SENATE
STATE OF MINNESOTA
NINETY-THIRD SESSION

S.F. No. 2995

(SENATE AUTHORS: WIKLUND)

DATE	D-PG	OFFICIAL STATUS
03/20/2023	2118	Introduction and first reading Referred to Health and Human Services
04/12/2023		Comm report: To pass as amended and re-refer to Finance

A bill for an act

relating to state government; modifying provisions governing child care, child safety and permanency, child support, economic assistance, deep poverty, housing and homelessness, behavioral health, the medical education and research cost account, MinnesotaCare, medical assistance, background studies, and human services licensing; establishing the Department of Children, Youth, and Families; making technical and conforming changes; establishing requirements for hospital nurse staffing committees and hospital nurse workload committees; modifying requirements of hospital core staffing plans; modifying requirements related to hospital preparedness and incident response action plans to acts of violence; modifying eligibility for the health professional education loan forgiveness program; establishing the Health Care Affordability Board and Health Care Affordability Advisory Council; establishing prescription contraceptive supply requirement; requiring health plan coverage of prescription contraceptives, certain services provided by a pharmacist, infertility treatment, treatment of rare diseases and conditions, and biomarker testing; modifying managed care withhold requirements; establishing filing requirements for a health plan's prescription drug formulary and for items and services provided by medical and dental practices; establishing notice and disclosure requirements for certain health care transactions; extending moratorium on certain conversion transactions; requiring disclosure of facility fees for telehealth; modifying provisions relating to the eligibility of undocumented children for MinnesotaCare and of children for medical assistance; prohibiting a medical assistance benefit plan from including cost-sharing provisions; authorizing a MinnesotaCare buy-in option; assessing alternative payment methods in rural health care; assessing feasibility for a health provider directory; requiring compliance with the No Surprises Act in billing; modifying prescription drug price provisions and continuity of care provisions; compiling health encounter data; modifying all-payer claims data provisions; establishing certain advisory councils, committees, public awareness campaigns, apprenticeship programs, and grant programs; modifying lead testing and remediation requirements; establishing Minnesota One Health Microbial Stewardship Collaborative and cultural communications program; providing for clinical health care training; establishing a climate resiliency program; changing assisted living provisions; establishing a program to monitor long COVID, a 988 suicide crisis lifeline, school-based health centers, Healthy Beginnings, Healthy Families Act, and Comprehensive and Collaborative Resource and Referral System for Children; establishing a moratorium on green burials; regulating submerged closed-loop exchanger systems; establishing a tobacco use prevention account; amending provisions relating to

adoptee birth records access; establishing Office of African American Health; establishing Office of American Indian Health; changing certain health board fees; establishing easy enrollment health insurance outreach program; establishing a state-funded cost-sharing reduction program for eligible persons enrolled in certain qualified health plans; setting certain fees; requiring reports; authorizing attorney general and commissioner of health review and enforcement of certain health care transactions; authorizing rulemaking; transferring money; allocating funds for a specific purpose; making forecast adjustments; appropriating money for the Department of Human Services, Department of Health, health-related boards, emergency medical services regulatory board, ombudsperson for families, ombudsperson for American Indian families, Office of the Foster Youth Ombudsperson, Rare Disease Advisory Council, the Department of Revenue, the Department of Management and Budget, Department of Children, Youth and Families, Department of Commerce, and Health Care Affordability Board; amending Minnesota Statutes 2022, sections 4.045; 10.65, subdivision 2; 13.10, subdivision 5; 13.46, subdivision 4; 13.465, subdivision 8; 15.01; 15.06, subdivision 1; 15A.0815, subdivision 2; 16A.151, subdivision 2; 43A.08, subdivision 1a; 62A.02, subdivision 1; 62A.045; 62A.15, subdivision 4, by adding a subdivision; 62A.30, by adding subdivisions; 62A.673, subdivision 2; 62J.497, subdivisions 1, 3; 62J.692, subdivisions 1, 3, 4, 5, 8; 62J.824; 62J.84, subdivisions 2, 3, 4, 6, 7, 8, 9, by adding subdivisions; 62K.10, subdivision 4; 62K.15; 62U.04, subdivisions 4, 5, 5a, 11, by adding subdivisions; 62U.10, subdivision 7; 103I.005, subdivisions 17a, 20a, by adding a subdivision; 119B.011, subdivisions 2, 5, 13, 19a; 119B.025, subdivision 4; 119B.03, subdivision 4a; 119B.125, subdivisions 1, 1a, 1b, 2, 3, 4, 6, 7; 119B.13, subdivisions 1, 6; 119B.16, subdivisions 1c, 3; 119B.161, subdivisions 2, 3; 119B.19, subdivision 7; 121A.335, subdivisions 3, 5, by adding a subdivision; 144.05, by adding a subdivision; 144.122; 144.1501, subdivisions 1, 2, 3, 4, 5; 144.1506, subdivision 4; 144.218, subdivisions 1, 2; 144.225, subdivision 2; 144.2252; 144.226, subdivisions 3, 4; 144.566; 144.608, subdivision 1; 144.651, by adding a subdivision; 144.653, subdivision 5; 144.7055; 144.7067, subdivision 1; 144.9501, subdivision 9; 144E.001, subdivision 1, by adding a subdivision; 144E.35; 145.4716, subdivision 3; 145.87, subdivision 4; 145.924; 145A.131, subdivisions 1, 2, 5; 145A.14, by adding a subdivision; 147A.08; 148B.392, subdivision 2; 150A.08, subdivisions 1, 5; 150A.091, by adding a subdivision; 150A.13, subdivision 10; 151.065, subdivisions 1, 2, 3, 4, 6; 151.071, subdivision 2; 151.555; 151.74, subdivisions 3, 4; 152.126, subdivisions 4, 5, 6, 9; 245.095; 245.4663, subdivision 4; 245.4889, subdivision 1; 245A.02, subdivision 2c; 245A.04, subdivisions 1, 7a; 245A.05; 245A.055, subdivision 2; 245A.06, subdivisions 1, 2, 4; 245A.07, subdivision 3; 245A.16, by adding a subdivision; 245A.50, subdivisions 3, 4, 5, 6, 9; 245C.02, subdivision 13e; 245C.04, subdivision 1; 245C.05, subdivisions 1, 2c, 4; 245C.10, subdivisions 2, 3, 4, 5, 6, 8, 9, 9a, 10, 11, 12, 13, 14, 16, 17, 20, 21, by adding a subdivision; 245C.17, subdivisions 2, 3, 6; 245C.22, subdivision 7; 245C.23, subdivisions 1, 2; 245C.32, subdivision 2; 245G.03, subdivision 1; 245H.03, subdivisions 2, 4; 245H.06, subdivisions 1, 2; 245H.07, subdivisions 1, 2; 245I.011, subdivision 3; 245I.20, subdivisions 10, 13, 14, 16; 254B.02, subdivision 5; 256.01, by adding a subdivision; 256.014, subdivisions 1, 2; 256.046, subdivision 3; 256.0471, subdivision 1; 256.962, subdivision 5; 256.969, subdivisions 2b, 9, 25, by adding a subdivision; 256.983, subdivision 5; 256B.04, by adding a subdivision; 256B.055, subdivision 17; 256B.056, subdivision 7; 256B.0625, subdivisions 9, 13, 13c, 13f, 13g, 28b, 30, 31, 34, 49, by adding subdivisions; 256B.0631, subdivision 2, by adding a subdivision; 256B.0941, by adding a subdivision; 256B.196, subdivision 2; 256B.69, subdivisions 4, 5a, 6d, 28, 36; 256B.692, subdivision 1; 256B.75; 256B.758; 256B.76, subdivisions 1, 2, 4; 256B.761; 256B.764; 256D.01, subdivision 1a; 256D.024, subdivision 1; 256D.03, by adding a subdivision; 256D.06, subdivision 5; 256D.44, subdivision 5; 256D.63, subdivision 2; 256E.34, subdivision 4; 256E.35, subdivisions 1, 2, 3, 4a, 6, 7; 256I.03, subdivisions 7, 13; 256I.04, subdivision 1; 256I.06, subdivisions 6, 8, by adding a subdivision; 256J.08,

subdivisions 71, 79; 256J.11, subdivision 1; 256J.21, subdivisions 3, 4; 256J.26, subdivision 1; 256J.33, subdivisions 1, 2; 256J.35; 256J.37, subdivisions 3, 3a; 256J.425, subdivisions 1, 4, 5, 7; 256J.46, subdivisions 1, 2, 2a; 256J.95, subdivision 19; 256L.03, subdivision 5; 256L.04, subdivisions 7a, 10, by adding a subdivision; 256L.07, subdivision 1; 256L.15, subdivision 2; 256N.26, subdivision 12; 256P.01, by adding subdivisions; 256P.02, subdivision 2, by adding subdivisions; 256P.04, subdivisions 4, 8; 256P.06, subdivision 3, by adding a subdivision; 256P.07, subdivisions 1, 2, 3, 4, 6, 7, by adding subdivisions; 259.83, subdivisions 1, 1a, 1b, by adding a subdivision; 260.761, subdivision 2; 260C.007, subdivisions 6, 14; 260C.317, subdivision 4; 260C.80, subdivision 1; 260E.01; 260E.02, subdivision 1; 260E.03, subdivision 22, by adding subdivisions; 260E.09; 260E.14, subdivisions 2, 5; 260E.17, subdivision 1; 260E.18; 260E.20, subdivision 2; 260E.24, subdivisions 2, 7; 260E.33, subdivision 1; 260E.35, subdivision 6; 270B.14, subdivision 1, by adding a subdivision; 297F.10, subdivision 1; 403.161, subdivisions 1, 3, 5, 6, 7; 403.162, subdivisions 1, 2, 5; 518A.31; 518A.32, subdivisions 3, 4; 518A.34; 518A.41; 518A.42, subdivisions 1, 3; 518A.65; 518A.77; 609B.425, subdivision 2; 609B.435, subdivision 2; Laws 2017, First Special Session chapter 6, article 5, section 11, as amended; Laws 2021, First Special Session chapter 7, article 6, section 26; article 17, section 5, subdivision 1; proposing coding for new law in Minnesota Statutes, chapters 62A; 62D; 62J; 62Q; 62V; 103I; 119B; 144; 144E; 145; 148; 245; 256B; 256E; 256K; 256N; 256P; 260; 290; proposing coding for new law as Minnesota Statutes, chapters 143; 245J; repealing Minnesota Statutes 2022, sections 62J.692, subdivisions 4a, 7, 7a; 119B.03, subdivision 4; 137.38, subdivision 1; 144.059, subdivision 10; 144.212, subdivision 11; 245C.02, subdivision 14b; 245C.032; 245C.11, subdivision 3; 245C.30, subdivision 1a; 256.8799; 256.9864; 256B.0631, subdivisions 1, 2, 3; 256B.69, subdivision 5c; 256J.08, subdivisions 10, 53, 61, 62, 81, 83; 256J.30, subdivisions 5, 7, 8; 256J.33, subdivisions 3, 4, 5; 256J.34, subdivisions 1, 2, 3, 4; 256J.37, subdivision 10; 259.83, subdivision 3; 259.89; 260C.637.

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

ARTICLE 1

HEALTH CARE

Section 1. Minnesota Statutes 2022, section 256.01, is amended by adding a subdivision to read:

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

Sec. 2. Minnesota Statutes 2022, section 256.0471, subdivision 1, is amended to read:

Subdivision 1. **Qualifying overpayment.** Any overpayment for assistance granted under ~~chapter 119B,~~ the MFIP program formerly codified under sections 256.031 to 256.0361~~,~~ and the AFDC program formerly codified under sections 256.72 to 256.871; for assistance granted under chapters ~~256B for state-funded medical assistance~~ 119B, 256D, 256I, 256J, and 256K~~, and 256L~~; for assistance granted pursuant to section 256.045, subdivision 10, for state-funded medical assistance and state-funded MinnesotaCare under chapters 256B and 256L; and for assistance granted under the Supplemental Nutrition Assistance Program (SNAP), except agency error claims, become a judgment by operation of law 90 days after the notice of overpayment is personally served upon the recipient in a manner that is sufficient under rule 4.03(a) of the Rules of Civil Procedure for district courts, or by certified mail, return receipt requested. This judgment shall be entitled to full faith and credit in this and any other state.

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

Sec. 3. Minnesota Statutes 2022, section 256.969, subdivision 2b, is amended to read:

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

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

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

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

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

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

(c) Effective for discharges occurring on and after November 1, 2014, payment rates for hospital inpatient services provided by hospitals located in Minnesota or the local trade area, except for the hospitals paid under the methodologies described in paragraph (a), clauses (2) and (3), shall be rebased, incorporating cost and payment methodologies in a manner similar to Medicare. The base year or years for the rates effective November 1, 2014, shall be calendar year 2012. The rebasing under this paragraph shall be budget neutral, ensuring that the total aggregate payments under the rebased system are equal to the total aggregate payments that were made for the same number and types of services in the base year. Separate budget neutrality calculations shall be determined for payments made to critical access hospitals and payments made to hospitals paid under the DRG system. Only the rate increases or decreases under subdivision 3a or 3c that applied to the hospitals being rebased during the entire base period shall be incorporated into the budget neutrality calculation.

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

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

(1) pediatric services;

(2) behavioral health services;

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

(4) transplant services;

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

(6) outlier admissions;

(7) low-volume providers; and

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

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

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

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

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

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

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

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

rebasing must be calculated and made available to the legislature by January 15 of each year in which rebasing is scheduled to occur, and must include by hospital the differential in payment rates compared to the individual hospital's costs.

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

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

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

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

(j) Effective for discharges occurring on or after July 1, 2023, payment rates under this section must be rebased to reflect those changes in hospital costs between the existing base year or years and one year prior to the rate year. In any year that inpatient claims volume falls below the threshold required to ensure a statistically valid sample of claims, the commissioner may combine claims data from two consecutive years to serve as the base year. Years in which inpatient claims volume is reduced or altered due to a pandemic or other public health emergency must not be used as a base year or part of a base year if the base year includes more than one year. Changes in costs between the base year or years and one year prior to the rate year must be measured using the hospital cost index defined in subdivision 1, paragraph (a). The commissioner must establish the base year for each rebasing

period considering the most recent year or years for which filed Medicare cost reports are available. The estimated change in the average payment per hospital discharge resulting from a scheduled rebasing must be calculated and made available to the legislature by January 15 of each year in which rebasing is scheduled to occur, and must include the differential in payment rates compared to the individual hospital's costs by hospital.

(k) Effective for discharges occurring on or after July 1, 2023, inpatient payment rates for critical access hospitals located in Minnesota or the local trade area must be a rate equal to 100 percent of their base year costs inflated to the year prior to the rate year using the hospital cost index defined in subdivision 1, paragraph (a).

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

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

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

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

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

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

(6) geographic location.

Sec. 4. Minnesota Statutes 2022, section 256.969, subdivision 9, is amended to read:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

$10,000,000. The department shall calculate the aggregate difference in payments for outpatient pharmacy claims for members enrolled with medical assistance prepaid health plans reimbursed at the 340B rate as compared to the non-340B rate, as defined in section 256B.0625. The department shall report the results to the chairs and ranking minority members of the legislative committees with jurisdiction over medical assistance hospital reimbursement no later than January 1 for the previous fiscal year.

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

Sec. 5. Minnesota Statutes 2022, section 256.969, subdivision 25, is amended to read:

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

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

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

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

Sec. 6. Minnesota Statutes 2022, section 256.969, is amended by adding a subdivision to read:

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

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

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

Sec. 7. Minnesota Statutes 2022, section 256B.055, subdivision 17, is amended to read:

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

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

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

Sec. 8. Minnesota Statutes 2022, section 256B.0625, subdivision 9, is amended to read:

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

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

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

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

~~(3) limited exams;~~

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

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

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

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

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

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

~~(10) anterior fillings;~~

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

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

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

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

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

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

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

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

~~(2) general anesthesia; and~~

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

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

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

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

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

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

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

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

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

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

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

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

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

Sec. 9. Minnesota Statutes 2022, section 256B.0625, subdivision 13, is amended to read:

Subd. 13. **Drugs.** (a) Medical assistance covers drugs, except for fertility drugs when specifically used to enhance fertility, if prescribed by a licensed practitioner and dispensed by a licensed pharmacist, by a physician enrolled in the medical assistance program as a dispensing physician, or by a physician, a physician assistant, or an advanced practice registered nurse employed by or under contract with a community health board as defined in section 145A.02, subdivision 5, for the purposes of communicable disease control.

(b) The dispensed quantity of a prescription drug must not exceed a 34-day supply~~,~~ unless authorized by the commissioner or as provided in paragraph (h) or the drug appears on the 90-day supply list published by the commissioner. The 90-day supply list shall be published by the commissioner on the department's website. The commissioner may add to, delete from, and otherwise modify the 90-day supply list after providing public notice and the opportunity for a 15-day public comment period. The 90-day supply list may include cost-effective generic drugs and shall not include controlled substances.

(c) For the purpose of this subdivision and subdivision 13d, an "active pharmaceutical ingredient" is defined as a substance that is represented for use in a drug and when used in the manufacturing, processing, or packaging of a drug becomes an active ingredient of the drug product. An "excipient" is defined as an inert substance used as a diluent or vehicle for a drug. The commissioner shall establish a list of active pharmaceutical ingredients and excipients which are included in the medical assistance formulary. Medical assistance covers selected active pharmaceutical ingredients and excipients used in compounded prescriptions when the compounded combination is specifically approved by the commissioner or when a commercially available product:

(1) is not a therapeutic option for the patient;

(2) does not exist in the same combination of active ingredients in the same strengths as the compounded prescription; and

(3) cannot be used in place of the active pharmaceutical ingredient in the compounded prescription.

(d) Medical assistance covers the following over-the-counter drugs when prescribed by a licensed practitioner or by a licensed pharmacist who meets standards established by the commissioner, in consultation with the board of pharmacy: antacids, acetaminophen, family planning products, aspirin, insulin, products for the treatment of lice, vitamins for adults with documented vitamin deficiencies, vitamins for children under the age of seven and pregnant or nursing women, and any other over-the-counter drug identified by the commissioner, in consultation with the Formulary Committee, as necessary, appropriate, and cost-effective for the treatment of certain specified chronic diseases, conditions, or disorders, and this determination shall not be subject to the requirements of chapter 14. A pharmacist may prescribe over-the-counter medications as provided under this paragraph for purposes of receiving reimbursement under Medicaid. When prescribing over-the-counter drugs under this paragraph, licensed pharmacists must consult with the recipient to determine necessity, provide drug counseling, review drug therapy for potential adverse interactions, and make referrals as needed to other health care professionals.

(e) Effective January 1, 2006, medical assistance shall not cover drugs that are coverable under Medicare Part D as defined in the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Public Law 108-173, section 1860D-2(e), for individuals eligible for drug coverage as defined in the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Public Law 108-173, section 1860D-1(a)(3)(A). For these individuals, medical assistance may cover drugs from the drug classes listed in United States Code, title 42, section 1396r-8(d)(2), subject to this subdivision and subdivisions 13a to 13g, except that drugs listed in United States Code, title 42, section 1396r-8(d)(2)(E), shall not be covered.

(f) Medical assistance covers drugs acquired through the federal 340B Drug Pricing Program and dispensed by 340B covered entities and ambulatory pharmacies under common ownership of the 340B covered entity. Medical assistance does not cover drugs acquired through the federal 340B Drug Pricing Program and dispensed by 340B contract pharmacies.

(g) Notwithstanding paragraph (a), medical assistance covers self-administered hormonal contraceptives prescribed and dispensed by a licensed pharmacist in accordance with section 151.37, subdivision 14; nicotine replacement medications prescribed and dispensed by a

licensed pharmacist in accordance with section 151.37, subdivision 15; and opiate antagonists used for the treatment of an acute opiate overdose prescribed and dispensed by a licensed pharmacist in accordance with section 151.37, subdivision 16.

(h) Medical assistance coverage for a prescription contraceptive must provide a 12-month supply for any prescription contraceptive if a 12-month supply is prescribed by the prescribing health care provider. The prescribing health care provider must determine the appropriate duration for which to prescribe the prescription contraceptives, up to 12 months. For purposes of this paragraph, "prescription contraceptive" means any drug or device that requires a prescription and is approved by the Food and Drug Administration to prevent pregnancy. Prescription contraceptive does not include an emergency contraceptive drug approved to prevent pregnancy when administered after sexual contact. For purposes of this paragraph, "health plan" has the meaning provided in section 62Q.01, subdivision 3.

EFFECTIVE DATE. This section applies to medical assistance and MinnesotaCare coverage effective January 1, 2024.

Sec. 10. Minnesota Statutes 2022, section 256B.0625, subdivision 13c, is amended to read:

Subd. 13c. **Formulary Committee.** The commissioner, after receiving recommendations from professional medical associations and professional pharmacy associations, and consumer groups shall designate a Formulary Committee to carry out duties as described in subdivisions 13 to 13g. The Formulary Committee shall be comprised of ~~four~~ at least five licensed physicians actively engaged in the practice of medicine in Minnesota, one of whom ~~must be actively engaged in the treatment of persons with mental illness~~ is an actively practicing psychiatrist, one of whom specializes in the diagnosis and treatment of rare diseases, one of whom specializes in pediatrics, and one of whom actively treats persons with disabilities; at least three licensed pharmacists actively engaged in the practice of pharmacy in Minnesota, one of whom practices outside the metropolitan counties listed in section 473.121, subdivision 4, one of whom practices in the metropolitan counties listed in section 473.121, subdivision 4, and one of whom is a practicing hospital pharmacist; ~~and one~~ at least four consumer ~~representative~~ representatives, all of whom must have a personal or professional connection to medical assistance; and one representative designated by the Minnesota Rare Disease Advisory Council established under section 256.4835; the remainder to be made up of health care professionals who are licensed in their field and have recognized knowledge in the clinically appropriate prescribing, dispensing, and monitoring of covered outpatient drugs. Members of the Formulary Committee shall not be employed by the Department of Human

Services, but the committee shall be staffed by an employee of the department who shall serve as an ex officio, nonvoting member of the committee. The department's medical director shall also serve as an ex officio, nonvoting member for the committee. Committee members shall serve three-year terms and may be reappointed once by the commissioner. The committee members shall vote on a chair from among their membership. The chair shall preside over all committee meetings. The Formulary Committee shall meet at least ~~twice~~ four times per year. The commissioner may require more frequent Formulary Committee meetings as needed. An honorarium of $100 per meeting and reimbursement for mileage shall be paid to each committee member in attendance. The Formulary Committee is subject to the Open Meeting Law under chapter 13D. The Formulary Committee expires June 30, ~~2023~~ 2027.

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

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

Subd. 13f. **Prior authorization.** (a) The Formulary Committee shall review and recommend drugs which require prior authorization. The Formulary Committee shall establish general criteria to be used for the prior authorization of brand-name drugs for which generically equivalent drugs are available, but the committee is not required to review each brand-name drug for which a generically equivalent drug is available.

(b) Prior authorization may be required by the commissioner before certain formulary drugs are eligible for payment. The Formulary Committee may recommend drugs for prior authorization directly to the commissioner. The commissioner may also request that the Formulary Committee review a drug for prior authorization. Before the commissioner may require prior authorization for a drug:

(1) the commissioner must provide information to the Formulary Committee on the impact that placing the drug on prior authorization may have on the quality of patient care and on program costs, information regarding whether the drug is subject to clinical abuse or misuse, and relevant data from the state Medicaid program if such data is available;

(2) the Formulary Committee must review the drug, taking into account medical and clinical data and the information provided by the commissioner; and

(3) the Formulary Committee must hold a public forum and receive public comment for an additional 15 days.

The commissioner must provide a 15-day notice period before implementing the prior authorization.

(c) Except as provided in subdivision 13j, prior authorization shall not be required or utilized for any atypical antipsychotic drug prescribed for the treatment of mental illness if:

(1) there is no generically equivalent drug available; and

(2) the drug was initially prescribed for the recipient prior to July 1, 2003; or

(3) the drug is part of the recipient's current course of treatment.

This paragraph applies to any multistate preferred drug list or supplemental drug rebate program established or administered by the commissioner. Prior authorization shall automatically be granted for 60 days for brand name drugs prescribed for treatment of mental illness within 60 days of when a generically equivalent drug becomes available, provided that the brand name drug was part of the recipient's course of treatment at the time the generically equivalent drug became available.

(d) Prior authorization shall not be required or utilized for:

(1) any liquid form of a medication for a patient who utilizes tube feedings of any kind, even if such patient has or had any paid claims for pills; and

(2) liquid methadone. If more than one version of liquid methadone is available, the commissioner shall select the version of liquid methadone that does not require prior authorization.

This paragraph applies to any multistate preferred drug list or supplemental drug rebate program established or administered by the commissioner.

(e) The commissioner may require prior authorization for brand name drugs whenever a generically equivalent product is available, even if the prescriber specifically indicates "dispense as written-brand necessary" on the prescription as required by section 151.21, subdivision 2.

~~(e)~~ (f) Notwithstanding this subdivision, the commissioner may automatically require prior authorization, for a period not to exceed 180 days, for any drug that is approved by the United States Food and Drug Administration on or after July 1, 2005. The 180-day period begins no later than the first day that a drug is available for shipment to pharmacies within the state. The Formulary Committee shall recommend to the commissioner general criteria to be used for the prior authorization of the drugs, but the committee is not required to review each individual drug. In order to continue prior authorizations for a drug after the 180-day period has expired, the commissioner must follow the provisions of this subdivision.

~~(f)~~ (g) Prior authorization under this subdivision shall comply with section 62Q.184.

~~(g)~~ (h) Any step therapy protocol requirements established by the commissioner must comply with section 62Q.1841.

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

Subd. 13g. **Preferred drug list.** (a) The commissioner shall adopt and implement a preferred drug list by January 1, 2004. The commissioner may enter into a contract with a vendor for the purpose of participating in a preferred drug list and supplemental rebate program. The terms of the contract with the vendor must be publicly disclosed on the website of the Department of Human Services. The commissioner shall ensure that any contract meets all federal requirements and maximizes federal financial participation. The commissioner shall publish the preferred drug list annually in the State Register and shall maintain an accurate and up-to-date list on the agency website. The commissioner shall implement and maintain an accurate archive of previous versions of the preferred drug list, and make this archive available to the public on the website of the Department of Human Services beginning January 1, 2024.

(b) The commissioner may add to, delete from, and otherwise modify the preferred drug list, after consulting with the Formulary Committee ~~and~~, appropriate medical specialists ~~and~~ , appropriate patient advocacy groups, and the Minnesota Rare Disease Advisory Council; providing public notice and the opportunity for public comment; and complying with the requirements of paragraph (f).

(c) The commissioner shall adopt and administer the preferred drug list as part of the administration of the supplemental drug rebate program. Reimbursement for prescription drugs not on the preferred drug list may be subject to prior authorization.

(d) For purposes of this subdivision, the following definitions apply:

(1) "appropriate medical specialist" means a medical professional who prescribes the relevant class of drug as part of their subspecialty;

(2) "patient advocacy group" means a nonprofit organization as described in United States Code, title 26, section 501(c)(3), that is exempt from income tax under United States Code, title 26, section 501(a), or a public entity that supports persons with the disease state treated by the therapeutic class of the preferred drug list being updated; and

(3) "preferred drug list" means a list of prescription drugs within designated therapeutic classes selected by the commissioner, for which prior authorization based on the identity of the drug or class is not required.

(e) The commissioner shall seek any federal waivers or approvals necessary to implement this subdivision. The commissioner shall maintain a public list of applicable patient advocacy groups.

(f) ~~Notwithstanding paragraph (b),~~ Before the commissioner may delete a drug from the preferred drug list or modify the inclusion of a drug on the preferred drug list, the commissioner shall consider any implications that the deletion or modification may have on state public health policies or initiatives and any impact that the deletion or modification may have on increasing health disparities in the state. Prior to deleting a drug or modifying the inclusion of a drug, the commissioner shall also conduct a public hearing. The commissioner shall provide adequate notice to the public and the commissioner of health prior to the hearing that specifies the drug that the commissioner is proposing to delete or modify, and shall disclose any ~~public~~ medical or clinical analysis that the commissioner has relied on in proposing the deletion or modification, and evidence that the commissioner has evaluated the impact of the proposed deletion or modification on public health and health disparities. Notwithstanding section 331A.05, a public notice of a Formulary Committee meeting must be published at least 30 days in advance of the meeting. The list of drugs to be discussed at the meeting must be announced at least 30 days before the meeting and must include the name and class of drug, the proposed action, and the proposed prior authorization requirements, if applicable.

Sec. 13. Minnesota Statutes 2022, section 256B.0625, subdivision 28b, is amended to read:

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

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

Sec. 14. Minnesota Statutes 2022, section 256B.0625, subdivision 30, is amended to read:

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

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

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

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

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

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

(g) Effective for services provided on or after January 1, 2021, all claims for payment of clinic services provided by FQHCs and rural health clinics shall be paid by the commissioner, according to an annual election by the FQHC or rural health clinic, under the current prospective payment system described in paragraph (f) or the alternative payment methodology described in paragraph (l), or, upon federal approval, for FQHCs that are also urban Indian organizations under Title V of the federal Indian Health Improvement Act, as provided under paragraph (k).

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

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

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

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

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

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

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

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

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

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

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

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

~~provides services to American Indian and Alaskan Native individuals eligible for services under this subdivision.~~

(k) The commissioner shall establish an encounter payment rate that is equivalent to the all inclusive rate (AIR) payment established by the Indian Health Service and published in the Federal Register. The encounter rate must be updated annually and must reflect the changes in the AIR established by the Indian Health Service each calendar year. FQHCs that are also urban Indian organizations under Title V of the federal Indian Health Improvement Act may elect to be paid: (1) at the encounter rate established under this paragraph; (2) under the alternative payment methodology described in paragraph (l); or (3) under the federally required prospective payment system described in paragraph (f). FQHCs that elect to be paid at the encounter rate established under this paragraph must

continue to meet all state and federal requirements related to FQHCs and urban Indian organizations, and must maintain their statuses as FQHCs and urban Indian organizations.

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

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

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

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

(i) general social services and administrative costs;

(ii) retail pharmacy;

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

(iv) external lab and x-ray;

(v) navigation services;

(vi) health care taxes;

(vii) advertising, public relations, and marketing;

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

(ix) contributions and donations;

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

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

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

(xiii) research and associated administrative costs;

(xiv) nonpaid workers;

(xv) lobbying;

(xvi) scholarships and student aid; and

(xvii) nonmedical assistance covered services;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(12) the commissioner, when establishing organization encounter rates for new FQHCs and rural health clinics, shall consider the patient caseload of existing FQHCs and rural

health clinics in a 60-mile radius for organizations established outside of the seven-county metropolitan area, and in a 30-mile radius for organizations in the seven-county metropolitan area. If this information is not available, the commissioner may use Medicare cost reports or audited financial statements to establish base rates;

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

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

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

EFFECTIVE DATE. This section is effective January 1, 2026, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 15. Minnesota Statutes 2022, section 256B.0625, subdivision 31, is amended to read:

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

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

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

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

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

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

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

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

(1) can withstand repeated use;

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

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

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

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

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

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

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

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

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

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

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

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

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

Sec. 16. Minnesota Statutes 2022, section 256B.0625, subdivision 34, is amended to read:

Subd. 34. **Indian health services facilities.** ~~(a)~~ Medical assistance payments and MinnesotaCare payments to facilities of the Indian health service and facilities operated by a Tribe or Tribal organization under funding authorized by United States Code, title 25, sections 450f to 450n, or title III of the Indian Self-Determination and Education Assistance Act, Public Law 93-638, for enrollees who are eligible for federal financial participation, shall be at the option of the facility in accordance with the rate published by the United States Assistant Secretary for Health under the authority of United States Code, title 42,

sections 248(a) and 249(b). MinnesotaCare payments for enrollees who are not eligible for federal financial participation at facilities of the Indian health service and facilities operated by a Tribe or Tribal organization for the provision of outpatient medical services must be in accordance with the medical assistance rates paid for the same services when provided in a facility other than a facility of the Indian health service or a facility operated by a Tribe or Tribal organization.

~~(b) Effective upon federal approval, the medical assistance payments to a dually certified facility as defined in subdivision 30, paragraph (j), shall be the encounter rate described in paragraph (a) or a rate that is substantially equivalent for services provided to American Indians and Alaskan Native populations. The rate established under this paragraph for dually certified facilities shall not apply to MinnesotaCare payments.~~

EFFECTIVE DATE. This section is effective January 1, 2026, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 17. Minnesota Statutes 2022, section 256B.0625, is amended by adding a subdivision to read:

Subd. 68. **Biomarker testing.** Medical assistance covers biomarker testing to diagnose, treat, manage, and monitor illness or disease. Medical assistance coverage must meet the requirements that would otherwise apply to a health plan under section 62Q.473.

EFFECTIVE DATE. This section is effective January 1, 2025, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

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

Subd. 69. **Recuperative care services.** Medical assistance covers recuperative care services according to section 256B.0701.

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

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

Subd. 70. **Coverage of services for the diagnosis, monitoring, and treatment of rare diseases.** (a) Medical assistance coverage for services related to the diagnosis, monitoring, and treatment of a rare disease or condition must meet the requirements in section 62Q.451.

(b) Nothing in this subdivision requires a managed care or county-based purchasing plan to provide coverage for a service that is not covered under medical assistance.

(c) Coverage for a service must not be denied solely on the basis that it was provided, referred for, or ordered by an out-of-network provider.

(d) Any prior authorization requirements for a service that is provided by, referred for, or ordered by an out-of-network provider must be the same as any prior authorization requirements for a service that is provided by, referred for, or ordered by an in-network provider.

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

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

Subd. 70a. **Payments to out-of-network providers for services provided in Minnesota.** (a) If a managed care or county-based purchasing plan has an established contractual payment under medical assistance with an out-of-network provider for a service provided in Minnesota related to the diagnosis, monitoring, and treatment of a rare disease or condition, then the provider must accept the established contractual payment for that service as payment in full.

(b) If a plan does not have an established contractual payment under medical assistance with an out-of-network provider for a service provided in Minnesota related to the diagnosis, monitoring, and treatment of a rare disease or condition, then the provider must accept the provider's established rate for uninsured patients for that service as payment in full. If the provider does not have an established rate for uninsured patients for that service, then the provider must accept the fee-for-service rate.

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

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

Subd. 70b. **Payments to out-of-network providers when services are provided outside of Minnesota.** (a) If a managed care or county-based purchasing plan has an established contractual payment under medical assistance with an out-of-network provider for a service provided in another state related to diagnosis, monitoring, and treatment of a rare disease or condition, then the plan must pay the established contractual payment for that service.

(b) If a plan does not have an established contractual payment under medical assistance with an out-of-network provider for a service provided in another state related to diagnosis, monitoring, and treatment of a rare disease or condition, then the plan must pay the provider's established rate for uninsured patients for that service. If the provider does not have an established rate for uninsured patients for that service, then the plan must pay the provider the fee-for-service rate in that state.

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

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

Subd. 71. **Coverage and payment for pharmacy services.** (a) Medical assistance coverage for services provided by a licensed physician must include coverage for services provided by a licensed pharmacist to the extent a licensed pharmacist's services are within the pharmacist's scope of practice. This requirement applies to services provided (1) under fee-for-service medical assistance, and (2) by a managed care plan under section 256B.69 or a county-based purchasing plan under section 256B.692.

(b) The commissioner, and managed care and county-based purchasing plans when providing services under sections 256B.69 and 256B.692, must reimburse a participating pharmacist or pharmacy for a service that is also within a physician's scope of practice at an amount no lower than the standard payment rate that would be applied when reimbursing a physician for the service.

EFFECTIVE DATE. This section is effective January 1, 2025, or upon federal approval, whichever is later. The commissioner of human services must notify the revisor of statutes when federal approval is obtained.

Sec. 23. Minnesota Statutes 2022, section 256B.0631, subdivision 2, is amended to read:

Subd. 2. **Exceptions.** Co-payments and deductibles shall be subject to the following exceptions:

(1) children under the age of 21;

(2) pregnant women for services that relate to the pregnancy or any other medical condition that may complicate the pregnancy;

(3) recipients expected to reside for at least 30 days in a hospital, nursing home, or intermediate care facility for the developmentally disabled;

(4) recipients receiving hospice care;

(5) 100 percent federally funded services provided by an Indian health service;

(6) emergency services;

(7) family planning services, including but not limited to the placement and removal of long-acting reversible contraceptives;

(8) services that are paid by Medicare, resulting in the medical assistance program paying for the coinsurance and deductible;

(9) co-payments that exceed one per day per provider for nonpreventive visits, eyeglasses, and nonemergency visits to a hospital-based emergency room;

(10) services, fee-for-service payments subject to volume purchase through competitive bidding;

(11) American Indians who meet the requirements in Code of Federal Regulations, title 42, sections 447.51 and 447.56;

(12) persons needing treatment for breast or cervical cancer as described under section 256B.057, subdivision 10; ~~and~~

(13) services that currently have a rating of A or B from the United States Preventive Services Task Force (USPSTF), immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention, and preventive services and screenings provided to women as described in Code of Federal Regulations, title 45, section 147.130~~.~~; and

(14) additional diagnostic services or testing that a health care provider determines an enrollee requires after a mammogram, as specified under section 62A.30, subdivision 5.

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

Sec. 24. **[256B.0701] RECUPERATIVE CARE SERVICES.**

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

(b) "Provider" means a recuperative care provider as defined by the standards established by the National Institute for Medical Respite Care.

(c) "Recuperative care" means a model of care that prevents hospitalization or that provides postacute medical care and support services for recipients experiencing homelessness who are too ill or frail to recover from a physical illness or injury while living in a shelter or are otherwise unhoused but who are not sick enough to be hospitalized or remain hospitalized, or to need other levels of care.

Subd. 2. **Recuperative care settings.** Recuperative care may be provided in any setting, including but not limited to homeless shelters, congregate care settings, single room occupancy settings, or supportive housing, so long as the provider of recuperative care or provider of housing is able to provide to the recipient within the designated setting, at a minimum:

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

(2) access to three meals a day;

(3) availability to environmental services;

(4) access to a telephone;

(5) a secure place to store belongings; and

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

Subd. 3. **Eligibility.** To be eligible for recuperative care service, a recipient must:

(1) be 21 years of age or older;

(2) be experiencing homelessness;

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

(4) meet clinical criteria, as established by the commissioner, that indicates that the recipient needs recuperative care; and

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

Subd. 4. **Total payment rates.** Total payment rates for recuperative care consist of the recuperative care services rate and the recuperative care facility rate.

Subd. 5. **Recuperative care services rate.** The recuperative care services rate is for the services provided to the recipient and must be a bundled daily per diem payment of at least $300 per day. Services provided within the bundled payment may include but are not limited to:

(1) basic nursing care, including:

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

(ii) providing wound care;

(iii) medication support;

(iv) patient education;

(v) immunization review and update; and

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

(2) care coordination, including:

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

(ii) development of a care plan;

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

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

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

(4) services provided by a community health worker as defined under section 256B.0625, subdivision 49.

Subd. 6. **Recuperative care facility rate.** (a) The recuperative care facility rate is for facility costs and must be paid from state money in an amount equal to the medical assistance room and board rate at the time the recuperative care services were provided. The eligibility standards in chapter 256I do not apply to the recuperative care facility rate. The recuperative care facility rate is only paid when the recuperative care services rate is paid to a provider. Providers may opt to only receive the recuperative care services rate.

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

Subd. 7. **Extended stay.** If a recipient requires care exceeding the 60-day limit described in subdivision 3, the provider may request in a format prescribed by the commissioner an extension to continue payments until the recipient is discharged.

Subd. 8. **Report.** (a) The commissioner must submit an initial report to the chairs and ranking minority members of the legislative committees having jurisdiction over health and human services by February 1, 2025, and a final report by February 1, 2027, on coverage of recuperative care services. The reports must include but are not limited to:

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

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

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

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

(b) This subdivision expires upon submission of the final report.

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

Sec. 25. Minnesota Statutes 2022, section 256B.196, subdivision 2, is amended to read:

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

in order to maximize the additional total payments. The commissioner shall inform Hennepin County and Ramsey County of the periodic intergovernmental transfers necessary to match federal Medicaid payments available under this subdivision in order to make supplementary medical assistance payments to Hennepin County Medical Center and Regions Hospital equal to an amount that when combined with existing medical assistance payments to nonstate governmental hospitals would increase total payments to hospitals in this category for outpatient services to the aggregate upper payment limit for all hospitals in this category in Minnesota. Upon receipt of these periodic transfers, the commissioner shall make supplementary payments to Hennepin County Medical Center and Regions Hospital.

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

(c) Beginning January 1, 2010, Ramsey County may make monthly voluntary intergovernmental transfers to the commissioner in amounts not to exceed $6,000,000 per year. The commissioner shall increase the medical assistance capitation payments to any licensed health plan under contract with the medical assistance program that agrees to make enhanced payments to Regions Hospital. The increase shall be in an amount equal to the annual value of the monthly transfers plus federal financial participation, with each health plan receiving its pro rata share of the increase based on the pro rata share of medical assistance admissions to Regions Hospital by those plans. For the purposes of this paragraph, "the base amount" means the total annual value of increased medical assistance capitation payments, including the voluntary intergovernmental transfers, under this paragraph in

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

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

(e) For the purposes of this subdivision and subdivision 3, the commissioner shall determine an upper payment limit for physicians, dentists, and other billing professionals affiliated with the University of Minnesota and University of Minnesota Physicians. The upper payment limit shall be based on the average commercial rate or be determined using another method acceptable to the Centers for Medicare and Medicaid Services. The commissioner shall inform the University of Minnesota Medical School and University of Minnesota School of Dentistry of the periodic intergovernmental transfers necessary to

match the federal Medicaid payments available under this subdivision in order to make supplementary payments to physicians, dentists, and other billing professionals affiliated with the University of Minnesota and the University of Minnesota Physicians equal to the difference between the established medical assistance payment for physician, dentist, and other billing professional services and the upper payment limit. Upon receipt of these periodic transfers, the commissioner shall make supplementary payments to physicians, dentists, and other billing professionals affiliated with the University of Minnesota and the University of Minnesota Physicians.

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

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

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

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

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

Sec. 26. Minnesota Statutes 2022, section 256B.69, subdivision 4, is amended to read:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Children under age 21 who are in foster placement may enroll in the project on an elective basis. Individuals excluded under clauses (1), (6), and (7) may choose to enroll on an elective basis. The commissioner may enroll recipients in the prepaid medical assistance program

for seniors who are (1) age 65 and over, and (2) eligible for medical assistance by spending down excess income.

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

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

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

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

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

Sec. 27. Minnesota Statutes 2022, section 256B.69, subdivision 5a, is amended to read:

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

(b) A prepaid health plan providing covered health services for eligible persons pursuant to chapters 256B and 256L is responsible for complying with the terms of its contract with

the commissioner. Requirements applicable to managed care programs under chapters 256B and 256L established after the effective date of a contract with the commissioner take effect when the contract is next issued or renewed.

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

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

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

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

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

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

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

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

~~in a managed care or county-based purchasing plan's membership in the baseline year compared to the measurement year, and work with the managed care or county-based purchasing plan to account for differences that they agree are significant.~~

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

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

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

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

~~The withhold described in this paragraph must continue for each consecutive contract period until the plan's subsequent hospitalization rate for medical assistance and MinnesotaCare enrollees, excluding enrollees in programs described in subdivisions 23 and~~

~~28, is reduced by 25 percent of the plan's subsequent hospitalization rate for calendar year 2011. Hospitals shall cooperate with the plans in meeting this performance target and shall accept payment withholds that must be returned to the hospitals if the performance target is achieved.~~

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

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

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

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

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

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

Nothing in this paragraph shall allow release of information that is nonpublic data pursuant to section 13.02.

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

Sec. 28. Minnesota Statutes 2022, section 256B.69, subdivision 6d, is amended to read:

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

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

EFFECTIVE DATE. The amendments to paragraph (a) are effective January 1, 2026, or the January 1 following certification of the modernized pharmacy claims processing system, whichever is later. Paragraph (b) is effective January 1, 2024, or upon federal approval, whichever is later. The commissioner must inform the revisor of statutes when federal approval is obtained and when certification of the modernized pharmacy claims processing system occurs.

Sec. 29. Minnesota Statutes 2022, section 256B.69, subdivision 28, is amended to read:

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

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

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

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

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

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

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

(a) and (b). The stakeholder group shall provide advice on program expansions under this subdivision and subdivision 23, including:

(1) implementation efforts;

(2) consumer protections; and

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

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

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

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

Sec. 30. Minnesota Statutes 2022, section 256B.69, subdivision 36, is amended to read:

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

(b) The enrollee support system must:

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

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

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

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

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

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

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

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

Sec. 31. Minnesota Statutes 2022, section 256B.692, subdivision 1, is amended to read:

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

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

Sec. 32. Minnesota Statutes 2022, section 256B.75, is amended to read:

256B.75 HOSPITAL OUTPATIENT REIMBURSEMENT.

(a) For outpatient hospital facility fee payments for services rendered on or after October 1, 1992, the commissioner of human services shall pay the lower of (1) submitted charge, or (2) 32 percent above the rate in effect on June 30, 1992, except for those services for which there is a federal maximum allowable payment. Effective for services rendered on or after January 1, 2000, payment rates for nonsurgical outpatient hospital facility fees and

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

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

(c) The rate described in paragraph (b) must be increased for hospitals providing high levels of 340B drugs. The rate adjustment must be based on four percent of each hospital's share of the total reimbursement for 340B drugs to all critical access hospitals, but must not exceed $3,000,000.

~~(c)~~ (d) Effective for services provided on or after July 1, 2003, rates that are based on the Medicare outpatient prospective payment system shall be replaced by a budget neutral prospective payment system that is derived using medical assistance data. The commissioner shall provide a proposal to the 2003 legislature to define and implement this provision.

When implementing prospective payment methodologies, the commissioner shall use general methods and rate calculation parameters similar to the applicable Medicare prospective payment systems for services delivered in outpatient hospital and ambulatory surgical center settings unless other payment methodologies for these services are specified in this chapter.

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

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

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

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

Sec. 33. Minnesota Statutes 2022, section 256B.758, is amended to read:

256B.758 REIMBURSEMENT FOR DOULA SERVICES.

(a) Effective for services provided on or after July 1, 2019, through December 31, 2023, payments for doula services provided by a certified doula shall be $47 per prenatal or postpartum visit and $488 for attending and providing doula services at a birth.

(b) Effective for services provided on or after January 1, 2024, payments for doula services provided by a certified doula are $100 per prenatal or postpartum visit and $1,400 for attending and providing doula services at birth.

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

Sec. 34. Minnesota Statutes 2022, section 256B.76, subdivision 1, is amended to read:

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

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

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

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

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

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

(d) Effective for services rendered on or after July 1, 2010, payment rates for physician and professional services shall be reduced an additional seven percent over the five percent

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

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

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

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

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

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

Sec. 35. Minnesota Statutes 2022, section 256B.76, subdivision 2, is amended to read:

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

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

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

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

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

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

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

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

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

~~(h) Effective for services rendered on or after January 1, 2014, through December 31, 2021, payment rates for dental services shall be increased by five percent from the rates in effect on December 31, 2013. This increase does not apply to state-operated dental clinics~~

~~in paragraph (f), federally qualified health centers, rural health centers, and Indian health services. Effective January 1, 2014, payments made to managed care plans and county-based purchasing plans under sections 256B.69, 256B.692, and 256L.12 shall reflect the payment increase described in this paragraph.~~

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

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

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

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

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

approval is not received for this paragraph, the commissioner shall not implement this paragraph for subsequent coverage years.

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

(l) Beginning January 1, 2027, and every three years thereafter, the commissioner shall rebase payment rates for dental services to a percentile of submitted charges for the applicable base year using charge data from claims paid by the commissioner so that the total aggregate expenditures does not exceed the total spend as outlined in paragraph (k) plus the change in the Medicare Economic Index (MEI). In 2027, the change in the MEI must be measured from midyear of 2024 and 2026. For each subsequent rebasing, the change in the MEI must be measured between the years that are one year after the rebasing years. The base year used for each rebasing must be the calendar year that is two years prior to the effective date of the rebasing. This paragraph does not apply to federally qualified health centers, rural health centers, state-operated dental clinics, or Indian health centers.

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

Sec. 36. Minnesota Statutes 2022, section 256B.76, subdivision 4, is amended to read:

Subd. 4. **Critical access dental providers.** ~~(a) The commissioner shall increase reimbursements to dentists and dental clinics deemed by the commissioner to be critical access dental providers. For dental services rendered on or after July 1, 2016, through December 31, 2021, the commissioner shall increase reimbursement by 37.5 percent above the reimbursement rate that would otherwise be paid to the critical access dental provider, except as specified under paragraph (b). The commissioner shall pay the managed care plans and county-based purchasing plans in amounts sufficient to reflect increased reimbursements to critical access dental providers as approved by the commissioner.~~

~~(b) For dental services rendered on or after July 1, 2016, through December 31, 2021, by a dental clinic or dental group that meets the critical access dental provider designation under paragraph (f), clause (4), and is owned and operated by a health maintenance organization licensed under chapter 62D, the commissioner shall increase reimbursement~~

~~by 35 percent above the reimbursement rate that would otherwise be paid to the critical access provider.~~

~~(c)~~ (a) The commissioner shall increase reimbursement to dentists and dental clinics deemed by the commissioner to be critical access dental providers. For dental services provided on or after January 1, 2022, by a dental provider deemed to be a critical access dental provider under paragraph (f), the commissioner shall increase reimbursement by 20 percent above the reimbursement rate that would otherwise be paid to the critical access dental provider. This paragraph does not apply to federally qualified health centers, rural health centers, state-operated dental clinics, or Indian health centers.

~~(d)~~ (b) Managed care plans and county-based purchasing plans shall increase reimbursement to critical access dental providers by at least the amount specified in paragraph (c). If, for any coverage year, federal approval is not received for this paragraph, the commissioner must adjust the capitation rates paid to managed care plans and county-based purchasing plans for that contract year to reflect the removal of this provision. Contracts between managed care plans and county-based purchasing plans and providers to whom this paragraph applies must allow recovery of payments from those providers if capitation rates are adjusted in accordance with this paragraph. Payment recoveries must not exceed an amount equal to any increase in rates that results from this provision. If, for any coverage year, federal approval is not received for this paragraph, the commissioner shall not implement this paragraph for subsequent coverage years.

~~(e)~~ (c) Critical access dental payments made under this subdivision for dental services provided by a critical access dental provider to an enrollee of a managed care plan or county-based purchasing plan must not reflect any capitated payments or cost-based payments from the managed care plan or county-based purchasing plan. The managed care plan or county-based purchasing plan must base the additional critical access dental payment on the amount that would have been paid for that service had the dental provider been paid according to the managed care plan or county-based purchasing plan's fee schedule that applies to dental providers that are not paid under a capitated payment or cost-based payment.

~~(f)~~ (d) The commissioner shall designate the following dentists and dental clinics as critical access dental providers:

(1) nonprofit community clinics that:

(i) have nonprofit status in accordance with chapter 317A;

(ii) have tax exempt status in accordance with the Internal Revenue Code, section 501(c)(3);

(iii) are established to provide oral health services to patients who are low income, uninsured, have special needs, and are underserved;

(iv) have professional staff familiar with the cultural background of the clinic's patients;

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

(vi) do not restrict access or services because of a patient's financial limitations or public assistance status; and

(vii) have free care available as needed;

(2) federally qualified health centers, rural health clinics, and public health clinics;

(3) hospital-based dental clinics owned and operated by a city, county, or former state hospital as defined in section 62Q.19, subdivision 1, paragraph (a), clause (4);

(4) a dental clinic or dental group owned and operated by a nonprofit corporation in accordance with chapter 317A with more than 10,000 patient encounters per year with patients who are uninsured or covered by medical assistance or MinnesotaCare;

(5) a dental clinic owned and operated by the University of Minnesota or the Minnesota State Colleges and Universities system; and

(6) private practicing dentists if:

(i) the dentist's office is located within the seven-county metropolitan area and more than 50 percent of the dentist's patient encounters per year are with patients who are uninsured or covered by medical assistance or MinnesotaCare; or

(ii) the dentist's office is located outside the seven-county metropolitan area and more than 25 percent of the dentist's patient encounters per year are with patients who are uninsured or covered by medical assistance or MinnesotaCare.

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

Sec. 37. Minnesota Statutes 2022, section 256B.761, is amended to read:

256B.761 REIMBURSEMENT FOR MENTAL HEALTH SERVICES.

(a) Effective for services rendered on or after July 1, 2001, payment for medication management provided to psychiatric patients, outpatient mental health services, day treatment services, home-based mental health services, and family community support services shall be paid at the lower of (1) submitted charges, or (2) 75.6 percent of the 50th percentile of 1999 charges.

(b) Effective July 1, 2001, the medical assistance rates for outpatient mental health services provided by an entity that operates: (1) a Medicare-certified comprehensive outpatient rehabilitation facility; and (2) a facility that was certified prior to January 1, 1993, with at least 33 percent of the clients receiving rehabilitation services in the most recent calendar year who are medical assistance recipients, will be increased by 38 percent, when those services are provided within the comprehensive outpatient rehabilitation facility and provided to residents of nursing facilities owned by the entity.

(c) In addition to rate increases otherwise provided, the commissioner may restructure coverage policy and rates to improve access to adult rehabilitative mental health services under section 256B.0623 and related mental health support services under section 256B.021, subdivision 4, paragraph (f), clause (2). For state fiscal years 2015 and 2016, the projected state share of increased costs due to this paragraph is transferred from adult mental health grants under sections 245.4661 and 256E.12. The transfer for fiscal year 2016 is a permanent base adjustment for subsequent fiscal years. Payments made to managed care plans and county-based purchasing plans under sections 256B.69, 256B.692, and 256L.12 shall reflect the rate changes described in this paragraph.

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

(e) Effective for services rendered on or after January 1, 2024, payment rates for behavioral health services included in the rate analysis required by Laws 2021, First Special Session chapter 7, article 17, section 18, must be increased by 35 percent from the rates in effect on December 31, 2023. Effective for services rendered on or after January 1, 2025, payment rates for behavioral health services included in the rate analysis required by Laws 2021, First Special Session chapter 7, article 17, section 18, must be annually adjusted according to the Consumer Price Index for medical care services. This paragraph does not apply to federally qualified health centers, rural health centers, Indian health services, certified community behavioral health clinics, cost-based rates, and rates that are negotiated with the county. This paragraph expires upon legislative implementation of the new rate methodology resulting from the rate analysis required by Laws 2021, First Special Session chapter 7, article 17, section 18.

(f) Effective January 1, 2024, the commissioner shall increase capitation payments made to managed care plans and county-based purchasing plans to reflect the behavioral health service rate increase provided in paragraph (e). Managed care and county-based purchasing plans must use the capitation rate increase provided under this paragraph to increase payment rates to behavioral health services providers. The commissioner must monitor the effect of

this rate increase on enrollee access to behavioral health services. If for any contract year federal approval is not received for this paragraph, the commissioner must adjust the capitation rates paid to managed care plans and county-based purchasing plans for that contract year to reflect the removal of this provision. Contracts between managed care plans and county-based purchasing plans and providers to whom this paragraph applies must allow recovery of payments from those providers if capitation rates are adjusted in accordance with this paragraph. Payment recoveries must not exceed the amount equal to any increase in rates that results from this provision.

Sec. 38. Minnesota Statutes 2022, section 256B.764, is amended to read:

256B.764 REIMBURSEMENT FOR FAMILY PLANNING SERVICES.

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

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

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

Sec. 39. Minnesota Statutes 2022, section 256L.03, subdivision 5, is amended to read:

Subd. 5. **Cost-sharing.** (a) Co-payments, coinsurance, and deductibles do not apply to children under the age of 21 ~~and~~; to American Indians as defined in Code of Federal Regulations, title 42, section 600.5; or to pre-exposure prophylaxis (PrEP) and postexposure prophylaxis (PEP) medications when used for the prevention or treatment of the human immunodeficiency virus (HIV).

(b) The commissioner shall adjust co-payments, coinsurance, and deductibles for covered services in a manner sufficient to maintain the actuarial value of the benefit to 94 percent.

The cost-sharing changes described in this paragraph do not apply to eligible recipients or services exempt from cost-sharing under state law. The cost-sharing changes described in this paragraph shall not be implemented prior to January 1, 2016.

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

(d) Co-payments, coinsurance, and deductibles do not apply to additional diagnostic services or testing that a health care provider determines an enrollee requires after a mammogram, as specified under section 62A.30, subdivision 5.

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

Sec. 40. Laws 2021, First Special Session chapter 7, article 6, section 26, is amended to read:

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

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

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

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

Sec. 41. **REPORT; MODIFY WITHHOLD PROVISIONS.**

By January 1, 2024, the commissioner of human services must submit a report to the chairs and ranking minority members of the legislative committees with jurisdiction over human services finance and policy evaluating the utility of the performance targets described

in Minnesota Statutes, section 256B.69, subdivision 5a, paragraphs (e) to (g). The report must include the applicable performance rates of managed care organizations and county-based purchasing plans in the past three years, projected impacts on performance rates for the next three years resulting from a repeal of Minnesota Statutes, section 256B.69, subdivision 5a, paragraphs (e) to (g), measures that the commissioner anticipates taking to continue monitoring and improving the applicable performance rates of managed care organizations and county-based purchasing plans upon a repeal of Minnesota Statutes, section 256B.69, subdivision 5a, paragraphs (e) to (g), proposals for additional performance targets that may improve quality of care for enrollees, and any additional legislative actions that may be required as the result of a repeal of Minnesota Statutes, section 256B.69, subdivision 5a, paragraphs (e) to (g).

ARTICLE 2
HEALTH INSURANCE

Section 1. Minnesota Statutes 2022, section 62A.02, subdivision 1, is amended to read:

Subdivision 1. **Filing.** (a) For purposes of this section, "health plan" means a health plan as defined in section 62A.011 or a policy of accident and sickness insurance as defined in section 62A.01. No health plan shall be issued or delivered to any person in this state, nor shall any application, rider, or endorsement be used in connection with the health plan, until a copy of its form and of the classification of risks and the premium rates pertaining to the form have been filed with the commissioner. The filing for nongroup health plan forms shall include a statement of actuarial reasons and data to support the rate. For health benefit plans as defined in section 62L.02, and for health plans to be issued to individuals, the health carrier shall file with the commissioner the information required in section 62L.08, subdivision 8. For group health plans for which approval is sought for sales only outside of the small employer market as defined in section 62L.02, this section applies only to policies or contracts of accident and sickness insurance. All forms intended for issuance in the individual or small employer market must be accompanied by a statement as to the expected loss ratio for the form. Premium rates and forms relating to specific insureds or proposed insureds, whether individuals or groups, need not be filed, unless requested by the commissioner.

(b) The filing must include the health plan's prescription drug formulary. Proposed revisions to the health plan's prescription drug formulary must be filed with the commissioner no later than August 1 of the application year.

