living alone in the community less the medical assistance personal needs allowance under section 256B.35. For the purposes of this section, the amount of the room and board rate that exceeds the medical assistance room and board rate is considered a remedial care cost. A remedial care cost may be used to meet a spenddown obligation under section 256B.056, subdivision 5. The medical assistance room and board rate is to be adjusted on the first day of January of each year.

261.28 SUBSIDY FOR ABORTIONS PROHIBITED.

No funds of this state or any subdivision thereof administered under this chapter shall be authorized for or in connection with any abortion that is not eligible for funding pursuant to sections 256B.02, subdivision 8, and 256B.0625.

393.07 POWERS AND DUTIES.

Subd. 11. **Abortion services; policy and powers.** In keeping with the public policy of Minnesota to give preference to childbirth over abortion, Minnesota local social services agencies shall not provide any medical assistance grant or reimbursement for any abortion not eligible for funding pursuant to sections 256B.02, subdivision 8, and 256B.0625.

4615.3600 REPORTS TO THE COMMISSIONER OF HEALTH.

Subpart 1. **Statistical reports.** Each ambulatory facility shall submit a written compilation of statistical data quarterly to the commissioner of health on such forms and in such manner as the commissioner may prescribe.

Subp. 2. **Reporting terminations.** An ambulatory facility shall report all pregnancy terminations performed by its staff as follows:

A. By the tenth of each month all pregnancy terminations performed in the ambulatory facility during the preceding month shall be reported on forms prescribed by the commissioner which shall include but not be limited to the following items:

- (1) patient's city, county and state of residency;
- (2) census tract for city of Minneapolis and city of Saint Paul;
- (3) patient or chart number;
- (4) age;
- (5) race;
- (6) marital status;
- (7) number of living children;
- (8) facility name;
- (9) facility address;
- (10) number of previous induced pregnancy terminations patient;
- (11) estimate of gestational age;
- (12) date of pregnancy termination; and
- (13) type of termination procedure.

B. All surgery-related or anesthesia-related complications which result in morbidity or death of a patient shall be reported in writing to the commissioner within 15 days from the notification to the ambulatory facility of the morbidity or death of the patient.

C. The commissioner shall ensure and maintain confidentiality of all individual pregnancy termination records.

4640.1500 LABORATORY SERVICE.

Subpart 1. **Providing of service.** Laboratory service shall be provided in the hospital.

Subp. 2. **Personnel.** A physician shall have responsibility for the supervision of the laboratory. The laboratory personnel shall be qualified by education, training, and experience for the type of service performed.

It is recommended that this physician be a clinical pathologist.

Subp. 3. **Facilities and equipment.** Facilities and equipment for the performance of routine clinical diagnostic procedures and other laboratory techniques shall be adequate for the services provided.

Subp. 4. **Tissue examination.** Tissue removed at operation or autopsy shall be examined by a competent pathologist and the report of this examination shall be made a part of the patient's record.

4640.1600 X-RAY SERVICE.

Subpart 1. **Providing of service.** X-ray service shall be provided in the hospital.

Subp. 2. **Personnel.** A physician shall have responsibility for the supervision of the X-ray service. The X-ray personnel shall be qualified by education, training, and experience for the type of service performed.

It is recommended that this physician be a radiologist.

Subp. 3. **Facilities and equipment.** Diagnostic and therapeutic X-ray facilities shall be adequate for the services provided. Protection against radiation hazards shall be provided for the patients, operators, and other personnel.

4640.1700 PATIENT ROOMS.

Subpart 1. **Bedrooms.** All bedrooms used for patients shall be outside rooms, dry, well ventilated, naturally lighted, and otherwise suitable for occupancy. Each bedroom shall have direct access to a corridor. Rooms extending below ground level shall not be used as bedrooms for patients, except that any patient bedroom in use prior to the effective date of these rules may be continued provided it does not extend more than three feet below ground level.

Subp. 2. **Rooms used for patients.** No patient shall at any time be admitted for regular bed care to any room other than one regularly designed as a patient room or ward, except in case of emergency and then only as a temporary measure.

Subp. 3. **Placement of beds.** Patients' beds shall not be placed in corridors nor shall furniture or equipment be kept in corridors except in the process of moving from one room to another. There shall be a space of at least three feet between beds and sufficient space around the bed to facilitate nursing care and to accommodate the necessary equipment for care. Beds shall be located to avoid drafts or other discomforts to patients.

Subp. 4. **Window area.** The window area of each bedroom shall equal at least one-eighth of the total floor area. The minimum floor area shall be at least 100 square feet in single bedrooms and at least 80 square feet per bed in multibed rooms. All hospitals in operation as of the effective date of these rules shall comply with the requirements of this subpart to the extent possible, but nothing contained herein shall be so construed as to require major alterations by such hospitals nor shall a license be suspended or revoked for an inability to comply fully with this subpart.

4640.1800 EQUIPMENT FOR PATIENT ROOMS.

The following items shall be provided for each patient unless clinically contraindicated:

A. a comfortable, hospital-type bed, a clean mattress, waterproof sheeting or pad, pillows, and necessary covering. Clean bedding, towels, washcloths, bath blankets, and other necessary supplies shall be kept on hand for use at all times;

B. at least one chair;

C. a locker or closet for storage of clothing. Where one closet is used for two or more persons, provisions shall be made for separation of patients' clothing;

D. a bedside table with compartment or drawer to accommodate personal possessions;

E. cubicle curtains or bed screens to afford privacy in all multibed rooms;

F. a device for signaling attendants which shall be kept in working order at all times, except in psychiatric and pediatric units where an emergency call should be available in each patient's room for the use of the nurse;

G. hand-washing facilities located in the room or convenient to the room for the use of patients and personnel. It is recommended that these be equipped with gooseneck spouts and wrist-action controls;

H. a clinical thermometer; and

I. individual bedpans, wash basins, emesis basins, and mouthwash cups shall be provided for each patient confined to bed. Such utensils shall be sterilized before use by any other patient.

4640.1900 NURSES' STATION.

There shall be one nurses' station provided for each nursing unit. Each station shall be conveniently located for patient service and observation of signals. It shall have a locked, well-illuminated medicine cabinet. Where narcotics are kept on the nursing station, a separate, locked, permanently secured cabinet for narcotics shall be provided. Adequate lighting, space for keeping patients' charts, and for personnel to record and chart shall be provided.

4640.2000 UTILITY ROOMS.

There shall be at least one conveniently located, well-illuminated, and ventilated utility room for each nursing unit. Such room shall provide adequate space and facilities for the emptying, cleaning, sterilizing, and storage of equipment. Bathtubs or lavatories or laundry trays shall not be used for these purposes. A segregation of clean and dirty activities shall be maintained.

It is recommended that a separate subutility room be provided for the exclusive use of maternity patients when other patients are housed on the same floor.

4640.2100 LINEN CLOSET.

A linen closet or linen supply cupboard shall be provided convenient to the nurses' station.

4640.2200 SUPPLIES AND EQUIPMENT.

Supplies and equipment for medical and nursing care shall be provided according to the type of patients accepted. Storage areas shall be provided for supplies and equipment. A separate enclosed space shall be provided and identified for the storage of sterile supplies. Sterile supplies and equipment for the administration of blood and intravenous or subcutaneous solutions shall be readily available. Acceptable arrangements shall be made for the provision of whole blood whenever indicated.

4640.2300 ISOLATION FACILITIES.

A room, or rooms, equipped for the isolation of cases or suspected cases of communicable disease shall be provided. Policies and procedures for the care of infectious patients including the handling of linens, utensils, dishes, and other supplies and equipment shall be established.

4640.2400 SURGICAL DEPARTMENT.

Subpart 1. **Areas to be provided.** All hospitals providing for the surgical care of patients shall have an operating room or rooms, scrub-up facilities, it is recommended that these be located just outside the operating room, cleanup facilities, and space for the storage of surgical supplies and instruments. The surgical suite shall be located to prevent routine traffic through it to any other part of the hospital. It is recommended that the surgical and obstetrical suites be entirely separate.

Subp. 2. **Operating room.** The operating room shall be of sufficient size to accommodate the personnel and equipment needed.

Subp. 3. **Illumination.** There shall be satisfactory illumination of the operative field as well as general illumination.

Subp. 4. **Sterilizing facilities.** Adequate work space, sterilizing space, and sterile storage space shall be provided. Sterilizers and autoclaves of the proper type and necessary capacity for the sterilization of utensils, instruments, dressings, water, and other solutions

shall be provided and maintained in an operating condition. Special precautions shall be taken so that sterile supplies are readily identifiable as such and are completely separated from unsterile supplies. A central sterilizing and supply room is recommended.

Provision of sterile water in flasks is recommended.

4640.2500 ANESTHESIA.

Subpart 1. **Administration.** Anesthesia shall be administered by a person adequately trained and competent in anesthesia administration, or under the close supervision of a physician.

Subp. 2. **Equipment.** Suitable equipment for the administration of the type of anesthesia used shall be available. Where conductive flooring is installed in anesthetizing areas, all equipment shall have safety features as defined in Part II of Standard No. 56, issued in May 1954, entitled Recommended Safe Practice for Hospital Operating Rooms by the National Fire Protection Association, 60 Batterymarch Street, Boston, Massachusetts, which part of said standard is hereby adopted by the commissioner of health with the same force and effect as if the same were fully set forth in and written as part of this subpart.

Subp. 3. **Oxygen.** Oxygen and equipment for its use shall be available.

Subp. 4. **Storage.** Proper provision shall be made for the safe storage of anesthetic materials.

4640.2600 OBSTETRICAL DEPARTMENT.

Subpart 1. **Areas to be provided.** Hospitals providing for the obstetrical care of maternity patients shall have a delivery room or rooms, in the ratio of one for each 20 maternity beds, scrub-up facilities, cleanup facilities, and space for the storage of obstetrical supplies and instruments. The obstetrical suite shall be located to prevent routine traffic through it to any other part of the hospital.

It is recommended that these be located just outside the delivery room.

An exception is made for those hospitals, which on the effective date of these rules, provide a single room which is used for both surgery and delivery purposes. Scrub-up facilities, cleanup facilities, and space for the storage of supplies and instruments shall be provided in such hospitals. Precautions shall be taken to avoid cross-infection.

Subp. 2. **Delivery room.** The delivery room shall be of sufficient size to accommodate the personnel and equipment needed.

Subp. 3. **Illumination.** There shall be satisfactory illumination of the delivery field as well as general illumination.

Subp. 4. **Labor beds.** One labor bed for each ten maternity beds or fraction thereof shall be provided in a labor room or rooms adjacent to or in the delivery suite unless the patient's own room is used for labor. It is recommended that the labor room be acoustically treated and provided with a toilet and lavatory.

Subp. 5. **Accommodations.** Maternity patients shall not be placed in rooms with other than maternity patients.

Subp. 6. **Minimum equipment requirements for delivery room.** The following shall be provided in the delivery room:

- A. equipment for anesthesia and for the administration of oxygen to the mother;
- B. a source of oxygen with a mechanism for controlling the concentration of oxygen and with a suitable device for administering oxygen to the infant;
- C. a safe and suitable type of suction device for cleaning the infant's upper respiratory tract of mucus and other fluid;

D. a properly heated bassinet for reception of the newborn infant. This shall include no hazardous electrical equipment;

E. sterile equipment suitable for clamping, cutting, tying, and dressing the umbilical cord;

F. provision for prophylactic treatment of the infant's eyes;

G. a device as well as an established procedure for easy and positive identification of the infant before removal from the delivery room. This shall be of a type which cannot be inadvertently removed during routine care of the infant; and

H. sterile supplies and equipment for the administration of blood and intravenous or subcutaneous solutions shall be readily available. Acceptable arrangements shall be made for the provision of the whole blood whenever indicated.

Subp. 7. **Obstetrical isolation facilities.** Maternity patients with infection, fever, or other conditions or symptoms which may constitute a hazard to other maternity patients shall be isolated immediately in a separate room which is properly equipped for isolation in an area removed from the obstetrical department.

4640.2700 NURSERY DEPARTMENT.

Subpart 1. **Newborn nursery.** Each hospital with a maternity service shall provide at least one newborn nursery for the exclusive use of well infants delivered within the institution. The number of bassinets provided shall be at least equal to the number of maternity beds. Each nursery shall be provided with a lavatory with gooseneck spout and other than hand-operated faucets.

It is recommended that each newborn nursery be limited to 12 bassinets. An exit door from the nursery into the corridor is recommended for emergency use.

Subp. 2. **Nursery space of new hospitals.** In hospitals constructed after the effective date of these rules, the total nursery space, exclusive of the workroom, shall provide a floor area of at least 24 square feet for each bassinet, with a distance of at least two feet between each bassinet and an aisle space of at least three feet.

Subp. 3. **Nursery space of existing hospitals.** Hospitals operating as of the effective date of these rules shall comply with subpart 2, to the extent possible, but no hospital shall have a nursery area which provides less than 18 inches between each bassinet and an aisle space of at least three feet, exclusive of the workroom or work area.

Subp. 4. **Bassinet.** Each bassinet shall be mounted on a single stand and be removable to facilitate cleaning.

Subp. 5. **Observation window.** An observation window shall be installed between the corridor and nursery for the viewing of infants.

Subp. 6. **Incubators.** Each nursery department shall have one or more incubators whereby temperature, humidity, and oxygen can be controlled and measured.

Subp. 7. **Premature nursery.** A separate premature nursery and workroom are recommended for hospitals with 25 or more maternity beds on the basis of 30 square feet per incubator and a maximum of six incubators per nursery.

It is recommended that the oxygen concentration be checked by measurement with an oxygen analyzer at least every eight hours or that an incubator-attached, minus 40 percent oxygen concentration limiting device be used.

Subp. 8. **Examination and workroom.** An adjoining examination and workroom shall be provided for each nursery or between each two nurseries. The workroom shall be of adequate size to provide facilities necessary to prepare personnel for work in the nursery, for the examination and treatment of infants by physicians, for charting, for storage of nursery linen, for disposal of soiled linen, for storage and dispensing of feedings, and for

initial rinsing of bottles and nipples. Each workroom shall be provided with a scrub-up sink having foot, knee, or elbow action controls; counter with counter sink having a gooseneck spout and other than hand-operated controls.

Hospitals operating as of the effective date of these rules shall comply with regulation subpart 2, to the extent possible, but if a separate examination and workroom is not provided, there shall be a segregated examination and work area in the nursery. The work area shall be of adequate size and provide the facilities and equipment necessary to prepare personnel for work in the nursery, for the examination and treatment of infants by physicians, for storage of nursery linen, and for the dispensing of feedings.

Subp. 9. **Formula preparation.** Space and equipment for cleanup, preparation, and refrigeration to be used exclusively for infant formulas shall be provided apart from care areas and apart from other food service areas. A registered nurse or a dietitian shall be responsible for the formula preparation. A separate formula room is recommended; terminal sterilization is recommended.

Subp. 10. **Suspect nursery or room.** There shall be a room available for the care of newborn infants suspected of having a communicable disease and for newborn infants admitted from the outside. Where a suspect nursery is available, it shall provide 40 square feet per bassinet with a maximum of six bassinets and have a separate workroom. Isolation technique shall be used in the suspect nursery.

Subp. 11. **Isolation.** Infants found to have an infectious condition shall be transferred promptly to an isolation area elsewhere in the hospital.

4640.2800 PREPARATION AND SERVING OF FOOD.

Subpart 1. **Supervision.** The dietary department shall be under the supervision of a trained dietitian or other person experienced in the handling, preparation, and serving of foods; in the preparation of special diets; and in the supervision and management of food service personnel. This person shall be responsible for compliance with safe practices in food service and sanitation.

Subp. 2. **Kitchen.** There shall be sufficient space and equipment for the proper preparation and serving of food for both patients and personnel. The kitchen shall be used for no other purpose than activities connected with the dietary service and the washing and storage of dishes and utensils. A dining room or rooms shall be provided for personnel.

It is recommended that a separate dishwashing area or room be provided.

Subp. 3. **Food.** Food for patients and employees shall be nutritious, free from contamination, properly prepared, palatable, and easily digestible. A file of the menus served shall be maintained for at least 30 days.

Subp. 4. **The serving and storage of food.** All foods shall be stored and served so as to be protected from dust, flies, rodents, vermin, unnecessary handling, overhead leakage, and other means of contamination. All readily perishable food shall be stored in clean refrigerators at temperatures of 50 degrees Fahrenheit or lower. Each refrigerator shall be equipped with a thermometer.

Subp. 5. **Milk and ice.** All fluid milk shall be procured from suppliers licensed by the commissioner of agriculture or pasteurized in accordance with the requirements prescribed by the commissioner of agriculture. The milk shall be dispensed directly from the container in which it was packaged at the pasteurization plant. Ice used in contact with food or drink shall be obtained from a source acceptable to the commissioner of health, and handled and dispensed in a sanitary manner.

Subp. 6. **Hand-washing facilities.** Hand-washing facilities with hot and cold running water, soap, and individual towels shall be accessible for the use of all food handlers and so located in the kitchen to permit direct observation by the supervisor. No employee shall resume work after using the toilet room without first washing his or her hands.

4640.2900 DISHWASHING FACILITIES AND METHODS.

Subpart 1. **Methods.** Either of the following methods may be employed in dishwashing.

Subp. 2. **Manual.** A three-compartment sink or equivalent of a size adequate to permit the introduction of long-handled wire baskets of dishes shall be provided. There shall be a sufficient number of baskets to hold the dishes used during the peak load for a period sufficient to permit complete air drying. Water-heating equipment capable of maintaining the temperature of the water in the disinfection compartment at 170 degrees Fahrenheit shall be provided. Drain boards shall be part of the three-compartment sink and adequate space shall be available for drainage. The dishes shall be washed in the first compartment of the sink with warm water containing a suitable detergent; rinsed in clear water in the second compartment; and disinfected by complete immersion in the third compartment for at least two minutes in water at a temperature not lower than 170 degrees Fahrenheit. Temperature readings shall be determined by a thermometer. Dishes and utensils shall be air-dried.

Subp. 3. **Mechanical.** Water pressure in the lines supplying the wash and rinse section of the dishwashing machine shall not be less than 15 pounds per square inch nor more than 30 pounds per square inch. The rinse water shall be at a temperature not lower than 180 degrees Fahrenheit at the machine. The machines shall be equipped with thermometers which will indicate accurately the temperature of the wash water and rinse water. Dishes and utensils shall be air-dried. New dishwashing machines shall conform to sections 1, 2, 3, 4, and 6 on pages 7-28 inclusive, of Standard No. 3 issued in May 1953, entitled Spray-Type Dishwashing Machines by the National Sanitation Foundation, Ann Arbor, Michigan, which sections of such standard are hereby adopted by the commissioner of health with the same force and effect as if the same were fully set forth in and written as part of this subpart.

4640.3000 VENTILATION.

All rooms in which food is stored, prepared, or served or in which utensils are washed shall be well ventilated. The cooking area shall be ventilated to control temperatures, smoke, and odors.

4640.3100 GARBAGE DISPOSAL.

Garbage shall be disposed of in a manner acceptable to the commissioner of health. When stored, it shall be retained in watertight metal cans equipped with tightly fitting metal covers. All containers for the collection of garbage and refuse shall be kept in a sanitary condition.

4640.3200 TOILET AND LAVATORY FACILITIES.

Conveniently located toilet and lavatory facilities shall be provided for employees engaged in food handling. Toilet rooms shall not open directly into any room in which food is prepared or utensils are handled or stored.

4640.3300 WATER FACILITIES.

Subpart 1. **Water supply.** The water supply shall be of safe sanitary quality, suitable for use, and shall be obtained from a water supply system, the location, construction, and operation of which are acceptable to the commissioner of health. Hot water of a temperature required for its specific use shall be available as needed. For the protection of patients and personnel, thermostatically controlled valves shall be installed where indicated.

Subp. 2. **Sewage disposal.** Sewage shall be discharged into a municipal sewerage system where such a system is available; otherwise, the sewage shall be collected, treated, and disposed of in a sewage disposal system which is acceptable to the commissioner of health.

Subp. 3. **Plumbing.** The plumbing and drainage, or other arrangements for the disposal of excreta and wastes, shall be in accordance with the rules of the commissioner of health and with the provisions of the Minnesota Plumbing Code, chapter 4714.

Subp. 4. **Toilets.** Toilets shall be conveniently located and provided in number ample for use according to the number of patients and personnel of both sexes. The minimum requirement is one toilet for each eight patients or fraction thereof. It is recommended that separate toilet and bathing facilities be provided for maternity patients.

Subp. 5. **Hand-washing facilities.** Hand-washing facilities of the proper type in each instance shall be readily available for physicians, nurses, and other personnel. Lavatories shall be provided in the ratio of at least one lavatory for each eight patients or fraction thereof. Lavatories shall be readily accessible to all toilets. Individual towels and soap shall be available at all times. The use of the common towel is prohibited. It is recommended that each patient's room be equipped with a lavatory.

Subp. 6. **Bathing facilities.** A bathtub or shower shall be provided in the ratio of at least one tub or shower for each 30 patients or fraction thereof. It is recommended that separate toilet and bathing facilities be provided for maternity patients.

4640.3400 SCREENS.

Outside openings including doors and windows shall be properly screened or otherwise protected to prevent the entrance of flies, mosquitoes, and other insects.

4640.3500 PHYSICAL PLANT.

Subpart 1. **Safety.** The hospital structure and its equipment shall be kept in good repair and operated at all times with regard for the health, treatment, comfort, safety, and well-being of the patients and personnel. All dangerous areas and equipment shall be provided with proper guards and appropriate devices to prevent accidents. Elevators, dumbwaiters, and machinery shall be so constructed and maintained as to comply with the rules of the Division of Accident Prevention, Minnesota Department of Labor and Industry. All electrical wiring, appliances, fixtures, and equipment shall be installed to comply with the requirements of the Board of Electricity.

Subp. 2. **Fire protection.** Fire protection for the hospital shall be provided in accordance with the requirements of the state fire marshal. Approval by the state fire marshal of the fire protection of a hospital shall be a prerequisite for licensure.

Subp. 3. **Heating.** The heating system shall be capable of maintaining temperatures adequate for the comfort and protection of all patients at all times.

Subp. 4. **Incinerator.** An incinerator shall be provided for the safe disposal of infected dressings, surgical and obstetrical wastes, and other similar materials.

Subp. 5. **Laundry.** The hospital shall make provision for the proper laundering of linen and washable goods. Where linen is sent to an outside laundry, the hospital shall take reasonable precautions to see that contaminated linen is properly handled.

Subp. 6. **General illumination.** All areas shall be adequately lighted.

Subp. 7. **Lighting in hazardous areas.** All lighting and electrical fixtures including emergency lighting in operating rooms, delivery rooms, and spaces where explosive gases are used or stored shall comply with Part II of Standard No. 56, issued in May 1954, entitled Recommended Safe Practice for Hospital Operating Rooms, by the National Fire Protection Association, 60 Batterymarch Street, Boston, Massachusetts, which part of said standard is hereby adopted by the commissioner of health with the same force and effect as if the same were fully set forth in and written as part of this subpart.

Subp. 8. **Emergency lighting.** Safe emergency lighting equipment shall be provided and distributed so as to be readily available to personnel on duty in the event of a power

failure. There shall be at least a battery operated lamp with vaporproof switch, in readiness at all times for use in the delivery and operating rooms.

It is recommended that an independent source of power be available for emergency lighting of surgical and obstetrical suites, exits, stairways, and corridors.