(c) The provisions of paragraph (b) shall not be severable from section 62Q.83. If any provision of paragraph (b) or its application to any individual, entity, or circumstance is found to be void for any reason, section 62Q.83 shall be void also.

Sec. 2. **[62A.0412] COVERAGE OF INFERTILITY TREATMENT.**

Subdivision 1. **Scope.** This section applies to all large group health plans that provide maternity benefits to Minnesota residents. This section only applies to large group health plans.

Subd. 2. **Required coverage.** (a) Every health plan under subdivision 1 must provide comprehensive coverage for the diagnosis of infertility, treatment for infertility, and standard fertility preservation services that are:

(1) considered medically necessary by the enrollee's treating health care provider; and

(2) recognized by either the American Society for Reproductive Medicine, the American College of Obstetrics and Gynecologists, or the American Society of Clinical Oncology.

(b) Coverage under this section must include but is not limited to ovulation induction, procedures and devices to monitor ovulation, artificial insemination, oocyte retrieval procedures, in vitro fertilization, gamete intrafallopian transfer, oocyte replacement, cryopreservation techniques, micromanipulation of gametes, and standard fertility preservation services.

(c) Coverage under this section must include unlimited embryo transfers, but may impose a limit of four completed oocyte retrievals. Single embryo transfer must be used when medically appropriate and recommended by the treating health care provider.

(d) Coverage for surgical reversal of elective sterilization is not required under this section.

(e) Cost-sharing requirements, including co-payments, deductibles, and coinsurance for infertility coverage, must not be greater than the cost-sharing requirements for maternity coverage under the enrollee's health plan.

(f) Health plans under subdivision 1 may not include in the coverage under this section:

(1) any exclusions, limitations, or other restrictions on coverage of fertility medications that are different from those imposed on other prescription medications;

(2) any exclusions, limitations, or other restrictions on coverage of any fertility services based on a covered individual's participation in fertility services provided by or to a third party; or

(3) any benefit maximums, waiting periods, or any other limitations on coverage for the diagnosis of infertility, treatment of infertility, and standard fertility preservation services, except as provided in paragraphs (c) and (d), that are different from those imposed upon benefits for services not related to infertility.

Subd. 3. **Definitions.** (a) For the purpose of this section, the definitions in this subdivision have the meanings given them.

(b) "Infertility" means a disease, condition, or status characterized by:

(1) the failure of a person with a uterus to establish a pregnancy or to carry a pregnancy to live birth after 12 months of unprotected sexual intercourse for a person under the age of 35 or six months for a person 35 years of age or older, regardless of whether a pregnancy resulting in miscarriage occurred during such time;

(2) a person's inability to reproduce either as a single individual or with the person's partner without medical intervention; or

(3) a licensed health care provider's findings based on a patient's medical, sexual, and reproductive history; age; physical findings; or diagnostic testing.

(c) "Diagnosis of and treatment for infertility" means the recommended procedures and medications from the direction of a licensed health care provider that are consistent with established, published, or approved medical practices or professional guidelines from the American College of Obstetricians and Gynecologists or the American Society for Reproductive Medicine.

(d) "Standard fertility preservation services" means procedures that are consistent with the established medical practices or professional guidelines published by the American Society for Reproductive Medicine or the American Society of Clinical Oncology for a person who has a medical condition or is expected to undergo medication therapy, surgery, radiation, chemotherapy, or other medical treatment that is recognized by medical professionals to cause a risk of impairment to fertility.

EFFECTIVE DATE. This section is effective August 1, 2023, and applies to all large group health plans issued or renewed on or after that date.

Sec. 3. Minnesota Statutes 2022, section 62A.045, is amended to read:

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

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

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

(b) No plan offered by a health insurer issued or renewed to provide coverage to a Minnesota resident shall contain any provision denying or reducing benefits because services are rendered to a person who is eligible for or receiving medical benefits pursuant to title XIX of the Social Security Act (Medicaid) in this or any other state; chapter 256 or 256B; or services pursuant to section 252.27; 256L.01 to 256L.10; 260B.331, subdivision 2; 260C.331, subdivision 2; or 393.07, subdivision 1 or 2. No health insurer providing benefits under plans covered by this section shall use eligibility for medical programs named in this section as an underwriting guideline or reason for nonacceptance of the risk.

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

under the alternative payment demonstration project under section 256B.434; and county-based purchasing entities under section 256B.692.

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

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

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

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

Sec. 4. Minnesota Statutes 2022, section 62A.15, is amended by adding a subdivision to read:

Subd. 3d. **Pharmacist.** All benefits provided by a policy or contract referred to in subdivision 1 relating to expenses incurred for medical treatment or services provided by

a licensed physician must include services provided by a licensed pharmacist, according to the requirements of section 151.01, to the extent a licensed pharmacist's services are within the pharmacist's scope of practice.

EFFECTIVE DATE. This section is effective January 1, 2025, and applies to policies or contracts offered, issued, or renewed on or after that date.

Sec. 5. Minnesota Statutes 2022, section 62A.15, subdivision 4, is amended to read:

Subd. 4. **Denial of benefits.** (a) No carrier referred to in subdivision 1 may, in the payment of claims to employees in this state, deny benefits payable for services covered by the policy or contract if the services are lawfully performed by a licensed chiropractor, a licensed optometrist, a registered nurse meeting the requirements of subdivision 3a, a licensed physician assistant, ~~or~~ a licensed acupuncture practitioner, or a licensed pharmacist.

(b) When carriers referred to in subdivision 1 make claim determinations concerning the appropriateness, quality, or utilization of chiropractic health care for Minnesotans, any of these determinations that are made by health care professionals must be made by, or under the direction of, or subject to the review of licensed doctors of chiropractic.

(c) When a carrier referred to in subdivision 1 makes a denial of payment claim determination concerning the appropriateness, quality, or utilization of acupuncture services for individuals in this state performed by a licensed acupuncture practitioner, a denial of payment claim determination that is made by a health professional must be made by, under the direction of, or subject to the review of a licensed acupuncture practitioner.

EFFECTIVE DATE. This section is effective January 1, 2025, and applies to policies or contracts offered, issued, or renewed on or after that date.

Sec. 6. Minnesota Statutes 2022, section 62A.30, is amended by adding a subdivision to read:

Subd. 5. **Mammogram; diagnostic services and testing.** If a health care provider determines an enrollee requires additional diagnostic services or testing after a mammogram, a health plan must provide coverage for the additional diagnostic services or testing with no cost sharing, including co-pay, deductible, or coinsurance.

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

Sec. 7. Minnesota Statutes 2022, section 62A.30, is amended by adding a subdivision to read:

Subd. 6. **Application.** If the application of subdivision 5 before an enrollee has met their health plan's deducible would result in: (1) health savings account ineligibility under United States Code, title 26, section 223; or (2) catastrophic health plan ineligibility under United States Code, title 42, section 18022(e), then subdivision 5 shall apply to diagnostic services or testing only after the enrollee has met their health plan's deductible.

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

Sec. 8. Minnesota Statutes 2022, section 62A.673, subdivision 2, is amended to read:

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

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

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

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

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

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

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

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

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

Sec. 9. **[62D.1071] COVERAGE OF LICENSED PHARMACIST SERVICES.**

Subdivision 1. **Pharmacist.** All benefits provided by a health maintenance contract relating to expenses incurred for medical treatment or services provided by a licensed physician must include services provided by a licensed pharmacist to the extent a licensed pharmacist's services are within the pharmacist's scope of practice.

Subd. 2. **Denial of benefits.** When paying claims for enrollees in Minnesota, a health maintenance organization must not deny payment for medical services covered by an enrollee's health maintenance contract if the services are lawfully performed by a licensed pharmacist.

Subd. 3. **Medication therapy management.** This section does not apply to or affect the coverage or reimbursement for medication therapy management services under section 62Q.676 or 256B.0625, subdivisions 5, 13h, and 28a.

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

Sec. 10. Minnesota Statutes 2022, section 62J.497, subdivision 1, is amended to read:

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

(b) "Dispense" or "dispensing" has the meaning given in section 151.01, subdivision 30. Dispensing does not include the direct administering of a controlled substance to a patient by a licensed health care professional.

(c) "Dispenser" means a person authorized by law to dispense a controlled substance, pursuant to a valid prescription.

(d) "Electronic media" has the meaning given under Code of Federal Regulations, title 45, part 160.103.

(e) "E-prescribing" means the transmission using electronic media of prescription or prescription-related information between a prescriber, dispenser, pharmacy benefit manager, or group purchaser, either directly or through an intermediary, including an e-prescribing network. E-prescribing includes, but is not limited to, two-way transmissions between the point of care and the dispenser and two-way transmissions related to eligibility, formulary, and medication history information.

(f) "Electronic prescription drug program" means a program that provides for e-prescribing.

(g) "Group purchaser" has the meaning given in section 62J.03, subdivision 6.

(h) "HL7 messages" means a standard approved by the standards development organization known as Health Level Seven.

(i) "National Provider Identifier" or "NPI" means the identifier described under Code of Federal Regulations, title 45, part 162.406.

(j) "NCPDP" means the National Council for Prescription Drug Programs, Inc.

(k) "NCPDP Formulary and Benefits Standard" means the most recent version of the National Council for Prescription Drug Programs Formulary and Benefits Standard or the most recent standard adopted by the Centers for Medicare and Medicaid Services for e-prescribing under Medicare Part D as required by section 1860D-4(e)(4)(D) of the Social Security Act and regulations adopted under it. The standards shall be implemented according to the Centers for Medicare and Medicaid Services schedule for compliance.

(l) "NCPDP Real-Time Prescription Benefit Standard" means the most recent National Council for Prescription Drug Programs Real-Time Prescription Benefit Standard adopted by the Centers for Medicare and Medicaid Services for e-prescribing under Medicare Part D as required by section 1860D-4(e)(2) of the Social Security Act, and regulations adopted pursuant to that section.

~~(l)~~ (m) "NCPDP SCRIPT Standard" means the most recent version of the National Council for Prescription Drug Programs SCRIPT Standard, or the most recent standard adopted by the Centers for Medicare and Medicaid Services for e-prescribing under Medicare Part D as required by section 1860D-4(e)(4)(D) of the Social Security Act, and regulations adopted under it. The standards shall be implemented according to the Centers for Medicare and Medicaid Services schedule for compliance.

~~(m)~~ (n) "Pharmacy" has the meaning given in section 151.01, subdivision 2.

(o) "Pharmacy benefit manager" has the meaning given in section 62W.02, subdivision 15.

~~(n)~~ (p) "Prescriber" means a licensed health care practitioner, other than a veterinarian, as defined in section 151.01, subdivision 23.

~~(o)~~ (q) "Prescription-related information" means information regarding eligibility for drug benefits, medication history, or related health or drug information.

~~(p)~~ (r) "Provider" or "health care provider" has the meaning given in section 62J.03, subdivision 8.

(s) "Real-time prescription benefit tool" means a tool that is capable of being integrated into a prescriber's e-prescribing system and that provides a prescriber with up-to-date and patient-specific formulary and benefit information at the time the prescriber submits a prescription.

Sec. 11. Minnesota Statutes 2022, section 62J.497, subdivision 3, is amended to read:

Subd. 3. **Standards for electronic prescribing.** (a) Prescribers and dispensers must use the NCPDP SCRIPT Standard for the communication of a prescription or prescription-related information.

(b) Providers, group purchasers, prescribers, and dispensers must use the NCPDP SCRIPT Standard for communicating and transmitting medication history information.

(c) Providers, group purchasers, prescribers, and dispensers must use the NCPDP Formulary and Benefits Standard for communicating and transmitting formulary and benefit information.

(d) Providers, group purchasers, prescribers, and dispensers must use the national provider identifier to identify a health care provider in e-prescribing or prescription-related transactions when a health care provider's identifier is required.

(e) Providers, group purchasers, prescribers, and dispensers must communicate eligibility information and conduct health care eligibility benefit inquiry and response transactions according to the requirements of section 62J.536.

(f) Group purchasers and pharmacy benefit managers must use a real-time prescription benefit tool that complies with the NCPDP Real-Time Prescription Benefit Standard and that, at a minimum, notifies a prescriber:

(1) if a prescribed drug is covered by the patient's group purchaser or pharmacy benefit manager;

(2) if a prescribed drug is included on the formulary or preferred drug list of the patient's group purchaser or pharmacy benefit manager;

(3) of any patient cost-sharing for the prescribed drug;

(4) if prior authorization is required for the prescribed drug; and

(5) of a list of any available alternative drugs that are in the same class as the drug originally prescribed and for which prior authorization is not required.

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

Sec. 12. Minnesota Statutes 2022, section 62J.824, is amended to read:

62J.824 FACILITY FEE DISCLOSURE.

(a) Prior to the delivery of nonemergency services, a provider-based clinic that charges a facility fee shall provide notice to any patient, including patients served by telehealth as defined in section 62A.673, subdivision 2, paragraph (h), stating that the clinic is part of a hospital and the patient may receive a separate charge or billing for the facility component, which may result in a higher out-of-pocket expense.

(b) Each health care facility must post prominently in locations easily accessible to and visible by patients, including on its website, a statement that the provider-based clinic is

part of a hospital and the patient may receive a separate charge or billing for the facility, which may result in a higher out-of-pocket expense.

(c) This section does not apply to laboratory services, imaging services, or other ancillary health services that are provided by staff who are not employed by the health care facility or clinic.

(d) For purposes of this section:

(1) "facility fee" means any separate charge or billing by a provider-based clinic in addition to a professional fee for physicians' services that is intended to cover building, electronic medical records systems, billing, and other administrative and operational expenses; and

(2) "provider-based clinic" means the site of an off-campus clinic or provider office, located at least 250 yards from the main hospital buildings or as determined by the Centers for Medicare and Medicaid Services, that is owned by a hospital licensed under chapter 144 or a health system that operates one or more hospitals licensed under chapter 144, and is primarily engaged in providing diagnostic and therapeutic care, including medical history, physical examinations, assessment of health status, and treatment monitoring. This definition does not include clinics that are exclusively providing laboratory, x-ray, testing, therapy, pharmacy, or educational services and does not include facilities designated as rural health clinics.

Sec. 13. **[62J.826] MEDICAL AND DENTAL PRACTICES; CURRENT STANDARD CHARGES; COMPARISON TOOL.**

Subdivision 1. **Definitions.** (a) The definitions in this subdivision apply to this section.

(b) "CDT code" means a code value drawn from the Code on Dental Procedures and Nomenclature published by the American Dental Association.

(c) "Chargemaster" means the list of all individual items and services maintained by a medical or dental practice for which the medical or dental practice has established a charge.

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

(e) "CPT code" means a code value drawn from the Current Procedural Terminology published by the American Medical Association.

(f) "Dental service" means a service charged using a CDT code.

(g) "Diagnostic laboratory testing" means a service charged using a CPT code within the CPT code range of 80047 to 89398.

(h) "Diagnostic radiology service" means a service charged using a CPT code within the CPT code range of 70010 to 79999 and includes the provision of x-rays, computed tomography scans, positron emission tomography scans, magnetic resonance imaging scans, and mammographies.

(i) "Hospital" means an acute care institution licensed under sections 144.50 to 144.58, but does not include a health care institution conducted for those who rely primarily upon treatment by prayer or spiritual means in accordance with the creed or tenets of any church or denomination.

(j) "Medical or dental practice" means a business that:

(1) earns revenue by providing medical care or dental services to the public;

(2) issues payment claims to health plan companies and other payers; and

(3) may be identified by its federal tax identification number.

(k) "Outpatient surgical center" means a health care facility other than a hospital offering elective outpatient surgery under a license issued under sections 144.50 to 144.58.

(l) "Standard charge" means the regular rate established by the medical or dental practice for an item or service provided to a specific group of paying patients. This includes all of the following:

(1) the charge for an individual item or service that is reflected on a medical or dental practice's chargemaster, absent any discounts;

(2) the charge that a medical or dental practice has negotiated with a third-party payer for an item or service;

(3) the lowest charge that a medical or dental practice has negotiated with all third-party payers for an item or service;

(4) the highest charge that a medical or dental practice has negotiated with all third-party payers for an item or service; and

(5) the charge that applies to an individual who pays cash, or cash equivalent, for an item or service.

Subd. 2. **Requirement; current standard charges.** The following medical or dental practices must make available to the public a list of their current standard charges for all items and services, as reflected in the medical or dental practice's chargemaster, provided by the medical or dental practice:

(1) hospitals;

(2) outpatient surgical centers; and

(3) any other medical or dental practice that has revenue of greater than $50,000,000 per year and that derives the majority of its revenue by providing one or more of the following services:

(i) diagnostic radiology services;

(ii) diagnostic laboratory testing;

(iii) orthopedic surgical procedures, including joint arthroplasty procedures within the CPT code range of 26990 to 27899;

(iv) ophthalmologic surgical procedures, including cataract surgery coded using CPT code 66982 or 66984, or refractive correction surgery to improve visual acuity;

(v) anesthesia services commonly provided as an ancillary to services provided at a hospital, outpatient surgical center, or medical practice that provides orthopedic surgical procedures or ophthalmologic surgical procedures;

(vi) oncology services, including radiation oncology treatments within the CPT code range of 77261 to 77799 and drug infusions; or

(vii) dental services.

Subd. 3. **Required file format and content.** (a) A medical or dental practice that is subject to this section must make available to the public, and must report to the commissioner, current standard charges using the format and data elements specified in the currently effective version of the Hospital Price Transparency Sample Format (Tall) (CSV) and related data dictionary recommended for hospitals by the Centers for Medicare and Medicaid Services (CMS). If CMS modifies or replaces the specifications for this format, the form of this file must be modified or replaced to conform with the new CMS specifications by the date specified by CMS for compliance with its new specifications. All prices included in the file must be expressed as dollar amounts. The data must be in the form of a comma separated values file which can be directly imported, without further editing or remediation, into a relational database table which has been designed to receive these files. The medical or dental practice must make the file available to the public in a manner specified by the commissioner and must report the file to the commissioner in a manner and frequency specified by the commissioner.

(b) A medical or dental practice must test its file for compliance with paragraph (a) before making the file available to the public and reporting the file to the commissioner.

(c) A hospital must comply with this section no later than January 1, 2024. A medical or dental practice that meets the requirements in subdivision 2, clause (3), or an outpatient surgical center must comply with this section no later than January 1, 2025.

Sec. 14. Minnesota Statutes 2022, section 62J.84, subdivision 2, is amended to read:

Subd. 2. **Definitions.** (a) For purposes of this section and section 62J.841, the terms defined in this subdivision have the meanings given.

(b) "Biosimilar" means a drug that is produced or distributed pursuant to a biologics license application approved under United States Code, title 42, section 262(K)(3).

(c) "Brand name drug" means a drug that is produced or distributed pursuant to:

(1) an original, new drug application approved under United States Code, title 21, section 355(c), except for a generic drug as defined under Code of Federal Regulations, title 42, section 447.502; or

(2) a biologics license application approved under United States Code, title 45, section 262(a)(c).

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

(e) "Generic drug" means a drug that is marketed or distributed pursuant to:

(1) an abbreviated new drug application approved under United States Code, title 21, section 355(j);

(2) an authorized generic as defined under Code of Federal Regulations, title 45, section 447.502; or

(3) a drug that entered the market the year before 1962 and was not originally marketed under a new drug application.

(f) "Manufacturer" means a drug manufacturer licensed under section 151.252, but does not include an entity required to be licensed under that section solely because the entity repackages or relabels drugs. The provisions of this paragraph shall not be severable from section 62Q.83. If this paragraph or its application to any individual, entity, or circumstance is found to be void for any reason, section 62Q.83 shall be void also.

(g) "New prescription drug" or "new drug" means a prescription drug approved for marketing by the United States Food and Drug Administration for which no previous wholesale acquisition cost has been established for comparison.

(h) "Patient assistance program" means a program that a manufacturer offers to the public in which a consumer may reduce the consumer's out-of-pocket costs for prescription drugs by using coupons, discount cards, prepaid gift cards, manufacturer debit cards, or by other means.

(i) "Prescription drug" or "drug" has the meaning provided in section 151.441, subdivision 8.

(j) "Price" means the wholesale acquisition cost as defined in United States Code, title 42, section 1395w-3a(c)(6)(B).

Sec. 15. Minnesota Statutes 2022, section 62J.84, subdivision 6, is amended to read:

Subd. 6. **Public posting of prescription drug price information.** (a) The commissioner shall post on the department's website, or may contract with a private entity or consortium that satisfies the standards of section 62U.04, subdivision 6, to meet this requirement, the following information:

(1) a list of the prescription drugs reported under subdivisions 3, 4, and 5, and the manufacturers of those prescription drugs; ~~and~~

(2) information reported to the commissioner under subdivisions 3, 4, and 5~~.~~; and

(3) information reported to the commissioner under section 62J.841, subdivision 2.

(b) The information must be published in an easy-to-read format and in a manner that identifies the information that is disclosed on a per-drug basis and must not be aggregated in a manner that prevents the identification of the prescription drug.

(c) The commissioner shall not post to the department's website or a private entity contracting with the commissioner shall not post any information described in this section if the information is not public data under section 13.02, subdivision 8a; or, subject to section 62J.841, subdivision 2, paragraph (e), is trade secret information under section 13.37, subdivision 1, paragraph (b); or, subject to section 62J.841, subdivision 2, paragraph (e), is trade secret information pursuant to the Defend Trade Secrets Act of 2016, United States Code, title 18, section 1836, as amended. If a manufacturer believes information should be withheld from public disclosure pursuant to this paragraph, the manufacturer must clearly and specifically identify that information and describe the legal basis in writing when the

manufacturer submits the information under this section. If the commissioner disagrees with the manufacturer's request to withhold information from public disclosure, the commissioner shall provide the manufacturer written notice that the information will be publicly posted 30 days after the date of the notice.

(d) If the commissioner withholds any information from public disclosure pursuant to this subdivision, the commissioner shall post to the department's website a report describing the nature of the information and the commissioner's basis for withholding the information from disclosure.

(e) To the extent the information required to be posted under this subdivision is collected and made available to the public by another state, by the University of Minnesota, or through an online drug pricing reference and analytical tool, the commissioner may reference the availability of this drug price data from another source including, within existing appropriations, creating the ability of the public to access the data from the source for purposes of meeting the reporting requirements of this subdivision.

(f) The provisions in this subdivision referencing 62J.841 shall not be severable from section 62Q.83. If any reference to section 62J.841 or its application to any individual, entity, or circumstance is found to be void for any reason, section 62Q.83 shall be void also.

Sec. 16. Minnesota Statutes 2022, section 62J.84, subdivision 7, is amended to read:

Subd. 7. **Consultation.** (a) The commissioner may consult with a private entity or consortium that satisfies the standards of section 62U.04, subdivision 6, the University of Minnesota, or the commissioner of commerce, as appropriate, in issuing the form and format of the information reported under this section and section 62J.841; in posting information pursuant to subdivision 6; and in taking any other action for the purpose of implementing this section and section 62J.841.

(b) The commissioner may consult with representatives of the manufacturers to establish a standard format for reporting information under this section and section 62J.841 and may use existing reporting methodologies to establish a standard format to minimize administrative burdens to the state and manufacturers.

(c) The provisions in this subdivision referencing 62J.841 shall not be severable from section 62Q.83. If any reference to section 62J.841 or its application to any individual, entity, or circumstance is found to be void for any reason, section 62Q.83 shall be void also.

Sec. 17. Minnesota Statutes 2022, section 62J.84, subdivision 8, is amended to read:

Subd. 8. **Enforcement and penalties.** (a) A manufacturer may be subject to a civil penalty, as provided in paragraph (b), for:

(1) failing to submit timely reports or notices as required by this section and section 62J.841;

(2) failing to provide information required under this section and section 62J.841; ~~or~~

(3) providing inaccurate or incomplete information under this section and section 62J.841; or

(4) failing to comply with section 62J.841, subdivisions 2, paragraph (e), and 4.

(b) The commissioner shall adopt a schedule of civil penalties, not to exceed $10,000 per day of violation, based on the severity of each violation.

(c) The commissioner shall impose civil penalties under this section and section 62J.841 as provided in section 144.99, subdivision 4.

(d) The commissioner may remit or mitigate civil penalties under this section and section 62J.841 upon terms and conditions the commissioner considers proper and consistent with public health and safety.

(e) Civil penalties collected under this section and section 62J.841 shall be deposited in the health care access fund.

(f) The provisions in this subdivision referencing 62J.841 shall not be severable from section 62Q.83. If any reference to section 62J.841 or its application to any individual, entity, or circumstance is found to be void for any reason, section 62Q.83 shall be void also.

Sec. 18. Minnesota Statutes 2022, section 62J.84, subdivision 9, is amended to read:

Subd. 9. **Legislative report.** (a) No later than May 15, ~~2022~~ 2024, and by January 15 of each year thereafter, the commissioner shall report to the chairs and ranking minority members of the legislative committees with jurisdiction over commerce and health and human services policy and finance on the implementation of this section and section 62J.841, including but not limited to the effectiveness in addressing the following goals:

(1) promoting transparency in pharmaceutical pricing for the state, health carriers, and other payers;

(2) enhancing the understanding on pharmaceutical spending trends; and

(3) assisting the state, health carriers, and other payers in the management of pharmaceutical costs and limiting formulary changes due to prescription drug cost increases during a coverage year.

(b) The report must include a summary of the information submitted to the commissioner under subdivisions 3, 4, and 5, and section 62J.841.

(c) The provisions in this subdivision shall not be severable from section 62Q.83. If this subdivision or its application to any individual, entity, or circumstance is found to be void for any reason, section 62Q.83 shall be void also.

Sec. 19. **[62J.841] REPORTING PRESCRIPTION DRUG PRICES; FORMULARY DEVELOPMENT AND PRICE STABILITY.**

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

(b) "Average wholesale price" means the customary reference price for sales by a drug wholesaler to a retail pharmacy, as established and published by the manufacturer.

(c) "National drug code" means the numerical code maintained by the United States Food and Drug Administration and includes the label code, product code, and package code.

(d) "Wholesale acquisition cost" has the meaning given in United States Code, title 42, section 1395w-3a(c)(6)(B).

(e) "Unit" has the meaning given in United States Code, title 42, section 1395w-3a(b)(2).

Subd. 2. **Price reporting.** (a) Beginning July 31, 2024, and by July 31 of each year thereafter, a manufacturer must report to the commissioner the information in paragraph (b) for every drug with a wholesale acquisition cost of $100 or more for a 30-day supply or for a course of treatment lasting less than 30 days, as applicable to the next calendar year.

(b) A manufacturer shall report a drug's:

(1) national drug code, labeler code, and the manufacturer name associated with the labeler code;

(2) brand name, if applicable;

(3) generic name, if applicable;

(4) wholesale acquisition cost for one unit;

(5) measure that constitutes a wholesale acquisition cost unit;

(6) average wholesale price; and

(7) status as brand name or generic.

(c) The effective date of the information described in paragraph (b) must be included in the report to the commissioner.

(d) A manufacturer must report the information described in this subdivision in the form and manner specified by the commissioner.

(e) Information reported under this subdivision is classified as public data not on individuals, as defined in section 13.02, subdivision 14, and must not be classified by the manufacturer as trade secret information, as defined in section 13.37, subdivision 1, paragraph (b).

(f) A manufacturer's failure to report the information required by this subdivision is grounds for disciplinary action under section 151.071, subdivision 2.

Subd. 3. **Public posting of prescription drug price information.** By October 1 of each year, beginning October 1, 2024, the commissioner must post the information reported under subdivision 2 on the department's website, as required by section 62J.84, subdivision 6.

Subd. 4. **Price change.** (a) If a drug subject to price reporting under subdivision 2 is included in the formulary of a health plan submitted to and approved by the commissioner of commerce for the next calendar year under section 62A.02, subdivision 1, the manufacturer may increase the wholesale acquisition cost of the drug for the next calendar year only after providing the commissioner with at least 90 days written notice.

(b) A manufacturer's failure to meet the requirements of paragraph (a) is grounds for disciplinary action under section 151.071, subdivision 2.

Subd. 5. **Not severable.** The provisions of this section shall not be severable from section 62Q.83. If any provision of this section or its application to any individual, entity, or circumstance is found to be void for any reason, section 62Q.83 shall be void also.

Sec. 20. Minnesota Statutes 2022, section 62K.10, subdivision 4, is amended to read:

Subd. 4. **Network adequacy.** (a) Each designated provider network must include a sufficient number and type of providers, including providers that specialize in mental health and substance use disorder services, to ensure that covered services are available to all enrollees without unreasonable delay. In determining network adequacy, the commissioner of health shall consider availability of services, including the following:

(1) primary care physician services are available and accessible 24 hours per day, seven days per week, within the network area;

(2) a sufficient number of primary care physicians have hospital admitting privileges at one or more participating hospitals within the network area so that necessary admissions are made on a timely basis consistent with generally accepted practice parameters;

(3) specialty physician service is available through the network or contract arrangement;

(4) mental health and substance use disorder treatment providers, including but not limited to psychiatric residential treatment facilities, are available and accessible through the network or contract arrangement;

(5) to the extent that primary care services are provided through primary care providers other than physicians, and to the extent permitted under applicable scope of practice in state law for a given provider, these services shall be available and accessible; and

(6) the network has available, either directly or through arrangements, appropriate and sufficient personnel, physical resources, and equipment to meet the projected needs of enrollees for covered health care services.

(b) The commissioner may establish sufficiency by referencing any reasonable criteria, which includes but is not limited to:

(1) ratios of providers to enrollees by specialty;

(2) ratios of primary care professionals to enrollees;

(3) geographic accessibility of providers;

(4) waiting times for an appointment with participating providers;

(5) hours of operation;

(6) the ability of the network to meet the needs of enrollees that are:

(i) low-income persons;

(ii) children and adults with serious, chronic, or complex health conditions, physical disabilities, or mental illness; or

(iii) persons with limited English proficiency and persons from underserved communities;

(7) other health care service delivery system options, including telemedicine or telehealth, mobile clinics, centers of excellence, and other ways of delivering care; and

(8) the volume of technological and specialty care services available to serve the needs of enrollees that need technologically advanced or specialty care services.

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

Sec. 21. **[62Q.451] UNRESTRICTED ACCESS TO SERVICES FOR THE DIAGNOSIS, MONITORING, AND TREATMENT OF RARE DISEASES.**

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

(b) "Rare disease or condition" means any disease or condition:

(1) that affects fewer than 200,000 persons in the United States and is chronic, serious, life-altering, or life-threatening;

(2) that affects more than 200,000 persons in the United States and a drug for treatment has been designated as a drug for a rare disease or condition pursuant to United States Code, title 21, section 360bb;

(3) that is labeled as a rare disease or condition on the Genetic and Rare Diseases Information Center list created by the National Institutes of Health; or

(4) for which an enrollee:

(i) has received two or more clinical consultations from a primary care provider or specialty provider that are specific to the presenting complaint;

(ii) has documentation in the enrollee's medical record of a developmental delay through standardized assessment, developmental regression, failure to thrive, or progressive multisystemic involvement; and

(iii) had laboratory or clinical testing that failed to provide a definitive diagnosis or resulted in conflicting diagnoses.

A rare disease or condition does not include an infectious disease that has widely available and known protocols for diagnosis and treatment and that is commonly treated in a primary care setting, even if it affects less than 200,000 persons in the United States.

Subd. 2. **Unrestricted access.** (a) No health plan company may restrict the choice of an enrollee as to where the enrollee receives services from a licensed health care provider related to the diagnosis, monitoring, and treatment of a rare disease or condition, including

but not limited to additional restrictions through any prior authorization, preauthorization, prior approval, precertification process, increased fees, or other methods.

(b) Any services provided, referred for, or ordered by an out-of-network provider for an enrollee who, before receiving and being notified of a definitive diagnosis, satisfied the requirements in subdivision 1, paragraph (b), clause (4), are governed by paragraph (c), even if the subsequent definitive diagnosis does not meet the definition of rare disease or condition in subdivision 1, paragraph (b), clause (1), (2), or (3). Once the enrollee is definitively diagnosed with a disease or condition that does not meet the definition of rare disease or condition in subdivision 1, paragraph (b), clause (1), (2), or (3), and the enrollee or a parent or guardian of a minor enrollee has been notified of the diagnosis, any services provided, referred for, or ordered by an out-of-network provider related to the diagnosis are governed by paragraph (c) for up to 60 days, providing time for care to be transferred to a qualified in-network provider and to schedule needed in-network appointments. After this 60-day period, subsequent services provided, referred for, or ordered by an out-of-network provider related to the diagnosis are no longer governed by paragraph (c).

(c) Cost-sharing requirements and benefit or services limitations for the diagnosis and treatment of a rare disease or condition must not place a greater financial burden on the enrollee or be more restrictive than those requirements for in-network medical treatment.

(d) A health plan company must provide enrollees with written information on the content and application of this section and must train customer service representatives on the content and application of this section.

Subd. 3. **Coverage; prior authorization.** (a) Nothing in this section requires a health plan company to provide coverage for a medication, procedure or treatment, or laboratory or clinical testing, that is not covered under the enrollee's health plan.

(b) Coverage for a service must not be denied solely on the basis that it was provided, referred for, or ordered by an out-of-network provider.

(c) Any prior authorization requirements for a service that is provided by, referred for, or ordered by an out-of-network provider must be the same as any prior authorization requirements for a service that is provided by, referred for, or ordered by an in-network provider.

Subd. 4. **Payments to out-of-network providers for services provided in this state.** (a) If a health plan company has an established contractual payment under a health plan in the commercial insurance market with an out-of-network provider for a service provided in Minnesota related to the diagnosis, monitoring, and treatment of a rare disease or condition,

across any of the health plan's networks, then the provider shall accept the established contractual payment for that service as payment in full.

(b) If a health plan company does not have an established contractual payment under a health plan in the commercial insurance market with an out-of-network provider for a service provided in Minnesota related to the diagnosis, monitoring, and treatment of a rare disease or condition, across any of the health plan's networks, then the provider shall accept:

(1) the provider's established rate for uninsured patients for that service as payment in full; or

(2) if the provider does not have an established rate for uninsured patients for that service, then the average commercial insurance rate the health plan company has paid for that service in this state over the past 12 months as payment in full.

(d) If the payment amount is determined under paragraph (b), clause (2), and the health plan company has not paid for that service in this state within the past 12 months, then the health plan company shall pay the lesser of the following:

(1) the average rate in the commercial insurance market the health plan company paid for that service across all states over the past 12 months; or

(2) the provider's standard charge.

(e) This subdivision does not apply to managed care organizations or county-based purchasing plans when the plan provides coverage to public health care program enrollees under chapters 256B or 256L.

Subd. 5. **Payments to out-of-network providers when services are provided outside of the state.** (a) If a health plan company has an established contractual payment under a health plan in the commercial insurance market with an out-of-network provider for a service provided in another state related to the diagnosis, monitoring, and treatment of a rare disease or condition, across any of the health plan's networks in the state where the service is provided, then the health plan company shall pay the established contractual payment for that service.

(b) If a health plan company does not have an established contractual payment under a health plan in the commercial insurance market with an out-of-network provider for a service provided in another state related to the diagnosis, monitoring, and treatment of a rare disease or condition, across any of the health plan's networks in the state where the service is provided, then the health plan company shall pay:

(1) the provider's established rate for uninsured patients for that service; or

(2) if the provider does not have an established rate for uninsured patients for that service, then the average commercial insurance rate the health plan company has paid for that service in the state where the service is provided over the past 12 months.

(c) If the payment amount is determined under paragraph (b), clause (2), and the health plan company has not paid for that service in the state where the service is provided within the past 12 months, then the health plan company shall pay the lesser of the following:

(1) the average commercial insurance rate the health plan company has paid for that service across all states over the last 12 months; or

(2) the provider's standard charge.

(d) This subdivision does not apply to managed care organizations or county-based purchasing plans when the plan provides coverage to public health care program enrollees under chapter 256B or 256L.

Subd. 6. **Exclusions.** (a) This section does not apply to health care coverage offered by the State Employee Group Insurance Program.

(b) This section does not apply to medications obtained from a retail pharmacy as defined in section 62W.02, subdivision 18.

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

Sec. 22. **[62Q.473] BIOMARKER TESTING.**

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

(b) "Biomarker" means a characteristic that is objectively measured and evaluated as an indicator of normal biological processes, pathogenic processes, or pharmacologic responses to a specific therapeutic intervention, including but not limited to known gene-drug interactions for medications being considered for use or already being administered. Biomarkers include but are not limited to gene mutations, characteristics of genes, or protein expression.

(c) "Biomarker testing" means the analysis of an individual's tissue, blood, or other biospecimen for the presence of a biomarker. Biomarker testing includes but is not limited to single-analyst tests; multiplex panel tests; protein expression; and whole exome, whole genome, and whole transcriptome sequencing.

(d) "Clinical utility" means a test provides information that is used to formulate a treatment or monitoring strategy that informs a patient's outcome and impacts the clinical decision. The most appropriate test may include information that is actionable and some information that cannot be immediately used to formulate a clinical decision.

(e) "Consensus statement" means a statement that: (1) describes optimal clinical care outcomes, based on the best available evidence, for a specific clinical circumstance; and (2) is developed by an independent, multidisciplinary panel of experts that: (i) uses a rigorous and validated development process that includes a transparent methodology and reporting structure; and (ii) strictly adheres to the panel's conflict of interest policy.

(f) "Nationally recognized clinical practice guideline" means an evidence-based clinical practice guideline that: (1) establishes a standard of care informed by (i) a systematic review of evidence, and (ii) an assessment of the risks and benefits of alternative care options; and (2) is developed by an independent organization or medical professional society that: (i) uses a transparent methodology and reporting structure; and (ii) adheres to a conflict of interest policy. Nationally recognized clinical practice guideline includes recommendations to optimize patient care.

Subd. 2. **Biomarker testing; coverage required.** (a) A health plan must provide coverage for biomarker testing to diagnose, treat, manage, and monitor illness or disease if the test provides clinical utility. For purposes of this section, a test's clinical utility may be demonstrated by medical and scientific evidence, including but not limited to:

(1) nationally recognized clinical practice guidelines as defined in this section;

(2) consensus statements as defined in this section;

(3) labeled indications for a United States Food and Drug Administration (FDA) approved or FDA-cleared test, indicated tests for an FDA-approved drug, or adherence to warnings and precautions on FDA-approved drug labels; or

(4) Centers for Medicare and Medicaid Services national coverage determinations or Medicare Administrative Contractor local coverage determinations.

(b) Coverage under this section must be provided in a manner that limits disruption of care, including the need for multiple biopsies or biospecimen samples.

(c) Nothing in this section prohibits a health plan company from requiring a prior authorization or imposing other utilization controls when approving coverage for biomarker testing.

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

Sec. 23. **[62Q.522] COVERAGE OF CONTRACEPTIVE METHODS AND SERVICES.**

Subdivision 1. **Definitions.** (a) The definitions in this subdivision apply to this section.

(b) "Closely held for-profit entity" means an entity that:

(1) is not a nonprofit entity;

(2) has more than 50 percent of the value of its ownership interest owned directly or indirectly by five or fewer owners; and

(3) has no publicly traded ownership interest.

For purposes of this paragraph:

(i) ownership interests owned by a corporation, partnership, limited liability company, estate, trust, or similar entity are considered owned by that entity's shareholders, partners, members, or beneficiaries in proportion to their interest held in the corporation, partnership, limited liability company, estate, trust, or similar entity;

(ii) ownership interests owned by a nonprofit entity are considered owned by a single owner;

(iii) ownership interests owned by all individuals in a family are considered held by a single owner. For purposes of this item, "family" means brothers and sisters, including half-brothers and half-sisters, a spouse, ancestors, and lineal descendants; and

(iv) if an individual or entity holds an option, warrant, or similar right to purchase an ownership interest, the individual or entity is considered to be the owner of those ownership interests.

(c) "Contraceptive method" means a drug, device, or other product approved by the Food and Drug Administration to prevent unintended pregnancy.

(d) "Contraceptive service" means consultation, examination, procedures, and medical services related to the prevention of unintended pregnancy, excluding vasectomies. This includes but is not limited to voluntary sterilization procedures, patient education, counseling on contraceptives, and follow-up services related to contraceptive methods or services, management of side effects, counseling for continued adherence, and device insertion or removal.

(e) "Eligible organization" means an organization that opposes providing coverage for some or all contraceptive methods or services on account of religious objections and that is:

(1) organized as a nonprofit entity and holds itself out to be religious; or

(2) organized and operates as a closely held for-profit entity, and the organization's owners or highest governing body has adopted, under the organization's applicable rules of governance and consistent with state law, a resolution or similar action establishing that the organization objects to covering some or all contraceptive methods or services on account of the owners' sincerely held religious beliefs.

(f) "Exempt organization" means an organization that is organized and operates as a nonprofit entity and meets the requirements of section 6033(a)(3)(A)(i) or (iii) of the Internal Revenue Code of 1986, as amended.

(g) "Medical necessity" includes but is not limited to considerations such as severity of side effects, difference in permanence and reversibility of a contraceptive method or service, and ability to adhere to the appropriate use of the contraceptive method or service, as determined by the attending provider.

(h) "Therapeutic equivalent version" means a drug, device, or product that can be expected to have the same clinical effect and safety profile when administered to a patient under the conditions specified in the labeling, and that:

(1) is approved as safe and effective;

(2) is a pharmaceutical equivalent: (i) containing identical amounts of the same active drug ingredient in the same dosage form and route of administration; and (ii) meeting compendial or other applicable standards of strength, quality, purity, and identity;

(3) is bioequivalent in that:

(i) the drug, device, or product does not present a known or potential bioequivalence problem and meets an acceptable in vitro standard; or

(ii) if the drug, device, or product does present a known or potential bioequivalence problem, it is shown to meet an appropriate bioequivalence standard;

(4) is adequately labeled; and

(5) is manufactured in compliance with current manufacturing practice regulations.

Subd. 2. **Required coverage; cost sharing prohibited.** (a) A health plan must provide coverage for contraceptive methods and services.

(b) A health plan company must not impose cost-sharing requirements, including copays, deductibles, or coinsurance, for contraceptive methods or services.

(c) A health plan company must not impose any referral requirements, restrictions, or delays for contraceptive methods or services.

(d) A health plan must include at least one of each type of Food and Drug Administration approved contraceptive method in its formulary. If more than one therapeutic equivalent version of a contraceptive method is approved, a health plan must include at least one therapeutic equivalent version in its formulary, but is not required to include all therapeutic equivalent versions.

(e) For each health plan, a health plan company must list the contraceptive methods and services that are covered without cost-sharing in a manner that is easily accessible to enrollees, health care providers, and representatives of health care providers. The list for each health plan must be promptly updated to reflect changes to the coverage.

(f) If an enrollee's attending provider recommends a particular contraceptive method or service based on a determination of medical necessity for that enrollee, the health plan must cover that contraceptive method or service without cost-sharing. The health plan company issuing the health plan must defer to the attending provider's determination that the particular contraceptive method or service is medically necessary for the enrollee.

Subd. 3. **Exemption.** (a) An exempt organization is not required to cover contraceptives or contraceptive services if the exempt organization has religious objections to the coverage. An exempt organization that chooses to not provide coverage for some or all contraceptives and contraceptive services must notify employees as part of the hiring process and to all employees at least 30 days before:

(1) an employee enrolls in the health plan; or

(2) the effective date of the health plan, whichever occurs first.

(b) If the exempt organization provides coverage for some contraceptive methods or services, the notice required under paragraph (a) must provide a list of the contraceptive methods or services the organization refuses to cover.

Subd. 4. **Accommodation for eligible organizations.** (a) A health plan established or maintained by an eligible organization complies with the requirements of subdivision 2 to provide coverage of contraceptive methods and services, with respect to the contraceptive methods or services identified in the notice under this paragraph, if the eligible organization provides notice to any health plan company the eligible organization contracts with that it

is an eligible organization and that the eligible organization has a religious objection to coverage for all or a subset of contraceptive methods or services.

(b) The notice from an eligible organization to a health plan company under paragraph (a) must include: (1) the name of the eligible organization; (2) a statement that it objects to coverage for some or all of contraceptive methods or services, including a list of the contraceptive methods or services the eligible organization objects to, if applicable; and (3) the health plan name. The notice must be executed by a person authorized to provide notice on behalf of the eligible organization.

(c) An eligible organization must provide a copy of the notice under paragraph (a) to prospective employees as part of the hiring process and to all employees at least 30 days before:

(1) an employee enrolls in the health plan; or

(2) the effective date of the health plan, whichever occurs first.

(d) A health plan company that receives a copy of the notice under paragraph (a) with respect to a health plan established or maintained by an eligible organization must, for all future enrollments in the health plan:

(1) expressly exclude coverage for those contraceptive methods or services identified in the notice under paragraph (a) from the health plan; and

(2) provide separate payments for any contraceptive methods or services required to be covered under subdivision 2 for enrollees as long as the enrollee remains enrolled in the health plan.

(e) The health plan company must not impose any cost-sharing requirements, including copays, deductibles, or coinsurance, or directly or indirectly impose any premium, fee, or other charge for contraceptive services or methods on the eligible organization, health plan, or enrollee.

(f) On January 1, 2024, and every year thereafter a health plan company must notify the commissioner, in a manner determined by the commissioner, of the number of eligible organizations granted an accommodation under this subdivision.

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

Sec. 24. **[62Q.523] COVERAGE FOR PRESCRIPTION CONTRACEPTIVES; SUPPLY REQUIREMENTS.**

Subdivision 1. **Scope of coverage.** Except as otherwise provided in section 62Q.522, subdivisions 3 and 4, all health plans that provide prescription coverage must comply with the requirements of this section.

Subd. 2. **Definition.** For purposes of this section, "prescription contraceptive" means any drug or device that requires a prescription and is approved by the Food and Drug Administration to prevent pregnancy. Prescription contraceptive does not include an emergency contraceptive drug that prevents pregnancy when administered after sexual contact.

Subd. 3. **Required coverage.** Health plan coverage for a prescription contraceptive must provide a 12-month supply for any prescription contraceptive if a 12-month supply is prescribed by the prescribing health care provider. The prescribing health care provider must determine the appropriate duration to prescribe the prescription contraceptives for up to 12 months.

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

Sec. 25. **[62Q.83] PRESCRIPTION DRUG BENEFIT TRANSPARENCY AND MANAGEMENT.**

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

(b) "Drug" has the meaning given in section 151.01, subdivision 5.

(c) "Enrollee contract term" means the 12-month term during which benefits associated with health plan company products are in effect. For managed care plans and county-based purchasing plans under section 256B.69 and chapter 256L, it means a single calendar year.

(d) "Formulary" means a list of prescription drugs that has been developed by clinical and pharmacy experts and that represents the health plan company's medically appropriate and cost-effective prescription drugs approved for use.

(e) "Health plan company" has the meaning given in section 62Q.01, subdivision 4, and includes an entity that performs pharmacy benefits management for the health plan company. For purposes of this definition, "pharmacy benefits management" means the administration or management of prescription drug benefits provided by the health plan company for the

benefit of the plan's enrollees and may include but is not limited to procurement of prescription drugs, clinical formulary development and management services, claims processing, and rebate contracting and administration.

(f) "Prescription" has the meaning given in section 151.01, subdivision 16a.

Subd. 2. **Prescription drug benefit disclosure.** (a) A health plan company that provides prescription drug benefit coverage and uses a formulary must make the plan's formulary and related benefit information available by electronic means and, upon request, in writing, at least 30 days prior to annual renewal dates.

(b) Formularies must be organized and disclosed consistent with the most recent version of the United States Pharmacopeia's Model Guidelines.

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

Subd. 3. **Formulary changes.** (a) Once a formulary has been established, a health plan company may, at any time during the enrollee's contract term:

(1) expand its formulary by adding drugs to the formulary;

(2) reduce co-payments or coinsurance; or

(3) move a drug to a benefit category that reduces an enrollee's cost.

(b) A health plan company may remove a brand name drug from the plan's formulary or place a brand name drug in a benefit category that increases an enrollee's cost only upon the addition to the formulary of a generic or multisource brand name drug rated as therapeutically equivalent according to the FDA Orange Book or a biologic drug rated as interchangeable according to the FDA Purple Book at a lower cost to the enrollee, or a biosimilar as defined by United States Code, title 42, section 262(i)(2), and upon at least a 60-day notice to prescribers, pharmacists, and affected enrollees.

(c) A health plan company may change utilization review requirements or move drugs to a benefit category that increases an enrollee's cost during the enrollee's contract term upon at least a 60-day notice to prescribers, pharmacists, and affected enrollees, provided that these changes do not apply to enrollees who are currently taking the drugs affected by these changes for the duration of the enrollee's contract term.

(d) A health plan company may remove any drugs from the plan's formulary that have been deemed unsafe by the Food and Drug Administration, that have been withdrawn by either the Food and Drug Administration or the product manufacturer, or when an

independent source of research, clinical guidelines, or evidence-based standards has issued drug-specific warnings or recommended changes in drug usage.

(e) Health plan companies, managed care plans, and county-based purchasing plans under section 256B.69 and chapter 256L, may update their formulary or preferred drug list quarterly, provided that these changes do not apply to enrollees who are currently taking the drugs affected by these changes for the duration of the calendar year.

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

Sec. 26. Minnesota Statutes 2022, section 62U.04, subdivision 4, is amended to read:

Subd. 4. **Encounter data.** (a) All health plan companies, dental organizations, and third-party administrators shall submit encounter data on a monthly basis to a private entity designated by the commissioner of health. The data shall be submitted in a form and manner specified by the commissioner subject to the following requirements:

(1) the data must be de-identified data as described under the Code of Federal Regulations, title 45, section 164.514;

(2) the data for each encounter must include an identifier for the patient's health care home if the patient has selected a health care home, data on contractual value-based payments, and~~, for claims incurred on or after January 1, 2019,~~ data deemed necessary by the commissioner to uniquely identify claims in the individual health insurance market; ~~and~~

(3) the data must include enrollee race and ethnicity, to the extent available, for claims incurred on or after January 1, 2023; and

(4) except for the ~~identifier~~ data described in ~~clause~~ clauses (2) and (3), the data must not include information that is not included in a health care claim, dental care claim, or equivalent encounter information transaction that is required under section 62J.536.

(b) The commissioner or the commissioner's designee shall only use the data submitted under paragraph (a) to carry out the commissioner's responsibilities in this section, including supplying the data to providers so they can verify their results of the peer grouping process consistent with the recommendations developed pursuant to subdivision 3c, paragraph (d), and adopted by the commissioner and, if necessary, submit comments to the commissioner or initiate an appeal.

(c) Data on providers collected under this subdivision are private data on individuals or nonpublic data, as defined in section 13.02. Notwithstanding the definition of summary data

in section 13.02, subdivision 19, summary data prepared under this subdivision may be derived from nonpublic data. The commissioner or the commissioner's designee shall establish procedures and safeguards to protect the integrity and confidentiality of any data that it maintains.

(d) The commissioner or the commissioner's designee shall not publish analyses or reports that identify, or could potentially identify, individual patients.

(e) The commissioner shall compile summary information on the data submitted under this subdivision. The commissioner shall work with its vendors to assess the data submitted in terms of compliance with the data submission requirements and the completeness of the data submitted by comparing the data with summary information compiled by the commissioner and with established and emerging data quality standards to ensure data quality.

Sec. 27. Minnesota Statutes 2022, section 62U.04, subdivision 5, is amended to read:

Subd. 5. **Pricing data.** (a) All health plan companies, dental organizations, and third-party administrators shall submit, on a monthly basis, data on their contracted prices with health care providers to a private entity designated by the commissioner of health for the purposes of performing the analyses required under this subdivision. Data on contracted prices submitted under this paragraph must include data on supplemental contractual value-based payments paid to health care providers. The data shall be submitted in the form and manner specified by the commissioner of health.

(b) The commissioner or the commissioner's designee shall only use the data submitted under this subdivision to carry out the commissioner's responsibilities under this section, including supplying the data to providers so they can verify their results of the peer grouping process consistent with the recommendations developed pursuant to subdivision 3c, paragraph (d), and adopted by the commissioner and, if necessary, submit comments to the commissioner or initiate an appeal.

(c) Data collected under this subdivision are private data on individuals or nonpublic data as defined in section 13.02. Notwithstanding the definition of summary data in section 13.02, subdivision 19, summary data prepared under this section may be derived from nonpublic data. The commissioner shall establish procedures and safeguards to protect the integrity and confidentiality of any data that it maintains.

Sec. 28. Minnesota Statutes 2022, section 62U.04, subdivision 5a, is amended to read:

Subd. 5a. **Self-insurers.** (a) The commissioner shall not require a self-insurer governed by the federal Employee Retirement Income Security Act of 1974 (ERISA) to comply with this section.

(b) A third-party administrator must annually notify the self-insurers whose health plans are administered by the third-party administrator that the self-insurer may elect to have the third-party administrator submit encounter data, data on contracted prices, and data on nonclaims-based payments under subdivisions 4, 5, and 5b, from the self-insurer's health plan for the upcoming plan year. This notice must be provided in a form and manner specified by the commissioner. After receiving responses from self-insurers, a third-party administrator must, in a form and manner specified by the commissioner, report to the commissioner:

(1) the self-insurers that elected to have the third-party administrator submit encounter data and data on contracted prices from the self-insurer's health plan for the upcoming plan year;

(2) the self-insurers that declined to have the third-party administrator submit encounter data and data on contracted prices from the self-insurer's health plan for the upcoming plan year; and

(3) data deemed necessary by the commissioner to identify and track the status of reporting of data from self-insured health plans.

(c) Data collected under this subdivision are private data on individuals or nonpublic data as defined in section 13.02. Notwithstanding the definition of summary data in section 13.02, subdivision 19, summary data prepared under this subdivision may be derived from nonpublic data. The commissioner shall establish procedures and safeguards to protect the integrity and confidentiality of any data maintained by the commissioner.

Sec. 29. Minnesota Statutes 2022, section 62U.04, is amended by adding a subdivision to read:

Subd. 5b. **Nonclaims-based payments.** (a) Beginning January 1, 2025, all health plan companies and third-party administrators shall submit to a private entity designated by the commissioner of health all nonclaims-based payments made to health care providers. The data shall be submitted in a form, manner, and frequency specified by the commissioner. Nonclaims-based payments are payments to health care providers designed to pay for value of health care services over volume of health care services and include alternative payment models or incentives, payments for infrastructure expenditures or investments, and payments

for workforce expenditures or investments. Nonclaims-based payments submitted under this subdivision must, to the extent possible, be attributed to a health care provider in the same manner in which claims-based data are attributed to a health care provider and, where appropriate, must be combined with data collected under subdivisions 4 to 5a in analyses of health care spending.

(b) Data collected under this subdivision are private data on individuals or nonpublic data as defined in section 13.02. Notwithstanding the definition of summary data in section 13.02, subdivision 19, summary data prepared under this subdivision may be derived from nonpublic data. The commissioner shall establish procedures and safeguards to protect the integrity and confidentiality of any data maintained by the commissioner.

(c) The commissioner shall consult with health plan companies, hospitals, and health care providers in developing the data reported under this subdivision and standardized reporting forms.

Sec. 30. Minnesota Statutes 2022, section 62U.04, subdivision 11, is amended to read:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Sec. 31. Minnesota Statutes 2022, section 62U.04, is amended by adding a subdivision to read:

Subd. 13. **Expanded access to and use of the all-payer claims data.** (a) The commissioner may make any data submitted under this section, including data classified as private or nonpublic, available to individuals and organizations engaged in efforts to research or affect transformation in health care outcomes, access, quality, disparities, or spending, provided use of the data serves a public benefit and is not employed to:

(1) create an unfair market advantage for any participant in the health care market in the state of Minnesota, health plan companies, payers, and providers;

(2) reidentify or attempt to reidentify an individual in the data; and

(3) publicly report details derived from the data regarding any contract between a health plan company and a provider.

(b) To implement the provisions in paragraph (a), the commissioner must:

(1) establish detailed requirements for data access; a process for data users to apply for access to and use of the data; legally enforceable data use agreements to which data users must consent; a clear and robust oversight process for data access and use, including a data management plan, that ensures compliance with state and federal data privacy laws; agreements for state agencies and the University of Minnesota to ensure proper and efficient use and security of data; and technical assistance for users of the data and stakeholders;

(2) develop a fee schedule to support the cost of expanded use of the data, provided the fees charged under the schedule do not create a barrier to access for those most affected by disparities; and

(3) create a research advisory group to advise the commissioner on applications for data use under this subdivision, including an examination of the rigor of the research approach, the technical capabilities of the proposed users, and the ability of the proposed user to successfully safeguard the data.

Sec. 32. Minnesota Statutes 2022, section 62U.10, subdivision 7, is amended to read:

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 5b, 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.