Subp. 9. **Stairways and ramps.** All stairways and ramps shall be provided with handrails on both sides and with nonskid treads.

Subp. 10. **General storage.** Space shall be provided for the storage of supplies and equipment. Corridors shall not be used as storage areas.

Subp. 11. **Telephones.** Adequate telephone service shall be provided in order to assure efficient service and operation of the institution and to summon help promptly in case of emergency.

Subp. 12. **Ventilation.** Kitchens, laundries, toilet rooms, and utility rooms shall be ventilated by windows or mechanical means to control temperatures and offensive odors. If ventilation is used in operating rooms, delivery rooms, or other anesthetizing areas, the system shall conform to the requirements of part 4645.3200.

Subp. 13. **Walls, floors, and ceilings.** Walls, floors, and ceilings shall be kept clean and in good repair at all times. They shall be of a type to permit good maintenance including frequent washings, cleaning, or painting.

4640.3600 STAFF.

Subpart 1. **Medical director or chief of staff.** There shall be a medical director or chief of staff who shall be a licensed physician with training and experience in psychiatry and who shall assume responsibility for the medical care rendered.

Subp. 2. **Medical and nursing staff.** An adequate medical staff shall be provided to assure optimum care of patients at all times. The director of the nursing service shall be a well-qualified, registered nurse with training and experience in psychiatric nursing. There shall be a sufficient number of nurses, psychiatric aides, and attendants under the director's supervision to assure optimum care of patients at all times.

Subp. 3. **Other staff.** The staff shall include a sufficient number of qualified physical and occupational therapists to provide rehabilitation services for the number of patients accommodated. The hospital shall make provisions in its staff organization for consultations in the specialized fields of medicine.

4640.3700 DENTAL SERVICE.

Provisions shall be made for dental service either within or outside the institution.

4640.3800 PROTECTION OF PATIENTS AND PERSONNEL.

Subpart 1. **Security.** Every reasonable precaution shall be taken for the security of patients and personnel. Drugs, narcotics, sharp instruments, and other potentially hazardous articles shall be inaccessible to patients.

Subp. 2. **Segregation of patients.** Patients with tuberculosis or other communicable disease shall be segregated.

Subp. 3. **Seclusion and restraints.** Patients shall not be placed in seclusion or mechanical restraints without the written order of the physician in charge unless, in the judgment of the supervisor in charge of the service, the safety and protection of the patient, hospital employees, or other patients require such immediate seclusion or restraint. Such seclusion or restraint shall not be continued beyond eight hours except by written or telephone order of the attending physician. Emergency orders given by telephone shall be reduced to writing immediately upon receipt and shall be signed by the staff member within 24 hours

after the order is given. Such patient shall be under reasonable observation and care of a nurse or attendant at all times.

4640.3900 FLOOR AREA IN PATIENTS' ROOMS.

The following minimum areas shall be provided:

A. psychiatric units and wards of general hospitals, and those units and wards of public and private mental hospitals where diagnosis and intensive treatment are provided, such as receiving, medical and surgical, tuberculosis, intensive treatment and rehabilitation, and units and wards for the acutely disturbed patient: parts 4640.1700 to 4640.2200 shall apply; and

B. continued treatment areas for long-term patients: in hospitals constructed after the effective date of these rules, the minimum floor area shall be at least 80 square feet in single rooms and 60 square feet in multibed rooms; in dormitory areas, this may include the space devoted to aisles. All main traffic aisles shall be five feet in width except in large dormitories where the aisle serves ten or more patients, it shall be six feet in width.

All hospitals in operation as of the effective date of these rules shall comply with the requirements of this part to the extent possible.

Beds shall be placed at least three feet from adjacent beds except where partitions or other barriers separate beds or where two beds are placed foot-to-foot. Beds shall be so located as to avoid drafts and other discomforts to patients.

Whenever the patient's condition permits, each individual patient's area shall be equipped with a chair and a bedside cabinet. Adequate provision shall be made for the storage of patients' clothes and other personal possessions.

4640.4000 DINING ROOM.

A minimum of 12 square feet of dining room space shall be provided for each patient. Arrangements may be made for multiple seatings.

4640.4100 RECREATION AND DAYROOMS.

Space shall be provided for recreation and dayroom areas.

4640.4200 SPECIALIZED TREATMENT FACILITIES.

Space and equipment for physical, occupational, and recreational therapy shall be provided. Storage space for equipment shall be provided.

4640.4300 INSTITUTIONS FOR THE MENTALLY DEFICIENT AND EPILEPTIC.

Hospital sections in institutions for persons with developmental disabilities and epilepsy shall comply with the applicable portions of the rules for general hospitals contained herein.

Parts 4640.3900, except for item A, 4640.4000, and 4640.4100 shall apply to the sections of these institutions other than the hospital sections. Hospital rules shall not apply to facilities for foster care licensed by the commissioner of human services nor to institutions that do not have hospital units.

4640.6100 STAFF.

Subpart 1. **Licensed physician.** A licensed physician with interest, training, and experience in the medical and physical rehabilitation of the chronically ill shall be responsible for the adequacy of the medical care rendered.

Subp. 2. **Medical and nursing staff.** An adequate medical staff shall be provided to assure optimum care of patients at all times. The director of the nursing service shall be a well-qualified, registered nurse with experience in rehabilitation nursing. There shall be a

sufficient number of nurses and attendants under the director's supervision to assure optimum care of patients at all times.

Subp. 3. **Other staff.** The services of at least one qualified physical therapist and one qualified occupational therapist shall be available, preferably on a full-time basis. Additional therapists shall be provided to assure optimum care for the number of patients accommodated. There shall be an adequate number of medical social workers. Educational and vocational educational personnel shall be provided where indicated. The hospital shall make provisions in its staff organization for consultations in the specialized fields of medicine.

4640.6200 DENTAL SERVICE.

Provision shall be made for dental service either within or outside the institution.

4640.6300 DIAGNOSTIC AND TREATMENT FACILITIES AND SERVICES.

Laboratory and X-ray facilities and services as well as basal metabolism and electrocardiograph shall be provided unless available in an adjacent general hospital.

4640.6400 ROOMS IN THE HOSPITAL.

Subpart 1. **Dining room.** Every possible effort shall be made to encourage all patients to eat in a common dining room. A minimum of 15 square feet shall be provided for each ambulatory patient. Arrangements may be made for multiple seatings. Areas in dayrooms and solaria may be utilized for this purpose.

Subp. 2. **Dayroom or solarium.** Every possible effort shall be made to encourage all patients to utilize dayrooms, solaria, recreational and occupational therapy, and similar areas. A minimum of 25 square feet per patient shall be provided.

Subp. 3. **Specialized treatment facilities.** Space and equipment for physical, occupational, and recreational therapy shall be provided. Storage space for equipment shall be provided.

4645.0300 DESIGN AND CONSTRUCTION.

All design and construction shall conform to all applicable portions of parts 4645.0200 to 4645.5200 of these hospital rules.

4645.0400 COMPLIANCE.

All construction including exit lights and fire towers; heating, piping, ventilation, and air-conditioning; plumbing and drainage; electrical installations; elevators and dumbwaiters; refrigeration; kitchen equipment; laundry equipment; and gas piping shall be in strict compliance with all applicable state and local codes, ordinances, and rules not in conflict with the provisions contained in parts 4645.0200 to 4645.5200.

4645.0500 HOSPITALS OF LESS THAN 50 BEDS.

In hospitals of less than 50 beds, the size of the various departments will be generally smaller and will depend upon the requirements of the particular hospital. Some of the functions allotted separate spaces or rooms may be combined in such hospitals provided that the resulting plan will not compromise the best standards of medical and nursing practice. In other respects the rules as set forth herein, including the area requirements, shall apply.

4645.0600 ADMINISTRATION DEPARTMENT.

The administration department shall consist of a business office with information counter, administrator's office, medical record room, staff lounge, lobby, and public toilets for each sex. If over 100 beds, the following additional areas shall be provided: director of nurses' office, admitting office, library, conference, and board room.

It is recommended that the following be provided: a PBX board and night information for all hospitals; director of nurses' office in hospitals under 100 beds; medical social service room, and retiring room in hospitals over 100 beds.

4645.0700 ADJUNCT DIAGNOSTIC AND TREATMENT FACILITIES.

Subpart 1. **Laboratory.** Adequate facilities and equipment for the performance of routine clinical diagnostic procedures and other laboratory techniques in keeping with the services rendered by the hospital shall be provided. Approximately 4-1/2 square feet of floor space per patient bed shall be provided.

Subp. 2. **Basal metabolism and electrocardiography.** One room shall be provided for basal metabolism and electrocardiography in hospitals with 100 beds or more.

Subp. 3. **Recommended facilities.** It is recommended that these facilities, except for morgue and autopsy, be located convenient to both inpatients and outpatients.

It is recommended that space be provided for electrotherapy, hydrotherapy, massage, and exercise in hospitals with 100 beds or more.

Subp. 4. **Radiology.** Radiographic room or rooms with adjoining darkroom, toilet, dressing cubicles, and office shall be provided. Protection against radiation hazards shall be provided for the patients, operators, and other personnel. To assure adequate protection against radiation hazards, X-ray apparatus and protection shall be installed in accordance with the applicable standards prescribed in Handbook 41, issued March 30, 1949, entitled Medical X-ray Protection up to Two Million Volts and Handbook 50, issued May 9, 1952, entitled X-Ray Protection Design by the National Bureau of Standards, U.S. Department of Commerce, Superintendent of Documents, Washington 25, D.C., which standards are hereby adopted by the commissioner of health with the same force and effect as if the same were fully set forth in and written as part of this subpart.

Subp. 5. **Pharmacy.** A drug room shall be provided.

Subp. 6. **Morgue and autopsy room.** A morgue and autopsy room shall be provided in hospitals with 100 beds or more. Where morgue and autopsy rooms are provided, they shall be properly equipped and ventilated and of sufficient size to allow for the performance of satisfactory pathological examinations. Definite arrangements for space and facilities for the performance of autopsies outside the hospital shall be made if the hospital does not have an autopsy room.

4645.0800 NURSING DEPARTMENT.

Subpart 1. **Patients' rooms.** All patients' rooms shall be outside rooms and have direct access to a hall. The window area shall not be less than one-eighth of the total floor area. No bedrooms shall be located below grade. Minimum room areas shall be 80 square feet per bed in rooms having two or more beds and 100 square feet in single rooms. No bedroom shall have more than four beds. Each bedroom or its adjoining toilet or bathroom shall have a lavatory equipped with gooseneck spout and wrist-action controls. A locker shall be provided for each patient.

Subp. 2. **Areas to be provided.** The following areas shall be provided in each nursing unit: nurses' station, utility room divided into dirty and clean areas, bedpan facilities, toilet facilities for each sex in a ratio of one toilet for each eight patients or fraction thereof, bathtubs or showers in a ratio of one tub or shower for each 30 patients or fraction thereof, linen and supply storage, and janitors' closet. Each nursing floor shall have a floor pantry and nurses' toilet room. Separate subutility, toilet, and bathing facilities shall be provided for the maternity section.

It is recommended that a stretcher alcove, treatment room, and solarium be provided.

A psychiatric or quiet room is recommended in general hospitals not providing a psychiatric unit.

Adjustments will be made where patients' rooms are provided with individual toilets.

Subp. 3. **Nurses' station.** Each nurses' station shall be conveniently located for patient service and observation of signals. It shall have a locked, well-illuminated medicine cabinet. Where narcotics are kept on the nursing station, a separate, locked, permanently secured cabinet for narcotics shall be provided. Adequate lighting, hand-washing facilities, space for keeping patients' charts, and for personnel to record and chart shall be provided. Refrigeration storage shall be provided for medications and biologics unless provided elsewhere.

Subp. 4. **Isolation suite.** One isolation suite shall be provided in each hospital unless a contagious disease nursing unit is available in the hospital. The isolation suite shall consist of one or more patients' rooms, each having an adjacent toilet equipped with bedpan lugs and spray attachment. Each suite shall have a subutility room equipped with utensil sterilizer, sink, and storage cabinets.

4645.0900 SURGICAL DEPARTMENT.

Subpart 1. **Location.** The surgical department shall be so located to prevent routine traffic through it to any other part of the hospital and completely separated from the obstetrical department.

Subp. 2. **The operating suite.** The operating suite shall consist of major operating room or rooms, each having an area of not less than 270 square feet with a minimum width of 15 feet; separate scrub-up area adjacent to operating room; cleanup room; storage areas for instruments, sterile supplies, and anesthesia equipment; and a janitors' closet. In hospitals consisting of 50 or more beds, a surgical supervisor's station, doctors' locker room and toilet, and nurses' locker room and toilet shall be provided. In hospitals of less than 50 beds, doctors' and nurses' locker and toilet rooms may be provided in a convenient location outside the operating and delivery suites to serve both units.

A stretcher alcove and a recovery (postanesthesia) room are recommended.

Subp. 3. **Central sterilizing and supply room.** A central sterilizing and supply room shall be provided and divided into work space, sterilizing space, and separate storage areas for sterile and unsterile supplies. Sterilizers and autoclaves for adequate sterilization of supplies and utensils shall be provided.

Provision of sterile water in flasks is recommended.

4645.1000 EMERGENCY ROOM.

An emergency room shall be provided separate from the operating and delivery suites.

4645.1100 OBSTETRICAL DEPARTMENT.

Subpart 1. **Location.** The obstetrical department shall be so located to prevent routine traffic through it to any other part of the hospital and completely separated from the surgical department. A combination classroom-parent teaching room is recommended in the obstetrical departments, outside the delivery suite.

Subp. 2. **The delivery suite.** The delivery suite shall consist of delivery room or rooms, each having an area of not less than 270 square feet with a minimum width of 15 feet; separate scrub-up area adjacent to delivery room; cleanup room; storage areas for instruments and sterile supplies; and a janitors' closet. In hospitals consisting of 50 or more beds, an obstetrical supervisor's station, doctors' locker room and toilet, and nurses' locker room and toilet shall be provided. In hospitals of less than 50 beds, doctors' and nurses' locker and toilet rooms may be provided in a convenient location outside the delivery and operating suites to serve both units. A stretcher alcove is recommended.

Subp. 3. **Delivery room.** One delivery room shall be provided for each 20 maternity beds.

Subp. 4. **Labor room.** A labor room with a lavatory and an adjacent toilet shall be provided in a convenient location with respect to the delivery room. One labor bed shall be provided for each 10 maternity beds. The labor room shall be acoustically treated or so located to minimize the possibility of sounds reaching other patients.

4645.1200 NURSERY DEPARTMENT.

Subpart 1. **Size.** Each hospital providing a maternity service shall have a nursery department of sufficient size to accommodate the anticipated load.

Subp. 2. **Newborn nursery.** A minimum floor area of 24 square feet per bassinet shall be provided in each newborn nursery with not more than 12 bassinets in each nursery. A connecting examination and work room shall be provided.

A separate premature nursery and work room are recommended for hospitals with 25 or more maternity beds on the basis of 30 square feet per incubator and a maximum of six incubators per nursery.

Subp. 3. **Suspect nursery.** A suspect nursery with a separate connecting workroom shall be provided in hospitals of 50 beds or more. At least 40 square feet of floor area shall be provided for each bassinet with no more than six bassinets in each suspect nursery.

Subp. 4. **Formula room.** A formula room shall be provided in the nursery area or in the dietary department where adequate supervision can be provided. This room shall be used exclusively for the preparation of infant formulas. The formula room shall contain a lavatory with gooseneck spout and wrist-action controls, a two-compartment sink for washing and rinsing bottles and utensils, and adequate storage and counter space. The work space shall be divided into clean and dirty sections. Equipment shall be provided for sterilization. Refrigerated storage space sufficient for one day's supply of prepared formulas shall be provided in this room or in the nursery workroom. Terminal sterilization is recommended.

4645.1300 SERVICE DEPARTMENT.

Subpart 1. **Dietary facilities.** Dietary facilities shall consist of main kitchen with provision for the protected storage of clean dishes, utensils, and foodstuffs; day storage room; adequate refrigeration; dishwashing facilities; and the necessary space and provisions for the handling and disposal of garbage. A dietitian's office shall be provided in hospitals of 50 or more beds. Hand-washing facilities with hot and cold water, soap, and individual towels shall be accessible for the use of all food-service personnel and so located to permit direct observation by the supervisor. Dining space for personnel, allowing 12 square feet per person, shall be provided. This space may be designed for multiple seatings.

Subp. 2. **Laundry facilities.** Each hospital shall have a laundry of sufficient capacity to process a full seven days' laundry during the work week unless commercial or other laundry facilities are available. It shall include sorting area; processing area; and clean linen and sewing room separate from the laundry. The sewing room may be combined with the clean linen room in hospitals of less than 100 beds. Where no laundry is provided in the hospital, a soiled linen room and a clean linen and sewing room shall be provided.

Subp. 3. **Housekeeper's office.** A housekeeper's office shall be provided. This may be combined with the clean linen room in hospitals of less than 100 beds.

Subp. 4. **Mechanical facilities.** A boiler and pump room with engineers' space and maintenance shop shall be provided. In hospitals of more than 100 beds, separate areas for carpentry, painting, and plumbing shall be provided.

Shower and locker facilities are recommended.

Subp. 5. **Employees facilities.** Locker rooms with lockers, rest rooms, toilets, and showers for nurses and female help; and a locker room with lockers, toilets, and showers for male help shall be provided.

Subp. 6. **Storage.** Inactive record storage shall be provided. General storage of not less than 20 square feet per bed shall be provided. General storage shall be concentrated in one area in so far as possible.

4645.1400 CONTAGIOUS DISEASE NURSING UNIT.

When ten or more beds are provided for contagious disease, they shall be contained in a separate nursing unit. Each patient room shall have a view window from the corridor, a separate toilet, a lavatory in the room, and shall contain no more than two beds. Each nursing unit shall contain a nurses' station, utility room, nurses' work room, treatment room, scrub sinks conveniently located in the corridor, serving pantry with separate dishwashing room adjacent, doctors' locker space and gown room, nurses' locker space and gown room, janitors' closet, and a storage closet.

Glazed partitions between beds and a stretcher alcove are recommended.

4645.1500 PEDIATRIC NURSING UNIT.

Where there are 16 or more pediatric beds a separate pediatric nursing unit shall be provided. Minimum room areas shall be 100 square feet in single rooms, 80 square feet per bed in rooms having two or more beds, and 40 square feet per bassinet in nurseries. Each nursing unit shall contain a nursery with bassinets in cubicles, isolation suite, treatment room, nurses' station with adjoining toilet room, utility room, floor pantry, play room or solarium, bath and toilet room with raised free-standing tub and 50 percent children's fixtures, bedpan facilities, janitors' closet, and a storage closet.

Glazed cubicles for each bed in multibed rooms, clear glazing between rooms and in corridor partitions, and a wheel chair and stretcher alcove are recommended.

4645.1600 PSYCHIATRIC NURSING UNIT.

Where a psychiatric nursing unit is provided, the principles of psychiatric security and safety shall be followed throughout. Layout and design shall be such that the patient will be under close observation and will not be afforded opportunity for hiding, escape, or suicide. Care shall be taken to avoid sharp projections, exposed pipes, fixtures, or heating elements to prevent injury by accident. Minimum room areas shall be 100 square feet in single rooms, 80 square feet per bed in rooms having two or more beds, and 25 square feet per patient in dayrooms. Each nursing unit shall contain a doctors' office, examination room, nurses' station, dayroom, pantry, dining room, utility room, bedpan facilities, toilet rooms for each sex, shower and bathroom, continuous tub room for disturbed patients, patients' personal laundry for women's wards only, patients' locker room, storage closet for therapy equipment, stretcher closet, linen closet, supply closet, and a janitors' closet.

4645.1700 ADMINISTRATION DEPARTMENT.

Where not available in an adjoining general hospital, the following facilities shall be provided in the administration department: a business office with information counter, telephone switchboard, cashiers' window, administrator's office, medical director's office, medical record room, medical social service office, combination conference room and doctors' lounge, lobby and waiting room, public toilets, and a locker room and toilets for personnel.

For efficiency and economy of operation, a chronic disease hospital is best located as an integral part or unit immediately adjacent to and operated in connection with a large, modern, well-equipped, and completely staffed acute general hospital. Essentially all of the services of the general hospital are necessary for the complete care of the chronic disease patient. The rehabilitation services and facilities of the chronic hospital should be readily available to the acute patient in need of such services and also available on an outpatient basis. The medical and nursing staff of the general hospital can also serve the chronic unit.

Some of the basic services (food service, laundry, boiler plant, etc.) can be provided through the general hospital thus making construction and operational costs less expensive.

4645.1800 ADJUNCT DIAGNOSTIC AND TREATMENT FACILITIES.

Where not available in an adjoining general hospital, adjunct diagnostic and treatment facilities shall be provided.

4645.1900 SPECIALIZED TREATMENT FACILITIES.

Subpart 1. **Physical therapy.** Space and equipment shall be provided for electrotherapy, massage, hydrotherapy, and exercise. In the larger unit, an office shall be provided for the physical therapist and a conference room shall be provided near the physical therapy area.

Subp. 2. **Occupational therapy.** Space and equipment shall be provided for diversified occupational therapy work. An exhibit space shall be provided. In the larger unit, an office shall be provided for the occupational therapist.

4645.2000 SPECIAL SERVICE ROOMS.

Where not available in the adjoining general hospital, the following special service rooms shall be provided: eye, ear, nose, and throat room; dental facilities; doctors' office; and a treatment room which may also be used as an emergency operating room. Provision shall also be made for a nurses' office and a patients' waiting room and toilets.

4645.2100 NURSING DEPARTMENT.

A nursing unit shall not exceed 50 beds unless additional services and facilities are provided. No room shall have more than six beds and not more than three beds deep from the outside wall. A quiet room shall be provided. Room locations, areas, and equipment as specified for general hospitals shall apply. In addition to the requirements for the general hospital, the following shall be provided: bathtubs or showers in the ratio of one tub or shower for each 20 patients or fraction thereof; wheelchair parking area; treatment room, one for each two nursing units on a floor; dayrooms or solariums for each nursing floor providing 25 square feet per patient; a dining room with a minimum of 15 square feet for each ambulatory patient, which may be designed for multiple seatings; assembly room, capable of seating the entire ambulant population with ample space for wheelchairs, adjacent wash rooms and toilets adequate in size to accommodate wheelchairs; and projection facilities. Provision shall be made for beauty parlor and barber shop services.

4645.2200 SERVICE DEPARTMENT.

Subpart 1. **Kitchen area for preparation of special diets.** In addition to the requirements for the general hospital, adequate space in the main kitchen shall be provided for the preparation of special diets.

Subp. 2. **Storage.** In addition to the requirements for the general hospital, a patient's clothes storage room shall be provided. Adequate storage space shall be provided for reserve equipment.

4645.2300 SPACE ALLOWANCES FOR WHEELCHAIRS.

Space allowance shall be more generous than in other types of hospitals to allow for wheelchair traffic in such areas as dining rooms, recreation rooms, and toilets. Corridors shall be not less than eight feet wide with handrails on both sides. Water closet enclosures, urinals, showers, and tubs shall be easily accessible and provided with grab bars. Lavatories shall be of sufficient height to allow for use by wheelchair patients. Doorways shall not have raised thresholds. Ten-foot corridors are recommended. It is recommended that walls of corridors, toilet rooms, etc. be constructed of durable material to the level of the hand rails in order to withstand the impact of wheelchairs and heavy equipment. Adjustable height beds are recommended.