Sec. 33. Minnesota Statutes 2022, section 151.071, subdivision 2, is amended to read:

Subd. 2. **Grounds for disciplinary action.** (a) The following conduct is prohibited and is grounds for disciplinary action:

(1) failure to demonstrate the qualifications or satisfy the requirements for a license or registration contained in this chapter or the rules of the board. The burden of proof is on the applicant to demonstrate such qualifications or satisfaction of such requirements;

(2) obtaining a license by fraud or by misleading the board in any way during the application process or obtaining a license by cheating, or attempting to subvert the licensing examination process. Conduct that subverts or attempts to subvert the licensing examination process includes, but is not limited to: (i) conduct that violates the security of the examination materials, such as removing examination materials from the examination room or having unauthorized possession of any portion of a future, current, or previously administered licensing examination; (ii) conduct that violates the standard of test administration, such as communicating with another examinee during administration of the examination, copying another examinee's answers, permitting another examinee to copy one's answers, or possessing unauthorized materials; or (iii) impersonating an examinee or permitting an impersonator to take the examination on one's own behalf;

(3) for a pharmacist, pharmacy technician, pharmacist intern, applicant for a pharmacist or pharmacy license, or applicant for a pharmacy technician or pharmacist intern registration, conviction of a felony reasonably related to the practice of pharmacy. Conviction as used in this subdivision includes a conviction of an offense that if committed in this state would be deemed a felony without regard to its designation elsewhere, or a criminal proceeding where a finding or verdict of guilt is made or returned but the adjudication of guilt is either withheld or not entered thereon. The board may delay the issuance of a new license or registration if the applicant has been charged with a felony until the matter has been adjudicated;

(4) for a facility, other than a pharmacy, licensed or registered by the board, if an owner or applicant is convicted of a felony reasonably related to the operation of the facility. The board may delay the issuance of a new license or registration if the owner or applicant has been charged with a felony until the matter has been adjudicated;

(5) for a controlled substance researcher, conviction of a felony reasonably related to controlled substances or to the practice of the researcher's profession. The board may delay the issuance of a registration if the applicant has been charged with a felony until the matter has been adjudicated;

(6) disciplinary action taken by another state or by one of this state's health licensing agencies:

(i) revocation, suspension, restriction, limitation, or other disciplinary action against a license or registration in another state or jurisdiction, failure to report to the board that charges or allegations regarding the person's license or registration have been brought in another state or jurisdiction, or having been refused a license or registration by any other state or jurisdiction. The board may delay the issuance of a new license or registration if an investigation or disciplinary action is pending in another state or jurisdiction until the investigation or action has been dismissed or otherwise resolved; and

(ii) revocation, suspension, restriction, limitation, or other disciplinary action against a license or registration issued by another of this state's health licensing agencies, failure to report to the board that charges regarding the person's license or registration have been brought by another of this state's health licensing agencies, or having been refused a license or registration by another of this state's health licensing agencies. The board may delay the issuance of a new license or registration if a disciplinary action is pending before another of this state's health licensing agencies until the action has been dismissed or otherwise resolved;

(7) for a pharmacist, pharmacy, pharmacy technician, or pharmacist intern, violation of any order of the board, of any of the provisions of this chapter or any rules of the board or violation of any federal, state, or local law or rule reasonably pertaining to the practice of pharmacy;

(8) for a facility, other than a pharmacy, licensed by the board, violations of any order of the board, of any of the provisions of this chapter or the rules of the board or violation of any federal, state, or local law relating to the operation of the facility;

(9) engaging in any unethical conduct; conduct likely to deceive, defraud, or harm the public, or demonstrating a willful or careless disregard for the health, welfare, or safety of a patient; or pharmacy practice that is professionally incompetent, in that it may create unnecessary danger to any patient's life, health, or safety, in any of which cases, proof of actual injury need not be established;

(10) aiding or abetting an unlicensed person in the practice of pharmacy, except that it is not a violation of this clause for a pharmacist to supervise a properly registered pharmacy technician or pharmacist intern if that person is performing duties allowed by this chapter or the rules of the board;

(11) for an individual licensed or registered by the board, adjudication as mentally ill or developmentally disabled, or as a chemically dependent person, a person dangerous to the public, a sexually dangerous person, or a person who has a sexual psychopathic personality, by a court of competent jurisdiction, within or without this state. Such adjudication shall automatically suspend a license for the duration thereof unless the board orders otherwise;

(12) for a pharmacist or pharmacy intern, engaging in unprofessional conduct as specified in the board's rules. In the case of a pharmacy technician, engaging in conduct specified in board rules that would be unprofessional if it were engaged in by a pharmacist or pharmacist intern or performing duties specifically reserved for pharmacists under this chapter or the rules of the board;

(13) for a pharmacy, operation of the pharmacy without a pharmacist present and on duty except as allowed by a variance approved by the board;

(14) for a pharmacist, the inability to practice pharmacy with reasonable skill and safety to patients by reason of illness, use of alcohol, drugs, narcotics, chemicals, or any other type of material or as a result of any mental or physical condition, including deterioration through the aging process or loss of motor skills. In the case of registered pharmacy technicians, pharmacist interns, or controlled substance researchers, the inability to carry out duties allowed under this chapter or the rules of the board with reasonable skill and safety to patients by reason of illness, use of alcohol, drugs, narcotics, chemicals, or any other type of material or as a result of any mental or physical condition, including deterioration through the aging process or loss of motor skills;

(15) for a pharmacist, pharmacy, pharmacist intern, pharmacy technician, medical gas dispenser, or controlled substance researcher, revealing a privileged communication from or relating to a patient except when otherwise required or permitted by law;

(16) for a pharmacist or pharmacy, improper management of patient records, including failure to maintain adequate patient records, to comply with a patient's request made pursuant to sections 144.291 to 144.298, or to furnish a patient record or report required by law;

(17) fee splitting, including without limitation:

(i) paying, offering to pay, receiving, or agreeing to receive, a commission, rebate, kickback, or other form of remuneration, directly or indirectly, for the referral of patients;

(ii) referring a patient to any health care provider as defined in sections 144.291 to 144.298 in which the licensee or registrant has a financial or economic interest as defined

in section 144.6521, subdivision 3, unless the licensee or registrant has disclosed the licensee's or registrant's financial or economic interest in accordance with section 144.6521; and

(iii) any arrangement through which a pharmacy, in which the prescribing practitioner does not have a significant ownership interest, fills a prescription drug order and the prescribing practitioner is involved in any manner, directly or indirectly, in setting the price for the filled prescription that is charged to the patient, the patient's insurer or pharmacy benefit manager, or other person paying for the prescription or, in the case of veterinary patients, the price for the filled prescription that is charged to the client or other person paying for the prescription, except that a veterinarian and a pharmacy may enter into such an arrangement provided that the client or other person paying for the prescription is notified, in writing and with each prescription dispensed, about the arrangement, unless such arrangement involves pharmacy services provided for livestock, poultry, and agricultural production systems, in which case client notification would not be required;

(18) engaging in abusive or fraudulent billing practices, including violations of the federal Medicare and Medicaid laws or state medical assistance laws or rules;

(19) engaging in conduct with a patient that is sexual or may reasonably be interpreted by the patient as sexual, or in any verbal behavior that is seductive or sexually demeaning to a patient;

(20) failure to make reports as required by section 151.072 or to cooperate with an investigation of the board as required by section 151.074;

(21) knowingly providing false or misleading information that is directly related to the care of a patient unless done for an accepted therapeutic purpose such as the dispensing and administration of a placebo;

(22) aiding suicide or aiding attempted suicide in violation of section 609.215 as established by any of the following:

(i) a copy of the record of criminal conviction or plea of guilty for a felony in violation of section 609.215, subdivision 1 or 2;

(ii) a copy of the record of a judgment of contempt of court for violating an injunction issued under section 609.215, subdivision 4;

(iii) a copy of the record of a judgment assessing damages under section 609.215, subdivision 5; or

(iv) a finding by the board that the person violated section 609.215, subdivision 1 or 2. The board must investigate any complaint of a violation of section 609.215, subdivision 1 or 2;

(23) for a pharmacist, practice of pharmacy under a lapsed or nonrenewed license. For a pharmacist intern, pharmacy technician, or controlled substance researcher, performing duties permitted to such individuals by this chapter or the rules of the board under a lapsed or nonrenewed registration. For a facility required to be licensed under this chapter, operation of the facility under a lapsed or nonrenewed license or registration; ~~and~~

(24) for a pharmacist, pharmacist intern, or pharmacy technician, termination or discharge from the health professionals services program for reasons other than the satisfactory completion of the program~~.~~; and

(25) for a drug manufacturer, failure to comply with section 62J.841.

(b) The provisions in clause (25) shall not be severable from section 62Q.83. If clause (25) or its application to any individual, entity, or circumstance is found to be void for any reason, section 62Q.83 shall be void also.

Sec. 34. **REPORT ON TRANSPARENCY OF HEALTH CARE PAYMENTS.**

Subdivision 1. **Definitions.** (a) The terms defined in this subdivision apply to this section.

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

(c) "Nonclaims-based payments" means payments to health care providers designed to support and reward value of health care services over volume of health care services and includes alternative payment models or incentives, payments for infrastructure expenditures or investments, and payments for workforce expenditures or investments.

(d) "Nonpublic data" has the meaning given in Minnesota Statutes, section 13.02, subdivision 9.

(e) "Primary care services" means integrated, accessible health care services provided by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community. Primary care services include but are not limited to preventive services, office visits, administration of vaccines, annual physicals, pre-operative physicals, assessments, care coordination, development of treatment plans, management of chronic conditions, and diagnostic tests.

Subd. 2. **Report.** (a) To provide the legislature with information needed to meet the evolving health care needs of Minnesotans, the commissioner shall report to the legislature by February 15, 2024, on the volume and distribution of health care spending across payment models used by health plan companies and third-party administrators, with a particular focus on value-based care models and primary care spending.

(b) The report must include specific health plan and third-party administrator estimates of health care spending for claims-based payments and nonclaims-based payments for the most recent available year, reported separately for Minnesotans enrolled in state health care programs, Medicare Advantage, and commercial health insurance. The report must also include recommendations on changes needed to gather better data from health plan companies and third-party administrators on the use of value-based payments that pay for value of health care services provided over volume of services provided, promote the health of all Minnesotans, reduce health disparities, and support the provision of primary care services and preventive services.

(c) In preparing the report, the commissioner shall:

(1) describe the form, manner, and timeline for submission of data by health plan companies and third-party administrators to produce estimates as specified in paragraph (b);

(2) collect summary data that permits the computation of:

(i) the percentage of total payments that are nonclaims-based payments; and

(ii) the percentage of payments in item (i) that are for primary care services;

(3) where data was not directly derived, specify the methods used to estimate data elements;

(4) notwithstanding Minnesota Statutes, section 62U.04, subdivision 11, conduct analyses of the magnitude of primary care payments using data collected by the commissioner under Minnesota Statutes, section 62U.04; and

(5) conduct interviews with health plan companies and third-party administrators to better understand the types of nonclaims-based payments and models in use, the purposes or goals of each, the criteria for health care providers to qualify for these payments, and the timing and structure of health plan companies or third-party administrators making these payments to health care provider organizations.

(d) Health plan companies and third-party administrators must comply with data requests from the commissioner under this section within 60 days after receiving the request.

(e) Data collected under this section is nonpublic data. Notwithstanding the definition of summary data in Minnesota Statutes, section 13.02, subdivision 19, summary data prepared under this section may be derived from nonpublic data. The commissioner shall establish procedures and safeguards to protect the integrity and confidentiality of any data maintained by the commissioner.

Sec. 35. **COMMISSIONER OF COMMERCE.**

The commissioner of commerce shall consult with health plan companies, pharmacies, and pharmacy benefit managers to develop guidance to implement coverage for the pharmacy services required by Minnesota Statutes, sections 62A.15, subdivisions 3d and 4; and 62D.1071.

ARTICLE 3
KEEPING NURSES AT THE BEDSIDE

Section 1. Minnesota Statutes 2022, section 144.1501, subdivision 1, is amended to read:

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

(b) "Advanced dental therapist" means an individual who is licensed as a dental therapist under section 150A.06, and who is certified as an advanced dental therapist under section 150A.106.

(c) "Alcohol and drug counselor" means an individual who is licensed as an alcohol and drug counselor under chapter 148F.

(d) "Dental therapist" means an individual who is licensed as a dental therapist under section 150A.06.

(e) "Dentist" means an individual who is licensed to practice dentistry.

(f) "Designated rural area" means a statutory and home rule charter city or township that is outside the seven-county metropolitan area as defined in section 473.121, subdivision 2, excluding the cities of Duluth, Mankato, Moorhead, Rochester, and St. Cloud.

(g) "Emergency circumstances" means those conditions that make it impossible for the participant to fulfill the service commitment, including death, total and permanent disability, or temporary disability lasting more than two years.

(h) "Hospital nurse" means an individual who is licensed as a registered nurse and who is providing direct patient care in a nonprofit hospital setting.

(i) "Mental health professional" means an individual providing clinical services in the treatment of mental illness who is qualified in at least one of the ways specified in section 245.462, subdivision 18.

~~(i)~~ (j) "Medical resident" means an individual participating in a medical residency in family practice, internal medicine, obstetrics and gynecology, pediatrics, or psychiatry.

~~(j)~~ (k) "Midlevel practitioner" means a nurse practitioner, nurse-midwife, nurse anesthetist, advanced clinical nurse specialist, or physician assistant.

~~(k)~~ (l) "Nurse" means an individual who has completed training and received all licensing or certification necessary to perform duties as a licensed practical nurse or registered nurse.

~~(l)~~ (m) "Nurse-midwife" means a registered nurse who has graduated from a program of study designed to prepare registered nurses for advanced practice as nurse-midwives.

~~(m)~~ (n) "Nurse practitioner" means a registered nurse who has graduated from a program of study designed to prepare registered nurses for advanced practice as nurse practitioners.

~~(n)~~ (o) "Pharmacist" means an individual with a valid license issued under chapter 151.

~~(o)~~ (p) "Physician" means an individual who is licensed to practice medicine in the areas of family practice, internal medicine, obstetrics and gynecology, pediatrics, or psychiatry.

~~(p)~~ (q) "Physician assistant" means a person licensed under chapter 147A.

(r) "PSLF program" means the federal Public Service Loan Forgiveness program established under Code of Federal Regulations, title 34, section 685.219.

~~(q)~~ (s) "Public health nurse" means a registered nurse licensed in Minnesota who has obtained a registration certificate as a public health nurse from the Board of Nursing in accordance with Minnesota Rules, chapter 6316.

~~(r)~~ (t) "Qualified educational loan" means a government, commercial, or foundation loan for actual costs paid for tuition, reasonable education expenses, and reasonable living expenses related to the graduate or undergraduate education of a health care professional.

~~(s)~~ (u) "Underserved urban community" means a Minnesota urban area or population included in the list of designated primary medical care health professional shortage areas (HPSAs), medically underserved areas (MUAs), or medically underserved populations (MUPs) maintained and updated by the United States Department of Health and Human Services.

Sec. 2. Minnesota Statutes 2022, section 144.1501, subdivision 2, is amended to read:

Subd. 2. **Creation of account.** (a) A health professional education loan forgiveness program account is established. The commissioner of health shall use money from the account to establish a loan forgiveness program:

(1) for medical residents, mental health professionals, and alcohol and drug counselors agreeing to practice in designated rural areas or underserved urban communities or specializing in the area of pediatric psychiatry;

(2) for midlevel practitioners agreeing to practice in designated rural areas or to teach at least 12 credit hours, or 720 hours per year in the nursing field in a postsecondary program at the undergraduate level or the equivalent at the graduate level;

(3) for nurses who agree to practice in a Minnesota nursing home; an intermediate care facility for persons with developmental disability; a hospital if the hospital owns and operates a Minnesota nursing home and a minimum of 50 percent of the hours worked by the nurse is in the nursing home; a housing with services establishment as defined in section 144D.01, subdivision 4; or for a home care provider as defined in section 144A.43, subdivision 4; or agree to teach at least 12 credit hours, or 720 hours per year in the nursing field in a postsecondary program at the undergraduate level or the equivalent at the graduate level;

(4) for other health care technicians agreeing to teach at least 12 credit hours, or 720 hours per year in their designated field in a postsecondary program at the undergraduate level or the equivalent at the graduate level. The commissioner, in consultation with the Healthcare Education-Industry Partnership, shall determine the health care fields where the need is the greatest, including, but not limited to, respiratory therapy, clinical laboratory technology, radiologic technology, and surgical technology;

(5) for pharmacists, advanced dental therapists, dental therapists, and public health nurses who agree to practice in designated rural areas; ~~and~~

(6) for dentists agreeing to deliver at least 25 percent of the dentist's yearly patient encounters to state public program enrollees or patients receiving sliding fee schedule discounts through a formal sliding fee schedule meeting the standards established by the United States Department of Health and Human Services under Code of Federal Regulations, title 42, section 51, chapter 303; and

(7) for nurses who are enrolled in the PSLF program, employed as a hospital nurse by a nonprofit hospital that is an eligible employer under the PSLF program, and providing direct care to patients at the nonprofit hospital.

(b) Appropriations made to the account do not cancel and are available until expended, except that at the end of each biennium, any remaining balance in the account that is not committed by contract and not needed to fulfill existing commitments shall cancel to the fund.

Sec. 3. Minnesota Statutes 2022, section 144.1501, subdivision 3, is amended to read:

Subd. 3. **Eligibility.** (a) To be eligible to participate in the loan forgiveness program, an individual must:

(1) be a medical or dental resident; a licensed pharmacist; or be enrolled in a training or education program to become a dentist, dental therapist, advanced dental therapist, mental health professional, alcohol and drug counselor, pharmacist, public health nurse, midlevel practitioner, registered nurse, or a licensed practical nurse. The commissioner may also consider applications submitted by graduates in eligible professions who are licensed and in practice; and

(2) submit an application to the commissioner of health. Nurses applying under subdivision 2, paragraph (a), clause (7), must also include proof that the applicant is enrolled in the PSLF program and confirmation that the applicant is employed as a hospital nurse.

(b) An applicant selected to participate must sign a contract to agree to serve a minimum three-year full-time service obligation according to subdivision 2, which shall begin no later than March 31 following completion of required training, with the exception of:

(1) a nurse, who must agree to serve a minimum two-year full-time service obligation according to subdivision 2, which shall begin no later than March 31 following completion of required training;

(2) a nurse selected under subdivision 2, paragraph (a), clause (7), must agree to continue as a hospital nurse for the repayment period of the participant's eligible loan under the PSLF program; and

(3) a nurse who agrees to teach according to subdivision 2, paragraph (a), clause (3), must sign a contract to agree to teach for a minimum of two years.

Sec. 4. Minnesota Statutes 2022, section 144.1501, subdivision 4, is amended to read:

Subd. 4. **Loan forgiveness.** (a) The commissioner of health may select applicants each year for participation in the loan forgiveness program, within the limits of available funding. In considering applications, the commissioner shall give preference to applicants who document diverse cultural competencies. The commissioner shall distribute available funds

for loan forgiveness proportionally among the eligible professions according to the vacancy rate for each profession in the required geographic area, facility type, teaching area, patient group, or specialty type specified in subdivision 2, except for hospital nurses. The commissioner shall allocate funds for physician loan forgiveness so that 75 percent of the funds available are used for rural physician loan forgiveness and 25 percent of the funds available are used for underserved urban communities and pediatric psychiatry loan forgiveness. If the commissioner does not receive enough qualified applicants each year to use the entire allocation of funds for any eligible profession, the remaining funds may be allocated proportionally among the other eligible professions according to the vacancy rate for each profession in the required geographic area, patient group, or facility type specified in subdivision 2. Applicants are responsible for securing their own qualified educational loans. The commissioner shall select participants based on their suitability for practice serving the required geographic area or facility type specified in subdivision 2, as indicated by experience or training. The commissioner shall give preference to applicants closest to completing their training. Except as specified in paragraphs (b) and (c), for each year that a participant meets the service obligation required under subdivision 3, up to a maximum of four years, the commissioner shall make annual disbursements directly to the participant equivalent to 15 percent of the average educational debt for indebted graduates in their profession in the year closest to the applicant's selection for which information is available, not to exceed the balance of the participant's qualifying educational loans. Before receiving loan repayment disbursements and as requested, the participant must complete and return to the commissioner a confirmation of practice form provided by the commissioner verifying that the participant is practicing as required under subdivisions 2 and 3. The participant must provide the commissioner with verification that the full amount of loan repayment disbursement received by the participant has been applied toward the designated loans. After each disbursement, verification must be received by the commissioner and approved before the next loan repayment disbursement is made. Participants who move their practice remain eligible for loan repayment as long as they practice as required under subdivision 2.

(b) For hospital nurses, the commissioner of health shall select applicants each year for participation in the hospital nursing education loan forgiveness program, within limits of available funding for hospital nurses. Applicants are responsible for applying for and maintaining eligibility for the PSLF program. For each year that a participant meets the eligibility requirements described in subdivision 3, the commissioner shall make an annual disbursement directly to the participant in an amount equal to the minimum loan payments required to be paid by the participant under the participant's repayment plan established for

the participant under the PSLF program for the previous loan year. Before receiving the annual loan repayment disbursement, the participant must complete and return to the commissioner a confirmation of practice form provided by the commissioner, verifying that the participant continues to meet the eligibility requirements under subdivision 3. The participant must provide the commissioner with verification that the full amount of loan repayment disbursement received by the participant has been applied toward the loan for which forgiveness is sought under the PSLF program.

(c) For each year that a participant who is a nurse and who has agreed to teach according to subdivision 2 meets the teaching obligation required in subdivision 3, the commissioner shall make annual disbursements directly to the participant equivalent to 15 percent of the average annual educational debt for indebted graduates in the nursing profession in the year closest to the participant's selection for which information is available, not to exceed the balance of the participant's qualifying educational loans.

Sec. 5. Minnesota Statutes 2022, section 144.1501, subdivision 5, is amended to read:

Subd. 5. **Penalty for nonfulfillment.** If a participant does not fulfill the required minimum commitment of service according to subdivision 3~~,~~ or, for hospital nurses, the secretary of education determines that the participant does not meet eligibility requirements for the PSLF, the commissioner of health shall collect from the participant the total amount paid to the participant under the loan forgiveness program plus interest at a rate established according to section 270C.40. The commissioner shall deposit the money collected in the health care access fund to be credited to the health professional education loan forgiveness program account established in subdivision 2. The commissioner shall allow waivers of all or part of the money owed the commissioner as a result of a nonfulfillment penalty if emergency circumstances prevented fulfillment of the minimum service commitment or, for hospital nurses, if the PSLF program is discontinued before the participant's service commitment is fulfilled.

Sec. 6. Minnesota Statutes 2022, section 144.566, is amended to read:

144.566 VIOLENCE AGAINST HEALTH CARE WORKERS.

Subdivision 1. **Definitions.** (a) The following definitions apply to this section and have the meanings given.

(b) "Act of violence" means an act by a patient or visitor against a health care worker that includes kicking, scratching, urinating, sexually harassing, or any act defined in sections 609.221 to 609.2241.

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

(d) "Health care worker" means any person, whether licensed or unlicensed, employed by, volunteering in, or under contract with a hospital, who has direct contact with a patient of the hospital for purposes of either medical care or emergency response to situations potentially involving violence.

(e) "Hospital" means any facility licensed as a hospital under section 144.55.

(f) "Incident response" means the actions taken by hospital administration and health care workers during and following an act of violence.

(g) "Interfere" means to prevent, impede, discourage, or delay a health care worker's ability to report acts of violence, including by retaliating or threatening to retaliate against a health care worker.

(h) "Preparedness" means the actions taken by hospital administration and health care workers to prevent a single act of violence or acts of violence generally.

(i) "Retaliate" means to discharge, discipline, threaten, otherwise discriminate against, or penalize a health care worker regarding the health care worker's compensation, terms, conditions, location, or privileges of employment.

(j) "Workplace violence hazards" means locations and situations where violent incidents are more likely to occur, including, as applicable, but not limited to locations isolated from other health care workers; health care workers working alone; health care workers working in remote locations; health care workers working late night or early morning hours; locations where an assailant could prevent entry of responders or other health care workers into a work area; locations with poor illumination; locations with poor visibility; lack of effective escape routes; obstacles and impediments to accessing alarm systems; locations within the facility where alarm systems are not operational; entryways where unauthorized entrance may occur, such as doors designated for staff entrance or emergency exits; presence, in the areas where patient contact activities are performed, of furnishings or objects that could be used as weapons; and locations where high-value items, currency, or pharmaceuticals are stored.

Subd. 2. **~~Hospital duties~~ Action plans and action plan reviews required.** ~~(a)~~ All hospitals must design and implement preparedness and incident response action plans to acts of violence by January 15, 2016, and review and update the plan at least annually thereafter. The plan must be in writing; specific to the workplace violence hazards and

corrective measures for the units, services, or operations of the hospital; and available to health care workers at all times.

Subd. 3. **Action plan committees.** ~~(b)~~ A hospital shall designate a committee of representatives of health care workers employed by the hospital, including nonmanagerial health care workers, nonclinical staff, administrators, patient safety experts, and other appropriate personnel to develop preparedness and incident response action plans to acts of violence. The hospital shall, in consultation with the designated committee, implement the plans under ~~paragraph (a)~~ subdivision 2. Nothing in this ~~paragraph~~ subdivision shall require the establishment of a separate committee solely for the purpose required by this subdivision.

Subd. 4. **Required elements of action plans; generally.** The preparedness and incident response action plans to acts of violence must include:

(1) effective procedures to obtain the active involvement of health care workers and their representatives in developing, implementing, and reviewing the plan, including their participation in identifying, evaluating, and correcting workplace violence hazards, designing and implementing training, and reporting and investigating incidents of workplace violence;

(2) names or job titles of the persons responsible for implementing the plan; and

(3) effective procedures to ensure that supervisory and nonsupervisory health care workers comply with the plan.

Subd. 5. **Required elements of action plans; evaluation of risk factors.** (a) The preparedness and incident response action plans to acts of violence must include assessment procedures to identify and evaluate workplace violence hazards for each facility, unit, service, or operation, including community-based risk factors and areas surrounding the facility, such as employee parking areas and other outdoor areas. Procedures shall specify the frequency that environmental assessments take place.

(b) The preparedness and incident response action plans to acts of violence must include assessment tools, environmental checklists, or other effective means to identify workplace violence hazards.

Subd. 6. **Required elements of action plans; review of workplace violence incidents.** The preparedness and incident response action plans to acts of violence must include procedures for reviewing all workplace violence incidents that occurred in the facility, unit, service, or operation within the previous year, whether or not an injury occurred.

Subd. 7. **Required elements of action plans; reporting workplace violence.** The preparedness and incident response action plans to acts of violence must include:

(1) effective procedures for health care workers to document information regarding conditions that may increase the potential for workplace violence incidents and communicate that information without fear of reprisal to other health care workers, shifts, or units;

(2) effective procedures for health care workers to report a violent incident, threat, or other workplace violence concern without fear of reprisal;

(3) effective procedures for the hospital to accept and respond to reports of workplace violence and to prohibit retaliation against a health care worker who makes such a report;

(4) a policy statement stating the hospital will not prevent a health care worker from reporting workplace violence or take punitive or retaliatory action against a health care worker for doing so;

(5) effective procedures for investigating health care worker concerns regarding workplace violence or workplace violence hazards;

(6) procedures for informing health care workers of the results of the investigation arising from a report of workplace violence or from a concern about a workplace violence hazard and of any corrective actions taken;

(7) effective procedures for obtaining assistance from the appropriate law enforcement agency or social service agency during all work shifts. The procedure may establish a central coordination procedure; and

(8) a policy statement stating the hospital will not prevent a health care worker from seeking assistance and intervention from local emergency services or law enforcement when a violent incident occurs or take punitive or retaliatory action against a health care worker for doing so.

Subd. 8. **Required elements of action plans; coordination with other employers.** The preparedness and incident response action plans to acts of violence must include methods the hospital will use to coordinate implementation of the plan with other employers whose employees work in the same health care facility, unit, service, or operation and to ensure that those employers and their employees understand their respective roles as provided in the plan. These methods must ensure that all employees working in the facility, unit, service, or operation are provided the training required by subdivision 11 and that workplace violence incidents involving any employee are reported, investigated, and recorded.

Subd. 9. **Required elements of action plans; white supremacist affiliation and support prohibited.** (a) The preparedness and incident response action plans to acts of violence must include a policy statement stating that security personnel employed by the hospital or assigned to the hospital by a contractor are prohibited from affiliating with, supporting, or advocating for white supremacist groups, causes, or ideologies or participating in, or actively promoting, an international or domestic extremist group that the Federal Bureau of Investigation has determined supports or encourages illegal, violent conduct.

(b) For purposes of this subdivision, white supremacist groups, causes, or ideologies include organizations and associations and ideologies that promote white supremacy and the idea that white people are superior to Black, Indigenous, and people of color (BIPOC); promote religious and racial bigotry; seek to exacerbate racial and ethnic tensions between BIPOC and non-BIPOC; or engage in patently hateful and inflammatory speech, intimidation, and violence against BIPOC as means of promoting white supremacy.

Subd. 10. **Required elements of action plans; training.** (a) The preparedness and incident response action plans to acts of violence must include:

(1) procedures for developing and providing the training required in subdivision 11 that permits health care workers and their representatives to participate in developing the training; and

(2) a requirement for cultural competency training and equity, diversity, and inclusion training.

(b) The preparedness and incident response action plans to acts of violence must include procedures to communicate with health care workers regarding workplace violence matters, including:

(1) how health care workers will document and communicate to other health care workers and between shifts and units information regarding conditions that may increase the potential for workplace violence incidents;

(2) how health care workers can report a violent incident, threat, or other workplace violence concern;

(3) how health care workers can communicate workplace violence concerns without fear of reprisal; and

(4) how health care worker concerns will be investigated, and how health care workers will be informed of the results of the investigation and any corrective actions to be taken.

Subd. 11. **Training required.** ~~(c)~~ A hospital ~~shall~~ must provide training to all health care workers employed or contracted with the hospital on safety during acts of violence. Each health care worker must receive safety training ~~annually and upon hire~~ during the health care worker's orientation and before the health care worker completes a shift independently, and annually thereafter. Training must, at a minimum, include:

(1) safety guidelines for response to and de-escalation of an act of violence;

(2) ways to identify potentially violent or abusive situations, including aggression and violence predicting factors; ~~and~~

(3) the hospital's ~~incident response reaction plan and violence prevention plan~~ preparedness and incident response action plans for acts of violence, including how the health care worker may report concerns about workplace violence within each hospital's reporting structure without fear of reprisal, how the hospital will address workplace violence incidents, and how the health care worker can participate in reviewing and revising the plan; and

(4) any resources available to health care workers for coping with incidents of violence, including but not limited to critical incident stress debriefing or employee assistance programs.

Subd. 12. **Annual review and update of action plans.** ~~(d)~~ (a) As part of its annual review of preparedness and incident response action plans required under ~~paragraph (a)~~ subdivision 2, the hospital must review with the designated committee:

(1) the effectiveness of its preparedness and incident response action plans, including the sufficiency of security systems, alarms, emergency responses, and security personnel availability;

(2) security risks associated with specific units, areas of the facility with uncontrolled access, late night shifts, early morning shifts, and areas surrounding the facility such as employee parking areas and other outdoor areas;

(3) the most recent gap analysis as provided by the commissioner; ~~and~~

~~(3)~~ (4) the number of acts of violence that occurred in the hospital during the previous year, including injuries sustained, if any, and the unit in which the incident occurred~~.~~;

(5) evaluations of staffing, including staffing patterns and patient classification systems that contribute to, or are insufficient to address, the risk of violence; and

(6) any reports of discrimination or abuse that arise from security resources, including from the behavior of security personnel.

(b) As part of the annual update of preparedness and incident response action plans required under subdivision 2, the hospital must incorporate corrective actions into the action plan to address workplace violence hazards identified during the annual action plan review, reports of workplace violence, reports of workplace violence hazards, and reports of discrimination or abuse that arise from the security resources.

Subd. 13. **Action plan updates.** Following the annual review of the action plan, a hospital must update the action plans to reflect the corrective actions the hospital will implement to mitigate the hazards and vulnerabilities identified during the annual review.

Subd. 14. **Requests for additional staffing.** A hospital shall create and implement a procedure for a health care worker to officially request of hospital supervisors or administration that additional staffing be provided. The hospital must document all requests for additional staffing made because of a health care worker's concern over a risk of an act of violence. If the request for additional staffing to reduce the risk of violence is denied, the hospital must provide the health care worker who made the request a written reason for the denial and must maintain documentation of that communication with the documentation of requests for additional staffing. A hospital must make documentation regarding staffing requests available to the commissioner for inspection at the commissioner's request. The commissioner may use documentation regarding staffing requests to inform the commissioner's determination on whether the hospital is providing adequate staffing and security to address acts of violence, and may use documentation regarding staffing requests if the commissioner imposes a penalty under subdivision 18.

Subd. 15. **Disclosure of action plans.** ~~(e)~~ (a) A hospital ~~shall~~ must make its most recent action plans and ~~the information listed in paragraph (d)~~ most recent action plan reviews available to local law enforcement, all direct care staff and, if any of its workers are represented by a collective bargaining unit, to the exclusive bargaining representatives of those collective bargaining units.

(b) Beginning January 1, 2025, a hospital must annually submit to the commissioner its most recent action plan and the results of the most recent annual review conducted under subdivision 12.

Subd. 16. **Legislative report required.** (a) Beginning January 15, 2026, the commissioner must compile the information into a single annual report and submit the report to the chairs

and ranking minority members of the legislative committees with jurisdiction over health care by January 15 of each year.

(b) This subdivision does not expire.

Subd. 17. **Interference prohibited.** ~~(f)~~ A hospital, including any individual, partner, association, or any person or group of persons acting directly or indirectly in the interest of the hospital, ~~shall~~ must not interfere with or discourage a health care worker if the health care worker wishes to contact law enforcement or the commissioner regarding an act of violence.

Subd. 18. **Penalties.** ~~(g)~~ Notwithstanding section 144.653, subdivision 6, the commissioner may impose ~~an administrative~~ a fine of up to ~~$250~~ $10,000 for failure to comply with the requirements of this ~~subdivision~~ section. The commissioner must allow the hospital at least 30 calendar days to correct a violation of this section before assessing a fine.

Sec. 7. Minnesota Statutes 2022, section 144.608, subdivision 1, is amended to read:

Subdivision 1. **Trauma Advisory Council established.** (a) A Trauma Advisory Council is established to advise, consult with, and make recommendations to the commissioner on the development, maintenance, and improvement of a statewide trauma system.

(b) The council shall consist of the following members:

(1) a trauma surgeon certified by the American Board of Surgery or the American Osteopathic Board of Surgery who practices in a level I or II trauma hospital;

(2) a general surgeon certified by the American Board of Surgery or the American Osteopathic Board of Surgery whose practice includes trauma and who practices in a designated rural area as defined under section 144.1501, subdivision 1~~, paragraph (c)~~;

(3) a neurosurgeon certified by the American Board of Neurological Surgery who practices in a level I or II trauma hospital;

(4) a trauma program nurse manager or coordinator practicing in a level I or II trauma hospital;

(5) an emergency physician certified by the American Board of Emergency Medicine or the American Osteopathic Board of Emergency Medicine whose practice includes emergency room care in a level I, II, III, or IV trauma hospital;

(6) a trauma program manager or coordinator who practices in a level III or IV trauma hospital;

(7) a physician certified by the American Board of Family Medicine or the American Osteopathic Board of Family Practice whose practice includes emergency department care in a level III or IV trauma hospital located in a designated rural area as defined under section 144.1501, subdivision 1~~, paragraph (e)~~;

(8) a nurse practitioner, as defined under section 144.1501, subdivision 1~~, paragraph (l)~~, or a physician assistant, as defined under section 144.1501, subdivision 1, ~~paragraph (o),~~ whose practice includes emergency room care in a level IV trauma hospital located in a designated rural area as defined under section 144.1501, subdivision 1~~, paragraph (e)~~;

(9) a physician certified in pediatric emergency medicine by the American Board of Pediatrics or certified in pediatric emergency medicine by the American Board of Emergency Medicine or certified by the American Osteopathic Board of Pediatrics whose practice primarily includes emergency department medical care in a level I, II, III, or IV trauma hospital, or a surgeon certified in pediatric surgery by the American Board of Surgery whose practice involves the care of pediatric trauma patients in a trauma hospital;

(10) an orthopedic surgeon certified by the American Board of Orthopaedic Surgery or the American Osteopathic Board of Orthopedic Surgery whose practice includes trauma and who practices in a level I, II, or III trauma hospital;

(11) the state emergency medical services medical director appointed by the Emergency Medical Services Regulatory Board;

(12) a hospital administrator of a level III or IV trauma hospital located in a designated rural area as defined under section 144.1501, subdivision 1~~, paragraph (e)~~;

(13) a rehabilitation specialist whose practice includes rehabilitation of patients with major trauma injuries or traumatic brain injuries and spinal cord injuries as defined under section 144.661;

(14) an attendant or ambulance director who is an EMT, EMT-I, or EMT-P within the meaning of section 144E.001 and who actively practices with a licensed ambulance service in a primary service area located in a designated rural area as defined under section 144.1501, subdivision 1~~, paragraph (e)~~; and

(15) the commissioner of public safety or the commissioner's designee.

Sec. 8. Minnesota Statutes 2022, section 144.653, subdivision 5, is amended to read:

Subd. 5. **Correction orders.** Whenever a duly authorized representative of the state commissioner of health finds upon inspection of a facility required to be licensed under the

provisions of sections 144.50 to 144.58 that the licensee of such facility is not in compliance with sections 144.411 to 144.417, 144.50 to 144.58, 144.651, 144.7051 to 144.7058, or 626.557, or the applicable rules promulgated under those sections, a correction order shall be issued to the licensee. The correction order shall state the deficiency, cite the specific rule violated, and specify the time allowed for correction.

Sec. 9. **[144.7051] DEFINITIONS.**

Subdivision 1. **Applicability.** For the purposes of sections 144.7051 to 144.7058, the terms defined in this section have the meanings given.

Subd. 2. **Concern for safe staffing form.** "Concern for safe staffing form" means a standard uniform form developed by the commissioner that may be used by any individual to report unsafe staffing situations while maintaining the privacy of patients.

Subd. 3. **Commissioner.** "Commissioner" means the commissioner of health.

Subd. 4. **Daily staffing schedule.** "Daily staffing schedule" means the actual number of full-time equivalent nonmanagerial care staff assigned to an inpatient care unit and providing care in that unit during a 24-hour period and the actual number of patients assigned to each direct care registered nurse present and providing care in the unit.

Subd. 5. **Direct-care registered nurse.** "Direct-care registered nurse" means a registered nurse, as defined in section 148.171, subdivision 20, who is nonsupervisory and nonmanagerial and who directly provides nursing care to patients more than 60 percent of the time.

Subd. 6. **Emergency.** "Emergency" means a period when replacement staff are not able to report for duty for the next shift or a period of increased patient need because of unusual, unpredictable, or unforeseen circumstances, including but not limited to an act of terrorism, a disease outbreak, adverse weather conditions, or a natural disaster that impacts continuity of patient care.

Subd. 7. **Hospital.** "Hospital" means any setting that is licensed under this chapter as a hospital.

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

Sec. 10. **[144.7053] HOSPITAL NURSE STAFFING COMMITTEE.**

Subdivision 1. **Hospital nurse staffing committee required.** (a) Each hospital must establish and maintain a functioning hospital nurse staffing committee. A hospital may

assign the functions and duties of a hospital nurse staffing committee to an existing committee provided the existing committee meets the membership requirements applicable to a hospital nurse staffing committee.

(b) The commissioner is not required to verify compliance with this section by an on-site visit.

Subd. 2. **Staffing committee membership.** (a) At least 35 percent of the hospital nurse staffing committee's membership must be direct care registered nurses typically assigned to a specific unit for an entire shift and at least 15 percent of the committee's membership must be other direct care workers typically assigned to a specific unit for an entire shift. A hospital's nurse staffing committee's membership must consist of at least one nurse from each unit covered by the hospital's core staffing plan. Direct care registered nurses and other direct care workers who are members of a collective bargaining unit shall be appointed or elected to the committee according to the guidelines of the applicable collective bargaining agreement. If there is no collective bargaining agreement, direct care registered nurses shall be elected to the committee by direct care registered nurses employed by the hospital and other direct care workers shall be elected to the committee by other direct care workers employed by the hospital.

(b) The hospital shall appoint 50 percent of the hospital nurse staffing committee's membership.

Subd. 3. **Staffing committee compensation.** A hospital must treat participation in the hospital nurse staffing committee meetings by any hospital employee as scheduled work time and compensate each committee member at the employee's existing rate of pay. A hospital must relieve all direct care registered nurse members of the hospital nurse staffing committee of other work duties during the times when the committee meets.

Subd. 4. **Staffing committee meeting frequency.** Each hospital nurse staffing committee must meet at least quarterly.

Subd. 5. **Staffing committee duties.** (a) Each hospital nurse staffing committee shall create, implement, continuously evaluate, and update as needed evidence-based written core staffing plans to guide the creation of daily staffing schedules for each inpatient care unit of the hospital. Each hospital nurse staffing committee must adopt a core staffing plan annually by a majority vote of all members.

(b) Each hospital nurse staffing committee must:

(1) establish a secure, uniform, and easily accessible method for any hospital employee, patient, or patient family member to submit directly to the committee a concern for safe staffing form;

(2) review each concern for safe staffing form;

(3) forward a copy of all concern for safe staffing forms to the relevant hospital nurse workload committee;

(4) review the documentation of compliance maintained by the hospital under section 144.7056, subdivision 10;

(5) conduct a trend analysis of the data related to all reported concerns regarding safe staffing;

(6) develop a mechanism for tracking and analyzing staffing trends within the hospital;

(7) submit a nurse staffing report to the commissioner;

(8) assist the commissioner in compiling data for the Nursing Workforce Report by encouraging participation in the commissioner's independent study on reasons licensed registered nurses are leaving the profession; and

(9) record in the committee minutes for each meeting a summary of the discussions and recommendations of the committee. Each committee must maintain the minutes, records, and distributed materials for five years.

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

Sec. 11. **[144.7054] HOSPITAL NURSE WORKLOAD COMMITTEE.**

Subdivision 1. **Hospital nurse workload committee required.** (a) Each hospital must establish and maintain functioning hospital nurse workload committees for each unit. A hospital designated as a critical access hospital under section 144.1483, clause (9), may assign the functions and duties of its nurse workload committees to the hospital's nurse staffing committee.

(b) The commissioner is not required to verify compliance with this section by an on-site visit.

Subd. 2. **Workload committee membership.** (a) At least 35 percent of each workload committee's membership must be direct care registered nurses typically assigned to the unit for an entire shift and at least 15 percent of the committee's membership must be other direct care workers typically assigned to the unit for an entire shift. Direct care registered nurses

and other direct care workers who are members of a collective bargaining unit shall be appointed or elected to the committee according to the guidelines of the applicable collective bargaining agreement. If there is no collective bargaining agreement, direct care registered nurses shall be elected to the committee by direct care registered nurses typically assigned to the unit for an entire shift and other direct care workers shall be elected to the committee by other direct care workers typically assigned to the unit for an entire shift.

(b) The hospital shall appoint 50 percent of each unit's nurse workload committee's membership.

(c) Notwithstanding paragraphs (a) and (b), if a hospital has established a staffing committee through collective bargaining, the composition of that committee prevails.

Subd. 3. **Workload committee compensation.** A hospital must treat participation in a hospital nurse workload committee meeting by any hospital employee as scheduled work time and compensate each committee member at the employee's existing rate of pay. A hospital must relieve all direct care registered nurse members of a hospital nurse workload committee of other work duties during the times when the committee meets.

Subd. 4. **Workload committee meeting frequency.** Each hospital nurse workload committee must meet at least monthly whenever the committee is in receipt of an unresolved concern for safe staffing form.

Subd. 5. **Workload committee duties.** (a) Each hospital nurse workload committee must create, implement, and maintain dispute resolution procedures to guide the committee's development and implementation of solutions to the staffing concerns raised in concern for safe staffing forms that have been forwarded to the committee. The dispute resolution procedures must include a two-step process. If the nurse workforce committee is not able to implement a solution to the concerns raised in a concern for safe staffing form, the workload committee must refer the matter to the hospital nurse staffing committee within 15 calendar days of the events described in the concern for safe staffing form. If after both the nurses and hospitals have attempted in good faith to resolve the concern either side may move forward to an expedited arbitration process with an arbitrator who has expertise in patient care that must be completed within 30 calendar days of the dispute being escalated to the hospital nurse staffing committee.

(b) In the event both parties believe that they have reached an impasse prior to the 15- or 30-day deadline, the parties may move to the next appropriate step. The committee must use the expedited arbitration process for any complaint that remains unresolved 45 days after the submission of the concern for safe staffing form that gave rise to the complaint.

(c) Each hospital nurse workload committee must attempt to expeditiously resolve staffing issues the committee determines arise from a violation of the hospital's core staffing plan.

(d) If the majority of the members of the workload committee agree that the concerns raised can be reasonably grouped together or considered together because multiple forms were submitted from one patient care unit on one date or shift, then the committee can decide to submit them as one occurrence.

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

Sec. 12. Minnesota Statutes 2022, section 144.7055, is amended to read:

144.7055 HOSPITAL CORE STAFFING PLAN ~~REPORTS~~.

Subdivision 1. **Definitions.** (a) For the purposes of ~~this section~~ sections 144.7051 to 144.7058, the following terms have the meanings given.

(b) "Core staffing plan" means ~~the projected number of full-time equivalent nonmanagerial care staff that will be assigned in a 24-hour period to an inpatient care unit~~ a plan described in subdivision 2.

(c) "Nonmanagerial care staff" means registered nurses, licensed practical nurses, and other health care workers, which may include but is not limited to nursing assistants, nursing aides, patient care technicians, and patient care assistants, who perform nonmanagerial direct patient care functions for more than 50 percent of their scheduled hours on a given patient care unit.

(d) "Inpatient care unit" or "unit" means a designated inpatient area for assigning patients and staff for which a ~~distinct staffing plan~~ daily staffing schedule exists and that operates 24 hours per day, seven days per week in a hospital setting. Inpatient care unit does not include any hospital-based clinic, long-term care facility, or outpatient hospital department.

(e) "Staffing hours per patient day" means the number of full-time equivalent nonmanagerial care staff who will ordinarily be assigned to provide direct patient care divided by the expected average number of patients upon which such assignments are based.

~~(f) "Patient acuity tool" means a system for measuring an individual patient's need for nursing care. This includes utilizing a professional registered nursing assessment of patient condition to assess staffing need.~~

Subd. 2. **Hospital core staffing ~~report~~ plans.** (a) The ~~chief nursing executive or nursing designee~~ hospital nurse staffing committee of every ~~reporting~~ hospital ~~in Minnesota under section 144.50 will~~ must develop a core staffing plan for each ~~patient~~ inpatient care unit.

(b) The commissioner is not required to verify compliance with this section by an on-site visit.

~~(b)~~ (c) Core staffing plans ~~shall~~ must specify all of the following:

(1) the projected number of full-time equivalent ~~for~~ nonmanagerial care staff that will be assigned in a 24-hour period to each ~~patient~~ inpatient care unit ~~for each 24-hour period.~~;

(2) the maximum number of patients on each inpatient care unit for whom a direct care nurse can typically safely care;

(3) criteria for determining when circumstances exist on each inpatient care unit such that a direct care nurse cannot safely care for the typical number of patients and when assigning a lower number of patients to each nurse on the inpatient unit would be appropriate;

(4) a procedure for each inpatient care unit to make shift-to-shift adjustments in staffing levels when such adjustments are required by patient acuity and nursing intensity in the unit;

(5) a contingency plan for each inpatient unit to safely address circumstances in which patient care needs unexpectedly exceed the staffing resources provided for in a daily staffing schedule. A contingency plan must include a method to quickly identify, for each daily staffing schedule, additional direct care registered nurses who are available to provide direct care on the inpatient care unit;

(6) strategies to enable direct care registered nurses to take breaks they are entitled to under law or under an applicable collective bargaining agreement; and

(7) strategies to eliminate patient boarding in emergency departments that do not rely on requiring direct care registered nurses to work additional hours to provide care.

~~(c)~~ (d) Core staffing plans must ensure that:

(1) the person creating a daily staffing schedule has sufficiently detailed information to create a daily staffing schedule that meets the requirements of the plan;

(2) daily staffing schedules do not rely on assigning individual nonmanagerial care staff to work overtime hours in excess of 16 hours in a 24-hour period or to work consecutive 24-hour periods requiring 16 or more hours;

(3) a direct care registered nurse is not required or expected to perform functions outside the nurse's professional license;

(4) a light duty direct care registered nurse is given appropriate assignments;

(5) a charge nurse does not have patient assignments; and

(6) daily staffing schedules do not interfere with applicable collective bargaining agreements.

Subd. 2a. **Development of hospital core staffing plans.** (a) Prior to ~~submitting~~ completing or updating the core staffing plan, ~~as required in subdivision 3, hospitals shall~~ a hospital nurse staffing committee must consult with representatives of the hospital medical staff, managerial and nonmanagerial care staff, and other relevant hospital personnel about the core staffing plan and the expected average number of patients upon which the core staffing plan is based.

(b) When developing a core staffing plan, a hospital nurse staffing committee must consider all of the following:

(1) the individual needs and expected census of each inpatient care unit;

(2) unit-specific patient acuity, including fall risk and behaviors requiring intervention, such as physical aggression toward self or others or destruction of property;

(3) unit-specific demands on direct care registered nurses' time, including: frequency of admissions, discharges, and transfers; frequency and complexity of patient evaluations and assessments; frequency and complexity of nursing care planning; planning for patient discharge; assessing for patient referral; patient education; and implementing infectious disease protocols;

(4) the architecture and geography of the inpatient care unit, including the placement of patient rooms, treatment areas, nursing stations, medication preparation areas, and equipment;

(5) mechanisms and procedures to provide for one-to-one patient observation for patients on psychiatric or other units;

(6) the stress that direct-care nurses experience when required to work extreme amounts of overtime, such as shifts in excess of 12 hours or multiple consecutive double shifts;

(7) the need for specialized equipment and technology on the unit;

(8) other special characteristics of the unit or community patient population, including age, cultural and linguistic diversity and needs, functional ability, communication skills, and other relevant social and socioeconomic factors;

(9) the skill mix of personnel other than direct care registered nurses providing or supporting direct patient care on the unit;

(10) mechanisms and procedures for identifying additional registered nurses who are available for direct patient care when patients' unexpected needs exceed the planned workload for direct care staff; and

(11) demands on direct care registered nurses' time not directly related to providing direct care on a unit, such as involvement in quality improvement activities, professional development, service to the hospital, including serving on the hospital nurse staffing committee or the hospital nurse workload committee, and service to the profession.

Subd. 2b. **Failure to develop hospital core staffing plans.** If a hospital nurse staffing committee cannot approve a hospital core staffing plan by a majority vote, the members of the nurse staffing committee must enter an expedited arbitration process with an arbitrator who understands patient care needs.

Subd. 2c. **Objections to hospital core staffing plans.** (a) If hospital management objects to a core staffing plan approved by a majority vote of the hospital nurse staffing committee, the hospital may elect to attempt to amend the core staffing plan through arbitration.

(b) During an ongoing dispute resolution process, a hospital must continue to implement the core staffing plan as written and approved by the hospital nurse staffing committee.

(c) If the dispute resolution process results in an amendment to the core staffing plan, the hospital must implement the amended core staffing plan.

Subd. 2d. **Mandatory submission of core staffing plan to commissioner.** Each hospital must submit to the commissioner the core staffing plans approved by the hospital's nurse staffing committee. A hospital must submit any substantial updates to any previously approved plan, including any amendments to the plan resulting from arbitration, within 30 calendar days of approval of the update by the committee or the conclusion of arbitration.

Subd. 3. **Standard electronic reporting developed.** ~~(a) Hospitals must submit the core staffing plans to the Minnesota Hospital Association by January 1, 2014. The Minnesota Hospital Association shall include each reporting hospital's core staffing plan on the Minnesota Hospital Association's Minnesota Hospital Quality Report website by April 1, 2014. any substantial changes to the core staffing plan shall be updated within 30 days.~~

~~(b)~~ The Minnesota Hospital Association shall include on its website for each reporting hospital on a quarterly basis the actual direct patient care hours per patient and per unit.

Hospitals must submit the direct patient care report to the Minnesota Hospital Association by July 1, 2014, and quarterly thereafter.

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

Sec. 13. **[144.7056] IMPLEMENTATION OF HOSPITAL CORE STAFFING PLANS.**

Subdivision 1. **Plan implementation required.** (a) A hospital must implement the core staffing plans approved annually by a majority vote of its hospital nurse staffing committee. Nothing in sections 144.7051 to 144.7058 relieves the chief nursing executive of a hospital from fulfilling the chief nursing executive's duties under Code of Federal Regulations, title 42, section 482.23. If at any time the chief nursing executive believes the types and numbers of nursing personnel and staff required under the hospital's core staffing plan are insufficient to provide nursing care for a unit in the hospital, the chief nursing executive may increase the staffing on that unit beyond the levels required by the plan.

(b) A core staffing plan does not apply during an emergency and a hospital is not out of compliance with its core staffing plan during an emergency. A nurse may be required to accept an additional patient assignment in an emergency.

(c) The commissioner is required to verify compliance with this section by on-site visits during routine hospital surveys.

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

Subd. 3. **Public posting of compliance with plan.** For each publicly posted core staffing plan, a hospital must post a notice stating whether the current staffing on the unit complies with the hospital's core staffing plan for that unit. The public notice of compliance must include a list of the number of nonmanagerial care staff working on the unit during the current shift and the number of patients assigned to each direct care registered nurse working on the unit during the current shift. The list must enumerate the nonmanagerial care staff by health care worker type. The public notice of compliance must be posted immediately adjacent to the publicly posted core staffing plan.

Subd. 4. **Public posting of emergency department wait times.** A hospital must maintain on its website and publicly display in its emergency department the approximate wait time for patients who are not in critical need of emergency care. The approximate wait time must be updated at least hourly.

Subd. 5. **Public distribution of core staffing plan and notice of compliance.** (a) A hospital must include with the posted materials described in subdivisions 2 and 3 a statement

that individual copies of the posted materials are available upon request to any patient on the unit, to any visitor of a patient on the unit, or prospective patient. The statement must include specific instructions for obtaining copies of the posted materials.

(b) A hospital must, within four hours after the request, provide individual copies of all the posted materials described in subdivisions 2 and 3 to any patient on the unit or to any visitor of a patient on the unit who requests the materials.

Subd. 6. **Reporting noncompliance.** (a) Any hospital employee, patient, or patient family member may submit a concern for safe staffing form to report an instance of noncompliance with a hospital's core staffing plan, to object to the contents of a core staffing plan, or to challenge the process of the hospital nurse staffing committee.

(b) A hospital must not interfere with or retaliate against a hospital employee for submitting a concern for safe staffing form.

(c) The commissioner of labor and industry may investigate any report of interference with or retaliation against a hospital employee for submitting a concern for safe staffing form. The commissioner of labor and industry may fine a hospital up to $250,000 if the commissioner finds the hospital interfered with or retaliated against a hospital employee for submitting a concern for safe staffing form.

Subd. 7. **Documentation of compliance.** Each hospital must document compliance with its core nursing plans and maintain records demonstrating compliance for each inpatient care unit for five years. Each hospital must provide to its nurse staffing committee access to all documentation required under this subdivision.

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

Sec. 14. **[144.7057] HOSPITAL NURSE STAFFING REPORTS.**

Subdivision 1. **Nurse staffing report required.** Each hospital nurse staffing committee must submit quarterly nurse staffing reports to the commissioner. Reports must be submitted within 60 days of the end of the quarter.

Subd. 2. **Nurse staffing report.** Nurse staffing reports submitted to the commissioner by a hospital nurse staffing committee must:

(1) identify any suspected incidents of the hospital failing during the reporting quarter to meet the standards of one of its core staffing plans;

(2) identify each occurrence of the hospital accepting an elective surgery at a time when the unit performing the surgery is out of compliance with its core staffing plan;

(3) identify problems of insufficient staffing, including but not limited to:

(i) inappropriate number of direct care registered nurses scheduled in a unit;

(ii) inappropriate number of direct care registered nurses present and delivering care in a unit;

(iii) inappropriately experienced direct care registered nurses scheduled for a particular unit;

(iv) inappropriately experienced direct care registered nurses present and delivering care in a unit;

(v) inability for nurse supervisors to adjust daily nursing schedules for increased patient acuity or nursing intensity in a unit; and

(vi) chronically unfilled direct care positions within the hospital;

(4) identify any units that pose a risk to patient safety due to inadequate staffing;

(5) propose solutions to solve insufficient staffing;

(6) propose solutions to reduce risks to patient safety in inadequately staffed units; and

(7) describe staffing trends within the hospital.

Subd. 3. **Public posting of nurse staffing reports.** The commissioner must include on its website each quarterly nurse staffing report submitted to the commissioner under subdivision 1.

Subd. 4. **Standardized reporting.** The commissioner shall develop and provide to each hospital nurse staffing committee a uniform format or standard form the committee must use to comply with the nurse staffing reporting requirements under this section. The format or form developed by the commissioner must present the reported information in a manner allowing patients and the public to clearly understand and compare staffing patterns and actual levels of staffing across reporting hospitals. The commissioner must include, in the uniform format or on the standardized form, space to allow the reporting hospital to include a description of additional resources available to support unit-level patient care and a description of the hospital.

Subd. 5. **Penalties.** Notwithstanding section 144.653, subdivisions 5 and 6, the commissioner may impose an immediate fine of up to $5,000 for each instance of a failure to report an elective surgery requiring reporting under subdivision 2, clause (2). The facility may request a hearing on the immediate fine under section 144.653, subdivision 8.

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

Sec. 15. **[144.7058] GRADING OF COMPLIANCE WITH CORE STAFFING PLANS.**

Subdivision 1. **Grading compliance with core staffing plans.** By January 1, 2026, the commissioner must develop a uniform annual grading system that evaluates each hospital's compliance with its own core staffing plan. The commissioner must assign each hospital a compliance grade based on a review of the hospital's nurse staffing report submitted under section 144.7057. The commissioner must assign a failing compliance grade to any hospital that has not been in compliance with its staffing plan for six or more months during the reporting year.

Subd. 2. **Grading factors.** When grading a hospital's compliance with its core staffing plan, the commissioner must consider at least the following factors:

(1) the number of assaults and injuries occurring in the hospital involving patients;

(2) the prevalence of infections, pressure ulcers, and falls among patients;

(3) emergency department wait times;

(4) readmissions;

(5) use of restraints and other behavior interventions;

(6) employment turnover rates among direct care registered nurses and other direct care health care workers;

(7) except in instances when nurses volunteer for overtime, prevalence of overtime among direct care registered nurses and other direct care health care workers;

(8) prevalence of missed shift breaks among direct care registered nurses and other direct care health care workers;

(9) frequency of incidents of being out of compliance with a core staffing plan;

(10) the extent of noncompliance with a core staffing plan; and

(11) number of inpatient psychiatric units.

Subd. 3. **Public disclosure of compliance grades.** Beginning January 1, 2027, the commissioner must publish a compliance grade for each hospital on the department website with a link to the hospital's core staffing plan, the hospital's nurse staffing reports, and an accessible and easily understandable explanation of what the compliance grade means.

EFFECTIVE DATE. This section is effective January 1, 2026.

Sec. 16. **[144.7059] RETALIATION AGAINST NURSES PROHIBITED.**

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

(b) "Emergency" means a period when replacement staff are not able to report for duty for the next shift, or a period of increased patient need, because of unusual, unpredictable, or unforeseen circumstances, including but not limited to an act of terrorism, a disease outbreak, adverse weather conditions, or a natural disaster, that impacts continuity of patient care.

(c) "Nurse" has the meaning given in section 148.171, subdivision 9, and includes nurses employed by the state.

(d) "Taking action against" means discharging, disciplining, threatening, reporting to the Board of Nursing, discriminating against, or penalizing regarding compensation, terms, conditions, location, or privileges of employment.

Subd. 2. **Prohibited actions.** Except as provided in subdivision 5, a hospital or other entity licensed under sections 144.50 to 144.58, and its agent, or other health care facility licensed by the commissioner of health, and the facility's agent, is prohibited from taking action against a nurse solely on the ground that the nurse fails to accept an assignment of one or more additional patients because the nurse reasonably determines that accepting an additional patient assignment may create an unnecessary danger to a patient's life, health, or safety or may otherwise constitute a ground for disciplinary action under section 148.261. This subdivision does not apply to a nursing facility, an intermediate care facility for persons with developmental disabilities, or a licensed boarding care home.

Subd. 3. **State nurses.** Subdivision 2 applies to nurses employed by the state regardless of the type of facility where the nurse is employed and regardless of the facility's license, if the nurse is involved in resident or patient care.

Subd. 4. **Collective bargaining rights.** This section does not diminish or impair the rights of a person under any collective bargaining agreement.

Subd. 5. **Emergency.** A nurse may be required to accept an additional patient assignment in an emergency.

Subd. 6. **Enforcement.** The commissioner of labor and industry may enforce this section by issuing a compliance order under section 177.27, subdivision 4. The commissioner of labor and industry may assess a fine of up to $5,000 for each violation of this section.