4645.2400 DETAILS AND FINISHES, GENERAL REQUIREMENTS FOR ALL HOSPITALS.

Subpart 1. **Ceilings.** The ceilings of the following areas shall have smooth, waterproof painted, glazed, or similar finishes: operating rooms, delivery rooms, sculleries, and kitchens. The ceilings of the following areas shall be acoustically treated: corridors in patient areas, nurses' stations, floor pantries, quiet rooms, and pediatric rooms. The ceiling of the labor room shall be acoustically treated unless it is located apart from the patient areas.

Ceiling heights shall be at least eight feet clear except for storage closets and other minor auxiliary rooms where they may be lower. Ceiling heights for laundry and kitchen shall be at least nine feet clear. Special equipment such as X-ray and surgical lights may require greater ceiling heights. Ceilings of boiler rooms located below occupied spaces shall be insulated or the temperatures otherwise controlled to permit comfortable occupancy of the spaces above.

Subp. 2. **Corridor widths.** Corridor widths shall be not less than seven feet. A greater width shall be provided at elevator entrances and in areas where special equipment is to be used.

Subp. 3. **Door widths.** Door widths shall be not less than three feet eight inches at all bedrooms, treatment rooms, operating rooms, X-ray rooms, delivery rooms, labor rooms, solariums, and physical therapy rooms. No doors shall swing into the corridor except closet doors and exit and stairway doors required to swing in the lane of egress travel. The door-swing requirement does not apply to psychiatric units or mental hospitals.

Subp. 4. **Floors.** The floors of the following areas shall have smooth, water-resistant surfaces: toilets, baths, bedpan rooms, utility rooms, janitors' closets, floor pantries, pharmacies, laboratories, and patients' rooms. The floors of the food preparation and formula rooms shall be water-resistant, grease-resistant, smooth, and resistant to heavy wear. The floors of the operating rooms, delivery rooms, and rooms or spaces where explosive gases are used or stored shall have conductive flooring as defined in Part II of Standard No. 56, issued in May, 1954, entitled Recommended Safe Practice for Hospital Operating Rooms by the National Fire Protection Association, 60 Batterymarch Street, Boston, Massachusetts which part of said standard is hereby adopted by the commissioner of health with the same force and effect as if the same were fully set forth in and written as part of this subpart.

Subp. 5. **Laundry chutes.** Where laundry chutes are used, they shall be not less than two feet in diameter.

Subp. 6. **Stair widths.** Stair widths shall be not less than three feet eight inches. The width shall be measured between handrails where handrails project more than 3-1/2 inches. Platforms and landings shall be large enough to permit stretcher travel in emergencies.

Subp. 7. **Walls.** The walls of the following areas shall have smooth, waterproof painted, glazed, or similar finishes: kitchens, sculleries, utility rooms, baths, showers, dishwashing rooms, janitors' closets, sterilizing room, spaces with sinks or lavatories, operating rooms, and delivery rooms.

4645.2500 DESIGN DATA.

The buildings and all parts thereof shall be of sufficient strength to support all dead, live, and lateral loads without exceeding the working stresses permitted for construction materials in generally accepted good engineering practice. Special provisions shall be made for machines or apparatus loads which would cause a greater load than the specified minimum live load. Consideration shall be given to structural members and connections of structures which may be subject to severe windstorms. Floor areas where partition locations are subject to change shall be designed to support, in addition to all other loads, a uniformly distributed load of 25 pounds per square foot.

4645.2600 LIVE LOADS.

The following unit live loads shall be taken as the minimum distributed live loads for:

- A. bedrooms and all adjoining service rooms which comprise a typical nursing unit, except solariums and corridors, 40 pounds per square foot;
- B. solariums, corridors in nursing units, operating suites, examination and treatment rooms, laboratories, toilet and locker rooms, 60 pounds per square foot;
- C. offices, conference room, library, kitchen, radiographic room, corridors, and other public areas on first floor, 80 pounds per square foot;
- D. stairways, laundry, large rooms used for dining, recreation, or assembly purposes, workshops, 100 pounds per square foot;
- E. records file room, storage and supply rooms, 125 pounds per square foot;
- F. mechanical equipment room, 150 pounds per square foot;
- G. roofs, 40 pounds per square foot; and
- H. wind loads, as required by design conditions, but not less than 15 pounds per square foot for buildings less than 60 feet above ground.

4645.2700 CONSTRUCTION.

Foundations shall rest on natural solid ground and shall be carried to depth of not less than one foot below the estimated frost line or shall rest on leveled rock or load-bearing piles when solid ground is not encountered. Footings, piers, and foundation walls shall be adequately protected against deterioration from the action of groundwater. Reasonable care shall be taken to establish proper soil-bearing values for the soil at the building site. If the bearing capacity of a soil is not definitely known or is in question, a recognized load test shall be used to determine the safe bearing value. Hospitals shall be constructed of incombustible materials, using a structural framework of reinforced concrete or structural steel except that masonry walls and piers may be utilized for buildings up to three stories in height not accounting for penthouses. The various elements of such buildings shall meet the following fire-resistive requirements:

- A. party and firewalls, four hours;
- B. exterior bearing walls, three hours;
- C. exterior panel and curtain walls, three hours;
- D. inner court walls, three hours;
- E. bearing partitions, three hours;
- F. non-load-bearing partitions, one hour;
- G. enclosures for stairs, elevators and other vertical openings, two hours;
- H. columns, girders, beams, trusses, three hours;
- I. floor panels, including beams and joists in same, two hours; and
- J. roof panels, including beams and joists in same, two hours.

Stairs and platforms shall be reinforced concrete or structural steel with hard incombustible materials for the finish of risers and treads. Rooms housing furnaces, boilers, combustible storage or other facilities which may provide fire hazards shall be of three-hour fire-resistive construction.

4645.2800 HEATING, PIPING, VENTILATION, AND AIR-CONDITIONING.

The heating system, piping, boilers, ventilation, and air-conditioning shall be furnished and installed to meet the requirements as set forth herein and the requirements of Part II of Standard No. 56, issued in May, 1954, entitled Recommended Safe Practice for Hospital Operating Rooms by the National Fire Protection Association, 60 Batterymarch Street, Boston, Massachusetts, which part of said standard is hereby adopted by the commissioner of health with the same force and effect as if the same were fully set forth in and written as part of this part. It is recommended that ventilating systems be designed for air cooling or for the future addition of air cooling.

4645.2900 BOILERS.

Boilers shall have the necessary capacity to supply the heating, ventilating, and air-conditioning systems and hot water and steam operated equipment, such as sterilizers and laundry and kitchen equipment. Spare boiler capacity shall be provided in a separate unit to replace any boiler which might break down. Standby boiler feed pumps, return pumps, and circulating pumps shall be provided.

4645.3000 HEATING.

Subpart 1. **Heating system.** The building shall be heated by a hot water, steam, or equal type heating system. Each radiator shall be provided with a hand control or automatic temperature control valve. The heating system shall be designed to maintain a minimum temperature of 75 degrees Fahrenheit in nurseries, delivery rooms, operating and recovery rooms, and similar spaces and a minimum temperature of 70 degrees Fahrenheit in all other rooms and occupied spaces. The outside design temperature for the locality shall be based on the information contained in that portion of chapter 12 of the publication, issued in 1954, entitled Heating Ventilating Air Conditioning Guide by the American Society of Heating and Ventilating Engineers, 51 Madison Avenue, New York, New York, starting with Design Outdoor Weather Conditions on page 240 and ending on page 247 which portion of chapter 12 of said guide is hereby adopted by the commissioner of health with the same force and effect as if the same were fully set forth in and written as part of this subpart.

Subp. 2. **Auxiliary heat.** Auxiliary heat supply shall be provided for heating in operating rooms, delivery rooms, and nurseries to supply heat when the main heating system is not in operation. This may be accomplished by proper separate zoning.

4645.3100 PIPING.

Subpart 1. **Pipe used in heating system.** Pipe used in heating and steam systems shall not be smaller in size than that prescribed in that portion of chapter 21 of the publication, issued in 1954, entitled Heating, Ventilating, Air Conditioning Guide, by the American Society of Heating and Ventilating Engineers, 51 Madison Avenue, New York, New York, starting with "Sizing Piping for Steam Heating Systems" on page 491 and continuing through "Sizing Piping for Indirect Heating Units" on page 506, which portion of chapter 21 of said guide is hereby adopted by the commissioner of health with the same force and effect as if the same were fully set forth in and written as part of this subpart. The ends of all steam mains and low points in steam mains shall be dripped.

Subp. 2. **Valves.** Steam return and heating mains shall be controlled separately by a valve at boiler or header. Each steam and return main shall be valved. Each piece of equipment supplied with steam shall be valved on the supply and return ends.

Subp. 3. **Thermostatic control.** The heating system shall be thermostatically controlled using one or more zones.

Subp. 4. **Coverings.** Boilers and smoke breeching shall be insulated with covering having a thermal resistance (1/c) value of not less than 1.96 and one-half inch plastic asbestos finish covered with four ounce canvas. All high-pressure steam and return piping shall be insulated with covering not less than the equivalent of one inch four-ply asbestos covering.

Heating supply mains in the boiler room, in unheated spaces, unexcavated spaces, and where concealed, shall be insulated with a covering of asbestos air cell having a thickness of not less than one inch.

4645.3200 VENTILATION.

Sterilizer rooms, sterilizer equipment chambers, bathrooms, hydrotherapy rooms, garbage storage, and can washing rooms shall be provided with forced or suitable exhaust ventilation to change the air at least once every six minutes. A similar ventilating system shall be provided for rooms lacking outside windows such as utility rooms, toilets, and bedpan rooms. Kitchens, morgues, and laundries which are located inside the hospital building shall be ventilated by exhaust systems which will discharge the air above the main roof or at least 50 feet from any window. The ventilation of these spaces shall comply with the state or local codes but if no code governs, the air in the work spaces shall be exhausted at least once every ten minutes with the greater part of the air being taken from the flat work ironer and ranges. All exhaust ducts shall be provided with control dampers. Summertime ventilation rate of laundry, in excess of equipment requirements, may be introduced through doors, windows, or louvers in laundry room walls and be exhausted by exhaust fans located in walls generally opposite from intakes or arranged to provide the best possible circulation within the room. Rooms used for the storage of inflammable material shall be ventilated in accordance with the requirements of the state fire marshal. The operating and delivery rooms shall be provided with a supply ventilating system with heaters and humidifiers which will change the air at least eight times per hour by supplying fresh filtered air humidified to reduce the electrostatic hazard. Humidifiers shall be capable of maintaining a minimum relative humidity of 55 percent at 75 degrees Fahrenheit temperature. No recirculation shall be permitted. The air shall be removed from these rooms by a forced system of exhaust. The sterilizing rooms adjoining these rooms shall be furnished with an exhaust ventilating system. The supply air to operating rooms may be exhausted from operating rooms to adjoining sterilizer or work rooms from where it shall be exhausted. Exhaust systems of ventilation shall be balanced with an approximately equal amount of supply air delivered directly into the rooms or areas being exhausted or to other spaces of the hospital such as corridors. All outdoor supply air shall be tempered and filtered. All outdoor air intake louvers shall be located in areas relatively free from dust, obnoxious fumes, and odors.

4645.3300 INCINERATOR.

An incinerator shall be provided to burn dressings, infectious materials, and amputations. When garbage is incinerated, the incinerator shall be of a design that will burn 50 percent wet garbage completely without objectionable smoke or odor. The incinerator shall be designed with drying hearth, grates, and combustion chamber lined with fire brick. The gases shall be carried to a point above the roof of the hospital. Provisions for air supply to the incinerator room shall be made. Gas- or oil-fired incinerators are desirable.

4645.3400 WATER SUPPLY.

The water supply shall be of safe sanitary quality, suitable for use, and shall be obtained from a water supply system, the location, construction, and operation of which are acceptable to the commissioner of health.

4645.3500 PLUMBING AND DRAINAGE.

Subpart 1. **Problems.** Problems of a special nature applicable to the hospital plumbing system include the following.

Subp. 2. **Vapor vent systems.** Permanently installed pressure sterilizers, other sterilizers which are provided with vent openings, steam kettles, and other fixtures requiring vapor vents shall be connected with a vapor venting system extending up through the roof independent of the plumbing fixture vent system. The vertical riser pipe shall be provided with a drip line which discharges into the drainage system through an air-gap or open fixture.

The connection between the fixture and the vertical vent riser pipe shall be made by means of a horizontal offset.

Subp. 3. **Plumbing fixtures.** Water closets in and adjoining patients' areas shall be of a quiet-operating type. Flush valves in rooms adjoining patients' rooms shall be designed for quiet operation with quiet-acting stops. Gooseneck spouts and wrist-action controls shall be used for patients' lavatories, nursery lavatories, and sinks which may be used for filling pitchers. Foot, knee, or elbow-action faucets shall be used for doctors' scrub-up, including nursery work room; utility and clinic sinks; and in treatment rooms. Elbow or wrist-action spade handle controls shall be provided on other lavatories and sinks used by doctors or nurses.

Subp. 4. **Special precautions for mental patients.** Plumbing fixtures which require hot water and which are accessible to mental patients shall be supplied with water which is thermostatically controlled to provide a maximum water temperature of 110 degrees Fahrenheit at the fixture. Special consideration shall be given to piping, controls, and fittings of plumbing fixtures as required by the types of mental patients. No pipes or traps shall be exposed and fixtures shall be substantially bolted through walls. Generally, for disturbed patients, special-type water closets without seats shall be used and shower and bath controls shall not be accessible to patients.

Subp. 5. **Hot water heaters and tanks.** The hot water heating equipment shall have sufficient capacity to supply at least five gallons of water at 150 degrees Fahrenheit per hour per bed for hospital fixtures, and at least eight gallons at 180 degrees Fahrenheit per hour per bed for the laundry and kitchen. The hot water storage tank or tanks shall have a capacity equal to 80 percent of the heater capacity. Where direct-fired hot water heaters are used, they shall be of the high-pressure cast iron type. Submerged steam heating coils shall be of copper. Storage tanks shall be of corrosion-resistant metal or be lined with corrosion-resistant material. Tanks and heaters shall be fitted with vacuum and relief valves, and where the water is heated by coal or gas, they shall have thermostatic relief valves. Heaters shall be thermostatically controlled.

Subp. 6. **Water supply systems.** Cold water and hot water mains and branches from the cold water service and hot water tanks shall be run to supply all plumbing fixtures and equipment which require cold or hot water or both for their operation. Pressure and pipe size shall be adequate to supply water to all fixtures with a minimum pressure of 15 pounds at the top floor fixtures during maximum demand periods. Where booster systems are necessary, water shall be supplied to the booster pump through a receiving tank in which the water level is automatically controlled. The receiving tank shall have a properly constructed and screened opening to the atmosphere and a watertight, overlapping cover. The receiving tank and booster pump shall be situated entirely above the ground level. If a pressure tank is employed in the booster system, it shall also be situated above ground level. Hot water circulating mains and risers shall be run from the hot water storage tank to a point directly below the highest fixture at the end of each branch main. Where the building is higher than three stories, each riser shall be circulated.

Subp. 7. **Roof and area drainage.** Leaders shall be provided to drain the water from roof areas to a point from which it cannot flow into the basement or areas around the building. Courts, yards, and drives which do not have natural drainage from the building shall have catch basins and drains to low ground, storm water system, or dry wells. Where dry wells are used, they shall be located at least 20 feet from the building.

Subp. 8. **Valves.** Each main, branch main, riser, and branch to a group of fixtures of the water systems shall be valved.

Subp. 9. **Insulation.** Hot water tanks and heaters shall be insulated with covering equal to one inch, four-ply air cell. Hot water and circulating pipes shall be insulated with covering equal to canvas jacketed three-ply asbestos air cell. Cold water mains and exposed rain water leaders in occupied spaces and in store rooms shall be insulated with

canvas-jacketed felt covering to prevent condensation. All pipes in outside walls shall be insulated to prevent freezing.

Subp. 10. **Tests.** Water pipe shall be hydraulically tested to a pressure equal to twice the working pressure.

4645.3600 STERILIZERS.

Sterilizers and autoclaves of the required types and necessary capacity shall be provided to sterilize instruments, utensils, dressings, water, and other materials and equipment. The flasking system for sterile water supply is recommended. The sterilizers shall be of recognized hospital types with approved controls and safety features.

4645.3700 SEWAGE AND WASTE DISPOSAL.

All building sewage shall be discharged into a municipal sanitary sewer system, if available, otherwise an independent sewage disposal system shall be provided which is constructed in accordance with the requirements of the commissioner of health.

4645.3800 GAS PIPING.

Gas appliances shall bear the stamp of approval of the American Gas Association. Oxygen piping outlets and manifolds where used shall be installed in accordance with publication No. 565, issued in 1951, entitled Standard for Nonflammable Medical Gas Systems by the National Fire Protection Association, 60 Batterymarch Street, Boston, Massachusetts, which standard is hereby adopted by the commissioner of health with the same force and effect as if the same were fully set forth and written as part of this part.

4645.3805 REFRIGERATION.

Subpart 1. **Extent of coverage.** This part shall include portable refrigerators, built-in refrigerators, garbage refrigerators, ice-making and refrigerator equipment, and morgue boxes.

Subp. 2. **Box construction.** Boxes shall be lined with nonabsorbent sanitary material which will withstand the heavy use to which they will be subjected and shall be constructed so as to be easily cleaned. Refrigerators of adequate capacity shall be provided in all kitchens and other preparation centers where perishable foods will be stored. In the main kitchen, a minimum of two separate sections or boxes shall be provided, one for meats and dairy products, and one for general storage.

Subp. 3. **Refrigerator machines.** Toxic, "irritant," or inflammable refrigerants shall not be used in refrigerator machines located in buildings occupied by patients. The compressors and evaporators shall have sufficient capacity to maintain temperatures of 35 degrees Fahrenheit in the meat and dairy boxes, and 40 degrees Fahrenheit in the general storage boxes when the boxes are being used normally. Compressors shall be automatically controlled.

Subp. 4. **Tests.** Compressors, piping, and evaporators shall be tested for leaks and capacity.

4645.3900 ELECTRICAL SYSTEMS.

Electrical systems shall be furnished and installed to meet the requirements as set forth herein and the requirements of part 2 of the Standard No. 56 issued in May 1954, entitled "Recommended Safe Practice for Hospital Operating Rooms," by the National Fire Protection Association, 60 Batterymarch Street, Boston, Massachusetts, which part of said standard is hereby adopted by the commissioner of health with the same force and effect as if the same were fully set forth and written as part of this part.

4645.4000 FEEDERS AND CIRCUITS.

Separate power and light feeders shall be run from the service to a main switchboard and from there, subfeeders shall be provided to the motors and power and light distributing panels. Where there is only one service feeder, separate power and light feeders from the service entrance to the switchboard will not be required. From the power panels, feeders shall be provided for large motors, and circuits from the light panels shall be run to the lighting outlets. Large heating elements shall be supplied by separate feeders from the local utility and installed as directed. Independent feeders shall be furnished for X-ray equipment.

4645.4100 LIGHT PANELS.

Light panels shall be provided on each floor for the lighting circuits on that floor. Light panels shall be located near the load centers not more than 100 feet from the farthest outlet.

4645.4200 LIGHTING OUTLETS, RECEPTACLES, AND SWITCHES.

All occupied areas shall be adequately lighted as required for the duties performed in the space. Patients' bedrooms shall have as a minimum: general illumination, a bracket or receptacle for each bed, a duplex receptacle for each two beds for doctor's examining light, and a night light. Where ceiling lights are used in patients' rooms, they shall be of a type which does not shine in the patients' eyes. The outlets for night lights shall be independently switched at the door. Receptacles for special equipment shall be of a heavy duty type on separate circuits. Switches in patients' rooms shall be of an approved mercury or equal, quiet-operating type, except for cord operated switches on fixtures. No lighting fixtures, switches, receptacles or electrical equipment shall be accessible to disturbed mental patients. Operating and delivery rooms shall be provided with special lights for the tables, each on an independent circuit, and lights for general illumination. Not less than three explosion-proof receptacles shall be provided in each operating and delivery room except that the explosion-proof type will not be required if the receptacles are above the five-foot level. Each operating room shall have a film-viewing box. All switches, viewing boxes, and equipment controls installed below the five-foot level shall be explosion-proof.

4645.4300 EMERGENCY ELECTRICAL SYSTEM.

Each hospital shall have a source of emergency power which may be an entirely separate outside source from an independent generating plant, a generator operated by a prime mover, or a battery with adequate means for charging. Where the installation consists of a standby generator operated by a prime mover, it shall be of a size sufficient to supply all estimated current demands for required areas. The system shall be so arranged that, in the event of failure of the principal source of current, the emergency system shall be automatically placed in operation. Emergency lighting shall be provided for: stairs; exits; patient corridors; corridors leading to exits; exit signs; operating, delivery, and emergency rooms; telephone switchboard room; nurseries; emergency generator room; boiler room; and all psychiatric patient areas.

It is recommended that emergency power be provided for the operation of at least one boiler.

4645.4400 NURSES' CALL.

Each patient shall be furnished with a nurses' call which will register at the corridor door, at the nurses' station, and in each floor kitchen and utility room of the nursing unit. A duplex unit may be used for two patients. Indicating lights shall be provided at each station where there are more than two beds in a room. Nurses' call stations will not be required for psychiatric occupancies, pediatric rooms, and nurseries where an emergency call shall be available in each room for the use of the nurse. A call station shall be provided in each operating and delivery room.

4645.4500 NUMBER OF CARS.

Any hospital with patients on one or more floors above the first floor or where the operating or delivery rooms are not on the first floor shall have at least one mechanically driven elevator. Hospitals with a bed capacity of from 60 to 200 above the first floor shall have not less than two elevators. Hospitals with a bed capacity of from 200 to 350 above the first floor shall have not less than three elevators, two passenger and one service.

4645.4600 CABS.

Cabs shall be constructed with fireproof material. Passenger cab platforms for the minimum required number of elevators shall be not less than five feet four inches by eight feet with a capacity of at least 3,500 pounds. Cab and shaft doors shall be not less than three feet ten inches clear opening. Service elevators shall be of sufficient size to receive a stretcher with patient.

4645.4700 CONTROLS.

Elevators, for which operators will not be employed, shall have automatic push-button control, signal control, or dual control for use with or without operator. Where two push-button elevators are located together and where one such elevator serves more than three floors and basement, they shall have collective or signal control. Where the car has a speed of more than 100 feet per minute or has a rise of four or more floors, the elevator shall be equipped with automatic self-leveling control which will automatically bring the car platform level with the landing with no load or full load. Multivoltage or variable voltage machines shall be used where speeds are greater than 150 feet per minute. For speeds above 350 feet per minute, the elevators shall be of the gearless type.

4645.4800 DUMBWAITERS.

Dumbwaiter cabs shall be not less than 24 inches by 24 inches by 36 inches of steel with one shelf to operate at a speed of 50 feet to 100 feet per minute when carrying a load of 100 pounds. Dumbwaiters serving basement and four floors shall have a minimum speed of 100 feet per minute.

4645.4900 TESTS.

Elevator machines shall be tested for speed and load with and without loads in both directions and shall be given overspeed tests as required by the Minnesota Department of Labor and Industry.