Sec. 17. Minnesota Statutes 2022, section 144.7067, subdivision 1, is amended to read:

Subdivision 1. **Establishment of reporting system.** (a) The commissioner shall establish an adverse health event reporting system designed to facilitate quality improvement in the health care system. The reporting system shall not be designed to punish errors by health care practitioners or health care facility employees.

(b) The reporting system shall consist of:

(1) mandatory reporting by facilities of 27 adverse health care events;

(2) mandatory reporting by facilities of whether the unit where an adverse event occurred was in compliance with the core staffing plan for the unit at the time of the adverse event;

(3) mandatory completion of a root cause analysis and a corrective action plan by the facility and reporting of the findings of the analysis and the plan to the commissioner or reporting of reasons for not taking corrective action;

~~(3)~~ (4) analysis of reported information by the commissioner to determine patterns of systemic failure in the health care system and successful methods to correct these failures;

~~(4)~~ (5) sanctions against facilities for failure to comply with reporting system requirements; and

~~(5)~~ (6) communication from the commissioner to facilities, health care purchasers, and the public to maximize the use of the reporting system to improve health care quality.

(c) The commissioner is not authorized to select from or between competing alternate acceptable medical practices.

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

Sec. 18. Minnesota Statutes 2022, section 147A.08, is amended to read:

147A.08 EXEMPTIONS.

(a) This chapter does not apply to, control, prevent, or restrict the practice, service, or activities of persons listed in section 147.09, clauses (1) to (6) and (8) to (13)~~,~~; persons regulated under section 214.01, subdivision 2~~,~~; or ~~persons~~ midlevel practitioners, nurses, or nurse-midwives as defined in section 144.1501, subdivision 1~~, paragraphs (i), (k), and (l)~~.

(b) Nothing in this chapter shall be construed to require licensure of:

(1) a physician assistant student enrolled in a physician assistant educational program accredited by the Accreditation Review Commission on Education for the Physician Assistant or by its successor agency approved by the board;

(2) a physician assistant employed in the service of the federal government while performing duties incident to that employment; or

(3) technicians, other assistants, or employees of physicians who perform delegated tasks in the office of a physician but who do not identify themselves as a physician assistant.

Sec. 19. **BEST PRACTICES TOOLKIT DEVELOPMENT.**

The commissioner of health must convene a stakeholder group that will meet for six months to develop a toolkit with best practices for implementation of workload committee and hospital staffing committees. The toolkit and best practices must include a recommendation that each hospital utilize a federal mediator or the Office of Collaboration and Dispute Resolution to moderate the establishment of committees in each hospital. The commissioner must make the toolkit with the recommended best practices available to hospitals by July 1, 2024.

Sec. 20. **DIRECTION TO COMMISSIONER OF HEALTH; DEVELOPMENT OF ANALYTICAL TOOLS.**

(a) The commissioner of health, in consultation with the Minnesota Nurses Association and other professional nursing organizations, must develop a means of analyzing available adverse event data, available staffing data, and available data from concern for safe staffing forms to examine potential causal links between adverse events and understaffing.

(b) The commissioner must develop an initial means of conducting the analysis described in paragraph (a) by January 1, 2025, and publish a public report on the commissioner's initial findings by January 1, 2026.

(c) By January 1, 2024, the commissioner must submit to the chairs and ranking minority members of the house and senate committees with jurisdiction over the regulation of hospitals a report on the available data, potential sources of additional useful data, and any additional statutory authority the commissioner requires to collect additional useful information from hospitals.

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

Sec. 21. **DIRECTION TO COMMISSIONER OF HEALTH; NURSING WORKFORCE REPORT.**

(a) The commissioner of health must publish a public report on the current status of the state's nursing workforce employed by hospitals. In preparing the report, the commissioner shall utilize information collected in collaboration with the Board of Nursing as directed under Minnesota Statutes, sections 144.051 and 144.052, on Minnesota's supply of active licensed nurses and reasons licensed nurses are leaving direct care positions at hospitals; information collected and shared by the Minnesota Hospital Association on retention by hospitals of licensed nurses; information collected through an independent study on reasons licensed nurses are choosing not to renew their licenses and leaving the profession; and other publicly available data the commissioner deems useful.

(b) The commissioner must publish the report by January 1, 2026.

Sec. 22. **DIRECTION TO COMMISSIONER OF HUMAN SERVICES.**

The commissioner of human services must define as a direct educational expense the reasonable child care costs incurred by a nursing facility employee scholarship recipient while the recipient is receiving a wage from the scholarship sponsoring facility, provided the scholarship recipient is making reasonable progress, as defined by the commissioner, toward the educational goal for which the scholarship was granted.

Sec. 23. **INITIAL IMPLEMENTATION OF THE KEEPING NURSES AT THE BEDSIDE ACT.**

(a) By October 1, 2024, each hospital must establish and convene a hospital nurse staffing committee as described under Minnesota Statutes, section 144.7053, and a hospital nurse workload committee as described under Minnesota Statutes, section 144.7054.

(b) By October 1, 2025, each hospital must implement core staffing plans developed by its hospital nurse staffing committee and satisfy the plan posting requirements under Minnesota Statutes, section 144.7056.

(c) By October 1, 2025, each hospital must submit to the commissioner of health core staffing plans meeting the requirements of Minnesota Statutes, section 144.7055.

(d) By October 1, 2025, the commissioner of health must develop a standard concern for safe staffing form and provide an electronic means of submitting the form to the relevant hospital nurse staffing committee. The commissioner must base the form on the existing concern for safe staffing form maintained by the Minnesota Nurses' Association.

(e) By January 1, 2026, the commissioner of health must provide electronic access to the uniform format or standard form for nurse staffing reporting described under Minnesota Statutes, section 144.7057, subdivision 4.

Sec. 24. **REVISOR INSTRUCTION.**

In Minnesota Statutes, section 144.7055, the revisor shall renumber paragraphs (b) to (e) alphabetically as individual subdivisions under Minnesota Statutes, section 144.7051. The revisor shall make any necessary changes to sentence structure for this renumbering while preserving the meaning of the text. The revisor shall also make necessary cross-reference changes in Minnesota Statutes and Minnesota Rules consistent with the renumbering.

ARTICLE 4
DEPARTMENT OF HEALTH

Section 1. Minnesota Statutes 2022, section 13.10, subdivision 5, is amended to read:

Subd. 5. **Adoption records.** Notwithstanding any provision of this or any other chapter, adoption records shall be treated as provided in sections 259.53, 259.61, 259.79, and 259.83 to ~~259.89~~ 259.88.

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

Sec. 2. Minnesota Statutes 2022, section 13.465, subdivision 8, is amended to read:

Subd. 8. **Adoption records.** Various adoption records are classified under section 259.53, subdivision 1. Access to the original birth record of a person who has been adopted is governed by section ~~259.89~~ 144.2252.

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

Sec. 3. Minnesota Statutes 2022, section 16A.151, subdivision 2, is amended to read:

Subd. 2. **Exceptions.** (a) If a state official litigates or settles a matter on behalf of specific injured persons or entities, this section does not prohibit distribution of money to the specific injured persons or entities on whose behalf the litigation or settlement efforts were initiated. If money recovered on behalf of injured persons or entities cannot reasonably be distributed to those persons or entities because they cannot readily be located or identified or because the cost of distributing the money would outweigh the benefit to the persons or entities, the money must be paid into the general fund.

(b) Money recovered on behalf of a fund in the state treasury other than the general fund may be deposited in that fund.

(c) This section does not prohibit a state official from distributing money to a person or entity other than the state in litigation or potential litigation in which the state is a defendant or potential defendant.

(d) State agencies may accept funds as directed by a federal court for any restitution or monetary penalty under United States Code, title 18, section 3663(a)(3), or United States Code, title 18, section 3663A(a)(3). Funds received must be deposited in a special revenue account and are appropriated to the commissioner of the agency for the purpose as directed by the federal court.

(e) Tobacco settlement revenues as defined in section 16A.98, subdivision 1, paragraph (t), may be deposited as provided in section 16A.98, subdivision 12.

(f) Any money received by the state resulting from a settlement agreement or an assurance of discontinuance entered into by the attorney general of the state, or a court order in litigation brought by the attorney general of the state, on behalf of the state or a state agency, related to alleged violations of consumer fraud laws in the marketing, sale, or distribution of opioids in this state or other alleged illegal actions that contributed to the excessive use of opioids, must be deposited in the settlement account established in the opiate epidemic response fund under section 256.043, subdivision 1. This paragraph does not apply to attorney fees and costs awarded to the state or the Attorney General's Office, to contract attorneys hired by the state or Attorney General's Office, or to other state agency attorneys.

(g) Notwithstanding paragraph (f), if money is received from a settlement agreement or an assurance of discontinuance entered into by the attorney general of the state or a court order in litigation brought by the attorney general of the state on behalf of the state or a state agency against a consulting firm working for an opioid manufacturer or opioid wholesale drug distributor, the commissioner shall deposit any money received into the settlement account established within the opiate epidemic response fund under section 256.042, subdivision 1. Notwithstanding section 256.043, subdivision 3a, paragraph (a), any amount deposited into the settlement account in accordance with this paragraph shall be appropriated to the commissioner of human services to award as grants as specified by the opiate epidemic response advisory council in accordance with section 256.043, subdivision 3a, paragraph (d).

(h) Any money received by the state resulting from a settlement agreement or an assurance of discontinuance entered into by the attorney general of the state, or a court order in litigation

brought by the attorney general of the state on behalf of the state or a state agency related to alleged violations of consumer fraud laws in the marketing, sale, or distribution of electronic nicotine delivery systems in this state or other alleged illegal actions that contributed to the exacerbation of youth nicotine use, must be deposited in the settlement account established in the tobacco use prevention account under section 144.398. This paragraph does not apply to: (1) attorney fees and costs awarded or paid to the state or the Attorney General's Office; (2) contract attorneys hired by the state or Attorney General's Office; or (3) other state agency attorneys.

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

Sec. 4. **[62J.811] PROVIDER BALANCE BILLING REQUIREMENTS.**

Subdivision 1. **Billing requirements.** (a) Each health care provider and health facility shall comply with Consolidated Appropriations Act, 2021, Division BB also known as the "No Surprises Act," including any federal regulations adopted under that act.

(b) For the purposes of this section, "provider" or "facility" means any health care provider or facility pursuant to section 62A.63, subdivision 2, or 62J.03, subdivision 8, that is subject to relevant provisions of the No Surprises Act.

Subd. 2. **Investigations and compliance.** (a) The commissioner shall, to the extent practicable, seek the cooperation of health care providers and facilities, and may provide any support and assistance as available, in obtaining compliance with this section.

(b) The commissioner shall determine the manner and processes for fulfilling any responsibilities and taking any of the actions in paragraphs (c) to (f).

(c) A person who believes a health care provider or facility has not complied with the requirements of the No Surprises Act or this section may file a complaint with the commissioner in the manner determined by the commissioner.

(d) The commissioner shall conduct compliance reviews and investigate complaints filed under this section in the manner determined by the commissioner to ascertain whether health care providers and facilities are complying with this section.

(e) The commissioner may report violations under this section to other relevant federal and state departments and jurisdictions as appropriate, including the attorney general and relevant licensing boards, and may also coordinate on investigations and enforcement of this section with other relevant federal and state departments and jurisdictions as appropriate, including the attorney general and relevant licensing boards.

(f) A health care provider or facility may contest whether the finding of facts constitute a violation of this section according to the contested case proceeding in sections 14.57 to 14.62, subject to appeal according to sections 14.63 to 14.68.

(g) Any data collected by the commissioner as part of an active investigation or active compliance review under this section are classified as protected nonpublic data pursuant to section 13.02, subdivision 13, in the case of data not on individuals and confidential pursuant to section 13.02, subdivision 3, in the case of data on individuals. Data describing the final disposition of an investigation or compliance review are classified as public.

Subd. 3. **Civil penalty.** (a) The commissioner, in monitoring and enforcing this section, may levy a civil monetary penalty against each health care provider or facility found to be in violation of up to $100 for each violation, but may not exceed $25,000 for identical violations during a calendar year.

(b) No civil monetary penalty shall be imposed under this section for violations that occur prior to January 1, 2024.

Sec. 5. Minnesota Statutes 2022, section 62J.84, subdivision 2, is amended to read:

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

(b) "Biosimilar" means a drug that is produced or distributed pursuant to a biologics license application approved under United States Code, title 42, section 262(K)(3).

(c) "Brand name drug" means a drug that is produced or distributed pursuant to:

(1) ~~an original,~~ a new drug application approved under United States Code, title 21, section 355(c), except for a generic drug as defined under Code of Federal Regulations, title 42, section 447.502; or

(2) a biologics license application approved under United States Code, title ~~45~~ 42, section 262(a)(c).

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

(e) "Generic drug" means a drug that is marketed or distributed pursuant to:

(1) an abbreviated new drug application approved under United States Code, title 21, section 355(j);

(2) an authorized generic as defined under Code of Federal Regulations, title ~~45~~ 42, section 447.502; or

(3) a drug that entered the market the year before 1962 and was not originally marketed under a new drug application.

(f) "Manufacturer" means a drug manufacturer licensed under section 151.252.

(g) "New prescription drug" or "new drug" means a prescription drug approved for marketing by the United States Food and Drug Administration (FDA) for which no previous wholesale acquisition cost has been established for comparison.

(h) "Patient assistance program" means a program that a manufacturer offers to the public in which a consumer may reduce the consumer's out-of-pocket costs for prescription drugs by using coupons, discount cards, prepaid gift cards, manufacturer debit cards, or by other means.

(i) "Prescription drug" or "drug" has the meaning provided in section 151.441, subdivision 8.

(j) "Price" means the wholesale acquisition cost as defined in United States Code, title 42, section 1395w-3a(c)(6)(B).

(k) "30-day supply" means the total daily dosage units of a prescription drug recommended by the prescribing label approved by the FDA for 30 days. If the FDA-approved prescribing label includes more than one recommended daily dosage, the 30-day supply is based on the maximum recommended daily dosage on the FDA-approved prescribing label.

(l) "Course of treatment" means the total dosage of a single prescription for a prescription drug recommended by the FDA-approved prescribing label. If the FDA-approved prescribing label includes more than one recommended dosage for a single course of treatment, the course of treatment is the maximum recommended dosage on the FDA-approved prescribing label.

(m) "Drug product family" means a group of one or more prescription drugs that share a unique generic drug description or nontrade name and dosage form.

(n) "National drug code" means the three-segment code maintained by the federal Food and Drug Administration that includes a labeler code, a product code, and a package code for a drug product and that has been converted to an 11-digit format consisting of five digits in the first segment, four digits in the second segment, and two digits in the third segment. A three-segment code shall be considered converted to an 11-digit format when, as necessary, at least one "0" has been added to the front of each segment containing less than the specified number of digits such that each segment contains the specified number of digits.

(o) "Pharmacy" or "pharmacy provider" means a place of business licensed by the Board of Pharmacy under section 151.19 in which prescription drugs are prepared, compounded, or dispensed under the supervision of a pharmacist.

(p) "Pharmacy benefits manager" or "PBM" means an entity licensed to act as a pharmacy benefits manager under section 62W.03.

(q) "Pricing unit" means the smallest dispensable amount of a prescription drug product that could be dispensed.

(r) "Reporting entity" means any manufacturer, pharmacy, pharmacy benefits manager, wholesale drug distributor, or any other entity required to submit data under section 62J.84.

(s) "Wholesale drug distributor" or "wholesaler" means an entity that:

(1) is licensed to act as a wholesale drug distributor under section 151.47; and

(2) distributes prescription drugs, of which it is not the manufacturer, to persons or entities, or both, other than a consumer or patient in the state.

Sec. 6. Minnesota Statutes 2022, section 62J.84, subdivision 3, is amended to read:

Subd. 3. **Prescription drug price increases reporting.** (a) Beginning January 1, 2022, a drug manufacturer must submit to the commissioner the information described in paragraph (b) for each prescription drug for which the price was $100 or greater for a 30-day supply or for a course of treatment lasting less than 30 days and:

(1) for brand name drugs where there is an increase of ten percent or greater in the price over the previous 12-month period or an increase of 16 percent or greater in the price over the previous 24-month period; and

(2) for generic or biosimilar drugs where there is an increase of 50 percent or greater in the price over the previous 12-month period.

(b) For each of the drugs described in paragraph (a), the manufacturer shall submit to the commissioner no later than 60 days after the price increase goes into effect, in the form and manner prescribed by the commissioner, the following information, if applicable:

(1) the ~~name~~ description and price of the drug and the net increase, expressed as a percentage~~;~~, with the following listed separately:

(i) the national drug code;

(ii) the product name;

(iii) the dosage form;

(iv) the strength;

(v) the package size;

(2) the factors that contributed to the price increase;

(3) the name of any generic version of the prescription drug available on the market;

(4) the introductory price of the prescription drug when it was ~~approved for marketing by the Food and Drug Administration and the net yearly increase, by calendar year, in the price of the prescription drug during the previous five years~~ introduced for sale in the United States and the price of the drug on the last day of each of the five calendar years preceding the price increase;

(5) the direct costs incurred during the previous 12-month period by the manufacturer that are associated with the prescription drug, listed separately:

(i) to manufacture the prescription drug;

(ii) to market the prescription drug, including advertising costs; and

(iii) to distribute the prescription drug;

(6) the total sales revenue for the prescription drug during the previous 12-month period;

(7) the manufacturer's net profit attributable to the prescription drug during the previous 12-month period;

(8) the total amount of financial assistance the manufacturer has provided through patient prescription assistance programs during the previous 12-month period, if applicable;

(9) any agreement between a manufacturer and another entity contingent upon any delay in offering to market a generic version of the prescription drug;

(10) the patent expiration date of the prescription drug if it is under patent;

(11) the name and location of the company that manufactured the drug; ~~and~~

(12) if a brand name prescription drug, the ~~ten~~ highest ~~prices~~ price paid for the prescription drug during the previous calendar year in ~~any country other than~~ the ten countries, excluding the United States~~.~~, that charged the highest single price for the prescription drug; and

(13) if the prescription drug was acquired by the manufacturer during the previous 12-month period, all of the following information:

(i) price at acquisition;

(ii) price in the calendar year prior to acquisition;

(iii) name of the company from which the drug was acquired;

(iv) date of acquisition; and

(v) acquisition price.

(c) The manufacturer may submit any documentation necessary to support the information reported under this subdivision.

Sec. 7. Minnesota Statutes 2022, section 62J.84, subdivision 4, is amended to read:

Subd. 4. **New prescription drug price reporting.** (a) Beginning January 1, 2022, no later than 60 days after a manufacturer introduces a new prescription drug for sale in the United States that is a new brand name drug with a price that is greater than the tier threshold established by the Centers for Medicare and Medicaid Services for specialty drugs in the Medicare Part D program for a 30-day supply or for a course of treatment lasting less than 30 days or a new generic or biosimilar drug with a price that is greater than the tier threshold established by the Centers for Medicare and Medicaid Services for specialty drugs in the Medicare Part D program for a 30-day supply or for a course of treatment lasting less than 30 days and is not at least 15 percent lower than the referenced brand name drug when the generic or biosimilar drug is launched, the manufacturer must submit to the commissioner, in the form and manner prescribed by the commissioner, the following information, if applicable:

(1) the description of the drug, with the following listed separately:

(i) the national drug code;

(ii) the product name;

(iii) the dosage form;

(iv) the strength;

(v) the package size;

~~(1)~~ (2) the price of the prescription drug;

~~(2)~~ (3) whether the Food and Drug Administration granted the new prescription drug a breakthrough therapy designation or a priority review;

~~(3)~~ (4) the direct costs incurred by the manufacturer that are associated with the prescription drug, listed separately:

(i) to manufacture the prescription drug;

(ii) to market the prescription drug, including advertising costs; and

(iii) to distribute the prescription drug; and

~~(4)~~ (5) the patent expiration date of the drug if it is under patent.

(b) The manufacturer may submit documentation necessary to support the information reported under this subdivision.

Sec. 8. Minnesota Statutes 2022, section 62J.84, subdivision 6, is amended to read:

Subd. 6. **Public posting of prescription drug price information.** (a) The commissioner shall post on the department's website, or may contract with a private entity or consortium that satisfies the standards of section 62U.04, subdivision 6, to meet this requirement, the following information:

(1) a list of the prescription drugs reported under subdivisions 3~~, 4, and 5,~~ to 6 and 9 to 14 and the manufacturers of those prescription drugs; and

(2) information reported to the commissioner under subdivisions 3~~, 4, and 5~~ to 6 and 9 to 14.

(b) The information must be published in an easy-to-read format and in a manner that identifies the information that is disclosed on a per-drug basis and must not be aggregated in a manner that prevents the identification of the prescription drug.

(c) The commissioner shall not post to the department's website or a private entity contracting with the commissioner shall not post any information described in this section if the information is not public data under section 13.02, subdivision 8a; or is trade secret information under section 13.37, subdivision 1, paragraph (b); or is trade secret information pursuant to the Defend Trade Secrets Act of 2016, United States Code, title 18, section 1836, as amended. If a manufacturer believes information should be withheld from public disclosure pursuant to this paragraph, the manufacturer must clearly and specifically identify that information and describe the legal basis in writing when the manufacturer submits the information under this section. If the commissioner disagrees with the manufacturer's request to withhold information from public disclosure, the commissioner shall provide the manufacturer written notice that the information will be publicly posted 30 days after the date of the notice.

(d) If the commissioner withholds any information from public disclosure pursuant to this subdivision, the commissioner shall post to the department's website a report describing

the nature of the information and the commissioner's basis for withholding the information from disclosure.

(e) To the extent the information required to be posted under this subdivision is collected and made available to the public by another state, by the University of Minnesota, or through an online drug pricing reference and analytical tool, the commissioner may reference the availability of this drug price data from another source including, within existing appropriations, creating the ability of the public to access the data from the source for purposes of meeting the reporting requirements of this subdivision.

Sec. 9. Minnesota Statutes 2022, section 62J.84, subdivision 7, is amended to read:

Subd. 7. **Consultation.** (a) The commissioner may consult with a private entity or consortium that satisfies the standards of section 62U.04, subdivision 6, the University of Minnesota, or the commissioner of commerce, as appropriate, in issuing the form and format of the information reported under this section; in posting information pursuant to subdivision 6; and in taking any other action for the purpose of implementing this section.

(b) The commissioner may consult with representatives of the ~~manufacturers~~ reporting entities to establish a standard format for reporting information under this section and may use existing reporting methodologies to establish a standard format to minimize administrative burdens to the state and ~~manufacturers~~ reporting entities.

Sec. 10. Minnesota Statutes 2022, section 62J.84, subdivision 8, is amended to read:

Subd. 8. **Enforcement and penalties.** (a) A ~~manufacturer~~ reporting entity may be subject to a civil penalty, as provided in paragraph (b), for:

(1) failing to register under subdivision 15;

~~(1)~~ (2) failing to submit timely reports or notices as required by this section;

~~(2)~~ (3) failing to provide information required under this section; or

~~(3)~~ (4) providing inaccurate or incomplete information under this section.

(b) The commissioner shall adopt a schedule of civil penalties, not to exceed $10,000 per day of violation, based on the severity of each violation.

(c) The commissioner shall impose civil penalties under this section as provided in section 144.99, subdivision 4.

(d) The commissioner may remit or mitigate civil penalties under this section upon terms and conditions the commissioner considers proper and consistent with public health and safety.

(e) Civil penalties collected under this section shall be deposited in the health care access fund.

Sec. 11. Minnesota Statutes 2022, section 62J.84, subdivision 9, is amended to read:

Subd. 9. **Legislative report.** (a) No later than May 15, 2022, and by January 15 of each year thereafter, the commissioner shall report to the chairs and ranking minority members of the legislative committees with jurisdiction over commerce and health and human services policy and finance on the implementation of this section, including but not limited to the effectiveness in addressing the following goals:

(1) promoting transparency in pharmaceutical pricing for the state and other payers;

(2) enhancing the understanding on pharmaceutical spending trends; and

(3) assisting the state and other payers in the management of pharmaceutical costs.

(b) The report must include a summary of the information submitted to the commissioner under subdivisions 3~~, 4, and 5~~ to 6 and 9 to 14.

Sec. 12. Minnesota Statutes 2022, section 62J.84, is amended by adding a subdivision to read:

Subd. 10. **Notice of prescription drugs of substantial public interest.** (a) No later than January 31, 2024, and quarterly thereafter, the commissioner shall produce and post on the department's website a list of prescription drugs that the department determines to represent a substantial public interest and for which the department intends to request data under subdivisions 9 to 14, subject to paragraph (c). The department shall base its inclusion of prescription drugs on any information the department determines is relevant to providing greater consumer awareness of the factors contributing to the cost of prescription drugs in the state, and the department shall consider drug product families that include prescription drugs:

(1) that triggered reporting under subdivisions 3, 4, or 6 during the previous calendar quarter;

(2) for which average claims paid amounts exceeded 125 percent of the price as of the claim incurred date during the most recent calendar quarter for which claims paid amounts are available; or

(3) that are identified by members of the public during a public comment period process.

(b) Not sooner than 30 days after publicly posting the list of prescription drugs under paragraph (a), the department shall notify, via email, reporting entities registered with the department of the requirement to report under subdivisions 9 to 14.

(c) No more than 500 prescription drugs may be designated as having a substantial public interest in any one notice.

Sec. 13. Minnesota Statutes 2022, section 62J.84, is amended by adding a subdivision to read:

Subd. 11. **Manufacturer prescription drug substantial public interest reporting.** (a) Beginning January 1, 2024, a manufacturer must submit to the commissioner the information described in paragraph (b) for any prescription drug:

(1) included in a notification to report issued to the manufacturer by the department under subdivision 10;

(2) which the manufacturer manufactures or repackages;

(3) for which the manufacturer sets the wholesale acquisition cost; and

(4) for which the manufacturer has not submitted data under subdivision 3 or 6 during the 120-day period prior to the date of the notification to report.

(b) For each of the drugs described in paragraph (a), the manufacturer shall submit to the commissioner no later than 60 days after the date of the notification to report, in the form and manner prescribed by the commissioner, the following information, if applicable:

(1) a description of the drug with the following listed separately:

(i) the national drug code;

(ii) the product name;

(iii) the dosage form;

(iv) the strength; and

(v) the package size;

(2) the price of the drug product on the later of:

(i) the day one year prior to the date of the notification to report;

(ii) the introduced to market date; or

(iii) the acquisition date;

(3) the price of the drug product on the date of the notification to report;

(4) the introductory price of the prescription drug when it was introduced for sale in the United States and the price of the drug on the last day of each of the five calendar years preceding the date of the notification to report;

(5) the direct costs incurred during the 12-month period prior to the date of the notification to report by the manufacturers that are associated with the prescription drug, listed separately:

(i) to manufacture the prescription drug;

(ii) to market the prescription drug, including advertising costs; and

(iii) to distribute the prescription drug;

(6) the number of units of the prescription drug sold during the 12-month period prior to the date of the notification to report;

(7) the total sales revenue for the prescription drug during the 12-month period prior to the date of the notification to report;

(8) the total rebate payable amount accrued for the prescription drug during the 12-month period prior to the date of the notification to report;

(9) the manufacturer's net profit attributable to the prescription drug during the 12-month period prior to the date of the notification to report;

(10) the total amount of financial assistance the manufacturer has provided through patient prescription assistance programs during the 12-month period prior to the date of the notification to report, if applicable;

(11) any agreement between a manufacturer and another entity contingent upon any delay in offering to market a generic version of the prescription drug;

(12) the patent expiration date of the prescription drug if the prescription drug is under patent;

(13) the name and location of the company that manufactured the drug;

(14) if the prescription drug is a brand name prescription drug, the ten countries other than the United States that paid the highest prices for the prescription drug during the previous calendar year and their prices; and

(15) if the prescription drug was acquired by the manufacturer within a 12-month period prior to the date of the notification to report, all of the following information:

(i) the price at acquisition;

(ii) the price in the calendar year prior to acquisition;

(iii) the name of the company from which the drug was acquired;

(iv) the date of acquisition; and

(v) the acquisition price.

(c) The manufacturer may submit any documentation necessary to support the information reported under this subdivision.

Sec. 14. Minnesota Statutes 2022, section 62J.84, is amended by adding a subdivision to read:

Subd. 12. **Pharmacy prescription drug substantial public interest reporting.** (a) Beginning January 1, 2024, a pharmacy must submit to the commissioner the information described in paragraph (b) for any prescription drug included in a notification to report issued to the pharmacy by the department under subdivision 9.

(b) For each of the drugs described in paragraph (a), the pharmacy shall submit to the commissioner no later than 60 days after the date of the notification to report, in the form and manner prescribed by the commissioner, the following information, if applicable:

(1) a description of the drug with the following listed separately:

(i) the national drug code;

(ii) the product name;

(iii) the dosage form;

(iv) the strength; and

(v) the package size;

(2) the number of units of the drug acquired during the 12-month period prior to the date of the notification to report;

(3) the total spent before rebates by the pharmacy to acquire the drug during the 12-month period prior to the date of the notification to report;

(4) the total rebate receivable amount accrued by the pharmacy for the drug during the 12-month period prior to the date of the notification to report;

(5) the number of pricing units of the drug dispensed by the pharmacy during the 12-month period prior to the date of the notification to report;

(6) the total payment receivable by the pharmacy for dispensing the drug including ingredient cost, dispensing fee, and administrative fees during the 12-month period prior to the date of the notification to report;

(7) the total rebate payable amount accrued by the pharmacy for the drug during the 12-month period prior to the date of the notification to report; and

(8) the average cash price paid by consumers per pricing unit for prescriptions dispensed where no claim was submitted to a health care service plan or health insurer during the 12-month period prior to the date of the notification to report.

(c) The pharmacy may submit any documentation necessary to support the information reported under this subdivision.

Sec. 15. Minnesota Statutes 2022, section 62J.84, is amended by adding a subdivision to read:

Subd. 13. **PBM prescription drug substantial public interest reporting.** (a) Beginning January 1, 2024, a PBM must submit to the commissioner the information described in paragraph (b) for any prescription drug included in a notification to report issued to the PBM by the department under subdivision 9.

(b) For each of the drugs described in paragraph (a), the PBM shall submit to the commissioner no later than 60 days after the date of the notification to report, in the form and manner prescribed by the commissioner, the following information, if applicable:

(1) a description of the drug with the following listed separately:

(i) the national drug code;

(ii) the product name;

(iii) the dosage form;

(iv) the strength; and

(v) the package size;

(2) the number of pricing units of the drug product filled for which the PBM administered claims during the 12-month period prior to the date of the notification to report;

(3) the total reimbursement amount accrued and payable to pharmacies for pricing units of the drug product filled for which the PBM administered claims during the 12-month period prior to the date of the notification to report;

(4) the total reimbursement or administrative fee amount, or both, accrued and receivable from payers for pricing units of the drug product filled for which the PBM administered claims during the 12-month period prior to the date of the notification to report;

(5) the total rebate receivable amount accrued by the PBM for the drug product during the 12-month period prior to the date of the notification to report; and

(6) the total rebate payable amount accrued by the PBM for the drug product during the 12-month period prior to the date of the notification to report.

(c) The PBM may submit any documentation necessary to support the information reported under this subdivision.

Sec. 16. Minnesota Statutes 2022, section 62J.84, is amended by adding a subdivision to read:

Subd. 14. **Wholesaler prescription drug substantial public interest reporting.** (a) Beginning January 1, 2024, a wholesaler must submit to the commissioner the information described in paragraph (b) for any prescription drug included in a notification to report issued to the wholesaler by the department under subdivision 10.

(b) For each of the drugs described in paragraph (a), the wholesaler shall submit to the commissioner no later than 60 days after the date of the notification to report, in the form and manner prescribed by the commissioner, the following information, if applicable:

(1) a description of the drug with the following listed separately:

(i) the national drug code;

(ii) the product name;

(iii) the dosage form;

(iv) the strength; and

(v) the package size;

(2) the number of units of the drug product acquired by the wholesale drug distributor during the 12-month period prior to the date of the notification to report;

(3) the total spent before rebates by the wholesale drug distributor to acquire the drug product during the 12-month period prior to the date of the notification to report;

(4) the total rebate receivable amount accrued by the wholesale drug distributor for the drug product during the 12-month period prior to the date of the notification to report;

(5) the number of units of the drug product sold by the wholesale drug distributor during the 12-month period prior to the date of the notification to report;

(6) gross revenue from sales in the United States generated by the wholesale drug distributor for this drug product during the 12-month period prior to the date of the notification to report; and

(7) total rebate payable amount accrued by the wholesale drug distributor for the drug product during the 12-month period prior to the date of the notification to report.

(c) The wholesaler may submit any documentation necessary to support the information reported under this subdivision.

Sec. 17. Minnesota Statutes 2022, section 62J.84, is amended by adding a subdivision to read:

Subd. 15. **Registration requirements.** Beginning January 1, 2024, a reporting entity subject to this chapter shall register with the department in a form and manner prescribed by the commissioner.

Sec. 18. Minnesota Statutes 2022, section 62J.84, is amended by adding a subdivision to read:

Subd. 16. **Rulemaking.** For the purposes of this section, the commissioner may use the expedited rulemaking process under section 14.389.

Sec. 19. Minnesota Statutes 2022, section 103I.005, subdivision 17a, is amended to read:

Subd. 17a. ~~**Temporary boring**~~ **Submerged closed-loop heat exchanger.** ~~"Temporary boring"~~ "Submerged closed-loop heat exchanger" means ~~an excavation that is 15 feet or more in depth, is sealed within 72 hours of the time of construction, and is drilled, cored, washed, driven, dug, jetted, or otherwise constructed to~~ a heating and cooling system that:

(1) ~~conduct physical, chemical, or biological testing of groundwater, including groundwater quality monitoring~~ is installed in a water supply well;

(2) ~~monitor or measure physical, chemical, radiological, or biological parameters of earth materials or earth fluids, including hydraulic conductivity, bearing capacity, or resistance~~ utilizes the convective flow of groundwater as the primary medium of heat exchange;

(3) ~~measure groundwater levels, including use of a piezometer~~ contains potable water as the heat transfer fluid; and

(4) ~~determine groundwater flow direction or velocity~~ is operated using nonconsumptive recirculation.

A submerged closed-loop heat exchanger also includes submersible pumps, a heat exchanger device, piping, and other necessary appurtenances.

Sec. 20. Minnesota Statutes 2022, section 103I.005, is amended by adding a subdivision to read:

Subd. 17b. **Temporary boring.** "Temporary boring" means an excavation that is 15 feet or more in depth; is sealed within 72 hours of the time of construction; and is drilled, cored, washed, driven, dug, jetted, or otherwise constructed to:

(1) conduct physical, chemical, or biological testing of groundwater, including groundwater quality monitoring;

(2) monitor or measure physical, chemical, radiological, or biological parameters of earth materials or earth fluids, including hydraulic conductivity, bearing capacity, or resistance;

(3) measure groundwater levels, including use of a piezometer; and

(4) determine groundwater flow direction or velocity.

Sec. 21. Minnesota Statutes 2022, section 103I.005, subdivision 20a, is amended to read:

Subd. 20a. **Water supply well.** "Water supply well" means a well that is not a dewatering well or environmental well and includes wells used:

(1) for potable water supply;

(2) for irrigation;

(3) for agricultural, commercial, or industrial water supply;

(4) for heating or cooling; ~~and~~

(5) for containing a submerged closed-loop heat exchanger; and

(6) for testing water yield for irrigation, commercial or industrial uses, residential supply, or public water supply.

Sec. 22. **[103I.631] INSTALLATION OF A SUBMERGED CLOSED-LOOP HEAT EXCHANGER.**

Subdivision 1. **Installation.** Notwithstanding any other provision of law, the commissioner must allow the installation of a submerged closed-loop heat exchanger in a water supply well. A project may consist of more than one water supply well on a particular site.

Subd. 2. **Setbacks.** Water supply wells used only for the nonpotable purpose of providing heating and cooling using a submerged closed-loop heat exchanger are exempt from isolation distance requirements greater than ten feet.

Subd. 3. **Construction.** The screened interval of a water supply well constructed to contain a submerged closed-loop heat exchanger completed within a single aquifer may be designed and constructed using any combination of screen, casing, leader, riser, sump, or other piping combinations if the screen configuration does not interconnect aquifers.

Subd. 4. **Permits.** A submerged closed-loop heat exchanger is not subject to the permit requirements in this chapter.

Subd. 5. **Variances.** A variance is not required to install or operate a submerged closed-loop heat exchanger.

Sec. 23. Minnesota Statutes 2022, section 121A.335, subdivision 3, is amended to read:

Subd. 3. **Frequency of testing.** ~~(a)~~ The plan under subdivision 2 must include a testing schedule for every building serving prekindergarten through grade 12 students. The schedule must require that each building be tested at least once every five years. A school district or charter school must begin testing school buildings by July 1, 2018, and complete testing of all buildings that serve students within five years.

~~(b) A school district or charter school that finds lead at a specific location providing cooking or drinking water within a facility must formulate, make publicly available, and implement a plan that is consistent with established guidelines and recommendations to ensure that student exposure to lead is minimized. This includes, when a school district or charter school finds the presence of lead at a level where action should be taken as set by the guidance in any water source that can provide cooking or drinking water, immediately shutting off the water source or making it unavailable until the hazard has been minimized.~~

Sec. 24. Minnesota Statutes 2022, section 121A.335, subdivision 5, is amended to read:

Subd. 5. **Reporting.** (a) A school district or charter school that has tested its buildings for the presence of lead shall make the results of the testing available to the public for review and must directly notify parents annually of the availability of the information. School districts and charter schools must follow the actions outlined in guidance from the commissioners of health and education. ~~If a test conducted under subdivision 3, paragraph (a), reveals the presence of lead above a level where action should be taken as set by the guidance, the school district or charter school must, within 30 days of receiving the test result, either remediate the presence of lead to below the level set in guidance, verified by retest, or directly notify parents of the test result. The school district or charter school must make the water source unavailable until the hazard has been minimized.~~

(b) Results of testing, and any planned remediation steps, shall be made available within 30 days of receiving results.

(c) A school district or charter school that has tested for lead in drinking water shall report the results of testing, and any planned remediation steps to the school board at the next available school board meeting or within 30 days of receiving results, whichever is sooner.

(d) The school district or charter school shall maintain records of lead testing in drinking water records electronically or by paper copy for at least 15 years.

(e) Beginning July 1, 2024, school districts and charter schools must report their test results and remediation activities to the commissioner of health annually on or before July 1 of each year.

Sec. 25. Minnesota Statutes 2022, section 121A.335, is amended by adding a subdivision to read:

Subd. 6. **Remediation.** (a) A school district or charter school that finds lead above five parts per billion at a specific location providing cooking or drinking water within a facility must formulate, make publicly available, and implement a plan to remediate the lead in drinking water. The plan must be consistent with established guidelines and recommendations to ensure exposure to lead is remediated.

(b) When lead is found above five parts per billion the water fixture shall immediately be shut off or made unavailable for consumption until the hazard has been minimized as verified by a test.

(c) If the school district or charter school receives water from a public water supply that has an action level exceedance of the federal Lead and Copper Rule, it may delay remediation activities until the public water system meets state and federal requirements for the Lead and Copper Rule. If the school district or charter school receives water from a lead service line or other lead infrastructure owned by the public water supply, the school district may delay remediation of fixtures until the lead service line is fully replaced. The school must ensure that any fixture testing above five parts per billion is not used for consumption until remediation activities are complete.

Sec. 26. Minnesota Statutes 2022, section 144.05, is amended by adding a subdivision to read:

Subd. 8. **Grant program reporting.** The commissioner must submit a report to the chairs and ranking minority members of the legislative committees with jurisdiction over health by December 31, 2023, and by each December 31 thereafter on the following information:

(1) the number of grant programs administered by the commissioner that required a full-time equivalent staff appropriation or administrative appropriation in order to implement;

(2) the total amount of funds appropriated to the commissioner for full-time equivalent staff or administration for all the grant programs; and

(3) for each grant program administered by the commissioner:

(i) the amount of funds appropriated to the commissioner for full-time equivalent staff or administration to administer that particular grant program;

(ii) the actual amount of funds that were spent on full-time equivalent staff or administration to administer that particular grant program; and

(iii) if there were funds appropriated that were not spent on full-time equivalent staff or administration to administer that particular grant program, what the funds were actually spent on.

Sec. 27. **[144.0526] MINNESOTA ONE HEALTH ANTIMICROBIAL STEWARDSHIP COLLABORATIVE.**

Subdivision 1. **Establishment.** The commissioner of health shall establish the Minnesota One Health Antimicrobial Stewardship Collaborative. The commissioner shall appoint a director to execute operations, conduct health education, and provide technical assistance.

Subd. 2. **Commissioner's duties.** The commissioner of health shall oversee a program to:

(1) maintain the position of director of One Health Antimicrobial Stewardship to lead state antimicrobial stewardship initiatives across human, animal, and environmental health;

(2) communicate to professionals and the public the interconnectedness of human, animal, and environmental health, especially related to preserving the efficacy of antibiotic medications, which are a shared resource;

(3) leverage new and existing partnerships. The commissioner of health shall consult and collaborate with organizations and agencies in fields including but not limited to health care, veterinary medicine, animal agriculture, academic institutions, and industry and community organizations to inform strategies for education, practice improvement, and research in all settings where antimicrobials are used;

(4) ensure that veterinary settings have education and strategies needed to practice appropriate antibiotic prescribing, implement clinical antimicrobial stewardship programs, and prevent transmission of antimicrobial-resistant microbes; and

(5) support collaborative research and programmatic initiatives to improve the understanding of the impact of antimicrobial use and resistance in the natural environment.

Sec. 28. **[144.0701] SPECIAL GUERILLA UNIT VETERANS GRANT PROGRAM.**

Subdivision 1. **Establishment.** The commissioner of health must establish a grant program to offer culturally specific and specialized assistance to support the health and well-being of special guerilla unit veterans.

Subd. 2. **Eligible applicants.** To be eligible for a grant under this section, applicants must be a nonprofit organization or a nongovernmental organization that offers culturally specific and specialized assistance to support the health and well-being of special guerilla unit veterans.

Subd. 3. **Application.** An organization seeking a grant under this section must apply to the commissioner at a time and in a manner specified by the commissioner.

Subd. 4. **Grant activities.** Grant funds must be used to offer programming and culturally specific and specialized assistance to support the health and well-being of special guerilla unit veterans.

Sec. 29. **[144.0752] CULTURAL COMMUNICATIONS.**

Subdivision 1. **Establishment.** The commissioner of health shall establish:

(1) a cultural communications program that advances culturally and linguistically appropriate communication services for communities most impacted by health disparities which includes limited English proficient (LEP) populations, African American, LGBTQ+, and people with disabilities; and

(2) a position that works with department leadership and division to ensure that the department follows the National Standards for Culturally and Linguistically Appropriate Services (CLAS) Standards.

Subd. 2. **Commissioner's duties.** The commissioner of health shall oversee a program to:

(1) align the department services, policies, procedures, and governance with the National CLAS Standards and establish culturally and linguistically appropriate goals, policies, and management accountability and apply them throughout the organization's planning and operations;

(2) ensure the department services respond to the cultural and linguistic diversity of Minnesotans and that the department partners with the community to design, implement, and evaluate policies, practices, and services that are aligned with the national cultural and linguistic appropriateness standard; and

(3) ensure the department leadership, workforce, and partners embed culturally and linguistically appropriate policies and practices into leadership and public health program planning, intervention, evaluation, and dissemination.

Subd. 3. **Eligible contractors.** Organizations eligible to receive contract funding under this section include:

(1) master contractors that are selected through the state to provide language and communication services; and

(2) organizations that are able to provide services for languages that master contracts are unable to cover.

Sec. 30. **[144.0754] OFFICE OF AFRICAN AMERICAN HEALTH; DUTIES.**

The commissioner shall establish the Office of African American Health to address the unique public health needs of African American Minnesotans and work to develop solutions and systems to address identified health disparities of African American Minnesotans arising

from a context of cumulative and historical discrimination and disadvantages in multiple systems, including but not limited to housing, education, employment, gun violence, incarceration, environmental factors, and health care discrimination and shall:

(1) convene the African American Health State Advisory Council (AAHSAC) under section 144.0755 to advise the commissioner on issues and to develop specific, targeted policy solutions to improve the health of African American Minnesotans, with a focus on United States born African Americans;

(2) based upon input from and collaboration with the AAHSAC, health indicators, and identified disparities, conduct analysis and develop policy and program recommendations and solutions targeted at improving African American health outcomes;

(3) coordinate and conduct community engagement across multiple systems, sectors, and communities to address racial disparities in labor force participation, educational achievement, and involvement with the criminal justice system that impact African American health and well-being;

(4) conduct data analysis and research to support policy goals and solutions;

(5) award and administer African American health special emphasis grants to health and community-based organizations to plan and develop programs targeted at improving African American health outcomes, based upon needs identified by the council, health indicators, and identified disparities and addressing historical trauma and systems of United States born African American Minnesotans; and

(6) develop and administer Department of Health immersion experiences for students in secondary education and community colleges to improve diversity of the public health workforce and introduce career pathways that contribute to reducing health disparities.

Sec. 31. **[144.0755] AFRICAN AMERICAN HEALTH STATE ADVISORY COUNCIL.**

Subdivision 1. **Establishment; purpose.** The commissioner of health shall establish and administer the African American Health State Advisory Council to advise the commissioner on implementing specific strategies to reduce health inequities and disparities that particularly affect African Americans in Minnesota.

Subd. 2. **Members.** (a) The council shall include no fewer than 12 or more than 20 members from any of the following groups:

(1) representatives of community-based organizations serving or advocating for African American citizens;

(2) at-large community leaders or elders, as nominated by other council members;

(3) African American individuals who provide and receive health care services;

(4) African American secondary or college students;

(5) health or human service professionals serving African American communities or clients;

(6) representatives with research or academic expertise in racial equity; and

(7) other members that the commissioner deems appropriate to facilitate the goals and duties of the council.

(b) The commissioner shall make recommendations for committee membership and, after considering recommendations from the council, shall appoint a chair or chairs of the committee. Committee members shall be appointed by the governor.

Subd. 3. **Terms.** A term shall be for two years and appointees may be reappointed to serve two additional terms. The commissioner shall recommend appointments to replace members vacating their positions in a timely manner, no more than three months after the council reviews panel recommendations.

Subd. 4. **Duties of commissioner.** The commissioner or commissioner's designee shall:

(1) maintain and actively engage with the council established in this section;

(2) based on recommendations of the council, review identified department or other related policies or practices that maintain health inequities and disparities that particularly affect African Americans in Minnesota;

(3) in partnership with the council, recommend or implement action plans and resources necessary to address identified disparities and advance African American health equity;

(4) support interagency collaboration to advance African American health equity; and

(5) support member participation in the council, including participation in educational and community engagement events across Minnesota that specifically address African American health equity.

Subd. 5. **Duties of council.** The council shall:

(1) identify health disparities found in African American communities and contributing factors;

(2) recommend to the commissioner for review any statutes, rules, or administrative policies or practices that would address African American health disparities;

(3) recommend policies and strategies to the commissioner of health to address disparities specifically affecting African American health;

(4) form work groups of council members who are persons who provide and receive services and representatives of advocacy groups;

(5) provide the work groups with clear guidelines, standardized parameters, and tasks for the work groups to accomplish; and

(6) annually submit to the commissioner a report that summarizes the activities of the council, identifies disparities specially affecting the health of African American Minnesotans, and makes recommendations to address identified disparities.

Subd. 6. **Duties of council members.** The members of the council shall:

(1) attend scheduled meetings with no more than three absences per year, participate in scheduled meetings, and prepare for meetings by reviewing meeting notes;

(2) maintain open communication channels with respective constituencies;

(3) identify and communicate issues and risks that may impact the timely completion of tasks;

(4) participate in any activities the council or commissioner deems appropriate and necessary to facilitate the goals and duties of the council; and

(5) participate in work groups to carry out council duties.

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

Subd. 8. **Reimbursement.** Compensation or reimbursement for travel and expenses, or both, incurred for council activities is governed in accordance with section 15.059, subdivision 3.

Sec. 32. **[144.0756] AFRICAN AMERICAN HEALTH SPECIAL EMPHASIS GRANT PROGRAM.**

Subdivision 1. **Establishment.** The commissioner of health shall establish the African American health special emphasis grant program administered by the Office of African American Health. The purposes of the program are to:

(1) identify disparities impacting African American health arising from cumulative and historical discrimination and disadvantages in multiple systems, including but not limited to housing, education, employment, gun violence, incarceration, environmental factors, and health care discrimination; and

(2) develop community-based solutions that incorporate a multisector approach to addressing identified disparities impacting African American health.

Subd. 2. **Requests for proposals; accountability; data collection.** As directed by the commissioner of health, the Office of African American Health shall:

(1) develop a request for proposals for an African American health special emphasis grant program in consultation with community stakeholders;

(2) provide outreach, technical assistance, and program development guidance to potential qualifying organizations or entities;

(3) review responses to requests for proposals in consultation with community stakeholders and award grants under this section;

(4) establish a transparent and objective accountability process in consultation with community stakeholders, focused on outcomes that grantees agree to achieve;

(5) provide grantees with access to summary and other public data to assist grantees in establishing and implementing effective community-led solutions; and

(6) collect and maintain data on outcomes reported by grantees.

Subd. 3. **Eligible grantees.** Organizations eligible to receive grant funding under this section include nonprofit organizations or entities that work with African American communities or are focused on addressing disparities impacting the health of African American communities.

Subd. 4. **Strategic consideration and priority of proposals; grant awards.** In developing the requests for proposals and awarding the grants, the commissioner and the Office of African American Health shall consider building upon the existing capacity of communities and on developing capacity where it is lacking. Proposals shall focus on addressing health equity issues specific to United States born African American communities; addressing the health impact of historical trauma; and reducing health disparities experienced by United States born African American communities; and incorporating a multisector approach to addressing identified disparities.

Subd. 5. **Report.** Grantees must report grant program outcomes to the commissioner on the forms and according to timelines established by the commissioner.

Sec. 33. **[144.0757] OFFICE OF AMERICAN INDIAN HEALTH.**

Subdivision 1. **Duties.** The Office of American Indian Health is established to address unique public health needs of American Indian Tribal communities in Minnesota, and shall:

(1) coordinate with Minnesota's Tribal Nations and urban American Indian community-based organizations to identify underlying causes of health disparities, address unique health needs of Minnesota's Tribal communities, and develop public health approaches to achieve health equity;

(2) strengthen capacity of American Indian and community-based organizations and Tribal Nations to address identified health disparities and needs;

(3) administer state and federal grant funding opportunities targeted to improve the health of American Indians;

(4) provide overall leadership for targeted development of holistic health and wellness strategies to improve health and to support Tribal and urban American Indian public health leadership and self-sufficiency;

(5) provide technical assistance to Tribal and American Indian urban community leaders to develop culturally appropriate activities to address public health emergencies;

(6) develop and administer the department immersion experiences for American Indian students in secondary education and community colleges to improve diversity of the public health workforce and introduce career pathways that contribute to reducing health disparities; and

(7) identify and promote workforce development strategies for Department of Health staff to work with the American Indian population and Tribal Nations more effectively in Minnesota.

Subd. 2. **Grants and contracts.** To carry out these duties, the office may contract with or provide grants to qualifying entities.

Sec. 34. **[144.0758] AMERICAN INDIAN SPECIAL EMPHASIS GRANTS.**

Subdivision 1. **Establishment.** The commissioner of health shall establish the American Indian health special emphasis grant program. The purposes of the program are to:

(1) plan and develop programs targeted to address continuing and persistent health disparities of Minnesota's American Indian population and improve American Indian health outcomes based upon needs identified by health indicators and identified disparities;

(2) identify disparities in American Indian health arising from cumulative and historical discrimination; and

(3) plan and develop community-based solutions with a multisector approach to addressing identified disparities in American Indian health.

Subd. 2. **Commissioner's duties.** The commissioner of health shall:

(1) develop a request for proposals for an American Indian special emphasis grant program in consultation with Minnesota's Tribal Nations and urban American Indian community-based organizations based upon needs identified by the community, health indicators, and identified disparities;

(2) provide outreach, technical assistance, and program development guidance to potential qualifying organizations or entities;

(3) review responses to requests for proposals in consultation with community stakeholders and award grants under this section;

(4) establish a transparent and objective accountability process in consultation with community stakeholders focused on outcomes that grantees agree to achieve;

(5) provide grantees with access to data to assist grantees in establishing and implementing effective community-led solutions; and

(6) collect and maintain data on outcomes reported by grantees.

Subd. 3. **Eligible grantees.** Organizations eligible to receive grant funding under this section are Minnesota's Tribal Nations and urban American Indian community-based organizations.

Subd. 4. **Strategic consideration and priority of proposals; grant awards.** In developing the proposals and awarding the grants, the commissioner shall consider building upon the existing capacity of Minnesota's Tribal Nations and urban American Indian community-based organizations and on developing capacity where it is lacking. Proposals should focus on addressing health equity issues specific to Tribal and urban American Indian communities; addressing the health impact of historical trauma; reducing health disparities experienced by American Indian communities; and incorporating a multisector approach to addressing identified disparities.

Subd. 5. **Report.** Grantees must report grant program outcomes to the commissioner on the forms and according to the timelines established by the commissioner.

Sec. 35. **[144.0759] PUBLIC HEALTH AMERICORPS.**

The commissioner may award a grant to a statewide, nonprofit organization to support Public Health AmeriCorps members. The organization awarded the grant shall provide the commissioner with any information needed by the commissioner to evaluate the program in the form and at the timelines specified by the commissioner.

Sec. 36. Minnesota Statutes 2022, section 144.122, is amended to read:

144.122 LICENSE, PERMIT, AND SURVEY FEES.

(a) The state commissioner of health, by rule, may prescribe procedures and fees for filing with the commissioner as prescribed by statute and for the issuance of original and renewal permits, licenses, registrations, and certifications issued under authority of the commissioner. The expiration dates of the various licenses, permits, registrations, and certifications as prescribed by the rules shall be plainly marked thereon. Fees may include application and examination fees and a penalty fee for renewal applications submitted after the expiration date of the previously issued permit, license, registration, and certification. The commissioner may also prescribe, by rule, reduced fees for permits, licenses, registrations, and certifications when the application therefor is submitted during the last three months of the permit, license, registration, or certification period. Fees proposed to be prescribed in the rules shall be first approved by the Department of Management and Budget. All fees proposed to be prescribed in rules shall be reasonable. The fees shall be in an amount so that the total fees collected by the commissioner will, where practical, approximate the cost to the commissioner in administering the program. All fees collected shall be deposited in the state treasury and credited to the state government special revenue fund unless otherwise specifically appropriated by law for specific purposes.

(b) The commissioner may charge a fee for voluntary certification of medical laboratories and environmental laboratories, and for environmental and medical laboratory services provided by the department, without complying with paragraph (a) or chapter 14. Fees charged for environment and medical laboratory services provided by the department must be approximately equal to the costs of providing the services.

(c) The commissioner may develop a schedule of fees for diagnostic evaluations conducted at clinics held by the services for children with disabilities program. All receipts

generated by the program are annually appropriated to the commissioner for use in the maternal and child health program.

(d) The commissioner shall set license fees for hospitals and nursing homes that are not boarding care homes at the following levels:

Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and American Osteopathic Association (AOA) hospitals	$7,655 plus $16 per bed
Non-JCAHO and non-AOA hospitals	$5,280 plus $250 per bed
Nursing home	$183 plus $91 per bed until June 30, 2018. $183 plus $100 per bed between July 1, 2018, and June 30, 2020. $183 plus $105 per bed beginning July 1, 2020.

The commissioner shall set license fees for outpatient surgical centers, boarding care homes, supervised living facilities, assisted living facilities, and assisted living facilities with dementia care at the following levels:

Outpatient surgical centers	$3,712
Boarding care homes	$183 plus $91 per bed
Supervised living facilities	$183 plus $91 per bed.
Assisted living facilities with dementia care	$3,000 plus $100 per resident.
Assisted living facilities	$2,000 plus $75 per resident.

Fees collected under this paragraph are nonrefundable. The fees are nonrefundable even if received before July 1, 2017, for licenses or registrations being issued effective July 1, 2017, or later.

(e) Unless prohibited by federal law, the commissioner of health shall charge applicants the following fees to cover the cost of any initial certification surveys required to determine a provider's eligibility to participate in the Medicare or Medicaid program:

Prospective payment surveys for hospitals	$ 900
Swing bed surveys for nursing homes	$ 1,200
Psychiatric hospitals	$ 1,400
Rural health facilities	$ 1,100
Portable x-ray providers	$ 500
Home health agencies	$ 1,800
Outpatient therapy agencies	$ 800
End stage renal dialysis providers	$ 2,100
Independent therapists	$ 800
Comprehensive rehabilitation outpatient facilities	$ 1,200

Hospice providers	$	1,700
Ambulatory surgical providers	$	1,800
Hospitals	$	4,200
Other provider categories or additional resurveys required to complete initial certification	Actual surveyor costs: average surveyor cost x number of hours for the survey process.	

These fees shall be submitted at the time of the application for federal certification and shall not be refunded. All fees collected after the date that the imposition of fees is not prohibited by federal law shall be deposited in the state treasury and credited to the state government special revenue fund.

(f) Notwithstanding section 16A.1283, the commissioner may adjust the fees assessed on assisted living facilities and assisted living facilities with dementia care under paragraph (d), in a revenue-neutral manner in accordance with the requirements of this paragraph:

(1) a facility seeking to renew a license shall pay a renewal fee in an amount that is up to ten percent lower than the applicable fee in paragraph (d) if residents who receive home and community-based waiver services under chapter 256S and section 256B.49 comprise more than 50 percent of the facility's capacity in the calendar year prior to the year in which the renewal application is submitted; and

(2) a facility seeking to renew a license shall pay a renewal fee in an amount that is up to ten percent higher than the applicable fee in paragraph (d) if residents who receive home and community-based waiver services under chapter 256S and section 256B.49 comprise less than 50 percent of the facility's capacity during the calendar year prior to the year in which the renewal application is submitted.

The commissioner may annually adjust the percentages in clauses (1) and (2), to ensure this paragraph is implemented in a revenue-neutral manner. The commissioner shall develop a method for determining capacity thresholds in this paragraph in consultation with the commissioner of human services and must coordinate the administration of this paragraph with the commissioner of human services for purposes of verification.

(g) The commissioner shall charge hospitals an annual licensing base fee of $1,826 per hospital, plus an additional $23 per licensed bed or bassinet fee. Revenue shall be deposited to the state government special revenue fund and credited toward trauma hospital designations under sections 144.605 and 144.6071.

Sec. 37. **[144.1462] COMMUNITY HEALTH WORKERS; GRANTS AUTHORIZED.**

Subdivision 1. **Establishment.** The commissioner of health shall support collaboration and coordination between state and community partners to develop, refine, and expand the community health workers (CHW) profession in Minnesota; equipping community health workers to address health needs; and to improve health outcomes. This work addresses the social conditions that impact community health and well-being in public safety, social services, youth and family services, schools, and neighborhood associations.

Subd. 2. **Grants and contracts authorized; eligibility.** The commissioner of health shall establish grants and contracts to expand and strengthen the community health worker workforce across Minnesota. The recipients shall include at least one not-for-profit community organization serving, convening, and supporting community health workers statewide.

Subd. 3. **Evaluation.** The commissioner of health shall design, conduct, and evaluate the CHW initiative using measures such as workforce capacity, employment opportunity, reach of services, and return on investment, as well as descriptive measures of the existing community health worker models as they compare with the national community health workers' landscape. These initial measures point to longer-term change in social determinants of health and rates of death and injury by suicide, overdose, firearms, alcohol, and chronic disease.

Subd. 4. **Report.** Grant recipients and contractors must report program outcomes to the department annually and by the guidelines established by the commissioner.

Sec. 38. Minnesota Statutes 2022, section 144.218, subdivision 1, is amended to read:

Subdivision 1. **Adoption.** Upon receipt of a certified copy of an order, decree, or certificate of adoption, the state registrar shall register a replacement vital record in the new name of the adopted person. The original record of birth is ~~confidential~~ private data pursuant to section 13.02, subdivision ~~3~~ 12, and shall not be disclosed except pursuant to court order or section 144.2252. The information contained on the original birth record, except for the registration number, shall be provided on request to a parent who is named on the original birth record. Upon the receipt of a certified copy of a court order of annulment of adoption the state registrar shall restore the original vital record to its original place in the file.

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

Sec. 39. Minnesota Statutes 2022, section 144.218, subdivision 2, is amended to read:

Subd. 2. **Adoption of foreign persons.** In proceedings for the adoption of a person who was born in a foreign country, the court, upon evidence presented by the commissioner of human services from information secured at the port of entry or upon evidence from other reliable sources, may make findings of fact as to the date and place of birth and parentage. Upon receipt of certified copies of the court findings and the order or decree of adoption, a certificate of adoption, or a certified copy of a decree issued under section 259.60, the state registrar shall register a birth record in the new name of the adopted person. The certified copies of the court findings and the order or decree of adoption, certificate of adoption, or decree issued under section 259.60 are ~~confidential~~ private data, pursuant to section 13.02, subdivision ~~3~~ 12, and shall not be disclosed except pursuant to court order or section 144.2252. The birth record shall state the place of birth as specifically as possible and that the vital record is not evidence of United States citizenship.

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

Sec. 40. Minnesota Statutes 2022, section 144.225, subdivision 2, is amended to read:

Subd. 2. **Data about births.** (a) Except as otherwise provided in this subdivision, data pertaining to the birth of a child to a woman who was not married to the child's father when the child was conceived nor when the child was born, including the original record of birth and the certified vital record, are confidential data. At the time of the birth of a child to a woman who was not married to the child's father when the child was conceived nor when the child was born, the mother may designate demographic data pertaining to the birth as public. Notwithstanding the designation of the data as confidential, it may be disclosed:

(1) to a parent or guardian of the child;

(2) to the child when the child is 16 years of age or older, except as provided in clause (3);

(3) to the child if the child is a homeless youth;

(4) under paragraph (b), (e), or (f); or

(5) pursuant to a court order. For purposes of this section, a subpoena does not constitute a court order.

(b) ~~Unless the child is adopted,~~ Data pertaining to the birth of a child that are not accessible to the public become public data if 100 years have elapsed since the birth of the

child who is the subject of the data, or as provided under section 13.10, whichever occurs first.

(c) If a child is adopted, data pertaining to the child's birth are governed by the provisions relating to adoption and birth records, including sections 13.10, subdivision 5; 144.218, subdivision 1; and 144.2252~~; and 259.89~~.

(d) The name and address of a mother under paragraph (a) and the child's date of birth may be disclosed to the county social services, Tribal health department, or public health member of a family services collaborative for purposes of providing services under section 124D.23.

(e) The commissioner of human services shall have access to birth records for:

(1) the purposes of administering medical assistance and the MinnesotaCare program;

(2) child support enforcement purposes; and

(3) other public health purposes as determined by the commissioner of health.

(f) Tribal child support programs shall have access to birth records for child support enforcement purposes.

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

Sec. 41. Minnesota Statutes 2022, section 144.2252, is amended to read:

144.2252 ACCESS TO ORIGINAL BIRTH RECORD AFTER ADOPTION.

Subdivision 1. **Definitions.** (a) ~~Whenever an adopted person requests the state registrar to disclose the information on the adopted person's original birth record, the state registrar shall act according to section 259.89.~~ For purposes of this section, the following terms have the meanings given.

(b) "Person related to the adopted person" means:

(1) the spouse, child, or grandchild of an adopted person, if the spouse, child, or grandchild is at least 18 years of age; or

(2) the legal representative of an adopted person.

The definition under this paragraph only applies when the adopted person is deceased.

(c) "Original birth record" means a copy of the original birth record for a person who is born in Minnesota and whose original birth record was sealed and replaced by a replacement

birth record after the state registrar received a certified copy of an order, decree, or certificate of adoption.

Subd. 2. **Release of original birth record.** (a) The state registrar must provide to an adopted person who is 18 years of age or older or a person related to the adopted person a copy of the adopted person's original birth record and any evidence of the adoption previously filed with the state registrar. To receive a copy of an original birth record under this subdivision, the adopted person or person related to the adopted person must make the request to the state registrar in writing. The copy of the original birth record must clearly indicate that it may not be used for identification purposes. All procedures, fees, and waiting periods applicable to a nonadopted person's request for a copy of a birth record apply in the same manner as requests made under this section.

(b) If a contact preference form is attached to the original birth record as authorized under section 144.2253, the state registrar must provide a copy of the contact preference form along with the copy of the adopted person's original birth record.

~~(b)~~ (c) The state registrar shall provide a transcript of an adopted person's original birth record to an authorized representative of a federally recognized American Indian Tribe for the sole purpose of determining the adopted person's eligibility for enrollment or membership. Information contained in the birth record may not be used to provide the adopted person information about the person's birth parents, except as provided in this section or section 259.83.

(d) For a replacement birth record issued under section 144.218, the adopted person or a person related to the adopted person may obtain from the state registrar copies of the order or decree of adoption, certificate of adoption, or decree issued under section 259.60, as filed with the state registrar.

Subd. 3. **Adult adoptions.** Notwithstanding section 144.218, a person adopted as an adult may access the person's birth records that existed before the person's adult adoption. Access to the existing birth records shall be the same access that was permitted prior to the adult adoption.

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

Sec. 42. **[144.2253] BIRTH PARENT CONTACT PREFERENCE FORM.**

(a) The commissioner must make available to the public a contact preference form as described in paragraph (b).

(b) The contact preference form must provide the following information to be completed at the option of a birth parent:

(1) "I would like to be contacted."

(2) "I would prefer to be contacted only through an intermediary."

(3) "I prefer not to be contacted at this time. If I decide later that I would like to be contacted, I will submit an updated contact preference form to the Minnesota Department of Health."

(c) If a birth parent of an adopted person submits a completed contact preference form to the commissioner, the commissioner must:

(1) match the contact preference form to the adopted person's original birth record; and

(2) attach the contact preference form to the original birth record as required under section 144.2252.

(d) A contact preference form submitted to the commissioner under this section is private data on an individual as defined in section 13.02, subdivision 12, except that the contact preference form may be released as provided under section 144.2252, subdivision 2.

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

Sec. 43. **[144.2254] PREVIOUSLY FILED CONSENTS TO DISCLOSURE AND AFFIDAVITS OF NONDISCLOSURE.**

(a) The commissioner must inform a person applying for an original birth record under section 144.2252 of the existence of an unrevoked consent to disclosure or an affidavit of nondisclosure on file with the department, including the name of the birth parent who filed the consent or affidavit. If a birth parent authorized the release of the birth parent's address on an unrevoked consent to disclosure, the commissioner shall provide the address to the person who requests the original birth record.

(b) A birth parent's consent to disclosure or affidavit of nondisclosure filed with the commissioner of health expires and has no force or effect beginning on June 30, 2024.

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

Sec. 44. Minnesota Statutes 2022, section 144.226, subdivision 3, is amended to read:

Subd. 3. **Birth record surcharge.** (a) In addition to any fee prescribed under subdivision 1, there shall be a nonrefundable surcharge of $3 for each certified birth or stillbirth record

and for a certification that the vital record cannot be found. The state registrar or local issuance office shall forward this amount to the commissioner of management and budget each month following the collection of the surcharge for deposit into the account for the children's trust fund for the prevention of child abuse established under section 256E.22. This surcharge shall not be charged under those circumstances in which no fee for a certified birth or stillbirth record is permitted under subdivision 1, paragraph (b). Upon certification by the commissioner of management and budget that the assets in that fund exceed $20,000,000, this surcharge shall be discontinued.

(b) In addition to any fee prescribed under subdivision 1, there shall be a nonrefundable surcharge of $10 for each certified birth record. The state registrar or local issuance office shall forward this amount to the commissioner of management and budget each month following the collection of the surcharge for deposit in the general fund.

Sec. 45. Minnesota Statutes 2022, section 144.226, subdivision 4, is amended to read:

Subd. 4. **Vital records surcharge.** In addition to any fee prescribed under subdivision 1, there is a nonrefundable surcharge of $4 for each certified and noncertified birth, stillbirth, or death record, and for a certification that the record cannot be found. The local issuance office or state registrar shall forward this amount to the commissioner of management and budget each month following the collection of the surcharge to be deposited into the state government special revenue fund.

Sec. 46. **[144.3832] PUBLIC WATER SYSTEM INFRASTRUCTURE STRENGTHENING GRANTS.**

Subdivision 1. **Establishment; purpose.** The commissioner of health shall establish a grant program to ensure the uninterrupted delivery of safe water through emergency power supplies and back-up wells, backflow prevention, water reuse, increased cybersecurity, floodplain mapping, support for very small water system infrastructure, and piloting solar farms in source water protection areas.

Subd. 2. **Grants authorized.** (a) The commissioner shall award grants for emergency power supplies, back-up wells, and cross connection prevention programs through a request for proposals process to public water systems. Priority shall be given to small and very small public water systems that serve populations of less than 3,300 and 500 respectively. The commissioner shall award matching grants to public water systems that serve populations of less than 500 for infrastructure improvements supporting system operations and resiliency.

(b) Grantees must address one or more areas of infrastructure strengthening with the goals of:

(1) ensuring the uninterrupted delivery of safe and affordable water to their customers;

(2) anticipating and mitigating potential threats arising from climate change such as flooding and drought;

(3) providing resiliency to maintain drinking water supply capacity in case of a loss of power;

(4) providing redundancy by having more than one source of water in case the main source of water fails; or

(5) preventing contamination by cross connections through a self-sustaining cross connection control program.

Sec. 47. **[144.3885] LABOR TRAFFICKING SERVICES GRANT PROGRAM.**

Subdivision 1. **Establishment.** The commissioner of health must establish a labor trafficking services grant program to provide comprehensive, trauma-informed, and culturally specific services for victims of labor trafficking or labor exploitation.

Subd. 2. **Eligibility; application.** To be eligible for a grant under this section, applicants must be a nonprofit organization or a nongovernmental organization serving victims of labor trafficking or labor exploitation. An organization seeking a grant under this section must apply to the commissioner at a time and in a manner specified by the commissioner. The commissioner must review each application to determine if the application is complete, the organization is eligible for a grant, and the proposed project is an allowable use of grant funds. The commissioner must determine the grant amount awarded to applicants that the commissioner determines will receive a grant.

Subd. 3. **Reporting.** (a) The grantee must submit a report to the commissioner in a manner and on a timeline specified by the commissioner on how the grant funds were spent and how many individuals were served.

(b) By January 15 of each year, the commissioner must submit a report to the chairs and ranking minority members of the legislative committees with jurisdiction over health policy and finance. The report must include the names of the grant recipients, how the grant funds were spent, and how many individuals were served.

Sec. 48. **[144.398] TOBACCO USE PREVENTION ACCOUNT; ESTABLISHMENT AND USES.**

Subdivision 1. **Definitions.** (a) As used in this section, the terms in this subdivision have the meanings given.

(b) "Electronic delivery device" has the meaning given in section 609.685, subdivision 1, paragraph (c).

(c) "Tobacco" has the meaning given in section 609.685, subdivision 1, paragraph (a).

(d) "Tobacco-related devices" has the meaning given in section 609.685, subdivision 1, paragraph (b).

(e) "Nicotine delivery product" has the meaning given in section 609.6855, subdivision 1, paragraph (c).

Subd. 2. **Account created.** A tobacco use prevention account is created in the special revenue fund. Pursuant to section 16A.151, subdivision 2, paragraph (h), the commissioner of management and budget shall deposit into the account any money received by the state resulting from a settlement agreement or an assurance of discontinuance entered into by the attorney general of the state, or a court order in litigation brought by the attorney general of the state on behalf of the state or a state agency related to alleged violations of consumer fraud laws in the marketing, sale, or distribution of electronic nicotine delivery systems in this state or other alleged illegal actions that contributed to the exacerbation of youth nicotine use.

Subd. 3. **Appropriations from tobacco use prevention account.** (a) Each fiscal year, the amount of money in the tobacco use prevention account is appropriated to the commissioner of health for:

(1) tobacco and electronic delivery device use prevention and cessation projects consistent with the duties specified in section 144.392;

(2) a public information program under section 144.393;

(3) the development of health promotion and health education materials about tobacco and electronic delivery device use prevention and cessation;

(4) tobacco and electronic delivery device use prevention activities under section 144.396; and

(5) statewide tobacco cessation services under section 144.397.

(b) In activities funded under this subdivision, the commissioner of health must:

(1) prioritize preventing persons under the age of 21 from using commercial tobacco, electronic delivery devices, tobacco-related devices, and nicotine delivery products;

(2) promote racial and health equity; and

(3) use strategies that are evidence-based or based on promising practices.

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

Sec. 49. **[144.4962] LOCAL AND TRIBAL PUBLIC HEALTH EMERGENCY PREPAREDNESS AND RESPONSE GRANT PROGRAM.**

Subdivision 1. **Establishment.** The commissioner of health must establish a local and Tribal public health emergency preparedness and response grant program.

Subd. 2. **Eligibility; application.** (a) Local and Tribal public health organizations are eligible to receive grants as provided in this section. Grant proceeds must align with the Centers for Disease Control and Prevention's issued report: Public Health Emergency Preparedness and Response Capabilities: National Standards for State, Local, Tribal, and Territorial Public Health.

(b) A local or Tribal public health organization seeking a grant under this section must apply to the commissioner at a time and in a manner specified by the commissioner. The commissioner must review each application to determine if the application is complete, the organization is eligible for a grant, and the proposed project is an allowable use of grant funds. The commissioner must determine the grant amount awarded to applicants that the commissioner determines will receive a grant.

Subd. 3. **Reporting.** (a) The grantee must submit a report to the commissioner in a manner and on a timeline specified by the commissioner on how the grant funds were spent and how many individuals were served.

(b) By January 15 of each year, the commissioner must submit a report to the chairs and ranking minority members of the legislative committees with jurisdiction over health policy and finance. The report must include the names of the grant recipients, how the grant funds were spent, and how many individuals were served.

Sec. 50. **[144.557] REQUIREMENTS FOR CERTAIN HEALTH CARE ENTITY TRANSACTIONS.**

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

(b) "Captive professional entity" means a professional corporation, limited liability company, or other entity formed to render professional services in which a beneficial owner is a health care provider employed by, controlled by, or subject to the direction of a hospital or hospital system.

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

(d) "Control," including the terms "controlling," "controlled by," and "under common control with," means the possession, direct or indirect, of the power to direct or cause the direction of the management and policies of a person, whether through the ownership of voting securities, membership in an entity formed under chapter 317A, by contract other than a commercial contract for goods or nonmanagement services, or otherwise, unless the power is the result of an official position with, corporate office held by, or court appointment of, the person. Control is presumed to exist if any person, directly or indirectly, owns, controls, holds with the power to vote, or holds proxies representing, 40 percent or more of the voting securities of any other person, or if any person, directly or indirectly, constitutes 40 percent or more of the membership of an entity formed under chapter 317A. The commissioner may determine, after furnishing all persons in interest notice and opportunity to be heard and making specific findings of fact to support such determination, that control exists in fact, notwithstanding the absence of a presumption to that effect.

(e) "Health care entity" means:

(1) a hospital;

(2) a hospital system;

(3) a captive professional entity;

(4) a medical foundation;

(5) a health care provider group practice;

(6) an entity organized or controlled by an entity listed in clauses (1) to (5); or

(7) an entity that owns or exercises control over an entity listed in clauses (1) to (5).

(f) "Health care provider" means a physician licensed under chapter 147, a physician assistant licensed under chapter 147A, or an advanced practice registered nurse as defined in section 148.171, subdivision 3, who provides health care services, including but not limited to medical care, consultation, diagnosis, or treatment.

(g) "Health care provider group practice" means two or more health care providers legally organized in a partnership, professional corporation, limited liability company, medical foundation, nonprofit corporation, faculty practice plan, or other similar entity:

(1) in which each health care provider who is a member of the group provides substantially the full range of services that a health care provider routinely provides, including but not limited to medical care, consultation, diagnosis, and treatment, through the joint use of shared office space, facilities, equipment, or personnel;

(2) for which substantially all services of the health care providers who are group members are provided through the group and are billed in the name of the group practice and amounts so received are treated as receipts of the group; or

(3) in which the overhead expenses of, and the income from, the group are distributed in accordance with methods previously determined by members of the group.

An entity that otherwise meets the definition of health care provider group practice in this paragraph shall be considered a health care provider group practice even if its shareholders, partners, members, or owners include a single-health care provider professional corporation, limited liability company, or another entity in which any beneficial owner is an individual health care provider and which is formed to render professional services.

(h) "Hospital" means a health care facility licensed as a hospital under sections 144.50 to 144.56.

(i) "Medical foundation" means a nonprofit legal entity through which physicians or other health care providers perform research or provide medical services.

(j) "Transaction" means a single action, or a series of actions within a five-year period, that constitutes:

(1) a merger or exchange of a health care entity with another entity;

(2) the sale, lease, or transfer of 40 percent or more of the assets of a health care entity to another entity;

(3) the granting of a security interest of 40 percent or more of the property and assets of a health care entity to another entity;

(4) the transfer of 40 percent or more of the shares or other ownership of the health care entity to another entity;

(5) an addition, removal, withdrawal, substitution, or other modification of one or more members of the health care entity's governing body that transfers control, responsibility for, or governance of the health care entity to another entity;

(6) the creation of a new health care entity;

(7) substantial investment of 40 percent or more in a health care entity that results in sharing of revenues without a change in ownership or voting shares;

(8) an addition, removal, withdrawal, substitution, or other modification of the members of a health care entity formed under chapter 317A that results in a change of 40 percent or more of the membership of the health care entity; or

(9) any other transfer of control of a health care entity to, or acquisition of control of a health care entity by, another entity.

A transaction does not include an action or series of actions which meets one or more of the criteria set forth in clauses (1) to (9) if, immediately prior to all such actions, the health care entity directly, or indirectly through one or more intermediaries, controls, or is controlled by, or is under common control with, all other parties to the action or series of actions.

Subd. 2. **Notice required.** (a) This subdivision applies to all transactions where:

(1) the health care entity involved in the transaction has average revenue of at least $40,000,000 per year; or

(2) an entity created by the transaction is projected to have average revenue of at least $40,000,000 per year once the entity is operating at full capacity.

(b) A health care entity must provide notice to the attorney general and the commissioner and comply with this subdivision before entering into a transaction. Notice must be provided at least 90 days before the proposed completion date for the transaction.

(c) As part of the notice required under this subdivision, at least 90 days before the proposed completion date of the transaction, a health care entity must affirmatively disclose the following to the attorney general and the commissioner:

(1) the entities involved in the transaction;

(2) the leadership of the entities involved in the transaction, including all directors, board members, and officers;

(3) the services provided by each entity and the attributed revenue for each entity by location;

(4) the primary service area for each location;

(5) the proposed service area for each location;

(6) the current relationships between the entities and the health care providers and practices affected, the locations of affected health care providers and practices, the services provided by affected health care providers and practices, and the proposed relationships between the entities and the health care providers and practices affected;

(7) the terms of the transaction agreement or agreements;

(8) the acquisition price;

(9) markets in which the entities expect postmerger synergies to produce a competitive advantage;

(10) potential areas of expansion, whether in existing markets or new markets;

(11) plans to close facilities, reduce workforce, or reduce or eliminate services;

(12) the experts and consultants used to evaluate the transaction;

(13) the number of full-time equivalent positions at each location before and after the transaction by job category, including administrative and contract positions; and

(14) any other information requested by the attorney general or commissioner.

(d) As part of the notice required under this subdivision, at least 90 days before the proposed completion date of the transaction, a health care entity must affirmatively produce the following to the attorney general and the commissioner:

(1) the current governing documents for all entities involved in the transaction and any amendments to these documents;

(2) the transaction agreement or agreements and all related agreements;

(3) any collateral agreements related to the principal transaction, including leases, management contracts, and service contracts;

(4) all expert or consultant reports or valuations conducted in evaluating the transaction, including any valuation of the assets that are subject to the transaction prepared within three years preceding the anticipated transaction completion date and any reports of financial or economic analysis conducted in anticipation of the transaction;

(5) the results of any projections or modeling of health care utilization or financial impacts related to the transaction, including but not limited to copies of reports by appraisers, accountants, investment bankers, actuaries, and other experts;

(6) a financial and economic analysis and report prepared by an independent expert or consultant on the effects of the transaction;

(7) an impact analysis report prepared by an independent expert or consultant on the effects of the transaction on communities and the workforce, including any changes in availability or accessibility of services;

(8) all documents reflecting the purposes of or restrictions on any related nonprofit entity's charitable assets;

(9) copies of all filings submitted to federal regulators, including any Hart-Scott-Rodino filing the entities submitted to the Federal Trade Commission in connection with the transaction;

(10) a certification sworn under oath by each board member and chief executive officer for any nonprofit entity involved in the transaction containing the following: an explanation of how the completed transaction is in the public interest, addressing the factors in subdivision 5, paragraph (a); a disclosure of each declarant's compensation and benefits relating to the transaction for the three years following the transaction's anticipated completion date; and a disclosure of any conflicts of interest;

(11) audited and unaudited financial statements from all entities involved in the transaction and tax filings for all entities involved in the transaction covering the preceding five fiscal years; and

(12) any other information or documents requested by the attorney general or commissioner.

(e) The attorney general may extend the notice and waiting period required under paragraph (b) for an additional 90 days by notifying the health care entity in writing of the extension.

(f) The attorney general may waive all or any part of the notice and waiting period required under paragraph (b).

(g) The attorney general or the commissioner may hold public listening sessions or forums to obtain input on the transaction from providers or community members who may be impacted by the transaction.

(h) The attorney general or the commissioner may bring an action in district court to compel compliance with the notice requirements in this subdivision.

Subd. 3. **Prohibited transactions.** No health care entity may enter into a transaction that will:

(1) substantially lessen competition; or

(2) tend to create a monopoly or monopsony.

Subd. 4. **Additional requirements for nonprofit health care entities.** A health care entity that is incorporated under chapter 317A or organized under section 322C.1101, or that is a subsidiary of any such entity, must, before entering into a transaction, ensure that:

(1) the transaction complies with chapters 317A and 501B and other applicable laws;

(2) the transaction does not involve or constitute a breach of charitable trust;

(3) the nonprofit health care entity will receive full and fair value for its public benefit assets, provided that this requirement is waived if application for waiver is made to the attorney general and the attorney general determines a waiver from this requirement is in the public interest;

(4) the value of the public benefit assets to be transferred has not been manipulated in a manner that causes or has caused the value of the assets to decrease;

(5) the proceeds of the transaction will be used in a manner consistent with the public benefit for which the assets are held by the nonprofit health care entity;

(6) the transaction will not result in a breach of fiduciary duty; and

(7) there are procedures and policies in place to prohibit any officer, director, trustee, or other executive of the nonprofit health care entity from directly or indirectly benefiting from the transaction.

Subd. 5. **Attorney general enforcement and supplemental authority.** (a) The attorney general may bring an action in district court to enjoin or unwind a transaction or seek other equitable relief necessary to protect the public interest if a health care entity or transaction violates this section, if the transaction is contrary to the public interest, or if both a health care entity or transaction violates this section and the transaction is contrary to the public interest. Factors informing whether a transaction is contrary to the public interest include but are not limited to whether the transaction:

(1) will harm public health;

(2) will reduce the affected community's continued access to affordable and quality care and to the range of services historically provided by the entities or will prevent members in the affected community from receiving a comparable or better patient experience;

(3) will have a detrimental impact on competing health care options within primary and dispersed service areas;

(4) will reduce delivery of health care to disadvantaged, uninsured, underinsured, and underserved populations and to populations enrolled in public health care programs;

(5) will have a substantial negative impact on medical education and teaching programs, health care workforce training, or medical research;

(6) will have a negative impact on the market for health care services, health insurance services, or skilled health care workers;

(7) will increase health care costs for patients; or

(8) will adversely impact provider cost trends and containment of total health care spending.

(b) The attorney general may enforce this section under section 8.31.

(c) Failure of the entities involved in a transaction to provide timely information as required by the attorney general or the commissioner shall be an independent and sufficient ground for a court to enjoin or unwind the transaction or provide other equitable relief, provided the attorney general notified the entities of the inadequacy of the information provided and provided the entities with a reasonable opportunity to remedy the inadequacy.

(d) The attorney general shall consult with the commissioner to determine whether a transaction is contrary to the public interest. Any information exchanged between the attorney general and the commissioner according to this subdivision is confidential data on individuals as defined in section 13.02, subdivision 3, or protected nonpublic data as defined in section 13.02, subdivision 13. The commissioner may share with the attorney general, according to section 13.05, subdivision 9, any not public data, as defined in section 13.02, subdivision 8a, held by the Department of Health to aid in the investigation and review of the transaction, and the attorney general must maintain this data with the same classification according to section 13.03, subdivision 4, paragraph (d).

Subd. 6. **Supplemental authority of commissioner.** (a) Notwithstanding any law to the contrary, the commissioner may use data or information submitted under this section, section 62U.04, and sections 144.695 to 144.705 to conduct analyses of the aggregate impact of health care transactions on access to or the cost of health care services, health care market consolidation, and health care quality.

(b) The commissioner shall issue periodic public reports on the number and types of transactions subject to this section and on the aggregate impact of transactions on health care cost, quality, and competition in Minnesota.

Subd. 7. **Relation to other law.** (a) The powers and authority under this section are in addition to, and do not affect or limit, all other rights, powers, and authority of the attorney general or the commissioner under chapter 8, 309, 317A, 325D, 501B, or other law.

(b) Nothing in this section shall suspend any obligation imposed under chapter 8, 309, 317A, 325D, 501B, or other law on the entities involved in a transaction.

EFFECTIVE DATE. This section is effective the day following final enactment and applies to transactions completed on or after that date. In determining whether a transaction was completed on or after the effective date, any actions or series of actions necessary to the completion of the transaction that occurred prior to the effective date must be considered.

Sec. 51. **[144.587] REQUIREMENTS FOR SCREENING FOR ELIGIBILITY FOR HEALTH COVERAGE OR ASSISTANCE.**

Subdivision 1. **Definitions.** (a) The terms defined in this subdivision apply to this section and sections 144.588 to 144.589.

(b) "Charity care" means the provision of free or discounted care to a patient according to a hospital's financial assistance policies.

(c) "Hospital" means a private, nonprofit, or municipal hospital licensed under sections 144.50 to 144.56.

(d) "Insurance affordability program" has the meaning given in section 256B.02, subdivision 19.

(e) "Navigator" has the meaning given in section 62V.02, subdivision 9.

(f) "Presumptive eligibility" has the meaning given in section 256B.057, subdivision 12.

(g) "Revenue recapture" means the use of the procedures in chapter 270A to collect debt.

(h) "Uninsured service or treatment" means any service or treatment that is not covered by:

(1) a health plan, contract, or policy that provides health coverage to a patient; or

(2) any other type of insurance coverage, including but not limited to no-fault automobile coverage, workers' compensation coverage, or liability coverage.

(i) "Unreasonable burden" includes requiring a patient to apply for enrollment in a state or federal program for which the patient is obviously or categorically ineligible or has been found to be ineligible in the previous 12 months.

Subd. 2. **Screening.** (a) A hospital participating in the hospital presumptive eligibility program under section 256B.057, subdivision 12, must determine whether a patient who is uninsured or whose insurance coverage status is not known by the hospital is eligible for hospital presumptive eligibility coverage.

(b) For any uninsured patient, including any patient the hospital determines is eligible for hospital presumptive eligibility coverage, and for any patient whose insurance coverage status is not known to the hospital, a hospital must:

(1) if it is a certified application counselor organization, schedule an appointment for the patient with a certified application counselor to occur prior to discharge unless the occurrence of the appointment would delay discharge;

(2) if the occurrence of the appointment under clause (1) would delay discharge or if the hospital is not a certified application counselor organization, schedule prior to discharge an appointment for the patient with a MNsure-certified navigator to occur after discharge unless the scheduling of an appointment would delay discharge; or

(3) if the scheduling of an appointment under clause (2) would delay discharge or if the patient declines the scheduling of an appointment under clause (1) or (2), provide the patient with contact information for available MNsure-certified navigators who can meet the needs of the patient.

(c) For any uninsured patient, including any patient the hospital determines is eligible for hospital presumptive eligibility coverage, and any patient whose insurance coverage status is not known to the hospital, a hospital must screen the patient for eligibility for charity care from the hospital. The hospital must attempt to complete the screening process for charity care in person or by telephone within 30 days after the patient receives services at the hospital or at the emergency department associated with the hospital.

Subd. 3. **Charity care.** (a) Upon completion of the screening process in subdivision 2, paragraph (c), the hospital must determine whether the patient is ineligible or potentially eligible for charity care. When a hospital evaluates a patient's eligibility for charity care, hospital requests to the responsible party for verification of assets or income shall be limited to:

(1) information that is reasonably necessary and readily available to determine eligibility; and

(2) facts that are relevant to determine eligibility.

A hospital must not demand duplicate forms of verification of assets.

(b) If the patient is not ineligible for charity care, the hospital must assist the patient with applying for charity care and refer the patient to the appropriate department in the hospital for follow-up. A hospital may not impose application procedures for charity care that place an unreasonable burden on the individual patient, taking into account the individual patient's physical, mental, intellectual, or sensory deficiencies or language barriers that may hinder the patient's ability to comply with application procedures.

(c) A hospital may not initiate any of the actions described in subdivision 4 while the patient's application for charity care is pending.

Subd. 4. **Prohibited actions.** A hospital must not initiate one or more of the following actions until the hospital determines that the patient is ineligible for charity care or denies an application for charity care:

(1) offering to enroll or enrolling the patient in a payment plan;

(2) changing the terms of a patient's payment plan;

(3) offering the patient a loan or line of credit, application materials for a loan or line of credit, or assistance with applying for a loan or line of credit, for the payment of medical debt;

(4) referring a patient's debt for collections, including in-house collections, third-party collections, revenue recapture, or any other process for the collection of debt;

(5) denying health care services to the patient or any member of the patient's household because of outstanding medical debt, regardless of whether the services are deemed necessary or may be available from another provider; or

(6) accepting a credit card payment of over $500 for the medical debt owed to the hospital.

Subd. 5. **Notice.** (a) A hospital must post notice of the availability of charity care from the hospital in at least the following locations: (1) areas of the hospital where patients are admitted or registered; (2) emergency departments; and (3) the portion of the hospital's financial services or billing department that is accessible to patients. The posted notice must be in all languages spoken by more than five percent of the population in the hospital's service area.

(b) A hospital must make available on the hospital's website the current version of the hospital's charity care policy, a plain-language summary of the policy, and the hospital's charity care application form. The summary and application form must be available in all languages spoken by more than five percent of the population in the hospital's service area.

Subd. 6. **Patient may decline services.** A patient may decline to complete an insurance affordability program application to schedule an appointment with a certified application counselor, to schedule an appointment with a MNsure-certified navigator, to accept information about navigator services, to participate in the charity care screening process, or to apply for charity care.

Subd. 7. **Enforcement.** In addition to the enforcement of this section by the commissioner, the attorney general may enforce this section under section 8.31.

EFFECTIVE DATE. This section is effective November 1, 2023, and applies to services and treatments provided on or after that date.

Sec. 52. **[144.588] CERTIFICATION OF EXPERT REVIEW.**

Subdivision 1. **Requirement; action to collect medical debt or garnish wages or bank accounts.** (a) In an action against a patient or guarantor for collection of medical debt owed to a hospital or for garnishment of the patient's or guarantor's wages or bank accounts to collect medical debt owed to a hospital, the hospital must serve on the defendant with the summons and complaint an affidavit of expert review certifying that:

(1) unless the patient declined to participate, the hospital complied with the requirements in section 144.587;

(2) there is a reasonable basis to believe that the patient owes the debt;

(3) all known third-party payors have been properly billed by the hospital, such that any remaining debt is the financial responsibility of the patient, and the hospital will not bill the patient for any amount that an insurance company is obligated to pay;

(4) the patient has been given a reasonable opportunity to apply for charity care, if the facts and circumstances suggest that the patient may be eligible for charity care;

(5) where the patient has indicated an inability to pay the full amount of the debt in one payment and provided reasonable verification of the inability to pay the full amount of the debt in one payment if requested by the hospital, the hospital has offered the patient a reasonable payment plan;

(6) there is no reasonable basis to believe that the patient's or guarantor's wages or funds at a financial institution are likely to be exempt from garnishment; and

(7) in the case of a default judgment proceeding, there is not a reasonable basis to believe:

(i) that the patient may already consider that the patient has adequately answered the complaint by calling or writing to the hospital, its debt collection agency, or its attorney;

(ii) that the patient is potentially unable to answer the complaint due to age, disability, or medical condition; or

(iii) the patient may not have received service of the complaint.

(b) The affidavit of expert review must be completed by a designated employee of the hospital seeking to initiate the action or garnishment.

Subd. 2. **Requirement; referral to third-party debt collection agency.** (a) In order to refer a patient's account to a third-party debt collection agency, a hospital must complete an affidavit of expert review certifying that:

(1) unless the patient declined to participate, the hospital complied with the requirements in section 144.587;

(2) there is a reasonable basis to believe that the patient owes the debt;

(3) all known third-party payors have been properly billed by the hospital, such that any remaining debt is the financial responsibility of the patient, and the hospital will not bill the patient for any amount that an insurance company is obligated to pay;

(4) the patient has been given a reasonable opportunity to apply for charity care, if the facts and circumstances suggest that the patient may be eligible for charity care; and

(5) where the patient has indicated an inability to pay the full amount of the debt in one payment and provided reasonable verification of the inability to pay the full amount of the debt in one payment if requested by the hospital, the hospital has offered the patient a reasonable payment plan.

(b) The affidavit of expert review must be completed by a designated employee of the hospital seeking to refer the patient's account to a third-party debt collection agency.

Subd. 3. **Penalty for noncompliance.** Failure to comply with subdivision 1 shall result, upon motion, in mandatory dismissal with prejudice of the action to collect the medical debt or to garnish the patient's or guarantor's wages or bank accounts. Failure to comply with subdivision 2 shall subject a hospital to a fine assessed by the commissioner of health.

In addition to the enforcement of this section by the commissioner, the attorney general may enforce this section under section 8.31.

Subd. 4. **Collection agency; immunity.** A collection agency, as defined in section 332.31, subdivision 3, is not liable under section 144.588, subdivision 3, for inaccuracies in an affidavit of expert review completed by a designated employee of the hospital.

EFFECTIVE DATE. This section is effective November 1, 2023, and applies to actions and referrals to third-party debt collection agencies stemming from services and treatments provided on or after that date.

Sec. 53. **[144.589] BILLING OF UNINSURED PATIENTS.**

Subdivision 1. **Limits on charges.** A hospital must not charge a patient whose annual household income is less than $125,000 for any uninsured service or treatment in an amount that exceeds the lowest total amount the provider would be reimbursed for that service or treatment from a nongovernmental third-party payor. The lowest total amount the provider would be reimbursed for that service or treatment from a nongovernmental third-party payor includes both the amount the provider would be reimbursed directly from the nongovernmental third-party payor and the amount the provider would be reimbursed from the insured's policyholder under any applicable co-payments, deductibles, and coinsurance. This statute supersedes the language in the Minnesota Attorney General Hospital Agreement.

Subd. 2. **Enforcement.** In addition to the enforcement of this section by the commissioner, the attorney general may enforce this section under section 8.31.

EFFECTIVE DATE. This section is effective November 1, 2023, and applies to services and treatments provided on or after that date.

Sec. 54. **[144.645] SUPPORTING HEALTHY DEVELOPMENT OF BABIES GRANT PROGRAM.**

Subdivision 1. **Establishment.** The commissioner of health must establish a supporting healthy development of babies grant program for community-driven training and education on best practices for supporting healthy development of babies during pregnancy and postpartum. The grant money must be used to build capacity in, train, educate, or improve practices among individuals, from youth to elders, serving families with members who are Black, Indigenous, or People of Color during pregnancy and postpartum.

Subd. 2. **Eligibility; application.** To be eligible for a grant under this section, applicants must be a nonprofit organization. A nonprofit organization seeking a grant under this section

must apply to the commissioner at a time and in a manner specified by the commissioner. The commissioner shall review each application to determine if the application is complete, the nonprofit organization is eligible for a grant, and the proposed project is an allowable use of grant funds. The commissioner must determine the grant amount awarded to applicants that the commissioner determines will receive a grant.

Sec. 55. **[144.6504] ALZHEIMER'S DISEASE AND DEMENTIA CARE TRAINING PROGRAM.**

(a) The commissioner of health, in collaboration with interested stakeholders, shall develop and provide a training program for community health workers on recognizing and understanding Alzheimer's disease and dementia. The training program may be conducted either virtually or in person and must, at a minimum, include instruction on:

(1) recognizing the common warning signs of Alzheimer's disease and dementia;

(2) understanding how Alzheimer's disease and dementia affect communication and behavior;

(3) recognizing potential safety risks for individuals living with dementia, including the risks of wandering and elder abuse; and

(4) identifying appropriate techniques to communicate with individuals living with dementia and how to appropriately respond to dementia-related behaviors.

(b) The commissioner shall work with the Minnesota State Colleges and University System (MNSCU) to explore the possibility of including a training program that meets the requirements of this section to the MNSCU-approved community health worker certification program.

(c) Notwithstanding paragraph (a), if a training program already exists that meets the requirements of this section, the commissioner may approve the existing training program or programs instead of developing a new program, and, in collaboration with interested stakeholders, ensure that the approved training program or programs are available to all community health workers.

Sec. 56. Minnesota Statutes 2022, section 144.651, is amended by adding a subdivision to read:

Subd. 10a. **Designated support person for pregnant patient.** (a) Subject to paragraph (c), a health care provider and a health care facility must allow, at a minimum, one designated

support person of a pregnant patient's choosing to be physically present while the patient is receiving health care services including during a hospital stay.

(b) For purposes of this subdivision, "designated support person" means any person chosen by the patient to provide comfort to the patient including but not limited to the patient's spouse, partner, family member, or another person related by affinity. Certified doulas and traditional midwives may not be counted toward the limit of one designated support person.

(c) A facility may restrict or prohibit the presence of a designed support person in treatment rooms, procedure rooms, and operating rooms when such a restriction or prohibition is strictly necessary to meet the appropriate standard of care. A facility may also restrict or prohibit the presence of a designated support person if the designated support person is acting in a violent or threatening manner towards others. Any restriction or prohibition of a designated support person by the facility is subject to the facility's written internal grievance procedure required by subdivision 20.

Sec. 57. Minnesota Statutes 2022, section 144.9501, subdivision 9, is amended to read:

Subd. 9. **Elevated blood lead level.** "Elevated blood lead level" means a diagnostic blood lead test with a result that is equal to or greater than ~~ten~~ 3.5 micrograms of lead per deciliter of whole blood in any person, unless the commissioner finds that a lower concentration is necessary to protect public health.

Sec. 58. **[144.9821] ADVANCING HEALTH EQUITY THROUGH CAPACITY BUILDING AND RESOURCE ALLOCATION.**

Subdivision 1. **Establishment of grant program.** The commissioner of health shall:

(1) establish an annual grant program to award infrastructure capacity building grants to help metro and rural community and faith-based organizations serving populations of color, American Indian, LGBTQIA+, and those with disabilities in Minnesota who have been disproportionately impacted by health and other inequities to be better equipped and prepared for success in procuring grants and contracts at the department and addressing inequities; and

(2) create a framework at the department to maintain equitable practices in grantmaking to ensure that internal grantmaking and procurement policies and practices prioritize equity, transparency, and accessibility to include:

(i) a tracking system for the department to better monitor and evaluate equitable procurement and grantmaking processes and their impacts; and

(ii) technical assistance and coaching to department leadership in grantmaking and procurement processes and programs and providing tools and guidance to ensure equitable and transparent competitive grantmaking processes and award distribution across communities most impacted by inequities and develop measures to track progress over time.

Subd. 2. **Commissioner's duties.** The commissioner of health shall:

(1) in consultation with community stakeholders, community health boards and Tribal nations, develop a request for proposals for infrastructure capacity building grant program to help community-based organizations, including faith-based organizations, to be better equipped and prepared for success in procuring grants and contracts at the department and beyond;

(2) provide outreach, technical assistance, and program development support to increase capacity for new and existing community-based organizations and other service providers in order to better meet statewide needs particularly in greater Minnesota and areas where services to reduce health disparities have not been established;

(3) in consultation with community stakeholders, review responses to requests for proposals and award of grants under this section;

(4) ensure communication with the ethnic councils, Minnesota Indian Affairs Council, Minnesota Council on Disability, Minnesota Commission of the Deaf, Deafblind, and Hard of Hearing, and the governor's office on the request for proposal process;

(5) in consultation with community stakeholders, establish a transparent and objective accountability process focused on outcomes that grantees agree to achieve;

(6) maintain data on outcomes reported by grantees; and

(7) establish a process or mechanism to evaluate the success of the capacity building grant program and to build the evidence base for effective community-based organizational capacity building in reducing disparities.

Subd. 3. **Eligible grantees.** Organizations eligible to receive grant funding under this section include: organizations or entities that work with diverse communities such populations of color, American Indian, LGBTQIA+, and those with disabilities in metro and rural communities.

Subd. 4. **Strategic consideration and priority of proposals; eligible populations; grant awards.** (a) The commissioner, in consultation with community stakeholders, shall develop a request for proposals for equity in procurement and grantmaking capacity building grant program to help community-based organizations, including faith-based organizations to be better equipped and prepared for success in procuring grants and contracts at the department and addressing inequities.

(b) In awarding the grants, the commissioner shall provide strategic consideration and give priority to proposals from organizations or entities led by populations of color, American Indians and those serving communities of color, American Indians; LGBTQIA+, and disability communities.

Subd. 5. **Geographic distribution of grants.** The commissioner shall ensure that grant funds are prioritized and awarded to organizations and entities that are within counties that have a higher proportion of Black or African American, nonwhite Latino(a), LGBTQIA+, and disability communities to the extent possible.

Subd. 6. **Report.** Grantees must report grant program outcomes to the commissioner on the forms and according to the timelines established by the commissioner.

Sec. 59. **[144.9981] CLIMATE RESILIENCY.**

Subdivision 1. **Climate resiliency program.** The commissioner of health shall implement a climate resiliency program to:

(1) increase awareness of climate change;

(2) track the public health impacts of climate change and extreme weather events;

(3) provide technical assistance and tools that support climate resiliency to local public health, Tribal health, soil and water conservation districts, and other local governmental and nongovernmental organizations; and

(4) coordinate with the commissioners of the pollution control agency, natural resources, and agriculture and other state agencies in climate resiliency related planning and implementation.

Subd. 2. **Grants authorized; allocation.** (a) The commissioner of health shall manage a grant program for the purpose of climate resiliency planning. The commissioner shall award grants through a request for proposals process to local public health, Tribal health, soil and water conservation districts, or other local organizations for planning for the health impacts of extreme weather events and developing adaptation actions. Priority shall be given

to organizations that serve communities that are disproportionately impacted by climate change.

(b) Grantees must use the funds to develop a plan or implement strategies that will reduce the risk of health impacts from extreme weather events. The grant application must include:

(1) a description of the plan or project for which the grant funds will be used;

(2) a description of the pathway between the plan or project and its impacts on health;

(3) a description of the objectives, a work plan, and a timeline for implementation; and

(4) the community or group the grant proposes to focus on.

Sec. 60. **[145.361] LONG COVID.**

Subdivision 1. **Definition.** (a) For the purpose of this section, the terms have the meanings given.

(b) "Long COVID" means health problems that people experience four or more weeks after being infected with SARS-CoV-2, the virus that causes COVID-19. Long COVID is also called post-COVID conditions, long-haul COVID, chronic COVID, post-acute COVID, or post-acute sequelae of COVID-19 (PASC).

(c) "Related conditions" means conditions related to or similar to long COVID including but not limited to myalgic encephalomyelitis/chronic fatigue syndrome (ME/CFS) and dysautonomia, and postural orthostatic tachycardia syndrome (POTS).

Subd. 2. **Establishment.** The commissioner of health shall establish a program to conduct community assessments and epidemiologic investigations to monitor and address impacts of long COVID and related conditions. The purposes of these activities are to:

(1) monitor trends in: incidence, prevalence, mortality, and health outcomes; changes in disability status, employment, and quality of life; and service needs of individuals with long COVID or related conditions and to detect potential public health problems, predict risks, and assist in investigating long COVID and related conditions health inequities;

(2) more accurately target information and resources for communities and patients and their families;

(3) inform health professionals and citizens about risks and early detection;

(4) promote evidence-based practices around long COVID and related conditions prevention and management and to address public concerns and questions about long COVID and related conditions; and

(5) research and track related conditions.

Subd. 3. **Partnerships.** The commissioner of health shall, in consultation with health care professionals, the Department of Human Services, local public health, health insurers, employers, schools, survivors of long COVID or related conditions, and community organizations serving people at high risk of long COVID or related conditions, identify priority actions and activities to address the needs for communication, services, resources, tools, strategies, and policies to support survivors of long COVID or related conditions and their families.

Subd. 4. **Grants and contracts.** The commissioner of health shall coordinate and collaborate with community and organizational partners to implement evidence-informed priority actions through community-based grants and contracts. The commissioner of health shall award contracts and grants to organizations that serve communities disproportionately impacted by COVID-19, long COVID, or related conditions, including but not limited to rural and low-income areas, Black and African Americans, African immigrants, American Indians, Asian American-Pacific Islanders, Latino(a), LGBTQ+, and persons with disabilities. Organizations may also address intersectionality within the groups. The commissioner shall award grants and contracts to eligible organizations to plan, construct, and disseminate resources and information to support survivors of long COVID or related conditions, including caregivers, health care providers, ancillary health care workers, workplaces, schools, communities, and local and Tribal public health.

Sec. 61. **[145.561] 988 SUICIDE AND CRISIS LIFELINE.**

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

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

(c) "Department" means the Department of Health.

(d) "Lifeline center" means a state-identified center that is a member of the Suicide and Crisis Lifeline network that responds to statewide or regional 988 contacts.

(e) "988" or "988 hotline" means the universal telephone number for the national suicide prevention and mental health crisis hotline system within the United States operating through the Suicide and Crisis Lifeline, or its successor, maintained by the assistant secretary for mental health and substance use under section 520E-2 of the Public Health Service Act.

(f) "988 administrator" means the administrator of the 988 Suicide and Crisis Lifeline maintained by the assistant secretary for mental health and substance use under section 520E-3 of the Public Health Service Act.

(g) "988 contact" means a communication with the 988 national suicide prevention and mental health crisis hotline system within the United States via modalities offered that may include call, chat, or text.

(h) "Veterans Crisis Line" means the Veterans Crisis Line maintained by the secretary of veterans affairs under United States Code, title 38, section 170F(h).

Subd. 2. **988 hotline; lifeline centers.** (a) The commissioner shall administer the designation of and oversee a lifeline center or network of lifeline centers to answer 988 contacts from individuals accessing the Suicide and Crisis Lifeline from any location in Minnesota 24 hours per day, seven days per week.

(b) The designated lifeline center or centers must:

(1) have an active agreement with the 988 administrator for participation within the network and with the department;

(2) meet the 988 administrator's requirements and best practice guidelines for operational and clinical standards;

(3) provide data, engage in reporting, and participate in evaluations and related quality improvement activities as required by the 988 administrator and the department;

(4) identify or adapt technology that is demonstrated to be interoperable across crisis and emergency response systems used in the state for the purpose of crisis care coordination;

(5) connect people to crisis response and outgoing services, including mobile crisis teams, in accordance with guidelines established by the 988 administrator and the department and in collaboration with the Department of Human Services;

(6) actively collaborate and coordinate service linkages with mental health and substance use disorder treatment providers; local community mental health centers, including certified community behavioral health clinics and community behavioral health centers; mobile crisis teams; and emergency departments;

(7) offer follow-up services to individuals accessing the lifeline center that are consistent with guidelines established by the 988 administrator and the department; and

(8) meet requirements set by the 988 administrator and the department for serving high-risk and specialized populations and culturally or ethnically diverse populations.

(c) The commissioner shall use the commissioner's rulemaking authority to allow appropriate information sharing and communication between and across crisis and emergency response systems.

(d) The commissioner, having primary oversight of suicide prevention, shall work with the Suicide and Crisis Lifeline, Veterans Crisis Line, and other SAMHSA-approved networks to ensure consistency of public messaging about 988 services. The commissioner may engage in activities to publicize and raise awareness about 988 services, or may provide grants to other organizations for these purposes.

(e) The commissioner shall provide an annual report to the legislature on usage of the 988 hotline, including answer rates, rates of abandoned calls, and referral rates to 911 emergency response and to mental health crisis teams. Notwithstanding section 144.05, subdivision 7, the reports required under this paragraph do not expire.

Subd. 3. **988 special revenue account.** (a) A 988 special revenue account is established as a dedicated account in the special revenue fund to create and maintain a statewide 988 suicide prevention crisis system according to the National Suicide Hotline Designation Act of 2020, the Federal Communications Commission's report and order FCC 20-100 adopted July 16, 2020, and national guidelines for crisis care.

(b) The 988 special revenue account shall consist of:

(1) a 988 telecommunications fee imposed under subdivision 4;

(2) a prepaid wireless 988 fee imposed under section 403.161;

(3) transfers of state money into the account;

(4) grants and gifts intended for deposit in the account;

(5) interest, premiums, gains, and other earnings of the account; and

(6) money from any other source that is deposited in or transferred to the account.

(c) The account shall be administered by the commissioner. Money in the account shall only be used to offset costs that are or may reasonably be attributed to:

(1) implementing, maintaining, and improving the 988 suicide and crisis lifeline, including staff and technology infrastructure enhancements needed to achieve the operational standards and best practices set forth by the 988 administrator and the department;

(2) data collection, reporting, participation in evaluations, public promotion, and related quality improvement activities as required by the 988 administrator and the department; and

(3) administration, oversight, and evaluation of the account.

(d) Money in the account:

(1) does not cancel at the end of any state fiscal year and is carried forward in subsequent state fiscal years;

(2) is not subject to transfer to any other account or fund or to transfer, assignment, or reassignment for any use or purpose other than the purposes specified in this subdivision; and

(3) is appropriated to the commissioner for the purposes specified in this subdivision.

(e) The commissioner shall submit an annual report to the legislature and to the Federal Communications Commission on deposits to and expenditures from the account. Notwithstanding section 144.05, subdivision 7, the reports required under this paragraph do not expire.

Subd. 4. **988 telecommunications fee.** (a) In compliance with the National Suicide Hotline Designation Act of 2020, the commissioner shall impose a monthly statewide fee on each subscriber of a wireline, wireless, or IP-enabled voice service at a rate that provides for the robust creation, operation, and maintenance of a statewide 988 suicide prevention and crisis system.

(b) The commissioner shall annually recommend to the Public Utilities Commission an adequate and appropriate fee to implement this section. The amount of the fee must comply with the limits in paragraph (c). The commissioner shall provide telecommunication service providers and carriers a minimum of 30 days' notice of each fee change.

(c) The amount of the 988 telecommunications fee must not be more than 25 cents per month on or after January 1, 2024, for each consumer access line, including trunk equivalents as designated by the commission pursuant to section 403.11, subdivision 1. The 988 telecommunications fee must be the same for all subscribers.

(d) Each wireline, wireless, and IP-enabled voice telecommunication service provider shall collect the 988 telecommunications fee and transfer the amounts collected to the commissioner of public safety in the same manner as provided in section 403.11, subdivision 1, paragraph (d).

(e) The commissioner of public safety shall deposit the money collected from the 988 telecommunications fee to the 988 special revenue account established in subdivision 3.

(f) All 988 telecommunications fee revenue must be used to supplement, and not supplant, federal, state, and local funding for suicide prevention.

(g) The 988 telecommunications fee amount shall be adjusted as needed to provide for continuous operation of the lifeline centers and 988 hotline, volume increases, and maintenance.

(h) The commissioner shall annually report to the Federal Communications Commission on revenue generated by the 988 telecommunications fee.

Subd. 5. **988 fee for prepaid wireless telecommunications services.** (a) The 988 telecommunications fee established in subdivision 4 does not apply to prepaid wireless telecommunications services. Prepaid wireless telecommunications services are subject to the prepaid wireless 988 fee established in section 403.161, subdivision 1, paragraph (c).

(b) Collection, remittance, and deposit of prepaid wireless 988 fees are governed by sections 403.161 and 403.162.

Subd. 6. **Biennial budget; annual financial report.** The commissioner must prepare a biennial budget for maintaining the 988 system. By December 15 of each year, the commissioner must submit a report to the legislature detailing the expenditures for maintaining the 988 system, the 988 fees collected, the balance of the 988 fund, the 988-related administrative expenses, and the most recent forecast of revenues and expenditures for the 988 special revenue account, including a separate projection of 988 fees from prepaid wireless customers and projections of year-end fund balances.

Subd. 7. **Waiver.** A wireless telecommunications service provider or wire-line telecommunications service provider may petition the commissioner for a waiver of all or portions of the requirements of this section. The commissioner may grant a waiver upon a demonstration by the petitioner that the requirement is economically infeasible.

Sec. 62. Minnesota Statutes 2022, section 145.87, subdivision 4, is amended to read:

Subd. 4. ~~**Administrative costs**~~ **Administration.** The commissioner may ~~use up to seven percent of the annual appropriation under this section to~~ provide training and technical assistance and ~~to~~ administer and evaluate the program. The commissioner may contract for training, capacity-building support for grantees or potential grantees, technical assistance, and evaluation support.

Sec. 63. **[145.9011] FETAL AND INFANT DEATH STUDIES.**

Subdivision 1. **Purpose.** (a) The commissioner of health may conduct fetal and infant death studies to assist the planning, implementation, and evaluation of medical, health, and social service systems, and to reduce the number of preventable fetal and infant deaths in Minnesota.

(b) Notwithstanding any other law or policy to the contrary, the fetal and infant mortality review committee must not expire.

Subd. 2. **Access to data.** (a) For purposes of this section, the subject of the data is defined as any of the following:

(1) a live born infant that died within the first year of life;

(2) a fetal death which meets the criteria required for reporting as defined in section 144.222; or

(3) the biological mother of an infant as defined in clause (1) or of a fetal death as defined in clause (2).

(b) To conduct fetal and infant death studies, the commissioner of health must have access to:

(1) medical data as defined in section 13.384, subdivision 1, paragraph (b); medical examiner data as defined in section 13.83, subdivision 1; and health records created, maintained, or stored by providers as defined in section 144.291, subdivision 2, paragraph (i), on the subject of the data;

(2) data on health and social support services, such as, but not limited to, family home visiting programs, the women, infants, and children (WIC) program, as well as access to prescription monitoring programs data, and data on behavioral health services, on the subject of the data;

(3) the name of a health care provider that provided prenatal, postpartum, pediatric, and other health services to the subject of the data, which must be provided by a coroner or medical examiner; and

(4) Department of Human Services and other state agency data to identify and receive information on the types and nature of other sources of care and social support received by the subject of the data, and parents and guardians of the subject of the data, to assist with evaluation of social service systems.

(c) When necessary to conduct a fetal and infant death study, the commissioner must have access to:

(1) data described in this subdivision relevant to fetal and infant death studies from before, during, and after pregnancy or birth for the subject of the data; and

(2) law enforcement reports or incident reports related to the subject of the data and must receive the reports when requested from law enforcement.

(d) The commissioner does not have access to coroner or medical examiner data that are part of an active investigation as described in section 13.83.

(e) The commissioner must have access to all data described within this section without the consent of the subject of the data and without the consent of the parent, other guardian, or legal representative of the subject of the data. The commissioner has access to the data in this subdivision to study fetal or infant deaths that occur on or after July 1, 2021.

(f) The commissioner must make a good faith reasonable effort to notify the subject of the data, parent, spouse, other guardian, or legal representative of the subject of the data before collecting data on the subject of the data. For purposes of this paragraph, "reasonable effort" means one notice is sent by certified mail to the last known address of the subject of the data, parent, spouse, other guardian, or legal representative informing of the data collection and offering a public health nurse support visit if desired.

Subd. 3. **Management of records.** After the commissioner has collected all data about the subject of a fetal or infant death study necessary to perform the study, the data extracted from source records obtained under subdivision 2, other than data identifying the subject of the data, must be transferred to separate records that must be maintained by the commissioner. Notwithstanding section 138.17, after the data have been transferred, all source records obtained under subdivision 2 that are possessed by the commissioner must be destroyed.

Subd. 4. **Classification of data.** (a) Data provided to the commissioner from source records under subdivision 2, including identifying information on individual providers, subjects of the data, their family, or guardians, and data derived by the commissioner under subdivision 3 for the purpose of carrying out fetal or infant death studies, are classified as confidential data on individuals or confidential data on decedents, as defined in sections 13.02, subdivision 3, and 13.10, subdivision 1, paragraph (a).

(b) Data classified under subdivision 4, paragraph (a), must not be subject to discovery or introduction into evidence in any administrative, civil, or criminal proceeding. Such

information otherwise available from an original source must not be immune from discovery or barred from introduction into evidence merely because it was utilized by the commissioner in carrying out fetal or infant death studies.

(c) Summary data on fetal and infant death studies created by the commissioner, which does not identify individual subjects of the data, their families, guardians, or individual providers, must be public in accordance with section 13.05, subdivision 7.

(d) Data provided by the commissioner of human services or other state agency to the commissioner of health under this section retains the same classification as the data held when retained by the commissioner of human services, as required under section 13.03, subdivision 4, paragraph (c).

Subd. 5. **Fetal and infant mortality reviews.** (a) The commissioner of health must convene case review committees to conduct death study reviews, make recommendations, and publicly share summary information, especially for and about racial and ethnic groups, including American Indians and African Americans, that experience significantly disparate rates of fetal and infant mortality.

(b) The case review committees may include, but are not limited to, medical examiners or coroners, representative from health care institutions that provide care to pregnant people and infants, obstetric and pediatric practitioners, Medicaid representatives, state agency women and infant program representatives, and individuals from the communities that experience disparate rates of fetal and infant deaths, and other subject matter experts as necessary.