4645.5100 KITCHEN EQUIPMENT FOR ALL HOSPITALS.

Subpart 1. **Equipment.** The equipment shall be adequate, properly constructed, and so arranged as to enable the storage, preparation, cooking, and serving of food and drink to patients, staff, and employees to be carried out in an efficient and sanitary manner. The equipment shall be selected and arranged in accordance with the types of food service adopted for the hospital. Cabinets or other enclosures shall be provided for the storage or display of food, drink, and utensils and shall be designed as to protect them from contamination by insects, rodents, other vermin, splash, dust, and overhead leakage. All utensils and equipment surfaces with which food or drink comes in contact shall be of smooth, nontoxic, corrosion-resistant material, free of breaks, open seams or cracks, chipped places, and V-type threads. Sufficient separation shall be provided between equipment and the walls or floor to permit easy cleaning or the equipment shall be set tight against the walls or floor and the joint properly sealed.

Subp. 2. **Dishwashing facilities.** The necessary equipment shall be provided to accomplish either of the two methods of dishwashing as described under part 4640.2900.

4645.5200 LAUNDRY FOR ALL HOSPITALS.

Where laundries are provided, they shall be complete with washers, extractors, tumblers, ironers, and presses which shall be provided with all safety appliances and meet all sanitary requirements.

4700.1900 PURPOSE, SCOPE, AND APPLICABILITY.

The purpose and scope of parts 4700.1900 to 4700.2500 is to prescribe requirements applicable to family planning special project grants, to establish minimum standards for family planning services supported in whole or in part by family planning special project grant funds, and to provide criteria for the review of family planning special project grant applications.

Minnesota Statutes, section 145.925, contains a provision prohibiting use of these funds for abortions, and for family planning services to unemancipated minors in an elementary or secondary school building; requiring notice to parents or guardians of unemancipated minors to whom abortion or sterilization is advised, except as provided in Minnesota Statutes, sections 144.341 and 144.342; and prohibiting coercing anyone to undergo an abortion or sterilization.

4700.2000 DEFINITIONS.

Subpart 1. **Scope.** For purposes of parts 4700.1900 to 4700.2500, the following terms have the meanings given them in this part.

Subp. 2. **Approvable application.** "Approvable application" means an application which meets the criteria for award, as specified in part 4700.2300.

Subp. 3. **Community health board.** "Community health board" means a community health board established, operating, and eligible for a subsidy under Minnesota Statutes, sections 145A.09 to 145A.13.

Subp. 4. **Current award.** "Current award" means the amount of family planning special project grant funds received in the year immediately preceding the one for which a new grant of family planning special project funds is requested.

Subp. 5. **Current recipient.** "Current recipient" means an agency receiving family planning special project grant funds in the year immediately preceding the one for which a new grant of family planning special project funds is requested.

Subp. 6. **Family planning.** "Family planning" means voluntary planning and action by individuals to attain or prevent pregnancy.

Subp. 7. **Family planning methods.** "Family planning methods" means agents and devices for the purpose of fertility regulation prescribed by a licensed physician, and other agents and devices for the purpose of fertility regulation including, spermicidal agents, diaphragms, condoms, oral contraceptives, intrauterine devices, natural family planning methods, sterilizations, and the diagnosis and treatment of infertility by a licensed physician, which can be paid for in whole or in part by family planning special project grant funds.

Subp. 8. **Family planning services components.** "Family planning services components" means the public information, outreach, counseling, method, referral, and follow-up categories under which all services provided by family planning service providers must be described. The minimum standards in part 4700.2210 serve to define these components.

Subp. 9. **High risk person.** "High risk person" means an individual whose age, health, prior pregnancy outcome, or socioeconomic status increases her chances of experiencing an unplanned pregnancy or problems during pregnancy. High risk persons include, but are not limited to, women under 18 or over 35; women who have experienced premature labor and delivery; women with existing health problems such as diabetes, anemia, and obesity; and persons whose individual or family income is determined to be at or below 200 percent

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of the official income poverty line as defined by United States Code, title 42, section 9902, and as published by the Federal Office of Management and Budget and revised annually in the Federal Register. A copy of the most current guideline is available from the Office of Planning and Evaluation, Department of Health and Human Services, Washington, D.C., 20201, (202) 245-6141.

Subp. 10. **Linkages.** "Linkages" means formal or informal arrangements between the applicant and other family planning providers including contracts, reciprocal referral agreements, and committees.

Subp. 11. **New applicant.** "New applicant" means an agency which did not receive family planning special project funds in the year immediately preceding the one for which a grant of family planning special project funds is requested.

Subp. 12. **Provide.** "Provide" means to directly supply or render or to pay for in whole or in part.

Subp. 13. **Publicly subsidized.** "Publicly subsidized" means funded by federal, state, county, or city tax dollars, but does not include title XIX of the Social Security Act medical assistance funds.

Subp. 14. **Region.** "Region" means that group of counties represented by a single person on the executive committee of the State Community Health Advisory Committee. The counties in each region are as follows:

Northeastern	Northwestern	West Central
Aitkin	Becker	Clay
Carlton	Beltrami	Douglas
Cook	Clearwater	Grant
Itasca	Hubbard	Otter Tail
Koochiching	Kittson	Pope
Lake	Lake of the Woods	Stevens
Saint Louis	Mahnomen	Traverse
	Marshall	Wilkin
	Norman	
	Pennington	
	Polk	
	Red Lake	
	Roseau	
Central	Metro	South Central
Benton	Anoka	Blue Earth
Cass	Carver	Brown
Chisago	Dakota	Faribault
Crow Wing	Hennepin	Le Sueur
Isanti	Ramsey	McLeod
Kanabec	Scott	Martin

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Mille Lacs	Washington	Meeker
Morrison		Nicollet
Pine		Sibley
Sherburne		Waseca
Stearns		Watonwan
Todd		
Wadena		
Wright		

Southeastern

Southwestern

Dodge

Big Stone

Fillmore

Chippewa

Freeborn

Cottonwood

Goodhue

Jackson

Houston

Kandiyohi

Mower

Lac Qui Parle

Olmsted

Lincoln

Rice

Lyon

Steele

Murray

Wabasha

Nobles

Winona

Pipestone

Redwood

Renville

Rock

Swift

Yellow Medicine

4700.2100 CONTENT OF APPLICATION.

The application shall identify the geographic area to be served by the applicant and shall provide the following required information:

A. An inventory of existing family planning services provider agencies in the geographic area served by the applicant. The inventory shall include, for each provider agency, at least the agency name; addresses of all agency service sites; the target population served, including total number served if available (if unavailable, estimates will be acceptable); and the family planning service components provided.

B. An assessment of unmet needs of the geographic area to be served by the applicant. The assessment of unmet needs must, at least, identify unavailable family planning service components or unserved or underserved populations. A description of the method used in making the assessment shall be provided by the applicant.

C. A description of the family planning service components to be provided by the applicant. Each component to be provided with family planning special project funds must

meet the standards for that component described in part 4700.2210. The application must include a budget and budget justification and summary of applicable training or experience of persons providing services relevant to these components. Also, for each component provided, the application must describe:

- (1) the goals;
- (2) the population to be served (target population);
- (3) the specific objectives to be achieved during the funding period;
- (4) the methods by which each objective will be achieved; and
- (5) the criteria to be used to evaluate the progress towards each objective.

D. A description of the linkages between the applicant and other family planning services in the geographic area.

E. A description of fees to be charged individuals for any family planning services. Fees must be charged for services to individuals and must be in accordance with a sliding fee schedule for services and supplies based on the cost of such services or supplies and on the individual's ability to pay as determined by income, family size, and other relevant factors. Services shall not be denied based on ability to pay as specified in item H.

F. Assurance that services will be provided in accordance with state and federal laws and rules.

G. Assurance that the use of third-party sources of funding will be employed whenever possible.

H. Assurance that services will be provided without regard to age, sex, race, religion, marital status, income level, residence, parity, or presence or degree of disability except as otherwise required by law.

I. Assurance that arrangements shall be made for communication to take place in a language understood by the family planning service recipient.

J. Assurance that the privacy of the service recipient will be maintained in accordance with law.

K. Original signature on face sheet and budget forms.

4700.2210 MINIMUM STANDARDS FOR FAMILY PLANNING SERVICE COMPONENTS.

An applicant is not required to provide all components to be eligible for funding. However, the applicant must make available the names and addresses of other family planning services provider agencies in the geographic area, if any, who offer components and services not offered by the applicant.

All funded projects must establish linkages to facilitate access to outreach, counseling, and other component services for service recipients.

Procedures for referral and follow-up must be incorporated into all services that are provided by the applicant on a one-to-one basis.

The provision of all service components except public information shall include information on family planning services available from the applicant.

Service components to be provided by the applicant shall be defined by, and shall meet or exceed, the following minimum standards:

A. Public information must include specific activities designed to inform the general population about family planning and how to obtain information on all family planning service components available in the geographic area.

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B. Outreach must include specific activities designed to inform members of the target population about family planning and all the family planning service components available in the geographic area. Outreach activities shall include one-to-one or small group contacts with the target population.

Outreach must be conducted at times and places convenient to the target population. Persons conducting outreach shall have training or experience in family planning services.

C. Counseling must include utilization of nondirective techniques in a decision-making format which enables individuals to voluntarily determine their participation in family planning services and their family planning method of choice, if any. "Nondirective techniques" means techniques that employ open-ended questions to enable individuals to consider their feelings, attitudes, and values about alternatives and outcomes. A decision-making format means a format that allows individuals to consider alternatives and outcomes, weigh advantages and disadvantages, and make choices.

When individuals are seeking to prevent pregnancy, counseling shall include the provision and explanation of factual information on all family planning pregnancy prevention methods in a nonjudgmental manner. "Nonjudgmental manner" means a manner in which the counselor's personal values and beliefs do not interfere with the client's choices.

When individuals are seeking to attain pregnancy, counseling shall include the provision and explanation of factual information on infertility diagnosis and treatment and services for pregnant women available in the geographic area.

Counseling shall be available to any individual in the target population and shall be conducted at times and places convenient to the target population.

Counseling shall include documentation that information required in Minnesota Statutes, section 145.925, has been provided. Counseling shall be conducted by persons with training or experience in counseling and family planning services.

D. Method must include the provision to a service recipient of the recipient's family planning method of choice. Provision of any family planning method must include:

- (1) procedures which document that the service recipient participated in counseling prior to selecting a family planning method to prevent pregnancy;
- (2) voluntary selection of the family planning method by the service recipient;
- (3) information on the advisability of females obtaining a gynecological examination with Pap smear prior to initiating any family planning method;
- (4) education on the use of the selected family planning method, including the risks and benefits of the method; and
- (5) medical/laboratory services prior to the provision of a family planning method when the selected method requires medical intervention for prescription, fitting, insertion, or for surgical or diagnostic procedures. When the selected method does not require medical intervention, as described herein, the applicant shall encourage service recipients to obtain medical/laboratory services, but provision by the applicant is not required. Medical/laboratory services shall include:
 - (a) social and medical/surgical history with emphasis on the reproductive system;
 - (b) height, weight, and blood pressure measures;
 - (c) bimanual pelvic examination for females;
 - (d) breast examination and instruction on self-examination for females;
 - (e) hemoglobin or hematocrit;
 - (f) urinalysis for sugar and protein;

(g) Pap smear; and

(h) when indicated by history or symptoms, for both male and female as appropriate, diagnosis and curative treatment of venereal disease, diagnosis and treatment of vaginitis, diagnosis of pregnancy, and for females, as appropriate, provision of rubella immunization.

Medical services shall be rendered by licensed physicians, or professional nurses with documentable training in gynecological care conducted under the supervision of a licensed physician, or nurse midwives certified by the American College of Nurse Midwifery, or physician assistants, under the supervision of a licensed physician. Laboratory tests shall be conducted by personnel trained to conduct such tests.