(c) The case review committees will review data from source records obtained under subdivision 2, other than data identifying the subject, the subject's family, or guardians, or the provider involved in the care of the subject.

(d) A person attending a fetal and infant mortality review committee meeting must not disclose what transpired at the meeting, except as necessary to carry out the purposes of the review committee. The proceedings and records of the review committee are protected nonpublic data as defined in section 13.02, subdivision 13. Discovery and introduction into evidence in legal proceedings of case review committee proceedings and records, and testimony in legal proceedings by review committee members and persons presenting information to the review committee, must occur in compliance with the requirements in section 256.01, subdivision 12, paragraph (e).

(e) Every three years beginning December 1, 2024, the case review committees will provide findings and recommendations to the Maternal and Child Health Advisory Task

Force and the commissioner from the committee's review of fetal and infant deaths and provide specific recommendations designed to reduce population-based disparities in fetal and infant deaths.

(f) This paragraph must govern case review committee member compensation and expense reimbursement, notwithstanding any other law or policy to the contrary. Members of the case review committee must be compensated by the commissioner of health for actual time spent in work on case reviews at a per diem rate established by the commissioner of health according to funding availability. Compensable time includes preparation for case reviews, time spent on collaborative review, including subcommittee meetings, committee meetings, and other preparation work for the committee review as identified by the commissioner of health. Members must also be reimbursed for expenses in the same manner and amount as provided in the Department of Management and Budget's commissioner's plan under section 43A.18, subdivision 2. To receive compensation or reimbursement, committee members must invoice the Department of Health on an invoice form provided by the commissioner.

Sec. 64. **[145.903] SCHOOL-BASED HEALTH CENTERS.**

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

(b) "School-based health center" or "comprehensive school-based health center" means a safety net health care delivery model that is located in or near a school facility and that offers comprehensive health care, including preventive and behavioral health services, provided by licensed and qualified health professionals in accordance with federal, state, and local law. When not located on school property, the school-based health center must have an established relationship with one or more schools in the community and operate to primarily serve those student groups.

(c) "Sponsoring organization" means any of the following that operate a school-based health center:

(1) health care providers;

(2) community clinics;

(3) hospitals;

(4) federally qualified health centers and look-alikes as defined in section 145.9269;

(5) health care foundations or nonprofit organizations;

(6) higher education institutions; or

(7) local health departments.

Subd. 2. **Expansion of Minnesota school-based health centers.** (a) The commissioner of health shall administer a program to provide grants to school districts and school-based health centers to support existing centers and facilitate the growth of school-based health centers in Minnesota.

(b) Grant funds distributed under this subdivision shall be used to support new or existing school-based health centers that:

(1) operate in partnership with a school or school district and with the permission of the school or school district board;

(2) provide health services through a sponsoring organization that meets the requirements in subdivision 1, paragraph (c); and

(3) provide health services to all students and youth within a school or school district, regardless of ability to pay, insurance coverage, or immigration status, and in accordance with federal, state, and local law.

(c) The commissioner of health shall administer a grant to a nonprofit organization to facilitate a community of practice among school-based health centers to improve quality, equity, and sustainability of care delivered through school-based health centers; encourage cross-sharing among school-based health centers; support existing clinics; and expand school-based health centers in new communities in Minnesota.

(d) Grant recipients shall report their activities and annual performance measures as defined by the commissioner in a format and time specified by the commissioner.

(e) The commissioners of health and of education shall coordinate the projects and initiatives funded under this section with other efforts at the local, state, or national level to avoid duplication and promote coordinated efforts.

Subd. 3. **School-based health center services.** (a) Services provided by a school-based health center may include but are not limited to:

(1) preventive health care;

(2) chronic medical condition management, including diabetes and asthma care;

(3) mental health care and crisis management;

(4) acute care for illness and injury;

(5) oral health care;

(6) vision care;

(7) nutritional counseling;

(8) substance abuse counseling;

(9) referral to a specialist, medical home, or hospital for care;

(10) additional services that address social determinants of health; and

(11) emerging services such as mobile health and telehealth.

(b) Services provided by a school-based health center must not replace the daily student support provided in the school by educational student service providers, including but not limited to licensed school nurses, educational psychologists, school social workers, and school counselors.

Subd. 4. **Sponsoring organizations.** A sponsoring organization that agrees to operate a school-based health center must enter into a memorandum of agreement with the school or school district. The memorandum of agreement must require the sponsoring organization to be financially responsible for the operation of school-based health centers in the school or school district and must identify the costs that are the responsibility of the school or school district, such as Internet access, custodial services, utilities, and facility maintenance. To the greatest extent possible, a sponsoring organization must bill private insurers, medical assistance, and other public programs for services provided in the school-based health centers in order to maintain the financial sustainability of school-based health centers.

Sec. 65. Minnesota Statutes 2022, section 145.924, is amended to read:

145.924 ~~AIDS~~ HIV PREVENTION GRANTS.

(a) The commissioner may award grants to community health boards as defined in section 145A.02, subdivision 5, state agencies, state councils, or nonprofit corporations to provide evaluation and counseling services to populations at risk for acquiring human immunodeficiency virus infection, including, but not limited to, ~~minorities~~ communities of color, adolescents, ~~intravenous drug users~~ women, people who inject drugs, and ~~homosexual men~~ gay, bisexual, and transgender individuals.

(b) The commissioner may award grants to agencies experienced in providing services to communities of color, for the design of innovative outreach and education programs for targeted groups within the community who may be at risk of acquiring the human immunodeficiency virus infection, including ~~intravenous drug users~~ people who inject drugs

and their partners, adolescents, women, and gay ~~and~~, bisexual, and transgender individuals ~~and women~~. Grants shall be awarded on a request for proposal basis and shall include funds for administrative costs. Priority for grants shall be given to agencies or organizations that have experience in providing service to the particular community which the grantee proposes to serve; that have policy makers representative of the targeted population; that have experience in dealing with issues relating to HIV/AIDS; and that have the capacity to deal effectively with persons of differing sexual orientations. For purposes of this paragraph, the "communities of color" are: the American-Indian community; the Hispanic community; the African-American community; and the Asian-Pacific Islander community.

(c) All state grants awarded under this section for programs targeted to adolescents shall include the promotion of abstinence from sexual activity and drug use.

(d) The commissioner shall administer a grant program to provide funds to organizations, including Tribal health agencies, to assist with HIV outbreaks.

Sec. 66. **[145.9275] SKIN-LIGHTENING PRODUCTS PUBLIC AWARENESS AND EDUCATION GRANT PROGRAM.**

Subdivision 1. **Grant program.** The commissioner of health shall award grants through a request for proposal process to community-based organizations that serve ethnic communities and focus on public health outreach to Black and people of color communities on the issues of colorism, skin-lightening products, and chemical exposures from these products. Priority in awarding grants shall be given to organizations that have historically provided services to ethnic communities on the skin-lightening and chemical exposure issue for the past four years.

Subd. 2. **Uses of grant funds.** Grant recipients must use grant funds awarded under this section to conduct public awareness and education activities that are culturally specific and community-based and that focus on:

(1) increasing public awareness and providing education on the health dangers associated with using skin-lightening creams and products that contain mercury and hydroquinone and are manufactured in other countries, brought into this country, and sold illegally online or in stores; the dangers of exposure to mercury through dermal absorption, inhalation, hand-to-mouth contact, and contact with individuals who have used these skin-lightening products; the health effects of mercury poisoning, including the permanent effects on the central nervous system and kidneys; and the dangers to mothers and infants from using these products or being exposed to these products during pregnancy and while breastfeeding;

(2) identifying products that contain mercury and hydroquinone by testing skin-lightening products;

(3) developing a train-the-trainer curriculum to increase community knowledge and influence behavior changes by training community leaders, cultural brokers, community health workers, and educators;

(4) continuing to build the self-esteem and overall wellness of young people who are using skin-lightening products or are at risk of starting the practice of skin lightening; and

(5) building the capacity of community-based organizations to continue to combat skin-lightening practices and chemical exposure.

Sec. 67. **[145.9571] HEALTHY BEGINNINGS, HEALTHY FAMILIES ACT.**

Subdivision 1. **Purpose.** The purpose of the Healthy Beginnings, Healthy Families Act is to build equitable, inclusive, and culturally and linguistically responsive systems that ensure the health and well-being of young children and their families by supporting the Minnesota perinatal quality collaborative, establishing the Minnesota partnership to prevent infant mortality, increasing access to culturally relevant developmental and social-emotional screening with follow-up, and sustaining and expanding the model jail practices for children of incarcerated parents in Minnesota jails.

Subd. 2. **Minnesota perinatal quality collaborative.** The Minnesota perinatal quality collaborative is established to improve pregnancy outcomes for pregnant people and newborns through efforts to:

(1) advance evidence-based and evidence-informed clinics and other health service practices and processes through quality care review, chart audits, and continuous quality improvement initiatives that enable equitable outcomes;

(2) review current data, trends, and research on best practices to inform and prioritize quality improvement initiatives;

(3) identify methods that incorporate antiracism into individual practice and organizational guidelines in the delivery of perinatal health services;

(4) support quality improvement initiatives to address substance use disorders in pregnant people and infants with neonatal abstinence syndrome or other effects of substance use;

(5) provide a forum to discuss state-specific system and policy issues to guide quality improvement efforts that improve population-level perinatal outcomes;

(6) reach providers and institutions in a multidisciplinary, collaborative, and coordinated effort across system organizations to reinforce a continuum of care model; and

(7) support health care facilities in monitoring interventions through rapid data collection and applying system changes to provide improved care in perinatal health.

Subd. 3. **Eligible organizations.** The commissioner of health shall make a grant to a nonprofit organization to create or sustain a multidisciplinary network of representatives of health care systems, health care providers, academic institutions, local and state agencies, and community partners that will collaboratively improve pregnancy and infant outcomes through evidence-based, population-level quality improvement initiatives.

Subd. 4. **Grants authorized.** The commissioner shall award one grant to a nonprofit organization to support efforts that improve maternal and infant health outcomes aligned with the purpose outlined in subdivision 2. The commissioner shall give preference to a nonprofit organization that has the ability to provide these services throughout the state. The commissioner shall provide content expertise to the grant recipient to further the accomplishment of the purpose.

Subd. 5. **Minnesota partnership to prevent infant mortality program.** (a) The commissioner of health shall establish the Minnesota partnership to prevent infant mortality program that is a statewide partnership program to engage communities, exchange best practices, share summary data on infant health, and promote policies to improve birth outcomes and eliminate preventable infant mortality.

(b) The goal of the Minnesota partnership to prevent infant mortality program is to:

(1) build a statewide multisectoral partnership including the state government, local public health agencies, Tribes, private sector, and community nonprofit organizations with the shared goal of decreasing infant mortality rates among populations with significant disparities, including among Black, American Indian, other nonwhite communities, and rural populations;

(2) address the leading causes of poor infant health outcomes such as premature birth, infant sleep-related deaths, and congenital anomalies through strategies to change social and environmental determinants of health; and

(3) promote the development, availability, and use of data-informed, community-driven strategies to improve infant health outcomes.

Subd. 5a. **Grants authorized.** (a) The commissioner of health shall award grants to eligible applicants to convene, coordinate, and implement data-driven strategies and culturally

relevant activities to improve infant health by reducing preterm birth, sleep-related infant deaths, and congenital malformations and address social and environmental determinants of health. Grants shall be awarded to support community nonprofit organizations, Tribal governments, and community health boards. In accordance with available funding, grants shall be noncompetitively awarded to the eleven sovereign Tribal governments if their respective proposals demonstrate the ability to implement programs designed to achieve the purposes in subdivision 2 and meet other requirements of this section. An eligible applicant must submit a complete application to the commissioner of health by the deadline established by the commissioner. The commissioner shall award all other grants competitively to eligible applicants in metropolitan and rural areas of the state and may consider geographic representation in grant awards.

(b) Grantee activities shall:

(1) address the leading cause or causes of infant mortality;

(2) be based on community input;

(3) focus on policy, systems, and environmental changes that support infant health; and

(4) address the health disparities and inequities that are experienced in the grantee's community.

(c) The commissioner shall review each application to determine whether the application is complete and whether the applicant and the project are eligible for a grant. In evaluating applications according to subdivision 2, the commissioner shall establish criteria including but not limited to: the eligibility of the applicant's project under this section; the applicant's thoroughness and clarity in describing the infant health issues grant funds are intended to address; a description of the applicant's proposed project; the project's likelihood to achieve the grant's purposes as described in this section; a description of the population demographics and service area of the proposed project; and evidence of efficiencies and effectiveness gained through collaborative efforts.

(d) Grant recipients shall report their activities to the commissioner in a format and at a time specified by the commissioner.

Subd. 5b. **Technical assistance.** (a) The commissioner shall provide content expertise, technical expertise, training to grant recipients, and advice on data-driven strategies.

(b) For the purposes of carrying out the grant program under subdivision 5, including for administrative purposes, the commissioner shall award contracts to appropriate entities to assist in training and provide technical assistance to grantees.

(c) Contracts awarded under paragraph (b) may be used to provide technical assistance and training in the areas of:

(1) partnership development and capacity building;

(2) Tribal support;

(3) implementation support for specific infant health strategies;

(4) communications by convening and sharing lessons learned; and

(5) health equity.

Subd. 6. **Developmental and social-emotional screening with follow-up.** The goal of the developmental and social-emotional screening is to identify young children at risk for developmental and behavioral concerns and provide follow-up services to connect families and young children to appropriate community-based resources and programs. The commissioner of health shall work with the commissioners of human services and education to implement this section and promote interagency coordination with other early childhood programs including those that provide screening and assessment.

Subd. 6a. **Duties.** The commissioner shall:

(1) increase the awareness of developmental and social-emotional screening with follow-up in coordination with community and state partners;

(2) expand existing electronic screening systems to administer developmental and social-emotional screening to children birth to kindergarten entrance;

(3) provide screening for developmental and social-emotional delays based on current recommended best practices;

(4) review and share the results of the screening with the parent or guardian. Support families in their role as caregivers by providing anticipatory guidance around typical growth and development;

(5) ensure children and families are referred to and linked with appropriate community-based services and resources when any developmental or social-emotional concerns are identified through screening; and

(6) establish performance measures and collect, analyze, and share program data regarding population-level outcomes of developmental and social-emotional screening, referrals to community-based services, and follow-up services.

Subd. 6b. **Grants authorized.** The commissioner shall award grants to community-based organizations, community health boards, and Tribal Nations to support follow-up services for children with developmental or social-emotional concerns identified through screening in order to link children and their families to appropriate community-based services and resources. Grants shall also be awarded to community-based organizations to train and utilize cultural liaisons to help families navigate the screening and follow-up process in a culturally and linguistically responsive manner. The commissioner shall provide technical assistance, content expertise, and training to grant recipients to ensure that follow-up services are effectively provided.

Subd. 7. **Model jail practices for incarcerated parents.** (a) The commissioner of health may make special grants to counties and groups of counties to implement model jail practices and to county governments, Tribal governments, or nonprofit organizations in corresponding geographic areas to build partnerships with county jails to support children of incarcerated parents and their caregivers.

(b) "Model jail practices" means a set of practices that correctional administrators can implement to remove barriers that may prevent children from cultivating or maintaining relationships with their incarcerated parents during and immediately after incarceration without compromising safety or security of the correctional facility.

Subd. 7a. **Grants authorized; model jail practices.** (a) The commissioner of health shall award grants to eligible county jails to implement model jail practices and separate grants to county governments, Tribal governments, or nonprofit organizations in corresponding geographic areas to build partnerships with county jails to support children of incarcerated parents and their caregivers.

(b) Grantee activities include but are not limited to:

(1) parenting classes or groups;

(2) family-centered intake and assessment of inmate programs;

(3) family notification, information, and communication strategies;

(4) correctional staff training;

(5) policies and practices for family visits; and

(6) family-focused reentry planning.

(c) Grant recipients shall report their activities to the commissioner in a format and at a time specified by the commissioner.

Subd. 7b. **Technical assistance and oversight; model jail practices.** (a) The commissioner shall provide content expertise, training to grant recipients, and advice on evidence-based strategies, including evidence-based training to support incarcerated parents.

(b) For the purposes of carrying out the grant program under subdivision 7a, including for administrative purposes, the commissioner shall award contracts to appropriate entities to assist in training and provide technical assistance to grantees.

(c) Contracts awarded under paragraph (b) may be used to provide technical assistance and training in the areas of:

(1) evidence-based training for incarcerated parents;

(2) partnership building and community engagement;

(3) evaluation of process and outcomes of model jail practices; and

(4) expert guidance on reducing the harm caused to children of incarcerated parents and application of model jail practices.

Sec. 68. **[145.987] HEALTH EQUITY ADVISORY AND LEADERSHIP (HEAL) COUNCIL.**

Subdivision 1. **Establishment; composition of advisory council.** The commissioner shall establish and appoint a health equity advisory and leadership (HEAL) council to provide guidance to the commissioner of health regarding strengthening and improving the health of communities most impacted by health inequities across the state. The council shall consist of 18 members who will provide representation from the following groups:

(1) African American and African heritage communities;

(2) Asian American and Pacific Islander communities;

(3) Latina/o/x communities;

(4) American Indian communities and Tribal governments and nations;

(5) disability communities;

(6) lesbian, gay, bisexual, transgender, and queer (LGBTQ) communities; and

(7) representatives who reside outside the seven-county metropolitan area.

Subd. 2. **Organization and meetings.** The advisory council shall be organized and administered under section 15.059. Meetings shall be held at least quarterly and hosted by

the department. Subcommittees may be convened as necessary. Advisory council meetings are subject to the open meeting law under chapter 13D.

Subd. 3. **Duties.** The advisory council shall:

(1) advise the commissioner on health equity issues and the health equity priorities and concerns of the populations specified in subdivision 1;

(2) assist the agency in efforts to advance health equity, including consulting in specific agency policies and programs, providing ideas and input about potential budget and policy proposals, and recommending review of agency policies, standards, or procedures that may create or perpetuate health inequities; and

(3) assist the agency in developing and monitoring meaningful performance measures related to advancing health equity.

Subd. 4. **Expiration.** The advisory council shall remain in existence until health inequities in the state are eliminated. Health inequities will be considered eliminated when race, ethnicity, income, gender, gender identity, geographic location, or other identity or social marker will no longer be predictors of health outcomes in the state. Section 145.928 describes nine health disparities that must be considered when determining whether health inequities have been eliminated in the state.

Sec. 69. **[145.988] COMPREHENSIVE AND COLLABORATIVE RESOURCE AND REFERRAL SYSTEM FOR CHILDREN.**

Subdivision 1. **Establishment; purpose.** The commissioner shall establish the Comprehensive and Collaborative Resource and Referral System for Children to support a comprehensive, collaborative resource and referral system for children from prenatal stage through age eight and their families. The commissioner of health shall work collaboratively with the commissioners of human services and education to implement this section.

Subd. 2. **Duties.** (a) The Help Me Connect system shall facilitate collaboration across sectors, including child health, early learning and education, child welfare, and family supports by:

(1) providing early childhood provider outreach to support knowledge of and access to local resources that provide early detection and intervention services;

(2) identifying and providing access to early childhood and family support navigation specialists that can support families and their children's needs; and

(3) linking children and families to appropriate community-based services.

(b) The Help Me Connect system shall provide community outreach that includes support for, and participation in, the Help Me Connect system, including disseminating information on the system and compiling and maintaining a current resource directory that includes but is not limited to primary and specialty medical care providers, early childhood education and child care programs, developmental disabilities assessment and intervention programs, mental health services, family and social support programs, child advocacy and legal services, public health services and resources, and other appropriate early childhood information.

(c) The Help Me Connect system shall maintain a centralized access point for parents and professionals to obtain information, resources, and other support services.

(d) The Help Me Connect system shall collect data to increase understanding of the current and ongoing system of support and resources for expectant families and children through age eight and their families, including identification of gaps in service, barriers to finding and receiving appropriate services, and lack of resources.

Sec. 70. Minnesota Statutes 2022, section 145A.131, subdivision 1, is amended to read:

Subdivision 1. **Funding formula for community health boards.** (a) Base funding for each community health board eligible for a local public health grant under section 145A.03, subdivision 7, shall be determined by each community health board's fiscal year 2003 allocations, prior to unallotment, for the following grant programs: community health services subsidy; state and federal maternal and child health special projects grants; family home visiting grants; TANF MN ENABL grants; TANF youth risk behavior grants; and available women, infants, and children grant funds in fiscal year 2003, prior to unallotment, distributed based on the proportion of WIC participants served in fiscal year 2003 within the CHS service area.

(b) Base funding for a community health board eligible for a local public health grant under section 145A.03, subdivision 7, as determined in paragraph (a), shall be adjusted by the percentage difference between the base, as calculated in paragraph (a), and the funding available for the local public health grant.

(c) Multicounty or multicity community health boards shall receive a local partnership base of up to $5,000 per year for each county or city in the case of a multicity community health board included in the community health board.

(d) The State Community Health Advisory Committee may recommend a formula to the commissioner to use in distributing funds to community health boards.

(e) Notwithstanding any adjustment in paragraph (b), community health boards, all or a portion of which are located outside of the counties of Anoka, Chisago, Carver, Dakota, Hennepin, Isanti, Ramsey, Scott, Sherburne, Washington, and Wright, are eligible to receive an increase equal to ten percent of the grant award to the community health board under paragraph (a) starting July 1, 2015. The increase in calendar year 2015 shall be prorated for the last six months of the year. For calendar years beginning on or after January 1, 2016, the amount distributed under this paragraph shall be adjusted each year based on available funding and the number of eligible community health boards.

(f) Funding for foundational public health responsibilities will be distributed based on a formula determined by the Commissioner in consultation with the State Community Health Services Advisory Committee. These funds must be used as described in subdivision 5.

Sec. 71. Minnesota Statutes 2022, section 145A.131, subdivision 2, is amended to read:

Subd. 2. **Local match.** (a) A community health board that receives a local public health grant shall provide at least a 75 percent match for the state funds received through the local public health grant described in subdivision 1 and subject to paragraphs (b) to ~~(d)~~ (f).

(b) Eligible funds must be used to meet match requirements. Eligible funds include funds from local property taxes, reimbursements from third parties, fees, other local funds, and donations or nonfederal grants that are used for community health services described in section 145A.02, subdivision 6.

(c) When the amount of local matching funds for a community health board is less than the amount required under paragraph (a), the local public health grant provided for that community health board under this section shall be reduced proportionally.

(d) A city organized under the provision of sections 145A.03 to 145A.131 that levies a tax for provision of community health services is exempt from any county levy for the same services to the extent of the levy imposed by the city.

Sec. 72. Minnesota Statutes 2022, section 145A.131, subdivision 5, is amended to read:

Subd. 5. **Use of funds.** (a) Community health boards may use the base funding of their local public health grant funds as described in subdivision 1, paragraphs (a) to (e) to address the areas of public health responsibility and local priorities developed through the community health assessment and community health improvement planning process.

(b) Except as otherwise provided in this paragraph, funding for foundational public health responsibilities as described in subdivision 1, paragraph (f), must be used to fulfill

foundational public health responsibilities as defined by the commissioner in consultation with the state community health service advisory committee. If a community health board can demonstrate foundational public health responsibilities are fulfilled, the board may use funds for local priorities developed through the community health assessment and community health improvement planning process.

Sec. 73. Minnesota Statutes 2022, section 145A.14, is amended by adding a subdivision to read:

Subd. 2b. **Grants to tribes.** The commissioner must distribute grants to Tribal governments for foundational public health responsibilities as defined by each Tribal government.

Sec. 74. Minnesota Statutes 2022, section 256B.0625, subdivision 49, is amended to read:

Subd. 49. **Community health worker.** (a) Medical assistance covers the care coordination and patient education services provided by a community health worker if the community health worker has received a certificate from the Minnesota State Colleges and Universities System approved community health worker curriculum.

(b) Community health workers must work under the supervision of a medical assistance enrolled physician, registered nurse, advanced practice registered nurse, physician assistant, mental health professional, or dentist, or work under the supervision of a certified public health nurse operating under the direct authority of an enrolled unit of government.

(c) Effective January 1, 2026, community health workers who are eligible for payment under this subdivision who are providing care coordination or patient education services in an adult day care, respite care, or in-home care setting must complete a training program in Alzheimer's disease and dementia care that has been developed or approved by the commissioner of health, in accordance with section 144.6504, to remain eligible for payment.

~~(c)~~ (d) Care coordination and patient education services covered under this subdivision include, but are not limited to, services relating to oral health and dental care.

Sec. 75. Minnesota Statutes 2022, section 259.83, subdivision 1, is amended to read:

Subdivision 1. **Services provided.** (a) Agencies shall provide assistance and counseling services upon receiving a request for current information from adoptive parents, birth parents, or adopted persons aged ~~19~~ 18 years of age and ~~over~~ older. The agency shall contact the other adult persons or the adoptive parents of a minor child in a personal and confidential manner to determine whether there is a desire to receive or share information or to have

contact. If there is such a desire, the agency shall provide the services requested. The agency shall provide services to adult genetic siblings if there is no known violation of the confidentiality of a birth parent or if the birth parent gives written consent.

(b) Upon a request for assistance or services from an adoptive parent, birth parent, or an adopted person 18 years of age or older, the agency must inform the person:

(1) about the right of an adopted person to request and obtain a copy of the adopted person's original birth record at the age and circumstances specified in section 144.2253; and

(2) about the right of the birth parent named on the adopted person's original birth record to file a contact preference form with the state registrar pursuant to section 144.2253.

In adoptive placements, the agency must provide in writing to the birth parents listed on the original birth record the information required under this section.

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

Sec. 76. Minnesota Statutes 2022, section 259.83, subdivision 1a, is amended to read:

Subd. 1a. **Social and medical history.** (a) If a person aged ~~19~~ 18 years of age and ~~over~~ older who was adopted on or after August 1, 1994, or the adoptive parent requests the detailed nonidentifying social and medical history of the adopted person's birth family that was provided at the time of the adoption, agencies must provide the information to the adopted person or adoptive parent on the applicable form required under sections 259.43 and 260C.212, subdivision 15.

(b) If an adopted person aged ~~19~~ 18 years of age and ~~over~~ older or the adoptive parent requests the agency to contact the adopted person's birth parents to request current nonidentifying social and medical history of the adopted person's birth family, agencies must use the applicable form required under sections 259.43 and 260C.212, subdivision 15, when obtaining the information for the adopted person or adoptive parent.

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

Sec. 77. Minnesota Statutes 2022, section 259.83, subdivision 1b, is amended to read:

Subd. 1b. **Genetic siblings.** (a) A person who is at least ~~19~~ 18 years ~~old~~ of age who was adopted or, because of a termination of parental rights, was committed to the guardianship of the commissioner of human services, whether adopted or not, must upon request be

advised of other siblings who were adopted or who were committed to the guardianship of the commissioner of human services and not adopted.

(b) Assistance must be provided by the county or placing agency of the person requesting information to the extent that information is available in the existing records at the Department of Human Services. If the sibling received services from another agency, the agencies must share necessary information in order to locate the other siblings and to offer services, as requested. Upon the determination that parental rights with respect to another sibling were terminated, identifying information and contact must be provided only upon mutual consent. A reasonable fee may be imposed by the county or placing agency.

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

Sec. 78. Minnesota Statutes 2022, section 259.83, is amended by adding a subdivision to read:

Subd. 3a. **Birth parent identifying information.** (a) This subdivision applies to adoptive placements where an adopted person does not have a record of live birth registered in this state. Upon written request by an adopted person 18 years of age or older, the agency responsible for or supervising the placement must provide to the requester the following identifying information related to the birth parents listed on that adopted person's original birth record:

(1) each of the birth parent's names; and

(2) each of the birth parent's birthdate and birthplace.

(b) The agency may charge a reasonable fee to the requester for providing the required information under paragraph (a).

(c) The agency, acting in good faith and in a lawful manner in disclosing the identifying information under this subdivision, is not civilly liable for such disclosure.

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

Sec. 79. Minnesota Statutes 2022, section 260C.317, subdivision 4, is amended to read:

Subd. 4. **Rights of terminated parent.** (a) Upon entry of an order terminating the parental rights of any person who is identified as a parent on the original birth record of the child as to whom the parental rights are terminated, the court shall cause written notice to be made to that person setting forth:

~~(1) the right of the person to file at any time with the state registrar of vital records a consent to disclosure, as defined in section 144.212, subdivision 11;~~

~~(2)~~ the right of the person to file at any time with the state registrar of vital records ~~an affidavit stating that the information on the original birth record shall not be disclosed as provided in section 144.2252; and~~ a contact preference form under section 144.2253.

~~(3) the effect of a failure to file either a consent to disclosure, as defined in section 144.212, subdivision 11, or an affidavit stating that the information on the original birth record shall not be disclosed.~~

(b) A parent whose rights are terminated under this section shall retain the ability to enter into a contact or communication agreement under section 260C.619 if an agreement is determined by the court to be in the best interests of the child. The agreement shall be filed with the court at or prior to the time the child is adopted. An order for termination of parental rights shall not be conditioned on an agreement under section 260C.619.

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

Sec. 80. Minnesota Statutes 2022, section 403.161, subdivision 1, is amended to read:

Subdivision 1. **Fees imposed.** (a) A prepaid wireless E911 fee of 80 cents per retail transaction is imposed on prepaid wireless telecommunications service until the fee is adjusted as an amount per retail transaction under subdivision 7.

(b) A prepaid wireless telecommunications access Minnesota fee, in the amount of the monthly charge provided for in section 237.52, subdivision 2, is imposed on each retail transaction for prepaid wireless telecommunications service until the fee is adjusted as an amount per retail transaction under subdivision 7.

(c) A prepaid wireless 988 fee, in the amount of the monthly charge provided for in section 145.561, subdivision 4, paragraph (b), is imposed on each retail transaction for prepaid wireless telecommunications service until the fee is adjusted as an amount per retail transaction under subdivision 7.

Sec. 81. Minnesota Statutes 2022, section 403.161, subdivision 3, is amended to read:

Subd. 3. **Fee collected.** The prepaid wireless E911 ~~and~~, telecommunications access Minnesota, and 988 fees must be collected by the seller from the consumer for each retail transaction occurring in this state. The amount of each fee must be combined into one amount, which must be separately stated on an invoice, receipt, or other similar document that is provided to the consumer by the seller.

Sec. 82. Minnesota Statutes 2022, section 403.161, subdivision 5, is amended to read:

Subd. 5. **Remittance.** The prepaid wireless E911 ~~and~~, telecommunications access Minnesota, and 988 fees are the liability of the consumer and not of the seller or of any provider, except that the seller is liable to remit all fees as provided in section 403.162.

Sec. 83. Minnesota Statutes 2022, section 403.161, subdivision 6, is amended to read:

Subd. 6. **Exclusion for calculating other charges.** The combined amount of the prepaid wireless E911 ~~and~~, telecommunications access Minnesota, and 988 fees collected by a seller from a consumer must not be included in the base for measuring any tax, fee, surcharge, or other charge that is imposed by this state, any political subdivision of this state, or any intergovernmental agency.

Sec. 84. Minnesota Statutes 2022, section 403.161, subdivision 7, is amended to read:

Subd. 7. **Fee changes.** (a) The prepaid wireless E911 ~~and~~, telecommunications access Minnesota ~~fee~~, and 988 fees must be proportionately increased or reduced upon any change to the fee imposed under section 403.11, subdivision 1, paragraph (c), after July 1, 2013, ~~or~~ the fee imposed under section 237.52, subdivision 2, or the fee imposed under section 145.561, subdivision 4, as applicable.

(b) The department shall post notice of any fee changes on its website at least 30 days in advance of the effective date of the fee changes. It is the responsibility of sellers to monitor the department's website for notice of fee changes.

(c) Fee changes are effective 60 days after the first day of the first calendar month after the commissioner of public safety or the Public Utilities Commission, as applicable, changes the fee.

Sec. 85. Minnesota Statutes 2022, section 403.162, subdivision 1, is amended to read:

Subdivision 1. **Remittance.** Prepaid wireless E911 ~~and~~, telecommunications access Minnesota, and 988 fees collected by sellers must be remitted to the commissioner of revenue at the times and in the manner provided by chapter 297A with respect to the general sales and use tax. The commissioner of revenue shall establish registration and payment procedures that substantially coincide with the registration and payment procedures that apply in chapter 297A.

Sec. 86. Minnesota Statutes 2022, section 403.162, subdivision 2, is amended to read:

Subd. 2. **Seller's fee retention.** A seller may deduct and retain three percent of prepaid wireless E911 ~~and~~, telecommunications access Minnesota, and 988 fees collected by the seller from consumers.

Sec. 87. Minnesota Statutes 2022, section 403.162, subdivision 5, is amended to read:

Subd. 5. **Fees deposited.** (a) The commissioner of revenue shall, based on the relative proportion of the prepaid wireless E911 fee ~~and~~, the prepaid wireless telecommunications access Minnesota fee, and the prepaid wireless 988 fee imposed per retail transaction, divide the fees collected in corresponding proportions. Within 30 days of receipt of the collected fees, the commissioner shall:

(1) deposit the proportion of the collected fees attributable to the prepaid wireless E911 fee in the 911 emergency telecommunications service account in the special revenue fund; ~~and~~

(2) deposit the proportion of collected fees attributable to the prepaid wireless telecommunications access Minnesota fee in the telecommunications access fund established in section 237.52, subdivision 1~~.~~; and

(3) deposit the proportion of the collected fees attributable to the prepaid wireless 988 fee in the 988 special revenue account established in section 145.561, subdivision 3.

(b) The commissioner of revenue may deduct and deposit in a special revenue account an amount not to exceed two percent of collected fees. Money in the account is annually appropriated to the commissioner of revenue to reimburse its direct costs of administering the collection and remittance of prepaid wireless E911 fees ~~and~~, prepaid wireless telecommunications access Minnesota fees, and prepaid wireless 988 fees.

Sec. 88. Laws 2017, First Special Session chapter 6, article 5, section 11, as amended by Laws 2019, First Special Session chapter 9, article 8, section 20, is amended to read:

Sec. 11. **MORATORIUM ON CONVERSION TRANSACTIONS.**

(a) Notwithstanding Laws 2017, chapter 2, article 2, a nonprofit ~~health~~ service plan corporation operating under Minnesota Statutes, chapter 62C, or a nonprofit health maintenance organization operating under Minnesota Statutes, chapter 62D, as of January 1, 2017, may only merge or consolidate with; convert; or transfer, as part of a single transaction or a series of transactions within a 24-month period, all or a material amount of

its assets to an entity that is a corporation organized under Minnesota Statutes, chapter 317A; or to a Minnesota nonprofit hospital within the same integrated health system as the health maintenance organization. For purposes of this section, "material amount" means the lesser of ten percent of such an entity's total admitted net assets as of December 31 of the previous year, or $50,000,000.

(b) Paragraph (a) does not apply if the nonprofit service plan corporation or nonprofit health maintenance organization files an intent to dissolve due to insolvency of the corporation in accordance with Minnesota Statutes, chapter 317A, or insolvency proceedings are commenced under Minnesota Statutes, chapter 60B.

(c) Nothing in this section shall be construed to authorize a nonprofit health maintenance organization or a nonprofit service plan corporation to engage in any transaction or activities not otherwise permitted under state law.

(d) This section expires July 1, ~~2023~~ 2026.

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

Sec. 89. **MEMBERSHIP TERMS; PALLIATIVE CARE ADVISORY COUNCIL.**

Notwithstanding the terms of office specified to the members upon their appointment, the terms for members appointed to the Palliative Care Advisory Council under Minnesota Statutes, section 144.059, on or after February 1, 2022, shall be three years, as provided in Minnesota Statutes, section 144.059, subdivision 3.

Sec. 90. **STUDY OF THE DEVELOPMENT OF A STATEWIDE REGISTRY FOR PROVIDER ORDERS FOR LIFE-SUSTAINING TREATMENT.**

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

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

(c) "Life-sustaining treatment" means any medical procedure, pharmaceutical drug, medical device, or medical intervention that maintains life by sustaining, restoring, or supplanting a vital function. Life-sustaining treatment does not include routine care necessary to sustain patient cleanliness and comfort.

(d) "POLST" means a provider order for life-sustaining treatment, signed by a physician, advanced practice registered nurse, or physician assistant, to ensure that the medical treatment

preferences of a patient with an advanced serious illness who is nearing the end of the their life are honored.

(e) "POLST form" means a portable medical form used to communicate a physician's order to help ensure that a patient's medical treatment preferences are conveyed to emergency medical service personnel and other health care providers.

Subd. 2. **Establishment.** (a) The commissioner, in consultation with the advisory committee established in paragraph (c), shall develop recommendations for a statewide registry of POLST forms to ensure that a patient's medical treatment preferences are followed by all health care providers. The registry must allow for the submission of completed POLST forms and for the forms to be accessed by health care providers and emergency medical service personnel in a timely manner for the provision of care or services.

(b) The commissioner shall develop recommendations on the following:

(1) electronic capture, storage, and security of information in the registry;

(2) procedures to protect the accuracy and confidentiality of information submitted to the registry;

(3) limits as to who can access the registry;

(4) where the registry should be housed;

(5) ongoing funding models for the registry; and

(6) any other action needed to ensure that patients' rights are protected and that their health care decisions are followed.

(c) The commissioner shall create an advisory committee with members representing physicians, physician assistants, advanced practice registered nurses, registered nurses, nursing homes, emergency medical system providers, hospice and palliative care providers, the disability community, attorneys, medical ethicists, and the religious community.

Subd. 3. **Report.** The commissioner shall submit recommendations on establishing a statewide registry of POLST forms to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services policy and finance by February 1, 2024.

Sec. 91. **DIRECTION TO THE COMMISSIONER; ALZHEIMER'S PUBLIC INFORMATION PROGRAM.**

(a) The commissioner of health shall design and make publicly available materials for a statewide public information program that:

(1) promotes the benefits of early detection and the importance of discussing cognition with a health care provider;

(2) outlines the benefits of cognitive testing, the early warning signs of cognitive impairment, and the difference between normal cognitive aging and dementia; and

(3) provides awareness of Alzheimer's disease and other dementias.

(b) The commissioner shall include in the program materials messages directed at the general population, as well as messages designed to reach underserved communities including but not limited to rural populations, Native and Indigenous communities, and communities of color. The program materials shall include culturally specific messages developed in consultation with leaders of targeted cultural communities who have experience with Alzheimer's disease and other dementias. The commissioner shall develop the materials for the program by June 30, 2024, and make them available online to local and county public health agencies and other interested parties.

(c) To the extent funds remain available for this purpose, the commissioner shall implement an initial statewide public information campaign using the developed program materials. The campaign must include culturally specific messages and the development of a community digital public forum. These messages may be disseminated by television and radio public service announcements, social media and digital advertising, print materials, or other means.

(d) The commissioner may contract with one or more third parties to initially implement some or all of the public information campaign, provided the contracted third party has prior experience promoting Alzheimer's awareness and the contract is awarded through a competitive process. The public information campaign must be implemented by July 1, 2025.

(e) By June 30, 2026, the commissioner shall report to the chairs and ranking minority members of the legislative committees and divisions with jurisdiction over public health or aging on the development of the program materials and initial implementation of the public information campaign, including how and where the funds appropriated for this purpose were spent.

Sec. 92. **MORATORIUM ON GREEN BURIALS; STUDY.**

Subdivision 1. **Definition.** For purposes of this section, "green burial" means a burial of a dead human body in a manner that minimizes environmental impact and does not inhibit decomposition of the body by using practices that include at least the following:

(1) the human body is not embalmed prior to burial or is embalmed only with nontoxic chemicals;

(2) a biodegradable casket or shroud is used for burial; and

(3) the casket or shroud holding the human body is not placed in an outer burial container when buried.

Subd. 2. **Moratorium.** Between July 1, 2023, and July 1, 2025, a green burial shall not be performed in this state unless the green burial is performed in a cemetery that permits green burials and at which green burials are permitted by any applicable ordinances or regulations.

Subd. 3. **Study and report.** (a) The commissioner of health shall study the environmental and health impacts of green burials and develop recommendations for the performance of green burials to prevent environmental harm, including contamination of groundwater and surface water, and to protect the health of workers performing green burials, mourners, and the public. The study and recommendations may address topics that include:

(1) the siting of locations where green burials are permitted;

(2) the minimum distance a green burial location must have from groundwater, surface water, and drinking water;

(3) the minimum depth at which a body buried via green burial must be buried, the minimum soil depth below the body, and the minimum soil depth covering the body;

(4) the maximum density of green burial interments in a green burial location;

(5) procedures used by individuals who come in direct contact with a body awaiting green burial to minimize the risk of infectious disease transmission from the body;

(6) methods to temporarily inhibit decomposition of an unembalmed body awaiting green burial; and

(7) the time period within which an unembalmed body awaiting green burial must be buried or held in a manner that delays decomposition.

(b) The commissioner shall submit the study and recommendations, including any statutory changes needed to implement the recommendations, to the chairs and ranking minority members of the legislative committees with jurisdiction over health and the environment by February 1, 2025.

Sec. 93. **ADOPTION LAW CHANGES; PUBLIC AWARENESS CAMPAIGN.**

(a) The commissioner of human services must, in consultation with licensed child-placing agencies, provide information and educational materials to adopted persons and birth parents about the changes in law made by this act affecting access to birth records.

(b) The commissioner of human services must provide notice on the department's website about the changes in the law. The commissioner or the commissioner's designee, in consultation with licensed child-placement agencies, must coordinate a public awareness campaign to advise the public about the changes in law made by this act.

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

Sec. 94. **STUDY OF THE DEVELOPMENT OF A STATEWIDE REGISTRY FOR PROVIDER ORDERS FOR LIFE-SUSTAINING TREATMENT.**

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

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

(c) "Life-sustaining treatment" means any medical procedure, pharmaceutical drug, medical device, or medical intervention that maintains life by sustaining, restoring, or supplanting a vital function. Life-sustaining treatment does not include routine care necessary to sustain patient cleanliness and comfort.

(d) "POLST" means a provider order for life-sustaining treatment, signed by a physician, advanced practice registered nurse, or physician assistant, to ensure that the medical treatment preferences of a patient with an advanced serious illness who is nearing the end of their life are honored.

(e) "POLST form" means a portable medical form used to communicate a physician's order to help ensure that a patient's medical treatment preferences are conveyed to emergency medical service personnel and other health care providers.

Subd. 2. **Establishment.** (a) The commissioner, in consultation with the advisory committee established in paragraph (c), shall develop recommendations for a statewide

registry of POLST forms to ensure that a patient's medical treatment preferences are followed by all health care providers. The registry must allow for the submission of completed POLST forms and for the forms to be accessed by health care providers and emergency medical service personnel in a timely manner for the provision of care or services.

(b) The commissioner shall develop recommendations on the following:

(1) electronic capture, storage, and security of information in the registry;

(2) procedures to protect the accuracy and confidentiality of information submitted to the registry;

(3) limits as to who can access the registry;

(4) where the registry should be housed;

(5) ongoing funding models for the registry; and

(6) any other action needed to ensure that patients' rights are protected and that their health care decisions are followed.

(c) The commissioner shall create an advisory committee with members representing physicians, physician assistants, advanced practice registered nurses, nursing homes, emergency medical system providers, hospice and palliative care providers, the disability community, attorneys, medical ethicists, and the religious community.

Subd. 3. **Report.** The commissioner shall submit recommendations on establishing a statewide registry of POLST forms to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services policy and finance by February 1, 2024.

Sec. 95. **EMMETT LOUIS TILL VICTIMS RECOVERY PROGRAM.**

Subdivision 1. **Short title.** This section shall be known as the Emmett Louis Till Victims Recovery Program.

Subd. 2. **Program established; grants.** (a) The commissioner of health shall establish the Emmett Louis Till Victims Recovery Program to address the health and wellness needs of:

(1) victims who experienced trauma, including historical trauma, resulting from events such as assault or another violent physical act, intimidation, false accusations, wrongful conviction, a hate crime, the violent death of a family member, or experiences of discrimination or oppression based on the victim's race, ethnicity, or national origin; and

(2) the families and heirs of victims described in clause (1), who experienced trauma, including historical trauma, because of their proximity or connection to the victim.

(b) The commissioner, in consultation with victims, families, and heirs described in paragraph (a), shall award competitive grants to applicants for projects to provide the following services to victims, families, and heirs described in paragraph (a):

(1) health and wellness services, which may include services and support to address physical health, mental health, cultural needs, and spiritual or faith-based needs;

(2) remembrance and legacy preservation activities;

(3) cultural awareness services;

(4) spiritual and faith-based support; and

(5) community resources and services to promote healing for victims, families, and heirs described in paragraph (a).

(c) In awarding grants under this section, the commissioner must prioritize grant awards to community-based organizations experienced in providing support and services to victims, families, and heirs described in paragraph (a).

Subd. 3. **Evaluation.** Grant recipients must provide the commissioner with information required by the commissioner to evaluate the grant program, in a time and manner specified by the commissioner.

Subd. 4. **Reports.** The commissioner must submit a status report by January 15, 2024, and an additional report by January 15, 2025, on the operation and results of the grant program, to the extent available. These reports must be submitted to the chairs and ranking minority members of the legislative committees with jurisdiction over health care. The report due January 15, 2024, must include information on grant program activities to date and an assessment of the need to continue to offer services provided by grant recipients to victims, families, and heirs who experienced trauma as described in subdivision 2, paragraph (a). The report due January 15, 2025, must include a summary of the services offered by grant recipients; an assessment of the need to continue to offer services provided by grant recipients to victims, families, and heirs described in subdivision 2, paragraph (a); and an evaluation of the grant program's goals and outcomes.

Sec. 96. **EMPLOYEE SAFETY AND SECURITY GRANTS.**

Subdivision 1. **Establishment.** The commissioner of health must establish a competitive grant program for workplace safety grants for eligible health care entities to increase the

employee safety or security. Each grant award must be for at least $5,000, but no more than $100,000.

Subd. 2. **Eligible applicants.** A health care entity located in this state is eligible to apply for a grant. For purposes of this section, a health care entity includes but is not limited to the following: health care systems, long-term care facilities, hospitals, nursing facilities, medical clinics, dental clinics, community health clinics, and ambulance services.

Subd. 3. **Applications.** An entity seeking a grant under this section must apply to the commissioner in a form and manner prescribed by the commissioner. The grant applicant, in its application, must include:

(1) a proposed plan for how the grant funds will be used to improve employee safety or security;

(2) a description of the achievable objectives the applicant plans to achieve through the use of the grant funds; and

(3) a process for documenting and evaluating the results achieved through the use of the grant funds.

Subd. 4. **Eligible uses.** Grant funds must be used for the following purposes:

(1) training for employees on self-defense;

(2) training for employees on de-escalation methods;

(3) creating and implementing a health care-based violence intervention programs (HBVI); or

(4) technology system improvements designed to improve employee safety or security.

Subd. 5. **Grant allocations.** For grants awarded prior to January 1, 2025, the commissioner must ensure that approximately 60 percent of awards are to health care entities in the seven-county metropolitan area and 40 percent are to health care entities outside of the seven-county metropolitan area. If funds remain on January 1, 2025, the commissioner may award grants to health care entities regardless of where the entity is located.

Subd. 6. **Report.** By January 15, 2026, the commissioner of health must report to the legislative committees with jurisdiction over health policy and finance on the grants awarded by this section. The report must include the following information:

(1) the name of each grantee, the amount awarded to the grantee, and how the grantee used the funds; and

(2) the percentage of awards made to entities outside of the seven-county metropolitan area.

Sec. 97. **EQUITABLE HEALTH CARE TASK FORCE.**

Subdivision 1. **Establishment; composition of task force.** The commissioner of health shall establish an equitable health care task force consisting of up to 20 members from both metropolitan and greater Minnesota. Members must include representatives of:

(1) African American and African heritage communities;

(2) Asian American and Pacific Islander communities;

(3) Latina/o/x/ communities;

(4) American Indian communities and Tribal Nations;

(5) disability communities;

(6) lesbian, gay, bisexual, transgender, queer, intergender, and asexual (LGBTQIA+) communities;

(7) organizations that advocate for the rights of individuals using the health care system;

(8) health care providers of primary care and specialty care; and

(9) organizations that provide health coverage in Minnesota.

Subd. 2. **Organization and meetings.** The task force shall be organized and administered under Minnesota Statutes, section 15.059. Meetings shall be held at least quarterly. Subcommittees or workgroups may be established as necessary. Task force meetings are subject to Minnesota Statutes, chapter 13D. The task force shall expire on June 30, 2025.

Subd. 3. **Duties of task force.** The task force shall examine inequities in how people access and receive health care based on race, religion, culture, sexual orientation, gender identity, age, or disability and identify strategies to ensure that all Minnesotans can receive care and coverage that is respectful and ensures optimal health outcomes, to include:

(1) identifying inequities experienced by Minnesotans in interacting with the health care system that originate from or can be attributed to their race, religion, culture, sexual orientation, gender identity, age, or disability status;

(2) conducting community engagement across multiple systems, sectors, and communities to identify barriers for these population groups that result in diminished standards of care and foregone care;

(3) identifying promising practices to improve the experience of care and health outcomes for individuals in these population groups; and

(4) making recommendations for changes in health care system practices or health insurance regulations that would address identified issues.

Sec. 98. **REPEALER.**

(a) Minnesota Statutes 2022, section 144.059, subdivision 10, is repealed.

(b) Minnesota Statutes 2022, sections 144.212, subdivision 11; 259.83, subdivision 3; 259.89; and 260C.637, are repealed.

(c) Minnesota Statutes 2022, sections 62J.692, subdivisions 4a, 7, and 7a; 137.38, subdivision 1; and 256B.69, subdivision 5c, are repealed.

EFFECTIVE DATE. Paragraph (b) is effective July 1, 2024.

ARTICLE 5
MEDICAL EDUCATION AND RESEARCH COSTS

Section 1. Minnesota Statutes 2022, section 62J.692, subdivision 1, is amended to read:

Subdivision 1. **Definitions.** (a) For purposes of this section, the following definitions apply:

(b) "Accredited clinical training" means the clinical training provided by a medical education program that is accredited through an organization recognized by the Department of Education, the Centers for Medicare and Medicaid Services, or another national body who reviews the accrediting organizations for multiple disciplines and whose standards for recognizing accrediting organizations are reviewed and approved by the commissioner of health.

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

(d) "Clinical medical education program" means the accredited clinical training of physicians (medical students and residents), doctor of pharmacy practitioners (pharmacy students and residents), doctors of chiropractic, dentists (dental students and residents), advanced practice registered nurses (clinical nurse specialists, certified registered nurse anesthetists, nurse practitioners, and certified nurse midwives), physician assistants, dental therapists and advanced dental therapists, psychologists, clinical social workers, community paramedics, and community health workers.

(e) "Sponsoring institution" means a hospital, school, or consortium located in Minnesota that sponsors and maintains primary organizational and financial responsibility for a clinical medical education program in Minnesota and which is accountable to the accrediting body.

(f) "Teaching institution" means a hospital, medical center, clinic, or other organization that conducts a clinical medical education program in Minnesota.

(g) "Trainee" means a student or resident involved in a clinical medical education program.

(h) "Eligible trainee FTE's" means the number of trainees, as measured by full-time equivalent counts, that are at training sites located in Minnesota with currently active medical assistance enrollment status and a National Provider Identification (NPI) number where training occurs ~~in~~ as part of or under the scope of either an inpatient or ambulatory patient care setting and where the training is funded, in part, by patient care revenues. Training that occurs in nursing facility settings is not eligible for funding under this section.

Sec. 2. Minnesota Statutes 2022, section 62J.692, subdivision 3, is amended to read:

Subd. 3. **Application process.** (a) A clinical medical education program conducted in Minnesota by a teaching institution to train physicians, doctor of pharmacy practitioners, dentists, chiropractors, physician assistants, dental therapists and advanced dental therapists, psychologists, clinical social workers, community paramedics, or community health workers is eligible for funds under subdivision 4 if the program:

(1) is funded, in part, by patient care revenues;

(2) occurs in patient care settings that face increased financial pressure as a result of competition with nonteaching patient care entities; ~~and~~

(3) includes training hours in settings outside of the hospital or clinic site, as applicable, including but not limited to school, home, and community settings; and

~~(3)~~ (4) emphasizes primary care or specialties that are in undersupply in Minnesota.

(b) A clinical medical education program for advanced practice nursing is eligible for funds under subdivision 4 if the program meets the eligibility requirements in paragraph (a), clauses (1) to (3), and is sponsored by the University of Minnesota Academic Health Center, the Mayo Foundation, or institutions that are part of the Minnesota State Colleges and Universities system or members of the Minnesota Private College Council.

(c) Applications must be submitted to the commissioner by a sponsoring institution on behalf of an eligible clinical medical education program ~~and must be received by October~~

~~31 of each year for distribution in the following year~~ on a timeline determined by the commissioner. An application for funds must contain ~~the following information:~~ information the commissioner deems necessary to determine program eligibility based on the criteria in paragraphs (a) and (b) and to ensure the equitable distribution of funds.

~~(1) the official name and address of the sponsoring institution and the official name and site address of the clinical medical education programs on whose behalf the sponsoring institution is applying;~~

~~(2) the name, title, and business address of those persons responsible for administering the funds;~~

~~(3) for each clinical medical education program for which funds are being sought; the type and specialty orientation of trainees in the program; the name, site address, and medical assistance provider number and national provider identification number of each training site used in the program; the federal tax identification number of each training site used in the program, where available; the total number of trainees at each training site; and the total number of eligible trainee FTEs at each site; and~~

~~(4) other supporting information the commissioner deems necessary to determine program eligibility based on the criteria in paragraphs (a) and (b) and to ensure the equitable distribution of funds.~~

~~(d) An application must include the information specified in clauses (1) to (3) for each clinical medical education program on an annual basis for three consecutive years. After that time, an application must include the information specified in clauses (1) to (3) when requested, at the discretion of the commissioner:~~

~~(1) audited clinical training costs per trainee for each clinical medical education program when available or estimates of clinical training costs based on audited financial data;~~

~~(2) a description of current sources of funding for clinical medical education costs, including a description and dollar amount of all state and federal financial support, including Medicare direct and indirect payments; and~~

~~(3) other revenue received for the purposes of clinical training.~~

~~(e)~~ (d) An applicant that does not provide information requested by the commissioner shall not be eligible for funds for the ~~current~~ applicable funding cycle.

Sec. 3. Minnesota Statutes 2022, section 62J.692, subdivision 4, is amended to read:

Subd. 4. **Distribution of funds.** (a) The commissioner shall annually distribute ~~the available medical education funds~~ revenue credited or money transferred to the medical education and research cost account under subdivision 8 and section 297F.10, subdivision 1, clause (2), to all qualifying applicants based on a public program volume factor, which is determined by the total volume of public program revenue received by each training site as a percentage of all public program revenue received by all training sites in the fund pool.

Public program revenue for the distribution formula includes revenue from medical assistance and prepaid medical assistance. Training sites that receive no public program revenue are ineligible for funds available under this subdivision. ~~For purposes of determining training-site level grants to be distributed under this paragraph, total statewide average costs per trainee for medical residents is based on audited clinical training costs per trainee in primary care clinical medical education programs for medical residents. Total statewide average costs per trainee for dental residents is based on audited clinical training costs per trainee in clinical medical education programs for dental students. Total statewide average costs per trainee for pharmacy residents is based on audited clinical training costs per trainee in clinical medical education programs for pharmacy students.~~

Training sites whose training site level grant is less than $5,000, based on the ~~formula~~ formulas described in this ~~paragraph~~ subdivision, or that train fewer than 0.1 FTE eligible trainees, are ineligible for funds available under this subdivision. No training sites shall receive a grant per FTE trainee that is in excess of the 95th percentile grant per FTE across all eligible training sites; grants in excess of this amount will be redistributed to other eligible sites based on the ~~formula~~ formulas described in this ~~paragraph~~ subdivision.

(b) ~~For funds distributed in fiscal years 2014 and 2015, the distribution formula shall include a supplemental public program volume factor, which is determined by providing a supplemental payment to training sites whose public program revenue accounted for at least 0.98 percent of the total public program revenue received by all eligible training sites. The supplemental public program volume factor shall be equal to ten percent of each training site's grant for funds distributed in fiscal year 2014 and for funds distributed in fiscal year 2015. Grants to training sites whose public program revenue accounted for less than 0.98 percent of the total public program revenue received by all eligible training sites shall be reduced by an amount equal to the total value of the supplemental payment. For fiscal year 2016 and beyond, the distribution of funds shall be based solely on the public program volume factor as described in paragraph (a).~~ Money appropriated through the state general fund, the health care access fund, and any additional fund for the purpose of funding medical

education and research costs and that does not require federal approval must be awarded only to eligible training sites that do not qualify for a medical education and research cost rate factor under sections 256.969, subdivision 2b, paragraph (k), or 256B.75, paragraph (b). The commissioner shall distribute the available medical education money appropriated to eligible training sites that do not qualify for a medical education and research cost rate factor based on a distribution formula determined by the commissioner. The distribution formula under this paragraph must consider clinical training costs, public program revenues, and other factors identified by the commissioner that address the objective of supporting clinical training.

(c) Funds distributed shall not be used to displace current funding appropriations from federal or state sources.

(d) Funds shall be distributed to the sponsoring institutions indicating the amount to be distributed to each of the sponsor's clinical medical education programs based on the criteria in this subdivision and in accordance with the commissioner's approval letter. Each clinical medical education program must distribute funds allocated under paragraphs (a) and (b) to the training sites as specified in the commissioner's approval letter. Sponsoring institutions, which are accredited through an organization recognized by the Department of Education or the Centers for Medicare and Medicaid Services, may contract directly with training sites to provide clinical training. To ensure the quality of clinical training, those accredited sponsoring institutions must:

(1) develop contracts specifying the terms, expectations, and outcomes of the clinical training conducted at sites; and

(2) take necessary action if the contract requirements are not met. Action may include ~~the withholding of payments~~ disqualifying the training site under this section or the removal of students from the site.

(e) Use of funds is limited to expenses related to eligible clinical training ~~program~~ costs ~~for eligible programs~~. The commissioner shall develop a methodology for determining eligible costs.

(f) Any funds ~~not~~ that cannot be distributed in accordance with the commissioner's approval letter must be returned to the medical education and research fund within 30 days of receiving notice from the commissioner. ~~The commissioner shall distribute returned funds to the appropriate training sites in accordance with the commissioner's approval letter.~~ When appropriate, the commissioner shall include the undistributed money in the subsequent distribution cycle using the applicable methodology described in this subdivision.

~~(g) A maximum of $150,000 of the funds dedicated to the commissioner under section 297F.10, subdivision 1, clause (2), may be used by the commissioner for administrative expenses associated with implementing this section.~~

Sec. 4. Minnesota Statutes 2022, section 62J.692, subdivision 5, is amended to read:

Subd. 5. **Report.** (a) Sponsoring institutions receiving funds under this section must ~~sign and~~ submit a medical education grant verification report (GVR) to verify that the correct grant amount was forwarded to each eligible training site. ~~If the sponsoring institution fails to submit the GVR by the stated deadline, or to request and meet the deadline for an extension, the sponsoring institution is required to return the full amount of funds received to the commissioner within 30 days of receiving notice from the commissioner. The commissioner shall distribute returned funds to the appropriate training sites in accordance with the commissioner's approval letter.~~

(b) The reports must provide verification of the distribution of the funds and must include:

~~(1) the total number of eligible trainee FTEs in each clinical medical education program;~~

~~(2) the name of each funded program and, for each program, the dollar amount distributed to each training site and a training site expenditure report;~~

~~(3)~~ (1) documentation of any discrepancies between the ~~initial~~ grant distribution notice included in the commissioner's approval letter and the actual distribution;

~~(4)~~ (2) a statement by the sponsoring institution stating that the completed grant verification report is valid and accurate; and

~~(5)~~ (3) other information the commissioner deems appropriate to evaluate the effectiveness of the use of funds for medical education.

~~(c) Each year, the commissioner shall provide an annual summary report to the legislature on the implementation of this section. This report is exempt from section 144.05, subdivision 7.~~

Sec. 5. Minnesota Statutes 2022, section 62J.692, subdivision 8, is amended to read:

Subd. 8. **Federal financial participation.** The commissioner of human services shall seek ~~to maximize~~ federal financial participation ~~in payments~~ for the dedicated revenue for medical education and research costs provided under section 297F.10, subdivision 1, clause (2).

~~The commissioner shall use physician clinic rates where possible to maximize federal financial participation. Any additional funds that become available must be distributed under subdivision 4, paragraph (a).~~

Sec. 6. Minnesota Statutes 2022, section 144.1501, subdivision 2, is amended to read:

Subd. 2. **Creation of account.** (a) A health professional education loan forgiveness program account is established. The commissioner of health shall use money from the account to establish a loan forgiveness program:

(1) for medical residents, mental health professionals, and alcohol and drug counselors agreeing to practice in designated rural areas or underserved urban communities or specializing in the area of ~~pediatric~~ psychiatry;

(2) for midlevel practitioners agreeing to practice in designated rural areas or to teach at least 12 credit hours, or 720 hours per year in the nursing field in a postsecondary program at the undergraduate level or the equivalent at the graduate level;

(3) for nurses who agree to practice in a Minnesota nursing home; in an intermediate care facility for persons with developmental disability; in a hospital if the hospital owns and operates a Minnesota nursing home and a minimum of 50 percent of the hours worked by the nurse is in the nursing home; ~~a housing with services establishment~~ in an assisted living facility as defined in section ~~144D.01~~ 144G.08, subdivision ~~4~~ 7; or for a home care provider as defined in section 144A.43, subdivision 4; or agree to teach at least 12 credit hours, or 720 hours per year in the nursing field in a postsecondary program at the undergraduate level or the equivalent at the graduate level;

(4) for other health care technicians agreeing to teach at least 12 credit hours, or 720 hours per year in their designated field in a postsecondary program at the undergraduate level or the equivalent at the graduate level. The commissioner, in consultation with the Healthcare Education-Industry Partnership, shall determine the health care fields where the need is the greatest, including, but not limited to, respiratory therapy, clinical laboratory technology, radiologic technology, and surgical technology;

(5) for pharmacists, advanced dental therapists, dental therapists, and public health nurses who agree to practice in designated rural areas; and

(6) for dentists agreeing to deliver at least 25 percent of the dentist's yearly patient encounters to state public program enrollees or patients receiving sliding fee schedule discounts through a formal sliding fee schedule meeting the standards established by the

United States Department of Health and Human Services under Code of Federal Regulations, title 42, section 51, chapter 303.

(b) Appropriations made to the account do not cancel and are available until expended, except that at the end of each biennium, any remaining balance in the account that is not committed by contract and not needed to fulfill existing commitments shall cancel to the fund.

Sec. 7. Minnesota Statutes 2022, section 144.1501, subdivision 3, is amended to read:

Subd. 3. **Eligibility.** (a) To be eligible to participate in the loan forgiveness program, an individual must:

(1) be a medical or dental resident; be a licensed pharmacist; or be enrolled in a training or education program or obtaining required supervision hours to become a dentist, dental therapist, advanced dental therapist, mental health professional, alcohol and drug counselor, pharmacist, public health nurse, midlevel practitioner, registered nurse, or a licensed practical nurse. The commissioner may also consider applications submitted by graduates in eligible professions who are licensed and in practice; and

(2) submit an application to the commissioner of health.

(b) An applicant selected to participate must sign a contract to agree to serve a minimum three-year full-time service obligation according to subdivision 2, which shall begin no later than March 31 following completion of required training, with the exception of a nurse, who must agree to serve a minimum two-year full-time service obligation according to subdivision 2, which shall begin no later than March 31 following completion of required training.

Sec. 8. Minnesota Statutes 2022, section 144.1506, subdivision 4, is amended to read:

Subd. 4. **Consideration of expansion grant applications.** The commissioner shall review each application to determine whether or not the residency program application is complete and whether the proposed new residency program and any new residency slots are eligible for a grant. The commissioner shall award grants to support up to six family medicine, general internal medicine, or general pediatrics residents; ~~four~~ five psychiatry residents; two geriatrics residents; and two general surgery residents. If insufficient applications are received from any eligible specialty, funds may be redistributed to applications from other eligible specialties.

Sec. 9. **[144.1507] PEDIATRIC PRIMARY CARE MENTAL HEALTH TRAINING; GRANT PROGRAM.**

Subdivision 1. **Establishment.** The commissioner of health shall award grants for the development of child mental health training programs that are located in outpatient primary care clinics. To be eligible for a grant, a training program must:

(1) focus on the training of pediatric primary care providers working with multidisciplinary mental health teams;

(2) provide training on conducting comprehensive clinical mental health assessments and potential pharmacological therapy;

(3) provide psychiatric consultation to pediatric primary care providers during their outpatient pediatric primary care experiences;

(4) emphasize longitudinal care for patients with behavioral health needs; and

(5) develop partnerships with community resources.

Subd. 2. **Child mental health training grant program.** (a) Child mental health training grants may be awarded to eligible primary care training programs to plan and implement new programs or expand existing programs in child mental health training.

(b) Money may be spent to cover the costs of:

(1) planning related to implementing or expanding child mental health training in an outpatient primary care clinic setting;

(2) training site improvements, fees, equipment, and supplies required for implementation of the training programs; and

(3) supporting clinical training in the outpatient primary clinic sites.

Subd. 3. **Applications for child mental health training grants.** Eligible primary care training programs seeking a grant shall apply to the commissioner. Applications must include the location of the training; a description of the training program, including all costs associated with the training program; all sources of money for the training program; detailed uses of all money for the training program; the results expected; and a plan to maintain the training program after the grant period. The applicant must describe achievable objectives and a timetable for the training program.

Subd. 4. **Consideration of child mental health training grant applications.** The commissioner shall review each application to determine whether the application meets the

stated goals of the grant and shall award grants to support up to four training program proposals.

Subd. 5. **Program oversight.** During the grant period, the commissioner may require and collect from grantees any information necessary to evaluate the training program.

Sec. 10. **[144.1511] MENTAL HEALTH CULTURAL COMMUNITY CONTINUING EDUCATION GRANT PROGRAM.**

The mental health cultural community continuing education grant program is established in the Department of Health to provide grants for the continuing education necessary for social workers, marriage and family therapists, psychologists, and professional clinical counselors to become supervisors for individuals pursuing licensure in mental health professions. The commissioner must consult with the relevant mental health licensing boards in creating the program. To be eligible for a grant under this section, a social worker, marriage and family therapist, psychologist, or professional clinical counselor must:

(1) be a member of a community of color or an underrepresented community as defined in section 148E.010, subdivision 20; and

(2) work for a community mental health provider and agree to deliver at least 25 percent of their yearly patient encounters to state public program enrollees or patients receiving sliding fee schedule discounts through a formal sliding fee schedule meeting the standards established by the United States Department of Health and Human Services under Code of Federal Regulations, title 42, section 51c.303.

Sec. 11. **[144.1913] CLINICAL DENTAL EDUCATION INNOVATION GRANTS.**

(a) The commissioner shall award clinical dental education innovation grants to teaching institutions and clinical training sites for projects that increase dental access for underserved populations and promote innovative clinical training of dental professionals. In awarding the grants, the commissioner shall consider the following:

(1) potential to successfully increase access to dental services for an underserved population;

(2) the long-term viability of the project to improve access to dental services beyond the period of initial funding;

(3) evidence of collaboration between the applicant and local communities;

(4) efficiency in the use of grant money; and

(5) the priority level of the project in relation to state education, access, and workforce goals.

(b) The commissioner shall periodically evaluate the priorities in awarding innovations grants under this section to ensure that the priorities meet the changing workforce needs of the state.

Sec. 12. **[144.88] MENTAL HEALTH AND SUBSTANCE USE DISORDER EDUCATION CENTER.**

Subdivision 1. **Establishment.** The Mental Health and Substance Use Disorder Education Center is established in the Department of Health. The purpose of the center is to increase the number of professionals, practitioners, and peers working in mental health and substance use disorder treatment; increase the diversity of professionals, practitioners, and peers working in mental health and substance use disorder treatment; and facilitate a culturally informed and responsive mental health and substance use disorder treatment workforce.

Subd. 2. **Activities.** The Mental Health and Substance Use Disorder Education Center must:

(1) analyze the geographic and demographic availability of licensed professionals in the field, identify gaps, and prioritize the need for additional licensed professionals by type, location, and demographics;

(2) create a program that exposes high school and college students to careers in the mental health and substance use disorder treatment field;

(3) create a website for individuals considering becoming a mental health provider that clearly labels the steps necessary to achieve licensure and certification in the various mental health fields and lists resources and links for more information;

(4) create a job board for organizations seeking employees to provide mental health and substance use disorder treatment, services, and supports;

(5) track the number of students at the college and graduate level who are graduating from programs that could facilitate a career as a mental health or substance use disorder treatment practitioner or professional and work with the colleges and universities to support the students in obtaining licensure;

(6) identify barriers to licensure and make recommendations to address the barriers;

(7) establish learning collaborative partnerships with mental health and substance use disorder treatment providers, schools, criminal justice agencies, and others;

(8) promote and expand loan forgiveness programs, funding for professionals to become supervisors, funding to pay for supervision, and funding for pathways to licensure;

(9) identify barriers to using loan forgiveness programs and develop recommendations to address the barriers;

(10) work to expand Medicaid graduate medical education to other mental health professionals;

(11) identify current sites for internships and practicums and assess the need for additional sites;

(12) develop training for other health care professionals to increase their knowledge about mental health and substance use disorder treatment, including but not limited to community health workers, pediatricians, primary care physicians, physician assistants, and nurses; and

(13) support training for integrated mental health and primary care in rural areas.

Subd. 3. **Reports.** Beginning January 1, 2024, the commissioner of health shall submit an annual report to the chairs and ranking minority members of the legislative committees with jurisdiction over health finance and policy summarizing the center's activities and progress in addressing the mental health and substance use disorder treatment workforce shortage.

Sec. 13. **[145.9272] FEDERALLY QUALIFIED HEALTH CENTERS APPRENTICESHIP PROGRAM.**

Subdivision 1. **Definitions.** (a) The terms defined in this subdivision apply to this section.

(b) "Federally qualified health center" has the meaning given in section 145.9269, subdivision 1.

(c) "Nonprofit organization of community health centers" means a nonprofit organization the membership of which consists of federally qualified health centers operating service delivery sites in Minnesota and that provides services to federally qualified health centers in Minnesota to promote the delivery of affordable, quality primary care services in the state.

Subd. 2. **Apprenticeship program.** The commissioner of health shall distribute a grant to a nonprofit organization of community health centers for an apprenticeship program in federally qualified health centers operating in Minnesota. Grant money must be used to establish and fund ongoing costs for apprenticeship programs for medical assistants and

dental assistants at federally qualified health center service delivery sites in Minnesota. An apprenticeship program funded under this section must be a 12-month program led by certified medical assistants and licensed dental assistants. Trainees for an apprenticeship program must be recruited from federally qualified health center staff and from the population in the geographic area served by the federally qualified health center.

Sec. 14. Minnesota Statutes 2022, section 245.4663, subdivision 4, is amended to read:

Subd. 4. **Allowable uses of grant funds.** A mental health provider must use grant funds received under this section for one or more of the following:

(1) to pay for direct supervision hours for interns and clinical trainees, in an amount up to $7,500 per intern or clinical trainee;

(2) to establish a program to provide supervision to multiple interns or clinical trainees; ~~or~~

(3) to pay licensing application and examination fees for clinical trainees~~.~~; or

(4) to provide a weekend training program for workers to become supervisors.

Sec. 15. **[245.4664] MENTAL HEALTH PROFESSIONAL SCHOLARSHIP GRANT PROGRAM.**

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

(b) "Mental health professional" means an individual with a qualification specified in section 245I.04, subdivision 2.

(c) "Underrepresented community" has the meaning given in section 148E.010, subdivision 20.

Subd. 2. **Grant program established.** The mental health professional scholarship program is established in the Department of Human Services to assist mental health providers in funding employee scholarships for master's degree-level education programs in order to create a pathway to becoming a mental health professional.

Subd. 3. **Provision of grants.** The commissioner of human services shall award grants to licensed or certified mental health providers who meet the criteria in subdivision 4 to provide tuition reimbursement for master's degree-level programs and certain related costs for individuals who have worked for the mental health provider for at least the past two years in one or more of the following roles:

(1) a mental health behavioral aide who meets a qualification in section 245I.04, subdivision 16;

(2) a mental health certified family peer specialist who meets the qualifications in section 245I.04, subdivision 12;

(3) a mental health certified peer specialist who meets the qualifications in section 245I.04, subdivision 10;

(4) a mental health practitioner who meets a qualification in section 245I.04, subdivision 4;

(5) a mental health rehabilitation worker who meets the qualifications in section 245I.04, subdivision 14;

(6) an individual employed in a role in which the individual provides face-to-face client services at a mental health center or certified community behavioral health center; or

(7) a staff person who provides care or services to residents of a residential treatment facility.

Subd. 4. **Eligibility.** In order to be eligible for a grant under this section, a mental health provider must:

(1) primarily provide at least 25 percent of the provider's yearly patient encounters to state public program enrollees or patients receiving sliding fee schedule discounts through a formal sliding fee schedule meeting the standards established by the United States Department of Health and Human Services under Code of Federal Regulations, title 42, section 51c.303; or

(2) primarily serve people from communities of color or underrepresented communities.

Subd. 5. **Request for proposals.** The commissioner must publish a request for proposals in the State Register specifying provider eligibility requirements, criteria for a qualifying employee scholarship program, provider selection criteria, documentation required for program participation, the maximum award amount, and methods of evaluation. The commissioner must publish additional requests for proposals each year in which funding is available for this purpose.

Subd. 6. **Application requirements.** An eligible provider seeking a grant under this section must submit an application to the commissioner. An application must contain a complete description of the employee scholarship program being proposed by the applicant, including the need for the mental health provider to enhance the education of its workforce,

the process the mental health provider will use to determine which employees will be eligible for scholarships, any other money sources for scholarships, the amount of money sought for the scholarship program, a proposed budget detailing how money will be spent, and plans to retain eligible employees after completion of the education program.

Subd. 7. **Selection process.** The commissioner shall determine a maximum award amount for grants and shall select grant recipients based on the information provided in the grant application, including the demonstrated need for the applicant provider to enhance the education of its workforce, the proposed process to select employees for scholarships, the applicant's proposed budget, and other criteria as determined by the commissioner. The commissioner shall give preference to grant applicants who work in rural or culturally specific organizations.

Subd. 8. **Grant agreements.** Notwithstanding any law or rule to the contrary, grant money awarded to a grant recipient in a grant agreement does not lapse until the grant agreement expires.

Subd. 9. **Allowable uses of grant money.** A mental health provider receiving a grant under this section must use the grant money for one or more of the following:

(1) to provide employees with tuition reimbursement for a master's degree-level program in a discipline that will allow the employee to qualify as a mental health professional; or

(2) for resources and supports, such as child care and transportation, that allow an employee to attend a master's degree-level program specified in clause (1).

Subd. 10. **Reporting requirements.** A mental health provider receiving a grant under this section must submit an invoice for reimbursement and a report to the commissioner on a schedule determined by the commissioner and using a form supplied by the commissioner. The report must include the amount spent on scholarships; the number of employees who received scholarships; and, for each scholarship recipient, the recipient's name, current position, amount awarded, educational institution attended, name of the educational program, and expected or actual program completion date.

Sec. 16. Minnesota Statutes 2022, section 256.969, subdivision 2b, is amended to read:

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

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

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

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

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

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

(c) Effective for discharges occurring on and after November 1, 2014, payment rates for hospital inpatient services provided by hospitals located in Minnesota or the local trade area, except for the hospitals paid under the methodologies described in paragraph (a), clauses (2) and (3), shall be rebased, incorporating cost and payment methodologies in a manner similar to Medicare. The base year or years for the rates effective November 1, 2014, shall be calendar year 2012. The rebasing under this paragraph shall be budget neutral, ensuring that the total aggregate payments under the rebased system are equal to the total aggregate payments that were made for the same number and types of services in the base year. Separate budget neutrality calculations shall be determined for payments made to critical access hospitals and payments made to hospitals paid under the DRG system. Only the rate increases or decreases under subdivision 3a or 3c that applied to the hospitals being rebased during the entire base period shall be incorporated into the budget neutrality calculation.

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

(e) For discharges occurring on or after November 1, 2014, the commissioner may make additional adjustments to the rebased rates, and when evaluating whether additional

adjustments should be made, the commissioner shall consider the impact of the rates on the following:

(1) pediatric services;

(2) behavioral health services;

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

(4) transplant services;

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

(6) outlier admissions;

(7) low-volume providers; and

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

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

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

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

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

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

(g) The commissioner shall validate the rates effective November 1, 2014, by applying the rates established under paragraph (c), and any adjustments made to the rates under paragraph (d) or (e), to hospital claims paid in calendar year 2013 to determine whether the

total aggregate payments for the same number and types of services under the rebased rates are equal to the total aggregate payments made during calendar year 2013.

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

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

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

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

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

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

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

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

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

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

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

(6) geographic location.

(k) Effective for discharges occurring on or after January 1, 2024, the rates paid to hospitals described in paragraph (a), clauses (2) to (4), must include a rate factor specific to each hospital that qualifies for a medical education and research cost distribution under section 62J.692 subdivision 4, paragraph (a).

Sec. 17. Minnesota Statutes 2022, section 256B.75, is amended to read:

256B.75 HOSPITAL OUTPATIENT REIMBURSEMENT.

(a) For outpatient hospital facility fee payments for services rendered on or after October 1, 1992, the commissioner of human services shall pay the lower of (1) submitted charge, or (2) 32 percent above the rate in effect on June 30, 1992, except for those services for which there is a federal maximum allowable payment. Effective for services rendered on or after January 1, 2000, payment rates for nonsurgical outpatient hospital facility fees and emergency room facility fees shall be increased by eight percent over the rates in effect on

December 31, 1999, except for those services for which there is a federal maximum allowable payment. Services for which there is a federal maximum allowable payment shall be paid at the lower of (1) submitted charge, or (2) the federal maximum allowable payment. Total aggregate payment for outpatient hospital facility fee services shall not exceed the Medicare upper limit. If it is determined that a provision of this section conflicts with existing or future requirements of the United States government with respect to federal financial participation in medical assistance, the federal requirements prevail. The commissioner may, in the aggregate, prospectively reduce payment rates to avoid reduced federal financial participation resulting from rates that are in excess of the Medicare upper limitations.

(b) Notwithstanding paragraph (a), payment for outpatient, emergency, and ambulatory surgery hospital facility fee services for critical access hospitals designated under section 144.1483, clause (9), shall be paid on a cost-based payment system that is based on the cost-finding methods and allowable costs of the Medicare program. Effective for services provided on or after July 1, 2015, rates established for critical access hospitals under this paragraph for the applicable payment year shall be the final payment and shall not be settled to actual costs. Effective for services delivered on or after the first day of the hospital's fiscal year ending in 2017, the rate for outpatient hospital services shall be computed using information from each hospital's Medicare cost report as filed with Medicare for the year that is two years before the year that the rate is being computed. Rates shall be computed using information from Worksheet C series until the department finalizes the medical assistance cost reporting process for critical access hospitals. After the cost reporting process is finalized, rates shall be computed using information from Title XIX Worksheet D series. The outpatient rate shall be equal to ancillary cost plus outpatient cost, excluding costs related to rural health clinics and federally qualified health clinics, divided by ancillary charges plus outpatient charges, excluding charges related to rural health clinics and federally qualified health clinics. Effective for services delivered on or after January 1, 2024, the rates paid to critical access hospitals under this section must be adjusted to include the amount of any distributions under section 62J.692, subdivision 4, paragraph (a), that were not included in the rate adjustment described under section 256.969, subdivision 2b, paragraph (k).

(c) Effective for services provided on or after July 1, 2003, rates that are based on the Medicare outpatient prospective payment system shall be replaced by a budget neutral prospective payment system that is derived using medical assistance data. The commissioner shall provide a proposal to the 2003 legislature to define and implement this provision. When implementing prospective payment methodologies, the commissioner shall use general

methods and rate calculation parameters similar to the applicable Medicare prospective payment systems for services delivered in outpatient hospital and ambulatory surgical center settings unless other payment methodologies for these services are specified in this chapter.

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

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

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

Sec. 18. Minnesota Statutes 2022, section 297F.10, subdivision 1, is amended to read:

Subdivision 1. **Tax and use tax on cigarettes.** Revenue received from cigarette taxes, as well as related penalties, interest, license fees, and miscellaneous sources of revenue shall be deposited by the commissioner in the state treasury and credited as follows:

(1) $22,250,000 each year must be credited to the Academic Health Center special revenue fund hereby created and is annually appropriated to the Board of Regents at the University of Minnesota for Academic Health Center funding at the University of Minnesota; and

(2) ~~$3,937,000~~ $3,788,000 each year must be credited to the medical education and research costs account hereby created in the special revenue fund and is annually appropriated to the commissioner of health for distribution under section 62J.692, subdivision 4, paragraph (a); and

(3) the balance of the revenues derived from taxes, penalties, and interest (under this chapter) and from license fees and miscellaneous sources of revenue shall be credited to the general fund.

Sec. 19. **REPEALER.**

Minnesota Statutes 2022, sections 62J.692, subdivisions 4a, 7, and 7a; 137.38, subdivision 1; and 256B.69, subdivision 5c, are repealed.

ARTICLE 6
HEALTH LICENSING BOARDS

Section 1. Minnesota Statutes 2022, section 144E.001, subdivision 1, is amended to read:

Subdivision 1. **Scope.** For the purposes of ~~sections 144E.001 to 144E.52~~ this chapter, the terms defined in this section have the meanings given them.

Sec. 2. Minnesota Statutes 2022, section 144E.001, is amended by adding a subdivision to read:

Subd. 8b. **Medical resource communication center.** "Medical resource communication center" means an entity that:

(1) facilitates hospital-to-ambulance communications for ambulance services, the regional emergency medical services systems, and the board by coordinating patient care and transportation for ground and air operations;

(2) is integrated with the state's Allied Radio Matrix for Emergency Response (ARMER) radio system; and

(3) is the point of contact and a communication resource for statewide public safety entities, hospitals, and communities.

Sec. 3. Minnesota Statutes 2022, section 144E.35, is amended to read:

144E.35 REIMBURSEMENT TO ~~NONPROFIT~~ AMBULANCE SERVICES FOR VOLUNTEER EDUCATION COSTS.

Subdivision 1. **Repayment for volunteer education.** A licensed ambulance service shall be reimbursed by the board for the necessary expense of the initial education of a volunteer ambulance attendant upon successful completion by the attendant of an EMT education course, or a continuing education course for EMT care, or both, which has been approved by the board, pursuant to section 144E.285. Reimbursement may include tuition, transportation, food, lodging, hourly payment for the time spent in the education course, and other necessary expenditures, except that in no instance shall a volunteer ambulance attendant be reimbursed more than ~~$600~~ $900 for successful completion of an initial education course, and ~~$275~~ $375 for successful completion of a continuing education course.

Subd. 2. **Reimbursement provisions.** Reimbursement ~~will~~ must be paid under provisions of this section when documentation is provided the board that the individual has served for one year from the date of the final certification exam as an active member of a Minnesota licensed ambulance service.

Sec. 4. **[144E.53] MEDICAL RESOURCE COMMUNICATION CENTER GRANTS.**

The board shall distribute medical resource communication center grants annually on a contract basis to the two medical resource communication centers that were in operation in the state prior to January 1, 2000.

Sec. 5. **[148.635] FEE.**

The fee for verification of licensure is $20. The fee is nonrefundable.

Sec. 6. Minnesota Statutes 2022, section 148B.392, subdivision 2, is amended to read:

Subd. 2. **Licensure and application fees.** Licensure and application fees established by the board shall not exceed the following amounts:

(1) application fee for national examination is $110;

(2) application fee for Licensed Marriage and Family Therapist (LMFT) state examination is $110;

(3) initial LMFT license fee is prorated, but cannot exceed ~~$125~~ $225;

(4) annual renewal fee for LMFT license is $125;

(5) late fee for LMFT license renewal is $50;

(6) application fee for LMFT licensure by reciprocity is $220;

(7) fee for initial Licensed Associate Marriage and Family Therapist (LAMFT) license is $75;

(8) annual renewal fee for LAMFT license is $75;

(9) late fee for LAMFT renewal is $25;

(10) fee for reinstatement of license is $150;

(11) fee for emeritus status is $125; and

(12) fee for temporary license for members of the military is $100.

Sec. 7. Minnesota Statutes 2022, section 150A.08, subdivision 1, is amended to read:

Subdivision 1. **Grounds.** The board may refuse or by order suspend or revoke, limit or modify by imposing conditions it deems necessary, the license of a dentist, dental therapist, dental hygienist, or dental ~~assisting~~ assistant upon any of the following grounds:

(1) fraud or deception in connection with the practice of dentistry or the securing of a license certificate;

(2) conviction, including a finding or verdict of guilt, an admission of guilt, or a no contest plea, in any court of a felony or gross misdemeanor reasonably related to the practice of dentistry as evidenced by a certified copy of the conviction;

(3) conviction, including a finding or verdict of guilt, an admission of guilt, or a no contest plea, in any court of an offense involving moral turpitude as evidenced by a certified copy of the conviction;

(4) habitual overindulgence in the use of intoxicating liquors;

(5) improper or unauthorized prescription, dispensing, administering, or personal or other use of any legend drug as defined in chapter 151, of any chemical as defined in chapter 151, or of any controlled substance as defined in chapter 152;

(6) conduct unbecoming a person licensed to practice dentistry, dental therapy, dental hygiene, or dental assisting, or conduct contrary to the best interest of the public, as such conduct is defined by the rules of the board;

(7) gross immorality;

(8) any physical, mental, emotional, or other disability which adversely affects a dentist's, dental therapist's, dental hygienist's, or dental assistant's ability to perform the service for which the person is licensed;

(9) revocation or suspension of a license or equivalent authority to practice, or other disciplinary action or denial of a license application taken by a licensing or credentialing authority of another state, territory, or country as evidenced by a certified copy of the licensing authority's order, if the disciplinary action or application denial was based on facts that would provide a basis for disciplinary action under this chapter and if the action was taken only after affording the credentialed person or applicant notice and opportunity to refute the allegations or pursuant to stipulation or other agreement;

(10) failure to maintain adequate safety and sanitary conditions for a dental office in accordance with the standards established by the rules of the board;

(11) employing, assisting, or enabling in any manner an unlicensed person to practice dentistry;

(12) failure or refusal to attend, testify, and produce records as directed by the board under subdivision 7;

(13) violation of, or failure to comply with, any other provisions of sections 150A.01 to 150A.12, the rules of the Board of Dentistry, or any disciplinary order issued by the board, sections 144.291 to 144.298 or 595.02, subdivision 1, paragraph (d), or for any other just cause related to the practice of dentistry. Suspension, revocation, modification or limitation of any license shall not be based upon any judgment as to therapeutic or monetary value of any individual drug prescribed or any individual treatment rendered, but only upon a repeated pattern of conduct;

(14) knowingly providing false or misleading information that is directly related to the care of that patient unless done for an accepted therapeutic purpose such as the administration of a placebo; or

(15) aiding suicide or aiding attempted suicide in violation of section 609.215 as established by any of the following:

(i) a copy of the record of criminal conviction or plea of guilty for a felony in violation of section 609.215, subdivision 1 or 2;

(ii) a copy of the record of a judgment of contempt of court for violating an injunction issued under section 609.215, subdivision 4;

(iii) a copy of the record of a judgment assessing damages under section 609.215, subdivision 5; or

(iv) a finding by the board that the person violated section 609.215, subdivision 1 or 2. The board shall investigate any complaint of a violation of section 609.215, subdivision 1 or 2.

Sec. 8. Minnesota Statutes 2022, section 150A.08, subdivision 5, is amended to read:

Subd. 5. **Medical examinations.** If the board has probable cause to believe that a dentist, dental therapist, dental hygienist, dental assistant, or applicant engages in acts described in subdivision 1, clause (4) or (5), or has a condition described in subdivision 1, clause (8), it shall direct the dentist, dental therapist, dental hygienist, <u>dental</u> assistant, or applicant to submit to a mental or physical examination or a substance use disorder assessment. For the purpose of this subdivision, every dentist, dental therapist, dental hygienist, or dental assistant

licensed under this chapter or person submitting an application for a license is deemed to have given consent to submit to a mental or physical examination when directed in writing by the board and to have waived all objections in any proceeding under this section to the admissibility of the examining physician's testimony or examination reports on the ground that they constitute a privileged communication. Failure to submit to an examination without just cause may result in an application being denied or a default and final order being entered without the taking of testimony or presentation of evidence, other than evidence which may be submitted by affidavit, that the licensee or applicant did not submit to the examination. A dentist, dental therapist, dental hygienist, dental assistant, or applicant affected under this section shall at reasonable intervals be afforded an opportunity to demonstrate ability to start or resume the competent practice of dentistry or perform the duties of a dental therapist, dental hygienist, or dental assistant with reasonable skill and safety to patients. In any proceeding under this subdivision, neither the record of proceedings nor the orders entered by the board is admissible, is subject to subpoena, or may be used against the dentist, dental therapist, dental hygienist, dental assistant, or applicant in any proceeding not commenced by the board. Information obtained under this subdivision shall be classified as private pursuant to the Minnesota Government Data Practices Act.

Sec. 9. Minnesota Statutes 2022, section 150A.091, is amended by adding a subdivision to read:

Subd. 23. **Mailing list services.** Each licensee must submit a nonrefundable $5 fee to request a mailing address list.

Sec. 10. Minnesota Statutes 2022, section 150A.13, subdivision 10, is amended to read:

Subd. 10. **Failure to report.** ~~On or after August 1, 2012,~~ Any person, institution, insurer, or organization that fails to report as required under subdivisions 2 to 6 shall be subject to civil penalties for failing to report as required by law.

Sec. 11. Minnesota Statutes 2022, section 151.065, subdivision 1, is amended to read:

Subdivision 1. **Application fees.** Application fees for licensure and registration are as follows:

(1) pharmacist licensed by examination, ~~$175~~ $225;

(2) pharmacist licensed by reciprocity, ~~$275~~ $300;

(3) pharmacy intern, $50;

(4) pharmacy technician, $50;

(5) pharmacy, ~~$260~~ $450;

(6) drug wholesaler, legend drugs only, ~~$5,260~~ $5,500;

(7) drug wholesaler, legend and nonlegend drugs, ~~$5,260~~ $5,500;

(8) drug wholesaler, nonlegend drugs, veterinary legend drugs, or both, ~~$5,260~~ $5,500;

(9) drug wholesaler, medical gases, ~~$5,260~~ $5,500 for the first facility and ~~$260~~ $500 for each additional facility;

(10) third-party logistics provider, $260;

(11) drug manufacturer, nonopiate legend drugs only, ~~$5,260~~ $5,500;

(12) drug manufacturer, nonopiate legend and nonlegend drugs, ~~$5,260~~ $5,500;

(13) drug manufacturer, nonlegend or veterinary legend drugs, ~~$5,260~~ $5,500;

(14) drug manufacturer, medical gases, ~~$5,260~~ $5,500 for the first facility and ~~$260~~ $500 for each additional facility;

(15) drug manufacturer, also licensed as a pharmacy in Minnesota, ~~$5,260~~ $5,500;

(16) drug manufacturer of opiate-containing controlled substances listed in section 152.02, subdivisions 3 to 5, ~~$55,260~~ $55,500;

(17) medical gas dispenser, ~~$260~~ $400;

(18) controlled substance researcher, $75; and

(19) pharmacy professional corporation, $150.

Sec. 12. Minnesota Statutes 2022, section 151.065, subdivision 2, is amended to read:

Subd. 2. **Original license fee.** The pharmacist original licensure fee, ~~$175~~ $225.

Sec. 13. Minnesota Statutes 2022, section 151.065, subdivision 3, is amended to read:

Subd. 3. **Annual renewal fees.** Annual licensure and registration renewal fees are as follows:

(1) pharmacist, ~~$175~~ $225;

(2) pharmacy technician, $50;

(3) pharmacy, ~~$260~~ $450;

(4) drug wholesaler, legend drugs only, ~~$5,260~~ $5,500;

(5) drug wholesaler, legend and nonlegend drugs, ~~$5,260~~ $5,500;

(6) drug wholesaler, nonlegend drugs, veterinary legend drugs, or both, ~~$5,260~~ $5,500;

(7) drug wholesaler, medical gases, ~~$5,260~~ $5,500 for the first facility and ~~$260~~ $500 for each additional facility;

(8) third-party logistics provider, $260;

(9) drug manufacturer, nonopiate legend drugs only, ~~$5,260~~ $5,500;

(10) drug manufacturer, nonopiate legend and nonlegend drugs, ~~$5,260~~ $5,500;

(11) drug manufacturer, nonlegend, veterinary legend drugs, or both, ~~$5,260~~ $5,500;

(12) drug manufacturer, medical gases, ~~$5,260~~ $5,500 for the first facility and ~~$260~~ $500 for each additional facility;

(13) drug manufacturer, also licensed as a pharmacy in Minnesota, ~~$5,260~~ $5,500;

(14) drug manufacturer of opiate-containing controlled substances listed in section 152.02, subdivisions 3 to 5, ~~$55,260~~ $55,500;

(15) medical gas dispenser, ~~$260~~ $400;

(16) controlled substance researcher, $75; and

(17) pharmacy professional corporation, $100.

Sec. 14. Minnesota Statutes 2022, section 151.065, subdivision 4, is amended to read:

Subd. 4. **Miscellaneous fees.** Fees for issuance of affidavits and duplicate licenses and certificates are as follows:

(1) intern affidavit, ~~$20~~ $30;

(2) duplicate small license, ~~$20~~ $30; and

(3) duplicate large certificate, $30.

Sec. 15. Minnesota Statutes 2022, section 151.065, subdivision 6, is amended to read:

Subd. 6. **Reinstatement fees.** (a) A pharmacist who has allowed the pharmacist's license to lapse may reinstate the license with board approval and upon payment of any fees and late fees in arrears, up to a maximum of $1,000.

(b) A pharmacy technician who has allowed the technician's registration to lapse may reinstate the registration with board approval and upon payment of any fees and late fees in arrears, up to a maximum of ~~$90~~ $250.

(c) An owner of a pharmacy, a drug wholesaler, a drug manufacturer, third-party logistics provider, or a medical gas dispenser who has allowed the license of the establishment to lapse may reinstate the license with board approval and upon payment of any fees and late fees in arrears.

(d) A controlled substance researcher who has allowed the researcher's registration to lapse may reinstate the registration with board approval and upon payment of any fees and late fees in arrears.

(e) A pharmacist owner of a professional corporation who has allowed the corporation's registration to lapse may reinstate the registration with board approval and upon payment of any fees and late fees in arrears.

Sec. 16. Minnesota Statutes 2022, section 151.555, is amended to read:

151.555 ~~PRESCRIPTION DRUG~~ MEDICATION REPOSITORY PROGRAM.

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

(b) "Central repository" means a wholesale distributor that meets the requirements under subdivision 3 and enters into a contract with the Board of Pharmacy in accordance with this section.

(c) "Distribute" means to deliver, other than by administering or dispensing.

(d) "Donor" means:

(1) a health care facility as defined in this subdivision;

(2) a skilled nursing facility licensed under chapter 144A;

(3) an assisted living facility licensed under chapter 144G;

(4) a pharmacy licensed under section 151.19, and located either in the state or outside the state;

(5) a drug wholesaler licensed under section 151.47;

(6) a drug manufacturer licensed under section 151.252; or

(7) an individual at least 18 years of age, provided that the drug or medical supply that is donated was obtained legally and meets the requirements of this section for donation.

(e) "Drug" means any prescription drug that has been approved for medical use in the United States, is listed in the United States Pharmacopoeia or National Formulary, and meets the criteria established under this section for donation; or any over-the-counter medication that meets the criteria established under this section for donation. This definition includes cancer drugs and antirejection drugs, but does not include controlled substances, as defined in section 152.01, subdivision 4, or a prescription drug that can only be dispensed to a patient registered with the drug's manufacturer in accordance with federal Food and Drug Administration requirements.

(f) "Health care facility" means:

(1) a physician's office or health care clinic where licensed practitioners provide health care to patients;

(2) a hospital licensed under section 144.50;

(3) a pharmacy licensed under section 151.19 and located in Minnesota; or

(4) a nonprofit community clinic, including a federally qualified health center; a rural health clinic; public health clinic; or other community clinic that provides health care utilizing a sliding fee scale to patients who are low-income, uninsured, or underinsured.

(g) "Local repository" means a health care facility that elects to accept donated drugs and medical supplies and meets the requirements of subdivision 4.

(h) "Medical supplies" or "supplies" means any prescription ~~and~~ or nonprescription medical supplies needed to administer a ~~prescription~~ drug.

(i) "Original, sealed, unopened, tamper-evident packaging" means packaging that is sealed, unopened, and tamper-evident, including a manufacturer's original unit dose or unit-of-use container, a repackager's original unit dose or unit-of-use container, or unit-dose packaging prepared by a licensed pharmacy according to the standards of Minnesota Rules, part 6800.3750.

(j) "Practitioner" has the meaning given in section 151.01, subdivision 23, except that it does not include a veterinarian.

Subd. 2. **Establishment; contract and oversight.** ~~By January 1, 2020,~~ (a) The Board of Pharmacy shall establish a ~~drug~~ medication repository program, through which donors

may donate a drug or medical supply for use by an individual who meets the eligibility criteria specified under subdivision 5.

(b) The board shall contract with a central repository that meets the requirements of subdivision 3 to implement and administer the ~~prescription drug~~ medication repository program. The contract must:

(1) require payment by the board to the central repository any amount appropriated by the legislature for the operation and administration of the medication repository program;

(2) require the central repository to report the following performance measures to the board:

(i) the number of individuals served and the types of medications these individuals received;

(ii) the number of clinics, pharmacies, and long-term care facilities with which the central repository partnered;

(iii) the number and cost of medications accepted for inventory, disposed of, and dispensed to individuals in need; and

(iv) locations within the state to which medications were shipped or delivered; and

(3) require the board to annually audit the expenditure by the central repository of any money appropriated by the legislature and paid under a contract by the board to ensure that the amount appropriated is used only for purposes specified in the contract.

Subd. 3. **Central repository requirements.** (a) The board may publish a request for proposal for participants who meet the requirements of this subdivision and are interested in acting as the central repository for the ~~drug~~ medication repository program. If the board publishes a request for proposal, it shall follow all applicable state procurement procedures in the selection process. The board may also work directly with the University of Minnesota to establish a central repository.

(b) To be eligible to act as the central repository, the participant must be a wholesale drug distributor located in Minnesota, licensed pursuant to section 151.47, and in compliance with all applicable federal and state statutes, rules, and regulations.

(c) The central repository shall be subject to inspection by the board pursuant to section 151.06, subdivision 1.

(d) The central repository shall comply with all applicable federal and state laws, rules, and regulations pertaining to the ~~drug~~ medication repository program, drug storage, and

dispensing. The facility must maintain in good standing any state license or registration that applies to the facility.

Subd. 4. **Local repository requirements.** (a) To be eligible for participation in the ~~drug~~ medication repository program, a health care facility must agree to comply with all applicable federal and state laws, rules, and regulations pertaining to the ~~drug~~ medication repository program, drug storage, and dispensing. The facility must also agree to maintain in good standing any required state license or registration that may apply to the facility.

(b) A local repository may elect to participate in the program by submitting the following information to the central repository on a form developed by the board and made available on the board's website:

(1) the name, street address, and telephone number of the health care facility and any state-issued license or registration number issued to the facility, including the issuing state agency;

(2) the name and telephone number of a responsible pharmacist or practitioner who is employed by or under contract with the health care facility; and

(3) a statement signed and dated by the responsible pharmacist or practitioner indicating that the health care facility meets the eligibility requirements under this section and agrees to comply with this section.

(c) Participation in the ~~drug~~ medication repository program is voluntary. A local repository may withdraw from participation in the ~~drug~~ medication repository program at any time by providing written notice to the central repository on a form developed by the board and made available on the board's website. The central repository shall provide the board with a copy of the withdrawal notice within ten business days from the date of receipt of the withdrawal notice.

Subd. 5. **Individual eligibility and application requirements.** (a) To be eligible for the ~~drug~~ medication repository program, an individual must submit to a local repository an intake application form that is signed by the individual and attests that the individual:

(1) is a resident of Minnesota;

(2) is uninsured and is not enrolled in the medical assistance program under chapter 256B or the MinnesotaCare program under chapter 256L, has no prescription drug coverage, or is underinsured;

(3) acknowledges that the drugs or medical supplies to be received through the program may have been donated; and

(4) consents to a waiver of the child-resistant packaging requirements of the federal Poison Prevention Packaging Act.

(b) Upon determining that an individual is eligible for the program, the local repository shall furnish the individual with an identification card. The card shall be valid for one year from the date of issuance and may be used at any local repository. A new identification card may be issued upon expiration once the individual submits a new application form.

(c) The local repository shall send a copy of the intake application form to the central repository by regular mail, facsimile, or secured email within ten days from the date the application is approved by the local repository.

(d) The board shall develop and make available on the board's website an application form and the format for the identification card.

Subd. 6. **Standards and procedures for accepting donations of drugs and supplies.** (a) A donor may donate ~~prescription~~ drugs or medical supplies to the central repository or a local repository if the drug or supply meets the requirements of this section as determined by a pharmacist or practitioner who is employed by or under contract with the central repository or a local repository.

(b) A ~~prescription~~ drug is eligible for donation under the ~~drug~~ medication repository program if the following requirements are met:

(1) the donation is accompanied by a ~~drug~~ medication repository donor form described under paragraph (d) that is signed by an individual who is authorized by the donor to attest to the donor's knowledge in accordance with paragraph (d);

(2) the drug's expiration date is at least six months after the date the drug was donated. If a donated drug bears an expiration date that is less than six months from the donation date, the drug may be accepted and distributed if the drug is in high demand and can be dispensed for use by a patient before the drug's expiration date;

(3) the drug is in its original, sealed, unopened, tamper-evident packaging that includes the expiration date. Single-unit-dose drugs may be accepted if the single-unit-dose packaging is unopened;

(4) the drug or the packaging does not have any physical signs of tampering, misbranding, deterioration, compromised integrity, or adulteration;

(5) the drug does not require storage temperatures other than normal room temperature as specified by the manufacturer or United States Pharmacopoeia, unless the drug is being

donated directly by its manufacturer, a wholesale drug distributor, or a pharmacy located in Minnesota; and

(6) the ~~prescription~~ drug is not a controlled substance.

(c) A medical supply is eligible for donation under the ~~drug~~ medication repository program if the following requirements are met:

(1) the supply has no physical signs of tampering, misbranding, or alteration and there is no reason to believe it has been adulterated, tampered with, or misbranded;

(2) the supply is in its original, unopened, sealed packaging;

(3) the donation is accompanied by a ~~drug~~ medication repository donor form described under paragraph (d) that is signed by an individual who is authorized by the donor to attest to the donor's knowledge in accordance with paragraph (d); and

(4) if the supply bears an expiration date, the date is at least six months later than the date the supply was donated. If the donated supply bears an expiration date that is less than six months from the date the supply was donated, the supply may be accepted and distributed if the supply is in high demand and can be dispensed for use by a patient before the supply's expiration date.

(d) The board shall develop the ~~drug~~ medication repository donor form and make it available on the board's website. The form must state that to the best of the donor's knowledge the donated drug or supply has been properly stored under appropriate temperature and humidity conditions and that the drug or supply has never been opened, used, tampered with, adulterated, or misbranded.

(e) Donated drugs and supplies may be shipped or delivered to the premises of the central repository or a local repository, and shall be inspected by a pharmacist or an authorized practitioner who is employed by or under contract with the repository and who has been designated by the repository to accept donations. A drop box must not be used to deliver or accept donations.

(f) The central repository and local repository shall inventory all drugs and supplies donated to the repository. For each drug, the inventory must include the drug's name, strength, quantity, manufacturer, expiration date, and the date the drug was donated. For each medical supply, the inventory must include a description of the supply, its manufacturer, the date the supply was donated, and, if applicable, the supply's brand name and expiration date.

Subd. 7. **Standards and procedures for inspecting and storing donated ~~prescription~~ drugs and supplies.** (a) A pharmacist or authorized practitioner who is employed by or

under contract with the central repository or a local repository shall inspect all donated ~~prescription~~ drugs and supplies before the drug or supply is dispensed to determine, to the extent reasonably possible in the professional judgment of the pharmacist or practitioner, that the drug or supply is not adulterated or misbranded, has not been tampered with, is safe and suitable for dispensing, has not been subject to a recall, and meets the requirements for donation. The pharmacist or practitioner who inspects the drugs or supplies shall sign an inspection record stating that the requirements for donation have been met. If a local repository receives drugs and supplies from the central repository, the local repository does not need to reinspect the drugs and supplies.

(b) The central repository and local repositories shall store donated drugs and supplies in a secure storage area under environmental conditions appropriate for the drug or supply being stored. Donated drugs and supplies may not be stored with nondonated inventory.

(c) The central repository and local repositories shall dispose of all ~~prescription~~ drugs and medical supplies that are not suitable for donation in compliance with applicable federal and state statutes, regulations, and rules concerning hazardous waste.

(d) In the event that controlled substances or ~~prescription~~ drugs that can only be dispensed to a patient registered with the drug's manufacturer are shipped or delivered to a central or local repository for donation, the shipment delivery must be documented by the repository and returned immediately to the donor or the donor's representative that provided the drugs.

(e) Each repository must develop drug and medical supply recall policies and procedures. If a repository receives a recall notification, the repository shall destroy all of the drug or medical supply in its inventory that is the subject of the recall and complete a record of destruction form in accordance with paragraph (f). If a drug or medical supply that is the subject of a Class I or Class II recall has been dispensed, the repository shall immediately notify the recipient of the recalled drug or medical supply. A drug that potentially is subject to a recall need not be destroyed if its packaging bears a lot number and that lot of the drug is not subject to the recall. If no lot number is on the drug's packaging, it must be destroyed.

(f) A record of destruction of donated drugs and supplies that are not dispensed under subdivision 8, are subject to a recall under paragraph (e), or are not suitable for donation shall be maintained by the repository for at least two years. For each drug or supply destroyed, the record shall include the following information:

(1) the date of destruction;

(2) the name, strength, and quantity of the drug destroyed; and

(3) the name of the person or firm that destroyed the drug.

Subd. 8. **Dispensing requirements.** (a) Donated drugs and supplies may be dispensed if the drugs or supplies are prescribed by a practitioner for use by an eligible individual and are dispensed by a pharmacist or practitioner. A repository shall dispense drugs and supplies to eligible individuals in the following priority order: (1) individuals who are uninsured; (2) individuals with no prescription drug coverage; and (3) individuals who are underinsured. A repository shall dispense donated ~~prescription~~ drugs in compliance with applicable federal and state laws and regulations for dispensing ~~prescription~~ drugs, including all requirements relating to packaging, labeling, record keeping, drug utilization review, and patient counseling.

(b) Before dispensing or administering a drug or supply, the pharmacist or practitioner shall visually inspect the drug or supply for adulteration, misbranding, tampering, and date of expiration. Drugs or supplies that have expired or appear upon visual inspection to be adulterated, misbranded, or tampered with in any way must not be dispensed or administered.

(c) Before a drug or supply is dispensed or administered to an individual, the individual must sign a drug repository recipient form acknowledging that the individual understands the information stated on the form. The board shall develop the form and make it available on the board's website. The form must include the following information:

(1) that the drug or supply being dispensed or administered has been donated and may have been previously dispensed;

(2) that a visual inspection has been conducted by the pharmacist or practitioner to ensure that the drug or supply has not expired, has not been adulterated or misbranded, and is in its original, unopened packaging; and

(3) that the dispensing pharmacist, the dispensing or administering practitioner, the central repository or local repository, the Board of Pharmacy, and any other participant of the ~~drug~~ medication repository program cannot guarantee the safety of the drug or medical supply being dispensed or administered and that the pharmacist or practitioner has determined that the drug or supply is safe to dispense or administer based on the accuracy of the donor's form submitted with the donated drug or medical supply and the visual inspection required to be performed by the pharmacist or practitioner before dispensing or administering.

Subd. 9. **Handling fees.** (a) The central or local repository may charge the individual receiving a drug or supply a handling fee of no more than 250 percent of the medical assistance program dispensing fee for each drug or medical supply dispensed or administered by that repository.

(b) A repository that dispenses or administers a drug or medical supply through the ~~drug~~ medication repository program shall not receive reimbursement under the medical assistance program or the MinnesotaCare program for that dispensed or administered drug or supply.

Subd. 10. **Distribution of donated drugs and supplies.** (a) The central repository and local repositories may distribute drugs and supplies donated under the ~~drug~~ medication repository program to other participating repositories for use pursuant to this program.

(b) A local repository that elects not to dispense donated drugs or supplies must transfer all donated drugs and supplies to the central repository. A copy of the donor form that was completed by the original donor under subdivision 6 must be provided to the central repository at the time of transfer.

Subd. 11. **Forms and record-keeping requirements.** (a) The following forms developed for the administration of this program shall be utilized by the participants of the program and shall be available on the board's website:

(1) intake application form described under subdivision 5;

(2) local repository participation form described under subdivision 4;

(3) local repository withdrawal form described under subdivision 4;

(4) ~~drug~~ medication repository donor form described under subdivision 6;

(5) record of destruction form described under subdivision 7; and

(6) ~~drug~~ medication repository recipient form described under subdivision 8.

(b) All records, including drug inventory, inspection, and disposal of donated ~~prescription~~ drugs and medical supplies, must be maintained by a repository for a minimum of two years. Records required as part of this program must be maintained pursuant to all applicable practice acts.

(c) Data collected by the ~~drug~~ medication repository program from all local repositories shall be submitted quarterly or upon request to the central repository. Data collected may consist of the information, records, and forms required to be collected under this section.

(d) The central repository shall submit reports to the board as required by the contract or upon request of the board.

Subd. 12. **Liability.** (a) The manufacturer of a drug or supply is not subject to criminal or civil liability for injury, death, or loss to a person or to property for causes of action described in clauses (1) and (2). A manufacturer is not liable for:

(1) the intentional or unintentional alteration of the drug or supply by a party not under the control of the manufacturer; or

(2) the failure of a party not under the control of the manufacturer to transfer or communicate product or consumer information or the expiration date of the donated drug or supply.

(b) A health care facility participating in the program, a pharmacist dispensing a drug or supply pursuant to the program, a practitioner dispensing or administering a drug or supply pursuant to the program, or a donor of a drug or medical supply is immune from civil liability for an act or omission that causes injury to or the death of an individual to whom the drug or supply is dispensed and no disciplinary action by a health-related licensing board shall be taken against a pharmacist or practitioner so long as the drug or supply is donated, accepted, distributed, and dispensed according to the requirements of this section. This immunity does not apply if the act or omission involves reckless, wanton, or intentional misconduct, or malpractice unrelated to the quality of the drug or medical supply.

Subd. 13. **Drug returned for credit.** Nothing in this section allows a long-term care facility to donate a drug to a central or local repository when federal or state law requires the drug to be returned to the pharmacy that initially dispensed it, so that the pharmacy can credit the payer for the amount of the drug returned.

Subd. 14. **Cooperation.** The central repository, as approved by the Board of Pharmacy, may enter into an agreement with another state that has an established drug repository or drug donation program if the other state's program includes regulations to ensure the purity, integrity, and safety of the drugs and supplies donated, to permit the central repository to offer to another state program inventory that is not needed by a Minnesota resident and to accept inventory from another state program to be distributed to local repositories and dispensed to Minnesota residents in accordance with this program.

Subd. 15. **Funding.** The central repository may seek grants and other money from nonprofit charitable organizations, the federal government, and other sources to fund the ongoing operations of the medication repository program.

Sec. 17. Minnesota Statutes 2022, section 151.74, subdivision 3, is amended to read:

Subd. 3. **Access to urgent-need insulin.** (a) MNsure shall develop an application form to be used by an individual who is in urgent need of insulin. The application must ask the individual to attest to the eligibility requirements described in subdivision 2. The form shall be accessible through MNsure's website. MNsure shall also make the form available to

pharmacies and health care providers who prescribe or dispense insulin, hospital emergency departments, urgent care clinics, and community health clinics. By submitting a completed, signed, and dated application to a pharmacy, the individual attests that the information contained in the application is correct.

(b) If the individual is in urgent need of insulin, the individual may present a completed, signed, and dated application form to a pharmacy. The individual must also:

(1) have a valid insulin prescription; and

(2) present the pharmacist with identification indicating Minnesota residency in the form of a valid Minnesota identification card, driver's license or permit, individual taxpayer identification number, or Tribal identification card as defined in section 171.072, paragraph (b). If the individual in urgent need of insulin is under the age of 18, the individual's parent or legal guardian must provide the pharmacist with proof of residency.

(c) Upon receipt of a completed and signed application, the pharmacist shall dispense the prescribed insulin in an amount that will provide the individual with a 30-day supply. The pharmacy must notify the health care practitioner who issued the prescription order no later than 72 hours after the insulin is dispensed.

(d) The pharmacy may submit to the manufacturer of the dispensed insulin product or to the manufacturer's vendor a claim for payment that is in accordance with the National Council for Prescription Drug Program standards for electronic claims processing, unless the manufacturer agrees to send to the pharmacy a replacement supply of the same insulin as dispensed in the amount dispensed. If the pharmacy submits an electronic claim to the manufacturer or the manufacturer's vendor, the manufacturer or vendor shall reimburse the pharmacy in an amount that covers the pharmacy's acquisition cost.

(e) The pharmacy may collect an insulin co-payment from the individual to cover the pharmacy's costs of processing and dispensing in an amount not to exceed $35 for the 30-day supply of insulin dispensed.

(f) The pharmacy shall also provide each eligible individual with the information sheet described in subdivision 7 and a list of trained navigators provided by the Board of Pharmacy for the individual to contact if the individual is in need of accessing ongoing insulin coverage options, including assistance in:

(1) applying for medical assistance or MinnesotaCare;

(2) applying for a qualified health plan offered through MNsure, subject to open and special enrollment periods;

(3) accessing information on providers who participate in prescription drug discount programs, including providers who are authorized to participate in the 340B program under section 340b of the federal Public Health Services Act, United States Code, title 42, section 256b; and

(4) accessing insulin manufacturers' patient assistance programs, co-payment assistance programs, and other foundation-based programs.

(g) The pharmacist shall retain a copy of the application form submitted by the individual to the pharmacy for reporting and auditing purposes.

Sec. 18. Minnesota Statutes 2022, section 151.74, subdivision 4, is amended to read:

Subd. 4. **Continuing safety net program; general.** (a) Each manufacturer shall make a patient assistance program available to any individual who meets the requirements of this subdivision. Each manufacturer's patient assistance programs must meet the requirements of this section. Each manufacturer shall provide the Board of Pharmacy with information regarding the manufacturer's patient assistance program, including contact information for individuals to call for assistance in accessing their patient assistance program.

(b) To be eligible to participate in a manufacturer's patient assistance program, the individual must:

(1) be a Minnesota resident with a valid Minnesota identification card that indicates Minnesota residency in the form of a Minnesota identification card, driver's license or permit, individual taxpayer identification number, or Tribal identification card as defined in section 171.072, paragraph (b). If the individual is under the age of 18, the individual's parent or legal guardian must provide proof of residency;

(2) have a family income that is equal to or less than 400 percent of the federal poverty guidelines;

(3) not be enrolled in medical assistance or MinnesotaCare;

(4) not be eligible to receive health care through a federally funded program or receive prescription drug benefits through the Department of Veterans Affairs; and

(5) not be enrolled in prescription drug coverage through an individual or group health plan that limits the total amount of cost-sharing that an enrollee is required to pay for a 30-day supply of insulin, including co-payments, deductibles, or coinsurance to $75 or less, regardless of the type or amount of insulin needed.

(c) Notwithstanding the requirement in paragraph (b), clause (4), an individual who is enrolled in Medicare Part D is eligible for a manufacturer's patient assistance program if the individual has spent $1,000 on prescription drugs in the current calendar year and meets the eligibility requirements in paragraph (b), clauses (1) to (3).

(d) An individual who is interested in participating in a manufacturer's patient assistance program may apply directly to the manufacturer; apply through the individual's health care practitioner, if the practitioner participates; or contact a trained navigator for assistance in finding a long-term insulin supply solution, including assistance in applying to a manufacturer's patient assistance program.

Sec. 19. Minnesota Statutes 2022, section 152.126, subdivision 4, is amended to read:

Subd. 4. **Reporting requirements; notice.** (a) Each dispenser must submit the following data to the board or its designated vendor:

(1) name of the prescriber;

(2) national provider identifier of the prescriber;

(3) name of the dispenser;

(4) national provider identifier of the dispenser;

(5) prescription number;

(6) name of the patient for whom the prescription was written;

(7) address of the patient for whom the prescription was written;

(8) date of birth of the patient for whom the prescription was written;

(9) date the prescription was written;

(10) date the prescription was filled;

(11) name and strength of the controlled substance;

(12) quantity of controlled substance prescribed;

(13) quantity of controlled substance dispensed; and

(14) number of days supply.

(b) The dispenser must submit the required information by a procedure and in a format established by the board. The board may allow dispensers to omit data listed in this subdivision or may require the submission of data not listed in this subdivision provided the omission or submission is necessary for the purpose of complying with the electronic

reporting or data transmission standards of the American Society for Automation in Pharmacy, the National Council on Prescription Drug Programs, or other relevant national standard-setting body.

(c) A dispenser is not required to submit this data for those controlled substance prescriptions dispensed for:

(1) individuals residing in a health care facility as defined in section 151.58, subdivision 2, paragraph (b), when a drug is distributed through the use of an automated drug distribution system according to section 151.58; ~~and~~

(2) individuals receiving a drug sample that was packaged by a manufacturer and provided to the dispenser for dispensing as a professional sample pursuant to Code of Federal Regulations, title 21, part 203, subpart D~~.~~; and

(3) individuals whose prescriptions are being mailed, shipped, or delivered from Minnesota to another state, so long as the data are reported to the prescription drug monitoring program of that state.