E. Referral must include the provision, in writing, of information to service recipients which enables them to participate in family planning and other needed health and human services. Documentation of referrals must be maintained.

F. Follow-up must include specific procedures of continuing care designed to encourage safe and consistent utilization of family planning and other needed health and human services, using protocols based on accepted professional standards of care.

4700.2300 CRITERIA FOR AWARD OF FAMILY PLANNING SPECIAL PROJECT GRANTS.

Subpart 1. **Application criteria.** Applications which meet the requirements of law and parts 4700.1900 to 4700.2500 shall be deemed approvable applications and eligible for award according to the notice of availability and the following criteria.

Subp. 3. **Quality and content.** Applications will be evaluated on the basis of:

A. the extent the funds will be used to meet unmet needs in the geographic area as identified in the application;

B. the extent the application proposes an identifiable expansion in the scope of the family planning service system in the geographic area to be served by the applicant;

C. the extent the application proposes to coordinate family planning services with organizations, agencies, and individual providers in the geographic area to be served;

D. the extent the application proposes to serve high risk persons;

E. the extent the application proposes to maximize use of alternative sources of funding; and

F. the extent the application proposes to provide family planning methods according to part 4700.2210, item D.

Subp. 4. **Agency.** When equivalent and competing applications are submitted for a geographic area, award priorities will be in accordance with the following:

A. first priority will be given to community health boards; and

B. second priority will be given to eligible nonprofit corporations.

Subp. 4a. **Priority.** Current recipients of family planning special project funds will not be accorded any priority over new applicants.

Subp. 5. **Review and comment by community health board.** Before submission to the commissioner, the applicant shall submit the proposal to the community health board responsible for the geographic area in which the applicant proposes to provide its services, for the community health board's review and comment. The community health board's comments shall address the application based on the criteria in subpart 3. Any comments of a community health board shall be submitted to the commissioner within 45 days of the date the proposal was received by the community health board.

4700.2410 ALLOCATION SCHEME.

Subpart 1. **Family planning hotline grant.** Five percent of the total annual funds available or \$100,000 per year, whichever is less, must be allocated for a statewide family planning hotline. Applications must contain identifiable plans and budget allocations for both the operation of the hotline and its promotion statewide. If the grant award is not for the full amount of funds allocated under this subpart, the funds remaining must be reallocated for distribution under subpart 2.

Subp. 2. **Family planning services grants.** The portion of the total funds remaining after the distribution made under subpart 1 must be allocated according to this subpart. Except as provided in part 4700.2420, subpart 4, the family planning special project grant funds must be allocated on a regional basis according to the following needs-based distribution formula.

A. Determine the regional need by totaling the following three factors:

(1) the number of resident women within the region who are 12 to 18 years of age, determined by using Department of Health data from the most recent year for which it is available;

(2) the number of resident women within the region 19 to 34 years of age who are on medical assistance as determined by using Department of Human Services data from the most recent year for which it is available; and

(3) the number of resident women within the region who are 35 to 44 years of age as determined by using Department of Health data from the most recent year for which it is available.

B. Compute the regional proportion of the total state need for services by totaling the three factors in item A for each region and dividing each regional total by the sum of the three factors for the entire state.

C. Calculate the amount of family planning special project grant funds available for each region by multiplying its regional proportion by the total amount of money available for family planning special projects under this subpart.

4700.2420 FAMILY PLANNING SERVICES GRANT FUNDING.

Subpart 1. **Funding limit.** An applicant, other than an applicant for a family planning hotline grant, shall be limited to an annual application request of \$75,000 per region. Two or more agencies may submit a joint application; each agency that is a party to it shall be limited to an annual application request of \$75,000 for each region covered by the joint application.

Subp. 2. **Grant allocations.** The applications, other than those for a family planning hotline grant, must be ranked in order within each region from highest to lowest based on the criteria for award in part 4700.2300. The applications must be funded in rank order from highest to lowest until all available funds for the region are allocated.

Subp. 3. **Funding awards.** If the amount requested by any applicant is more than that reasonably required to provide the proposed services, or if the proposed services are not based on part 4700.2210 or 4700.2300, the commissioner must either deny funding or award less than the amount the applicant requested. When the commissioner decides to award less than requested, the applicant must submit a revised description of the target population, methodologies, budget, or budget justification as required by the commissioner to receive funding.

Subp. 4. **Contingency funding.** If any of the conditions in items A to D exist, the commissioner shall redistribute the funds according to this subpart.

A. If funds remain available in a region after all approvable applications are funded according to this part, the commissioner shall redistribute the funds to the other regions,

proportional to their share of funding need, based upon the process stated in part 4700.2410, subpart 2. The redistributed funds shall be awarded according to subpart 2.

B. Funds remaining available after all approvable applications are funded at the funding limit in subpart 1, and awarded according to subpart 2, will be proportionally distributed to all applicants with approvable applications. In order to receive additional funds, an applicant with an approvable application must submit a revised description of the target population, objectives, methodologies, budget, and budget justification to the commissioner within 60 days after receiving notice of the availability of additional funds.

C. If the department funds for family planning special project grants are increased after awards have been made under part 4700.2410, subpart 1, or 4700.2420, subparts 2 to 4, funds must first be allocated to the family planning hotline grant recipient within the funding limits specified in part 4700.2410, subpart 1. Remaining funds must then be distributed to the regions proportional to their share of funding need as determined according to part 4700.2410, subpart 2, and awarded according to part 4700.2420, subparts 2 to 4.

D. If department funds for family planning special project grants are reduced after awards have been made under this subpart or subpart 2 and part 4700.2410, subpart 1, all awards must be reduced proportionate to the department's reduction in these funds. A grant award recipient must submit a revised description of the target population, objectives, methodologies, budget, and budget justification to the commissioner within 60 days after receiving notice of reduced awards.

4700.2500 USE OF STATE FUNDS AVAILABLE FOR FAMILY PLANNING SPECIAL PROJECT GRANTS.

Family planning special project grant recipients may not replace funds from other sources, such as existing federal, state, or local funds which the recipient uses for family planning information or services and over which the recipient exercises discretion, with family planning special project grant funds. Recipients are not required to match funds available under family planning special project grants.

5610.0100 SWORN STATEMENT TO BOARD.

At the time a professional corporation files with the board the copy of its articles of incorporation as required by Minnesota Statutes, section 319A.08, and annually thereafter when such corporation files with the board its annual report as required by Minnesota Statutes, section 319A.21, it shall file with the board a statement under oath as to each and all of the following:

A. the address of the registered office of the corporation and the name of its proposed registered agent, if any, for service and process;

B. the name or names and respective office and residence addresses of the directors and officers of the corporation;

C. in the case of a corporation organized under Minnesota Statutes, chapter 301, a statement of the aggregate number of issued shares, itemized by classes and the person or persons to whom issued;

D. in the case of a corporation organized under Minnesota Statutes, chapter 317A, a statement of the names of the members of the corporation if no stock has been issued, or if stock has been issued, a statement of the aggregate number of issued shares, itemized by classes and the person or persons to whom issued;

E. a description of the nature of the professional services and ancillary services, if any, to be provided by the corporation;

F. the location or locations of the premises at which the applicant corporation proposes to provide professional services;

G. a statement listing the name or names of employees, other than members or shareholders of the corporation, who are licensed under Minnesota Statutes, chapter 147, to practice medicine and surgery within the state of Minnesota; and

H. a statement whether or not all shareholders, members, directors, officers, employees, and agents rendering professional service in Minnesota on behalf of the corporation are licensed to practice medicine and surgery in Minnesota or are otherwise authorized to render the professional service being rendered by the corporation.

5610.0200 SUSPENSION OR REVOCATION OF LICENSE OF SHAREHOLDER, MEMBER, DIRECTOR, OFFICER, EMPLOYEE, OR AGENT.

If the license to practice medicine in Minnesota of any shareholder, member, director, officer, employee, or agent rendering professional service in this state on behalf of the corporation is revoked or suspended by the board, the corporation shall forthwith remove from office and terminate the employment of such shareholder, member, director, officer, employee, or agent, and shall not reinstate in office or reemploy such shareholder, member, director, officer, employee, or agent unless and until the license to practice medicine in Minnesota is restored by the board.

5610.0300 WRITTEN NOTICE REQUIREMENT.

Every professional corporation shall promptly notify the board in writing upon the happening of any of the following events:

A. the death of any shareholder, member, director, officer, employee, or agent who is licensed to practice medicine in Minnesota;

B. the revocation or suspension of the license to practice medicine in Minnesota of any shareholder, member, director, officer, employee, or agent;

C. the amendment of the articles of incorporation or bylaws of the corporation, in which case a copy of such amendment shall be furnished to the board with such notice;

D. a change in the registered office of the corporation;

E. a change in the registered agent of the corporation;

F. the admission, election, or employment of a new shareholder, member, director, officer, employee, or agent of the corporation;

G. the termination, replacement, or discharge of a shareholder, member, director, officer, employee, or agent, in which case the professional corporation shall notify the board of the date thereof and reason therefor;

H. a change in the nature of the professional services and ancillary services, if any, provided by the corporation; or

I. a change in the location or locations of the premises at which the corporation provides or intends to provide professional services.

9505.0235 ABORTION SERVICES.

Subpart 1. **Definition.** For purposes of this part, "abortion related services" means services provided in connection with an elective abortion except those services which would otherwise be provided in the course of a pregnancy. Examples of abortion related services include hospitalization when the abortion is performed in an inpatient setting, the use of a facility when the abortion is performed in an outpatient setting, counseling about the abortion, general and local anesthesia provided in connection with the abortion, and antibiotics provided directly after the abortion.

Medically necessary services that are not considered to be abortion related include family planning services as defined in part 9505.0280, subpart 1, history and physical examination, tests for pregnancy and venereal disease, blood tests, rubella titer, ultrasound

tests, rhoGAM(TM), pap smear, and laboratory examinations for the purpose of detecting fetal abnormalities.

Treatment for infection or other complications of the abortion are covered services.

Subp. 2. **Payment limitation.** Unless otherwise provided by law, an abortion related service provided to a recipient is eligible for medical assistance payment if the abortion meets the conditions in item A, B, or C.

A. The abortion must be necessary to prevent the death of a pregnant woman who has given her written consent to the abortion. If the pregnant woman is physically or legally incapable of giving her written consent to the procedure, authorization for the abortion must be obtained as specified in Minnesota Statutes, section 144.343. The necessity of the abortion to prevent the death of the pregnant woman must be certified in writing by two physicians before the abortion is performed.

B. The pregnancy is the result of criminal sexual conduct as defined in Minnesota Statutes, section 609.342, paragraphs (c) to (f). The conduct must be reported to a law enforcement agency within 48 hours after its occurrence. If the victim is physically unable to report the criminal sexual conduct within 48 hours after its occurrence, the report must be made within 48 hours after the victim becomes physically able to report the criminal sexual conduct.

C. The pregnancy is the result of incest. Before the abortion, the incest and the name of the relative allegedly committing the incest must be reported to a law enforcement agency.

9505.0505 DEFINITIONS.

Subp. 18. **Medical review agent.** "Medical review agent" means the representative of the commissioner who is authorized by the commissioner to administer procedures for admission certifications, medical record reviews and reconsideration, and perform other functions as stipulated in the terms of the agent's contract with the department.

9505.0520 INPATIENT ADMISSION CERTIFICATION.

Subp. 9b. **Reconsideration; physician advisers appointed by medical review agent.** Upon receipt of a request for reconsideration under subpart 9, the medical review agent shall appoint at least three physician advisers who did not take part in the decision to deny or withdraw all or part of the admission certification. Each physician adviser shall determine the medical necessity of the admission or the continued stay or, in the case of a readmission, determine whether the admission and readmission meet the criteria in part 9505.0540. The reconsideration decision must be the majority opinion of the physician advisers. In making the decision, the three physician advisers shall use the criteria of medical necessity set out in part 9505.0530.