(d) A dispenser must provide notice to the patient for whom the prescription was written ~~a conspicuous notice~~, or to that patient's authorized representative, of the reporting requirements of this section and notice that the information may be used for program administration purposes.

(e) The dispenser must submit the required information within the timeframe specified by the board; if no reportable prescriptions are dispensed or sold on any day, a report indicating that fact must be filed with the board.

(f) The dispenser must submit accurate information to the database and must correct errors identified during the submission process within seven calendar days.

(g) For the purposes of this paragraph, the term "subject of the data" means the individual reported as being the patient, the practitioner reported as being the prescriber, the client when an animal is reported as being the patient, or an authorized agent of these individuals. The dispenser must correct errors brought to its attention by the subject of the data within seven calendar days, unless the dispenser verifies that an error did not occur and the data were correctly submitted. The dispenser must notify the subject of the data that either the error was corrected or that no error occurred.

Sec. 20. Minnesota Statutes 2022, section 152.126, subdivision 5, is amended to read:

Subd. 5. **Use of data by board.** (a) The board shall develop and maintain a database of the data reported under subdivision 4. The board shall maintain data that could identify an individual prescriber or dispenser in encrypted form. Except as otherwise allowed under subdivision 6, the database may be used by permissible users identified under subdivision 6 for the identification of:

(1) individuals receiving prescriptions for controlled substances from prescribers who subsequently obtain controlled substances from dispensers in quantities or with a frequency inconsistent with generally recognized standards of use for those controlled substances, including standards accepted by national and international pain management associations; and

(2) individuals presenting forged or otherwise false or altered prescriptions for controlled substances to dispensers.

(b) No permissible user identified under subdivision 6 may access the database for the sole purpose of identifying prescribers of controlled substances for unusual or excessive prescribing patterns without a valid search warrant or court order.

(c) No personnel of a state or federal occupational licensing board or agency may access the database for the purpose of obtaining information to be used to initiate a disciplinary action against a prescriber.

(d) Data reported under subdivision 4 shall be made available to permissible users for a 12-month period beginning the day the data was received and ending 12 months from the last day of the month in which the data was received, except that permissible users defined in subdivision 6, paragraph (b), clauses ~~(6)~~ (7) and ~~(7)~~ (8), may use all data collected under this section for the purposes of administering, operating, and maintaining the prescription monitoring program and conducting trend analyses and other studies necessary to evaluate the effectiveness of the program.

(e) Data reported during the period January 1, 2015, through December 31, 2018, may be retained through December 31, 2019, in an identifiable manner. Effective January 1, 2020, data older than 24 months must be destroyed. Data reported for prescriptions dispensed on or after January 1, 2020, must be destroyed no later than 12 months from the date the ~~data~~ prescription was ~~received~~ reported as dispensed.

Sec. 21. Minnesota Statutes 2022, section 152.126, subdivision 6, is amended to read:

Subd. 6. **Access to reporting system data.** (a) Except as indicated in this subdivision, the data submitted to the board under subdivision 4 is private data on individuals as defined in section 13.02, subdivision 12, and not subject to public disclosure.

(b) Except as specified in subdivision 5, the following persons shall be considered permissible users and may access the data submitted under subdivision 4 in the same or similar manner, and for the same or similar purposes, as those persons who are authorized to access similar private data on individuals under federal and state law:

(1) a prescriber or an agent or employee of the prescriber to whom the prescriber has delegated the task of accessing the data, to the extent the information relates specifically to a current patient, to whom the prescriber is:

(i) prescribing or considering prescribing any controlled substance;

(ii) providing emergency medical treatment for which access to the data may be necessary;

(iii) providing care, and the prescriber has reason to believe, based on clinically valid indications, that the patient is potentially abusing a controlled substance; or

(iv) providing other medical treatment for which access to the data may be necessary for a clinically valid purpose and the patient has consented to access to the submitted data, and with the provision that the prescriber remains responsible for the use or misuse of data accessed by a delegated agent or employee;

(2) a dispenser or an agent or employee of the dispenser to whom the dispenser has delegated the task of accessing the data, to the extent the information relates specifically to a current patient to whom that dispenser is dispensing or considering dispensing any controlled substance and with the provision that the dispenser remains responsible for the use or misuse of data accessed by a delegated agent or employee;

(3) a licensed dispensing practitioner or licensed pharmacist to the extent necessary to determine whether corrections made to the data reported under subdivision 4 are accurate;

(4) a licensed pharmacist who is providing pharmaceutical care for which access to the data may be necessary to the extent that the information relates specifically to a current patient for whom the pharmacist is providing pharmaceutical care: (i) if the patient has consented to access to the submitted data; or (ii) if the pharmacist is consulted by a prescriber who is requesting data in accordance with clause (1);

~~(4)~~ (5) an individual who is the recipient of a controlled substance prescription for which data was submitted under subdivision 4, or a guardian of the individual, parent or guardian of a minor, or health care agent of the individual acting under a health care directive under chapter 145C. For purposes of this clause, access by individuals includes persons in the definition of an individual under section 13.02;

~~(5)~~ (6) personnel or designees of a health-related licensing board listed in section 214.01, subdivision 2, or of the Emergency Medical Services Regulatory Board, assigned to conduct a bona fide investigation of a complaint received by that board that alleges that a specific licensee is impaired by use of a drug for which data is collected under subdivision 4, has engaged in activity that would constitute a crime as defined in section 152.025, or has engaged in the behavior specified in subdivision 5, paragraph (a);

~~(6)~~ (7) personnel of the board engaged in the collection, review, and analysis of controlled substance prescription information as part of the assigned duties and responsibilities under this section;

~~(7)~~ (8) authorized personnel ~~of a vendor~~ under contract with the board, or under contract with the state of Minnesota and approved by the board, who are engaged in the design, evaluation, implementation, operation, ~~and~~ or maintenance of the prescription monitoring program as part of the assigned duties and responsibilities of their employment, provided that access to data is limited to the minimum amount necessary to carry out such duties and responsibilities, and subject to the requirement of de-identification and time limit on retention of data specified in subdivision 5, paragraphs (d) and (e);

~~(8)~~ (9) federal, state, and local law enforcement authorities acting pursuant to a valid search warrant;

~~(9)~~ (10) personnel of the Minnesota health care programs assigned to use the data collected under this section to identify and manage recipients whose usage of controlled substances may warrant restriction to a single primary care provider, a single outpatient pharmacy, and a single hospital;

~~(10)~~ (11) personnel of the Department of Human Services assigned to access the data pursuant to paragraph (k);

~~(11)~~ (12) personnel of the health professionals services program established under section 214.31, to the extent that the information relates specifically to an individual who is currently enrolled in and being monitored by the program, and the individual consents to access to that information. The health professionals services program personnel shall not provide this

data to a health-related licensing board or the Emergency Medical Services Regulatory Board, except as permitted under section 214.33, subdivision 3; ~~and~~

~~(12)~~ (13) personnel or designees of a health-related licensing board other than the Board of Pharmacy listed in section 214.01, subdivision 2, assigned to conduct a bona fide investigation of a complaint received by that board that alleges that a specific licensee is inappropriately prescribing controlled substances as defined in this section. For the purposes of this clause, the health-related licensing board may also obtain utilization data; and

(14) personnel of the board specifically assigned to conduct a bona fide investigation of a specific licensee or registrant. For the purposes of this clause, the board may also obtain utilization data.

(c) By July 1, 2017, every prescriber licensed by a health-related licensing board listed in section 214.01, subdivision 2, practicing within this state who is authorized to prescribe controlled substances for humans and who holds a current registration issued by the federal Drug Enforcement Administration, and every pharmacist licensed by the board and practicing within the state, shall register and maintain a user account with the prescription monitoring program. Data submitted by a prescriber, pharmacist, or their delegate during the registration application process, other than their name, license number, and license type, is classified as private pursuant to section 13.02, subdivision 12.

(d) Notwithstanding paragraph (b), beginning January 1, 2021, a prescriber or an agent or employee of the prescriber to whom the prescriber has delegated the task of accessing the data, must access the data submitted under subdivision 4 to the extent the information relates specifically to the patient:

(1) before the prescriber issues an initial prescription order for a Schedules II through IV opiate controlled substance to the patient; and

(2) at least once every three months for patients receiving an opiate for treatment of chronic pain or participating in medically assisted treatment for an opioid addiction.

(e) Paragraph (d) does not apply if:

(1) the patient is receiving palliative care, or hospice or other end-of-life care;

(2) the patient is being treated for pain due to cancer or the treatment of cancer;

(3) the prescription order is for a number of doses that is intended to last the patient five days or less and is not subject to a refill;

(4) the prescriber and patient have a current or ongoing provider/patient relationship of a duration longer than one year;

(5) the prescription order is issued within 14 days following surgery or three days following oral surgery or follows the prescribing protocols established under the opioid prescribing improvement program under section 256B.0638;

(6) the controlled substance is prescribed or administered to a patient who is admitted to an inpatient hospital;

(7) the controlled substance is lawfully administered by injection, ingestion, or any other means to the patient by the prescriber, a pharmacist, or by the patient at the direction of a prescriber and in the presence of the prescriber or pharmacist;

(8) due to a medical emergency, it is not possible for the prescriber to review the data before the prescriber issues the prescription order for the patient; or

(9) the prescriber is unable to access the data due to operational or other technological failure of the program so long as the prescriber reports the failure to the board.

(f) Only permissible users identified in paragraph (b), clauses (1), (2), (3), ~~(6)~~ (4), (7), ~~(9), and~~ (8), (10), and (11), may directly access the data electronically. No other permissible users may directly access the data electronically. If the data is directly accessed electronically, the permissible user shall implement and maintain a comprehensive information security program that contains administrative, technical, and physical safeguards that are appropriate to the user's size and complexity, and the sensitivity of the personal information obtained. The permissible user shall identify reasonably foreseeable internal and external risks to the security, confidentiality, and integrity of personal information that could result in the unauthorized disclosure, misuse, or other compromise of the information and assess the sufficiency of any safeguards in place to control the risks.

(g) The board shall not release data submitted under subdivision 4 unless it is provided with evidence, satisfactory to the board, that the person requesting the information is entitled to receive the data.

(h) The board shall maintain a log of all persons who access the data for a period of at least three years and shall ensure that any permissible user complies with paragraph (c) prior to attaining direct access to the data.

(i) Section 13.05, subdivision 6, shall apply to any contract the board enters into pursuant to subdivision 2. A vendor shall not use data collected under this section for any purpose not specified in this section.

(j) The board may participate in an interstate prescription monitoring program data exchange system provided that permissible users in other states have access to the data only as allowed under this section, and that section 13.05, subdivision 6, applies to any contract or memorandum of understanding that the board enters into under this paragraph.

(k) With available appropriations, the commissioner of human services shall establish and implement a system through which the Department of Human Services shall routinely access the data for the purpose of determining whether any client enrolled in an opioid treatment program licensed according to chapter 245A has been prescribed or dispensed a controlled substance in addition to that administered or dispensed by the opioid treatment program. When the commissioner determines there have been multiple prescribers or multiple prescriptions of controlled substances, the commissioner shall:

(1) inform the medical director of the opioid treatment program only that the commissioner determined the existence of multiple prescribers or multiple prescriptions of controlled substances; and

(2) direct the medical director of the opioid treatment program to access the data directly, review the effect of the multiple prescribers or multiple prescriptions, and document the review.

If determined necessary, the commissioner of human services shall seek a federal waiver of, or exception to, any applicable provision of Code of Federal Regulations, title 42, section 2.34, paragraph (c), prior to implementing this paragraph.

(l) The board shall review the data submitted under subdivision 4 on at least a quarterly basis and shall establish criteria, in consultation with the advisory task force, for referring information about a patient to prescribers and dispensers who prescribed or dispensed the prescriptions in question if the criteria are met.

(m) The board shall conduct random audits, on at least a quarterly basis, of electronic access by permissible users, as identified in paragraph (b), clauses (1), (2), (3), ~~(6)~~ (4), (7), ~~(9), and~~ (8), (10), and (11), to the data in subdivision 4, to ensure compliance with permissible use as defined in this section. A permissible user whose account has been selected for a random audit shall respond to an inquiry by the board, no later than 30 days after receipt of notice that an audit is being conducted. Failure to respond may result in deactivation of access to the electronic system and referral to the appropriate health licensing board, or the commissioner of human services, for further action. The board shall report the results of random audits to the chairs and ranking minority members of the legislative committees

with jurisdiction over health and human services policy and finance and government data practices.

(n) A permissible user who has delegated the task of accessing the data in subdivision 4 to an agent or employee shall audit the use of the electronic system by delegated agents or employees on at least a quarterly basis to ensure compliance with permissible use as defined in this section. When a delegated agent or employee has been identified as inappropriately accessing data, the permissible user must immediately remove access for that individual and notify the board within seven days. The board shall notify all permissible users associated with the delegated agent or employee of the alleged violation.

(o) A permissible user who delegates access to the data submitted under subdivision 4 to an agent or employee shall terminate that individual's access to the data within three business days of the agent or employee leaving employment with the permissible user. The board may conduct random audits to determine compliance with this requirement.

Sec. 22. Minnesota Statutes 2022, section 152.126, subdivision 9, is amended to read:

Subd. 9. **Immunity from liability~~; no requirement to obtain information~~.** (a) A pharmacist, prescriber, or other dispenser making a report to the program in good faith under this section is immune from any civil, criminal, or administrative liability, which might otherwise be incurred or imposed as a result of the report~~, or on the basis that the pharmacist or prescriber did or did not seek or obtain or use information from the program~~.

(b) Except as required by subdivision 6, paragraph (d), nothing in this section shall require a pharmacist, prescriber, or other dispenser to obtain information about a patient from the program, and the pharmacist, prescriber, or other dispenser, if acting in good faith, is immune from any civil, criminal, or administrative liability that might otherwise be incurred or imposed for requesting, receiving, or using information from the program.

Sec. 23. **LICENSED TRADITIONAL MIDWIVES; AUTHORITY TO PURCHASE CERTAIN DRUGS.**

By November 15, 2023, the Minnesota Board of Medical Practice, in consultation with the Advisory Council on Licensed Traditional Midwifery, must:

(1) issue an administrative order to allow licensed traditional midwives to purchase drugs listed in Minnesota Statutes, section 147D.09, paragraph (b); or

(2) make recommendations to the chairs and ranking minority members of the legislative committees with jurisdiction on health finance and policy on how to amend Minnesota

Statutes, section 147D.09, or other statutes to allow licensed traditional midwives to purchase drugs listed in Minnesota Statutes, section 147D.09, paragraph (b).

ARTICLE 7
BACKGROUND STUDIES

Section 1. Minnesota Statutes 2022, section 13.46, subdivision 4, is amended to read:

Subd. 4. **Licensing data.** (a) As used in this subdivision:

(1) "licensing data" are all data collected, maintained, used, or disseminated by the welfare system pertaining to persons licensed or registered or who apply for licensure or registration or who formerly were licensed or registered under the authority of the commissioner of human services;

(2) "client" means a person who is receiving services from a licensee or from an applicant for licensure; and

(3) "personal and personal financial data" are Social Security numbers, identity of and letters of reference, insurance information, reports from the Bureau of Criminal Apprehension, health examination reports, and social/home studies.

(b)(1)(i) Except as provided in paragraph (c), the following data on applicants, license holders, and former licensees are public: name, address, telephone number of licensees, date of receipt of a completed application, dates of licensure, licensed capacity, type of client preferred, variances granted, record of training and education in child care and child development, type of dwelling, name and relationship of other family members, previous license history, class of license, the existence and status of complaints, and the number of serious injuries to or deaths of individuals in the licensed program as reported to the commissioner of human services, the local social services agency, or any other county welfare agency. For purposes of this clause, a serious injury is one that is treated by a physician.

(ii) Except as provided in item (v), when a correction order, an order to forfeit a fine, an order of license suspension, an order of temporary immediate suspension, an order of license revocation, an order of license denial, or an order of conditional license has been issued, or a complaint is resolved, the following data on current and former licensees and applicants are public: the general nature of the complaint or allegations leading to the temporary immediate suspension; the substance and investigative findings of the licensing or maltreatment complaint, licensing violation, or substantiated maltreatment; the existence of settlement negotiations; the record of informal resolution of a licensing violation; orders

of hearing; findings of fact; conclusions of law; specifications of the final correction order, fine, suspension, temporary immediate suspension, revocation, denial, or conditional license contained in the record of licensing action; whether a fine has been paid; and the status of any appeal of these actions.

(iii) When a license denial under section 245A.05 or a sanction under section 245A.07 is based on a determination that a license holder, applicant, or controlling individual is responsible for maltreatment under section 626.557 or chapter 260E, the identity of the applicant, license holder, or controlling individual as the individual responsible for maltreatment is public data at the time of the issuance of the license denial or sanction.

(iv) When a license denial under section 245A.05 or a sanction under section 245A.07 is based on a determination that a license holder, applicant, or controlling individual is disqualified under chapter 245C, the identity of the license holder, applicant, or controlling individual as the disqualified individual ~~and the reason for the disqualification are~~ is public data at the time of the issuance of the licensing sanction or denial. If the applicant, license holder, or controlling individual requests reconsideration of the disqualification and the disqualification is affirmed, the reason for the disqualification and the reason to not set aside the disqualification are ~~public~~ private data.

(v) A correction order or fine issued to a child care provider for a licensing violation is private data on individuals under section 13.02, subdivision 12, or nonpublic data under section 13.02, subdivision 9, if the correction order or fine is seven years old or older.

(2) For applicants who withdraw their application prior to licensure or denial of a license, the following data are public: the name of the applicant, the city and county in which the applicant was seeking licensure, the dates of the commissioner's receipt of the initial application and completed application, the type of license sought, and the date of withdrawal of the application.

(3) For applicants who are denied a license, the following data are public: the name and address of the applicant, the city and county in which the applicant was seeking licensure, the dates of the commissioner's receipt of the initial application and completed application, the type of license sought, the date of denial of the application, the nature of the basis for the denial, the existence of settlement negotiations, the record of informal resolution of a denial, orders of hearings, findings of fact, conclusions of law, specifications of the final order of denial, and the status of any appeal of the denial.

(4) When maltreatment is substantiated under section 626.557 or chapter 260E and the victim and the substantiated perpetrator are affiliated with a program licensed under chapter

245A, the commissioner of human services, local social services agency, or county welfare agency may inform the license holder where the maltreatment occurred of the identity of the substantiated perpetrator and the victim.

(5) Notwithstanding clause (1), for child foster care, only the name of the license holder and the status of the license are public if the county attorney has requested that data otherwise classified as public data under clause (1) be considered private data based on the best interests of a child in placement in a licensed program.

(c) The following are private data on individuals under section 13.02, subdivision 12, or nonpublic data under section 13.02, subdivision 9: personal and personal financial data on family day care program and family foster care program applicants and licensees and their family members who provide services under the license.

(d) The following are private data on individuals: the identity of persons who have made reports concerning licensees or applicants that appear in inactive investigative data, and the records of clients or employees of the licensee or applicant for licensure whose records are received by the licensing agency for purposes of review or in anticipation of a contested matter. The names of reporters of complaints or alleged violations of licensing standards under chapters 245A, 245B, 245C, and 245D, and applicable rules and alleged maltreatment under section 626.557 and chapter 260E, are confidential data and may be disclosed only as provided in section 260E.21, subdivision 4; 260E.35; or 626.557, subdivision 12b.

(e) Data classified as private, confidential, nonpublic, or protected nonpublic under this subdivision become public data if submitted to a court or administrative law judge as part of a disciplinary proceeding in which there is a public hearing concerning a license which has been suspended, immediately suspended, revoked, or denied.

(f) Data generated in the course of licensing investigations that relate to an alleged violation of law are investigative data under subdivision 3.

(g) Data that are not public data collected, maintained, used, or disseminated under this subdivision that relate to or are derived from a report as defined in section 260E.03, or 626.5572, subdivision 18, are subject to the destruction provisions of sections 260E.35, subdivision 6, and 626.557, subdivision 12b.

(h) Upon request, not public data collected, maintained, used, or disseminated under this subdivision that relate to or are derived from a report of substantiated maltreatment as defined in section 626.557 or chapter 260E may be exchanged with the Department of Health for purposes of completing background studies pursuant to section 144.057 and with

the Department of Corrections for purposes of completing background studies pursuant to section 241.021.

(i) Data on individuals collected according to licensing activities under chapters 245A and 245C, data on individuals collected by the commissioner of human services according to investigations under section 626.557 and chapters 245A, 245B, 245C, 245D, and 260E may be shared with the Department of Human Rights, the Department of Health, the Department of Corrections, the ombudsman for mental health and developmental disabilities, and the individual's professional regulatory board when there is reason to believe that laws or standards under the jurisdiction of those agencies may have been violated or the information may otherwise be relevant to the board's regulatory jurisdiction. Background study data on an individual who is the subject of a background study under chapter 245C for a licensed service for which the commissioner of human services is the license holder may be shared with the commissioner and the commissioner's delegate by the licensing division. Unless otherwise specified in this chapter, the identity of a reporter of alleged maltreatment or licensing violations may not be disclosed.

(j) In addition to the notice of determinations required under sections 260E.24, subdivisions 5 and 7, and 260E.30, subdivision 6, paragraphs (b), (c), (d), (e), and (f), if the commissioner or the local social services agency has determined that an individual is a substantiated perpetrator of maltreatment of a child based on sexual abuse, as defined in section 260E.03, and the commissioner or local social services agency knows that the individual is a person responsible for a child's care in another facility, the commissioner or local social services agency shall notify the head of that facility of this determination. The notification must include an explanation of the individual's available appeal rights and the status of any appeal. If a notice is given under this paragraph, the government entity making the notification shall provide a copy of the notice to the individual who is the subject of the notice.

(k) All not public data collected, maintained, used, or disseminated under this subdivision and subdivision 3 may be exchanged between the Department of Human Services, Licensing Division, and the Department of Corrections for purposes of regulating services for which the Department of Human Services and the Department of Corrections have regulatory authority.

Sec. 2. Minnesota Statutes 2022, section 245C.02, subdivision 13e, is amended to read:

Subd. 13e. **NETStudy 2.0.** "NETStudy 2.0" means the commissioner's system that replaces both NETStudy and the department's internal background study processing system.

NETStudy 2.0 is designed to enhance protection of children and vulnerable adults by improving the accuracy of background studies through fingerprint-based criminal record checks and expanding the background studies to include a review of information from the Minnesota Court Information System and the national crime information database. NETStudy 2.0 is also designed to increase efficiencies in and the speed of the hiring process by:

(1) providing access to and updates from public web-based data related to employment eligibility;

(2) decreasing the need for repeat studies through electronic updates of background study subjects' criminal records;

(3) supporting identity verification using subjects' Social Security numbers and photographs;

(4) using electronic employer notifications; ~~and~~

(5) issuing immediate verification of subjects' eligibility to provide services as more studies are completed under the NETStudy 2.0 system~~.~~; and

(6) providing electronic access to certain notices for entities and background study subjects.

Sec. 3. Minnesota Statutes 2022, section 245C.04, subdivision 1, is amended to read:

Subdivision 1. **Licensed programs; other child care programs.** (a) The commissioner shall conduct a background study of an individual required to be studied under section 245C.03, subdivision 1, at least upon application for initial license for all license types.

(b) The commissioner shall conduct a background study of an individual required to be studied under section 245C.03, subdivision 1, including a child care background study subject as defined in section 245C.02, subdivision 6a, in a family child care program, licensed child care center, certified license-exempt child care center, or legal nonlicensed child care provider, on a schedule determined by the commissioner. Except as provided in section 245C.05, subdivision 5a, a child care background study must include submission of fingerprints for a national criminal history record check and a review of the information under section 245C.08. A background study for a child care program must be repeated within five years from the most recent study conducted under this paragraph.

(c) At reauthorization or when a new background study is needed under section 119B.125, subdivision 1a, for a legal nonlicensed child care provider authorized under chapter 119B, the individual shall provide information required under section 245C.05, subdivision 1,

paragraphs (a), (b), and (d), to the commissioner and be fingerprinted and photographed under section 245C.05, subdivision 5. The commissioner shall verify the information received under this paragraph and submit the request in NETStudy 2.0 to complete the background study.

~~(c)~~ (d) At reapplication for a family child care license:

(1) for a background study affiliated with a licensed family child care center ~~or legal nonlicensed child care provider~~, the individual shall provide information required under section 245C.05, subdivision 1, paragraphs (a), (b), and (d), to the county agency, and be fingerprinted and photographed under section 245C.05, subdivision 5;

(2) the county agency shall verify the information received under clause (1) and forward the information to the commissioner and submit the request in NETStudy 2.0 to complete the background study; and

(3) the background study conducted by the commissioner under this paragraph must include a review of the information required under section 245C.08.

~~(d)~~ (e) The commissioner is not required to conduct a study of an individual at the time of reapplication for a license if the individual's background study was completed by the commissioner of human services and the following conditions are met:

(1) a study of the individual was conducted either at the time of initial licensure or when the individual became affiliated with the license holder;

(2) the individual has been continuously affiliated with the license holder since the last study was conducted; and

(3) the last study of the individual was conducted on or after October 1, 1995.

~~(e)~~ (f) The commissioner of human services shall conduct a background study of an individual specified under section 245C.03, subdivision 1, paragraph (a), clauses (2) to (6), who is newly affiliated with a child foster family setting license holder:

(1) the county or private agency shall collect and forward to the commissioner the information required under section 245C.05, subdivisions 1 and 5, when the child foster family setting applicant or license holder resides in the home where child foster care services are provided; and

(2) the background study conducted by the commissioner of human services under this paragraph must include a review of the information required under section 245C.08, subdivisions 1, 3, and 4.

~~(f)~~ (g) The commissioner shall conduct a background study of an individual specified under section 245C.03, subdivision 1, paragraph (a), clauses (2) to (6), who is newly affiliated with an adult foster care or family adult day services and with a family child care license holder or a legal nonlicensed child care provider authorized under chapter 119B and:

(1) except as provided in section 245C.05, subdivision 5a, the county shall collect and forward to the commissioner the information required under section 245C.05, subdivision 1, paragraphs (a) and (b), and subdivision 5, paragraph (b), for background studies conducted by the commissioner for all family adult day services, for adult foster care when the adult foster care license holder resides in the adult foster care residence, and for family child care and legal nonlicensed child care authorized under chapter 119B;

(2) the license holder shall collect and forward to the commissioner the information required under section 245C.05, subdivisions 1, paragraphs (a) and (b); and 5, paragraphs (a) and (b), for background studies conducted by the commissioner for adult foster care when the license holder does not reside in the adult foster care residence; and

(3) the background study conducted by the commissioner under this paragraph must include a review of the information required under section 245C.08, subdivision 1, paragraph (a), and subdivisions 3 and 4.

~~(g)~~ (h) Applicants for licensure, license holders, and other entities as provided in this chapter must submit completed background study requests to the commissioner using the electronic system known as NETStudy before individuals specified in section 245C.03, subdivision 1, begin positions allowing direct contact in any licensed program.

~~(h)~~ (i) For an individual who is not on the entity's active roster, the entity must initiate a new background study through NETStudy when:

(1) an individual returns to a position requiring a background study following an absence of 120 or more consecutive days; or

(2) a program that discontinued providing licensed direct contact services for 120 or more consecutive days begins to provide direct contact licensed services again.

The license holder shall maintain a copy of the notification provided to the commissioner under this paragraph in the program's files. If the individual's disqualification was previously set aside for the license holder's program and the new background study results in no new information that indicates the individual may pose a risk of harm to persons receiving services from the license holder, the previous set-aside shall remain in effect.

~~(i)~~ (j) For purposes of this section, a physician licensed under chapter 147, advanced practice registered nurse licensed under chapter 148, or physician assistant licensed under chapter 147A is considered to be continuously affiliated upon the license holder's receipt from the commissioner of health or human services of the physician's, advanced practice registered nurse's, or physician assistant's background study results.

~~(j)~~ (k) For purposes of family child care, a substitute caregiver must receive repeat background studies at the time of each license renewal.

~~(k)~~ (l) A repeat background study at the time of license renewal is not required if the family child care substitute caregiver's background study was completed by the commissioner on or after October 1, 2017, and the substitute caregiver is on the license holder's active roster in NETStudy 2.0.

~~(l)~~ (m) Before and after school programs authorized under chapter 119B, are exempt from the background study requirements under section 123B.03, for an employee for whom a background study under this chapter has been completed.

EFFECTIVE DATE. This section is effective April 28, 2025.

Sec. 4. Minnesota Statutes 2022, section 245C.05, subdivision 1, is amended to read:

Subdivision 1. **Individual studied.** (a) The individual who is the subject of the background study must provide the applicant, license holder, or other entity under section 245C.04 with sufficient information to ensure an accurate study, including:

(1) the individual's first, middle, and last name and all other names by which the individual has been known;

(2) current home address, city, and state of residence;

(3) current zip code;

(4) sex;

(5) date of birth;

(6) driver's license number or state identification number; and

(7) upon implementation of NETStudy 2.0, the home address, city, county, and state of residence for the past five years.

(b) Every subject of a background study conducted or initiated by counties or private agencies under this chapter must also provide the home address, city, county, and state of residence for the past five years.

(c) Every subject of a background study related to private agency adoptions or related to child foster care licensed through a private agency, who is 18 years of age or older, shall also provide the commissioner a signed consent for the release of any information received from national crime information databases to the private agency that initiated the background study.

(d) The subject of a background study shall provide fingerprints and a photograph as required in subdivision 5.

(e) The subject of a background study shall submit a completed criminal and maltreatment history records check consent form for applicable national and state level record checks.

(f) A background study subject who has access to the NETStudy 2.0 applicant portal must provide updated contact information to the commissioner via NETStudy 2.0 any time the subject's personal information changes for as long as they remain affiliated on any roster.

(g) An entity must update contact information in NETStudy 2.0 for a background study subject on the entity's roster any time the entity receives new contact information from the study subject.

Sec. 5. Minnesota Statutes 2022, section 245C.05, subdivision 2c, is amended to read:

Subd. 2c. **Privacy notice to background study subject.** (a) Prior to initiating each background study, the entity initiating the study must provide the commissioner's privacy notice to the background study subject required under section 13.04, subdivision 2. The notice must be available through the commissioner's electronic NETStudy and NETStudy 2.0 systems and shall include the information in paragraphs (b) and (c).

(b) The background study subject shall be informed that any previous background studies that received a set-aside will be reviewed, and without further contact with the background study subject, the commissioner may notify the agency that initiated the subsequent background study~~:~~

~~(1)~~ that the individual has a disqualification that has been set aside for the program or agency that initiated the study~~;~~.

~~(2) the reason for the disqualification; and~~

~~(3) that information about the decision to set aside the disqualification will be available to the license holder upon request without the consent of the background study subject.~~

(c) The background study subject must also be informed that:

(1) the subject's fingerprints collected for purposes of completing the background study under this chapter must not be retained by the Department of Public Safety, Bureau of Criminal Apprehension, or by the commissioner. The Federal Bureau of Investigation will not retain background study subjects' fingerprints;

(2) effective upon implementation of NETStudy 2.0, the subject's photographic image will be retained by the commissioner, and if the subject has provided the subject's Social Security number for purposes of the background study, the photographic image will be available to prospective employers and agencies initiating background studies under this chapter to verify the identity of the subject of the background study;

(3) the authorized fingerprint collection vendor or vendors shall, for purposes of verifying the identity of the background study subject, be able to view the identifying information entered into NETStudy 2.0 by the entity that initiated the background study, but shall not retain the subject's fingerprints, photograph, or information from NETStudy 2.0. The authorized fingerprint collection vendor or vendors shall retain no more than the subject's name and the date and time the subject's fingerprints were recorded and sent, only as necessary for auditing and billing activities;

(4) the commissioner shall provide the subject notice, as required in section 245C.17, subdivision 1, paragraph (a), when an entity initiates a background study on the individual;

(5) the subject may request in writing a report listing the entities that initiated a background study on the individual as provided in section 245C.17, subdivision 1, paragraph (b);

(6) the subject may request in writing that information used to complete the individual's background study in NETStudy 2.0 be destroyed if the requirements of section 245C.051, paragraph (a), are met; and

(7) notwithstanding clause (6), the commissioner shall destroy:

(i) the subject's photograph after a period of two years when the requirements of section 245C.051, paragraph (c), are met; and

(ii) any data collected on a subject under this chapter after a period of two years following the individual's death as provided in section 245C.051, paragraph (d).

Sec. 6. Minnesota Statutes 2022, section 245C.05, subdivision 4, is amended to read:

Subd. 4. **Electronic transmission.** (a) For background studies conducted by the Department of Human Services, the commissioner shall implement a secure system for the electronic transmission of:

(1) background study information to the commissioner;

(2) background study results to the license holder;

(3) background study information obtained under this section and section 245C.08 to counties and private agencies for background studies conducted by the commissioner for child foster care, including a summary of nondisqualifying results, except as prohibited by law; and

(4) background study results to county agencies for background studies conducted by the commissioner for adult foster care and family adult day services and, upon implementation of NETStudy 2.0, family child care ~~and legal nonlicensed child care authorized under chapter 119B~~.

(b) Unless the commissioner has granted a hardship variance under paragraph (c), a license holder or an applicant must use the electronic transmission system known as NETStudy or NETStudy 2.0 to submit all requests for background studies to the commissioner as required by this chapter.

(c) A license holder or applicant whose program is located in an area in which high-speed Internet is inaccessible may request the commissioner to grant a variance to the electronic transmission requirement.

(d) Section 245C.08, subdivision 3, paragraph (c), applies to results transmitted under this subdivision.

(e) The background study subject shall access background study-related documents electronically in the applicant portal. A background study subject may request for the commissioner to grant a variance to the requirement to access documents electronically in the NETStudy 2.0 applicant portal and may also request paper documentation of their background studies.

EFFECTIVE DATE. The amendments to paragraph (a), clause (4), are effective April 28, 2025.

Sec. 7. Minnesota Statutes 2022, section 245C.10, subdivision 2, is amended to read:

Subd. 2. **Supplemental nursing services agencies.** The commissioner shall recover the cost of the background studies initiated by supplemental nursing services agencies registered under section 144A.71, subdivision 1, through a fee of no more than ~~$42~~ $44 per study charged to the agency. The fees collected under this subdivision are appropriated to the commissioner for the purpose of conducting background studies.

Sec. 8. Minnesota Statutes 2022, section 245C.10, subdivision 3, is amended to read:

Subd. 3. **Personal care provider organizations.** The commissioner shall recover the cost of background studies initiated by a personal care provider organization under sections 256B.0651 to 256B.0654 and 256B.0659 through a fee of no more than ~~$42~~ $44 per study charged to the organization responsible for submitting the background study form. The fees collected under this subdivision are appropriated to the commissioner for the purpose of conducting background studies.

Sec. 9. Minnesota Statutes 2022, section 245C.10, subdivision 4, is amended to read:

Subd. 4. **Temporary personnel agencies, educational programs, and professional services agencies.** The commissioner shall recover the cost of the background studies initiated by temporary personnel agencies, educational programs, and professional services agencies that initiate background studies under section 245C.03, subdivision 4, through a fee of no more than ~~$42~~ $44 per study charged to the agency. The fees collected under this subdivision are appropriated to the commissioner for the purpose of conducting background studies.

Sec. 10. Minnesota Statutes 2022, section 245C.10, subdivision 5, is amended to read:

Subd. 5. **Adult foster care and family adult day services.** The commissioner shall recover the cost of background studies required under section 245C.03, subdivision 1, for the purposes of adult foster care and family adult day services licensing, through a fee of no more than ~~$42~~ $44 per study charged to the license holder. The fees collected under this subdivision are appropriated to the commissioner for the purpose of conducting background studies.

Sec. 11. Minnesota Statutes 2022, section 245C.10, subdivision 6, is amended to read:

Subd. 6. **Unlicensed home and community-based waiver providers of service to seniors and individuals with disabilities.** The commissioner shall recover the cost of

background studies initiated by unlicensed home and community-based waiver providers of service to seniors and individuals with disabilities under section 256B.4912 through a fee of no more than ~~$42~~ $44 per study.

Sec. 12. Minnesota Statutes 2022, section 245C.10, subdivision 8, is amended to read:

Subd. 8. **Children's therapeutic services and supports providers.** The commissioner shall recover the cost of background studies required under section 245C.03, subdivision 7, for the purposes of children's therapeutic services and supports under section 256B.0943, through a fee of no more than ~~$42~~ $44 per study charged to the license holder. The fees collected under this subdivision are appropriated to the commissioner for the purpose of conducting background studies.

Sec. 13. Minnesota Statutes 2022, section 245C.10, subdivision 9, is amended to read:

Subd. 9. **Human services licensed programs.** The commissioner shall recover the cost of background studies required under section 245C.03, subdivision 1, for all programs that are licensed by the commissioner, except child foster care when the applicant or license holder resides in the home where child foster care services are provided, family child care, child care centers, certified license-exempt child care centers, and legal nonlicensed child care authorized under chapter 119B, through a fee of no more than ~~$42~~ $44 per study charged to the license holder. The fees collected under this subdivision are appropriated to the commissioner for the purpose of conducting background studies.

Sec. 14. Minnesota Statutes 2022, section 245C.10, subdivision 9a, is amended to read:

Subd. 9a. **Child care programs.** The commissioner shall recover the cost of a background study required for family child care, certified license-exempt child care centers, licensed child care centers, and legal nonlicensed child care providers authorized under chapter 119B through a fee of no more than ~~$40~~ $44 per study charged to the license holder. A fee of no more than ~~$42~~ $44 per study shall be charged for studies conducted under section 245C.05, subdivision 5a, paragraph (a). The fees collected under this subdivision are appropriated to the commissioner to conduct background studies.

Sec. 15. Minnesota Statutes 2022, section 245C.10, subdivision 10, is amended to read:

Subd. 10. **Community first services and supports organizations.** The commissioner shall recover the cost of background studies initiated by an agency-provider delivering services under section 256B.85, subdivision 11, or a financial management services provider

providing service functions under section 256B.85, subdivision 13, through a fee of no more than ~~$42~~ $44 per study, charged to the organization responsible for submitting the background study form. The fees collected under this subdivision are appropriated to the commissioner for the purpose of conducting background studies.

Sec. 16. Minnesota Statutes 2022, section 245C.10, subdivision 11, is amended to read:

Subd. 11. **Providers of housing support.** The commissioner shall recover the cost of background studies initiated by providers of housing support under section 256I.04 through a fee of no more than ~~$42~~ $44 per study. The fees collected under this subdivision are appropriated to the commissioner for the purpose of conducting background studies.

Sec. 17. Minnesota Statutes 2022, section 245C.10, subdivision 12, is amended to read:

Subd. 12. **Child protection workers or social services staff having responsibility for child protective duties.** The commissioner shall recover the cost of background studies initiated by county social services agencies and local welfare agencies for individuals who are required to have a background study under section 260E.36, subdivision 3, through a fee of no more than ~~$42~~ $44 per study. The fees collected under this subdivision are appropriated to the commissioner for the purpose of conducting background studies.

Sec. 18. Minnesota Statutes 2022, section 245C.10, subdivision 13, is amended to read:

Subd. 13. **Providers of special transportation service.** The commissioner shall recover the cost of background studies initiated by providers of special transportation service under section 174.30 through a fee of no more than ~~$42~~ $44 per study. The fees collected under this subdivision are appropriated to the commissioner for the purpose of conducting background studies.

Sec. 19. Minnesota Statutes 2022, section 245C.10, subdivision 14, is amended to read:

Subd. 14. **Children's residential facilities.** The commissioner shall recover the cost of background studies initiated by a licensed children's residential facility through a fee of no more than ~~$51~~ $53 per study. Fees collected under this subdivision are appropriated to the commissioner for purposes of conducting background studies.

Sec. 20. Minnesota Statutes 2022, section 245C.10, subdivision 16, is amended to read:

Subd. 16. **Providers of housing support services.** The commissioner shall recover the cost of background studies initiated by providers of housing support services under section

256B.051 through a fee of no more than ~~$42~~ $44 per study. The fees collected under this subdivision are appropriated to the commissioner for the purpose of conducting background studies.

Sec. 21. Minnesota Statutes 2022, section 245C.10, subdivision 17, is amended to read:

Subd. 17. **Early intensive developmental and behavioral intervention providers.** The commissioner shall recover the cost of background studies required under section 245C.03, subdivision 15, for the purposes of early intensive developmental and behavioral intervention under section 256B.0949, through a fee of no more than ~~$42~~ $44 per study charged to the enrolled agency. The fees collected under this subdivision are appropriated to the commissioner for the purpose of conducting background studies.

Sec. 22. Minnesota Statutes 2022, section 245C.10, subdivision 20, is amended to read:

Subd. 20. **Professional Educators Licensing Standards Board.** The commissioner shall recover the cost of background studies initiated by the Professional Educators Licensing Standards Board through a fee of no more than ~~$51~~ $53 per study. Fees collected under this subdivision are appropriated to the commissioner for purposes of conducting background studies.

Sec. 23. Minnesota Statutes 2022, section 245C.10, subdivision 21, is amended to read:

Subd. 21. **Board of School Administrators.** The commissioner shall recover the cost of background studies initiated by the Board of School Administrators through a fee of no more than ~~$51~~ $53 per study. Fees collected under this subdivision are appropriated to the commissioner for purposes of conducting background studies.

Sec. 24. Minnesota Statutes 2022, section 245C.10, is amended by adding a subdivision to read:

Subd. 22. **Tribal organizations.** The commissioner shall recover the cost of background studies initiated by Tribal organizations under section 245C.34 for adoption and child foster care. The fee amount shall be established through interagency agreements between the commissioner and Tribal organizations or their designees. The fees collected under this subdivision shall be deposited in the special revenue fund and are appropriated to the commissioner for the purpose of conducting background studies and criminal background checks. This change shall go into effect July 1, 2024.

Sec. 25. Minnesota Statutes 2022, section 245C.17, subdivision 2, is amended to read:

Subd. 2. **Disqualification notice sent to subject.** (a) If the information in the study indicates the individual is disqualified from direct contact with, or from access to, persons served by the program, the commissioner shall disclose to the individual studied:

(1) the information causing disqualification;

(2) instructions on how to request a reconsideration of the disqualification;

(3) an explanation of any restrictions on the commissioner's discretion to set aside the disqualification under section 245C.24, when applicable to the individual;

~~(4) a statement that, if the individual's disqualification is set aside under section 245C.22, the applicant, license holder, or other entity that initiated the background study will be provided with the reason for the individual's disqualification and an explanation that the factors under section 245C.22, subdivision 4, which were the basis of the decision to set aside the disqualification shall be made available to the license holder upon request without the consent of the subject of the background study;~~

~~(5) a statement indicating that if the individual's disqualification is set aside or the facility is granted a variance under section 245C.30, the individual's identity and the reason for the individual's disqualification will become public data under section 245C.22, subdivision 7, when applicable to the individual;~~

~~(6)~~ (4) a statement that when a subsequent background study is initiated on the individual following a set-aside of the individual's disqualification, and the commissioner makes a determination under section 245C.22, subdivision 5, paragraph (b), that the previous set-aside applies to the subsequent background study, the applicant, license holder, or other entity that initiated the background study will be informed in the notice under section 245C.22, subdivision 5, paragraph (c)~~:~~

~~(i)~~ of the reason for the individual's disqualification; and

~~(ii) that the individual's disqualification is set aside for that program or agency; and~~

~~(iii) that information about the factors under section 245C.22, subdivision 4, that were the basis of the decision to set aside the disqualification are available to the license holder upon request without the consent of the background study subject; and~~

~~(7)~~ (5) the commissioner's determination of the individual's immediate risk of harm under section 245C.16.

(b) If the commissioner determines under section 245C.16 that an individual poses an imminent risk of harm to persons served by the program where the individual will have direct contact with, or access to, people receiving services, the commissioner's notice must include an explanation of the basis of this determination.

(c) If the commissioner determines under section 245C.16 that an individual studied does not pose a risk of harm that requires immediate removal, the individual shall be informed of the conditions under which the agency that initiated the background study may allow the individual to have direct contact with, or access to, people receiving services, as provided under subdivision 3.

Sec. 26. Minnesota Statutes 2022, section 245C.17, subdivision 3, is amended to read:

Subd. 3. **Disqualification notification.** (a) The commissioner shall notify an applicant, license holder, or other entity as provided in this chapter who is not the subject of the study:

(1) that the commissioner has found information that disqualifies the individual studied from being in a position allowing direct contact with, or access to, people served by the program; and

(2) the commissioner's determination of the individual's risk of harm under section 245C.16.

(b) If the commissioner determines under section 245C.16 that an individual studied poses an imminent risk of harm to persons served by the program where the individual studied will have direct contact with, or access to, people served by the program, the commissioner shall order the license holder to immediately remove the individual studied from any position allowing direct contact with, or access to, people served by the program.

(c) If the commissioner determines under section 245C.16 that an individual studied poses a risk of harm that requires continuous, direct supervision, the commissioner shall order the applicant, license holder, or other entities as provided in this chapter to:

(1) immediately remove the individual studied from any position allowing direct contact with, or access to, people receiving services; or

(2) before allowing the disqualified individual to be in a position allowing direct contact with, or access to, people receiving services, the applicant, license holder, or other entity, as provided in this chapter, must:

~~(i) obtain from the disqualified individual a copy of the individual's notice of disqualification from the commissioner that explains the reason for disqualification;~~

~~(ii)~~ (i) ensure that the individual studied is under continuous, direct supervision when in a position allowing direct contact with, or access to, people receiving services during the period in which the individual may request a reconsideration of the disqualification under section 245C.21; and

~~(iii)~~ (ii) ensure that the disqualified individual requests reconsideration within 30 days of receipt of the notice of disqualification.

(d) If the commissioner determines under section 245C.16 that an individual studied does not pose a risk of harm that requires continuous, direct supervision, the commissioner shall order the applicant, license holder, or other entities as provided in this chapter to:

(1) immediately remove the individual studied from any position allowing direct contact with, or access to, people receiving services; or

(2) before allowing the disqualified individual to be in any position allowing direct contact with, or access to, people receiving services, the applicant, license holder, or other entity as provided in this chapter must~~:~~

~~(i) obtain from the disqualified individual a copy of the individual's notice of disqualification from the commissioner that explains the reason for disqualification; and~~

~~(ii)~~ ensure that the disqualified individual requests reconsideration within 15 days of receipt of the notice of disqualification.

(e) The commissioner shall not notify the applicant, license holder, or other entity as provided in this chapter of the information contained in the subject's background study unless:

(1) the basis for the disqualification is failure to cooperate with the background study ~~or substantiated maltreatment under section 626.557 or chapter 260E~~;

(2) the Data Practices Act under chapter 13 provides for release of the information; or

(3) the individual studied authorizes the release of the information.

Sec. 27. Minnesota Statutes 2022, section 245C.17, subdivision 6, is amended to read:

Subd. 6. **Notice to county agency.** For studies on individuals related to a license to provide adult foster care when the applicant or license holder resides in the adult foster care residence and family adult day services and, effective upon implementation of NETStudy 2.0, family child care ~~and legal nonlicensed child care authorized under chapter 119B~~, the commissioner shall also provide a notice of the background study results to the county agency that initiated the background study.

EFFECTIVE DATE. This section is effective April 28, 2025.

Sec. 28. Minnesota Statutes 2022, section 245C.22, subdivision 7, is amended to read:

Subd. 7. **Classification of certain data.** (a) Notwithstanding section 13.46, except as provided in paragraph ~~(f)~~ (e), upon setting aside a disqualification under this section, the identity of the disqualified individual who received the set-aside and the individual's disqualifying characteristics are ~~public~~ private data ~~if the set-aside was:~~.

~~(1) for any disqualifying characteristic under section 245C.15, except a felony-level conviction for a drug-related offense within the past five years, when the set-aside relates to a child care center or a family child care provider licensed under chapter 245A, certified license-exempt child care center, or legal nonlicensed family child care; or~~

~~(2) for a disqualifying characteristic under section 245C.15, subdivision 2.~~

(b) Notwithstanding section 13.46, upon granting a variance to a license holder under section 245C.30, the identity of the disqualified individual who is the subject of the variance, the individual's disqualifying characteristics under section 245C.15, and the terms of the variance are ~~public data, except as provided in paragraph (c), clause (6), when the variance:~~ private data.

~~(1) is issued to a child care center or a family child care provider licensed under chapter 245A; or~~

~~(2) relates to an individual with a disqualifying characteristic under section 245C.15, subdivision 2.~~

(c) The identity of a disqualified individual and the reason for disqualification remain private data when:

(1) a disqualification is not set aside and no variance is granted, except as provided under section 13.46, subdivision 4;

(2) the data are not public under paragraph (a) or (b);

(3) the disqualification is rescinded because the information relied upon to disqualify the individual is incorrect;

(4) the disqualification relates to a license to provide relative child foster care. As used in this clause, "relative" has the meaning given it under section 260C.007, subdivision 26b or 27;

(5) the disqualified individual is a household member of a licensed foster care provider and:

(i) the disqualified individual previously received foster care services from this licensed foster care provider;

(ii) the disqualified individual was subsequently adopted by this licensed foster care provider; and

(iii) the disqualifying act occurred before the adoption; or

(6) a variance is granted to a child care center or family child care license holder for an individual's disqualification that is based on a felony-level conviction for a drug-related offense that occurred within the past five years.

~~(d) Licensed family child care providers and child care centers must provide notices as required under section 245C.301.~~

~~(e)~~ (d) Notwithstanding paragraphs (a) and (b), the identity of household members who are the subject of a disqualification related set-aside or variance is not public data if:

(1) the household member resides in the residence where the family child care is provided;

(2) the subject of the set-aside or variance is under the age of 18 years; and

(3) the set-aside or variance only relates to a disqualification under section 245C.15, subdivision 4, for a misdemeanor-level theft crime as defined in section 609.52.

~~(f)~~ (e) When the commissioner has reason to know that a disqualified individual has received an order for expungement for the disqualifying record that does not limit the commissioner's access to the record, and the record was opened or exchanged with the commissioner for purposes of a background study under this chapter, the data that would otherwise become public under paragraph (a) or (b) remain private data.

Sec. 29. Minnesota Statutes 2022, section 245C.23, subdivision 1, is amended to read:

Subdivision 1. **Disqualification that is rescinded or set aside.** (a) If the commissioner rescinds or sets aside a disqualification, the commissioner shall notify the applicant, license holder, or other entity in writing or by electronic transmission of the decision.

(b) In the notice from the commissioner that a disqualification has been rescinded, the commissioner must inform the applicant, license holder, or other entity that the information relied upon to disqualify the individual was incorrect.

~~(c) Except as provided in paragraphs (d) and (e), in the notice from the commissioner that a disqualification has been set aside, the commissioner must inform the applicant, license holder, or other entity of the reason for the individual's disqualification and that information about which factors under section 245C.22, subdivision 4, were the basis of the decision to set aside the disqualification are available to the license holder upon request without the consent of the background study subject.~~

~~(d) When the commissioner has reason to know that a disqualified individual has received an order for expungement for the disqualifying record that does not limit the commissioner's access to the record, and the record was opened or exchanged with the commissioner for purposes of a background study under this chapter, the information provided under paragraph (c) must only inform the applicant, license holder, or other entity that the disqualifying criminal record is sealed under a court order.~~

~~(e) The notification requirements in paragraph (c) do not apply when the set aside is granted to an individual related to a background study for a licensed child care center, certified license-exempt child care center, or family child care license holder, or for a legal nonlicensed child care provider authorized under chapter 119B, and the individual is disqualified for a felony-level conviction for a drug-related offense that occurred within the past five years. The notice that the individual's disqualification is set aside must inform the applicant, license holder, or legal nonlicensed child care provider that the disqualifying criminal record is not public.~~

Sec. 30. Minnesota Statutes 2022, section 245C.23, subdivision 2, is amended to read:

Subd. 2. **Commissioner's notice of disqualification that is not set aside.** (a) The commissioner shall notify the license holder of the disqualification and order the license holder to immediately remove the individual from any position allowing direct contact with persons receiving services from the license holder if:

(1) the individual studied does not submit a timely request for reconsideration under section 245C.21;

(2) the individual submits a timely request for reconsideration, but the commissioner does not set aside the disqualification for that license holder under section 245C.22, unless the individual has a right to request a hearing under section 245C.27, 245C.28, or 256.045;

(3) an individual who has a right to request a hearing under sections 245C.27 and 256.045, or 245C.28 and chapter 14 for a disqualification that has not been set aside, does not request a hearing within the specified time; or

(4) an individual submitted a timely request for a hearing under sections 245C.27 and 256.045, or 245C.28 and chapter 14, but the commissioner does not set aside the disqualification under section 245A.08, subdivision 5, or 256.045.

(b) If the commissioner does not set aside the disqualification under section 245C.22, and the license holder was previously ordered under section 245C.17 to immediately remove the disqualified individual from direct contact with persons receiving services or to ensure that the individual is under continuous, direct supervision when providing direct contact services, the order remains in effect pending the outcome of a hearing under sections 245C.27 and 256.045, or 245C.28 and chapter 14.

(c) If the commissioner does not set aside the disqualification under section 245C.22, and the license holder was not previously ordered under section 245C.17 to immediately remove the disqualified individual from direct contact with persons receiving services or to ensure that the individual is under continuous direct supervision when providing direct contact services, the commissioner shall order the individual to remain under continuous direct supervision pending the outcome of a hearing under sections 245C.27 and 256.045, or 245C.28 and chapter 14.

(d) For background studies related to child foster care when the applicant or license holder resides in the home where services are provided, the commissioner shall also notify the county or private agency that initiated the study of the results of the reconsideration.

(e) For background studies related to family child care, ~~legal nonlicensed child care,~~ adult foster care programs when the applicant or license holder resides in the home where services are provided, and family adult day services, the commissioner shall also notify the county that initiated the study of the results of the reconsideration.

EFFECTIVE DATE. This section is effective April 28, 2025.

Sec. 31. Minnesota Statutes 2022, section 245C.32, subdivision 2, is amended to read:

Subd. 2. **Use.** (a) The commissioner may also use these systems and records to obtain and provide criminal history data from the Bureau of Criminal Apprehension, criminal history data held by the commissioner, and data about substantiated maltreatment under section 626.557 or chapter 260E, for other purposes, provided that:

(1) the background study is specifically authorized in statute; or

(2) the request is made with the informed consent of the subject of the study as provided in section 13.05, subdivision 4.

(b) An individual making a request under paragraph (a), clause (2), must agree in writing not to disclose the data to any other individual without the consent of the subject of the data.

(c) The commissioner may use these systems to share background study documentation electronically with entities and individuals who are the subject of a background study.

(d) The commissioner may recover the cost of obtaining and providing background study data by charging the individual or entity requesting the study a fee ~~of no more than $42 per study~~ as described in section 245C.10. The fees collected under this paragraph are appropriated to the commissioner for the purpose of conducting background studies.

Sec. 32. **[245J.01] TITLE.**

This chapter may be cited as the "Department of Human Services Public Law Background Studies Act."

Sec. 33. **[245J.02] DEFINITIONS.**

Subdivision 1. **Scope.** The definitions in this section apply to this chapter.

Subd. 2. **Access to persons served by a program.** "Access to persons served by a program" means physical access to persons receiving services, access to the persons' personal property, or access to the persons' personal, financial, or health information, without continuous, direct supervision, as defined in subdivision 8.

Subd. 3. **Applicant.** "Applicant" has the meaning given in section 245A.02, subdivision 3, and applies to entities listed in section 245J.03.

Subd. 4. **Authorized fingerprint collection vendor.** "Authorized fingerprint collection vendor" means a qualified organization under a written contract with the commissioner to provide services in accordance with section 245J.05, subdivision 6, paragraph (a).

Subd. 5. **Commissioner.** "Commissioner" means the commissioner of human services.

Subd. 6. **Continuous, direct supervision.** "Continuous, direct supervision" means an individual is within sight or hearing of the entity's supervising individual to the extent that the program's supervising individual is capable at all times of intervening to protect the health and safety of the persons served by the program.

Subd. 7. **Conviction.** "Conviction" has the meaning given in section 609.02, subdivision 5.

Subd. 8. **Direct contact.** "Direct contact" means providing face-to-face care, training, supervision, counseling, consultation, or medication assistance to persons served by the program.

Subd. 9. **Employee.** "Employee" means an individual who provides or seeks to provide services for an entity with which the employee is affiliated in NETStudy 2.0 and who is subject to oversight by the entity, including but not limited to continuous, direct supervision and immediate removal from providing direct care services.

Subd. 10. **Entity.** "Entity" means a program, organization, or agency listed in section 245J.03.

Subd. 11. **License.** "License" has the meaning given in section 245A.02, subdivision 8.

Subd. 12. **License holder.** "License holder" has the meaning given in section 245A.02, subdivision 9, and applies to entities listed in section 245J.03.

Subd. 13. **National criminal history record check.** (a) "National criminal history record check" means a check of records maintained by the Federal Bureau of Investigation through submission of fingerprints through the Bureau of Criminal Apprehension to the Federal Bureau of Investigation, when specifically required by law.

(b) For the purposes of this chapter, "national crime information database," "national criminal records repository," "criminal history with the Federal Bureau of Investigation," and "national criminal record check" refer to a national criminal history record check as defined in this subdivision.

Subd. 14. **NETStudy 2.0.** "NETStudy 2.0" means the commissioner's system that replaces both NETStudy and the department's internal background study processing system. NETStudy 2.0 is designed to enhance protection of children and vulnerable adults by improving the accuracy of background studies through fingerprint-based criminal record checks and expanding the background studies to include a review of information from the Minnesota Court Information System and the national crime information database. NETStudy 2.0 is also designed to increase efficiencies in and the speed of the hiring process by:

(1) providing access to and updates from public web-based data related to employment eligibility;

(2) decreasing the need for repeat studies through electronic updates of background study subjects' criminal records;

(3) supporting identity verification using subjects' Social Security numbers and photographs;

(4) using electronic employer notifications; and

(5) issuing immediate verification of subjects' eligibility to provide services as more studies are completed under the NETStudy 2.0 system.

Subd. 15. **Person.** "Person" means a child as defined in subdivision 6 or an adult as defined in section 245A.02, subdivision 2.

Subd. 16. **Public law background study.** "Public law background study" means a background study conducted by the Department of Human Services under this chapter. All data obtained by the commissioner for a background study completed under this chapter shall be classified as private data.

Subd. 17. **Reasonable cause.** "Reasonable cause" means information or circumstances exist that provide the commissioner with articulable suspicion that further pertinent information may exist concerning a subject. The commissioner has reasonable cause to require a background study when the commissioner has received a report from the subject, the entity, or a third party indicating that the subject has a history that would disqualify the individual or that may pose a risk to the health or safety of persons receiving services.

Subd. 18. **Reasonable cause to require a national criminal history record check.** (a) "Reasonable cause to require a national criminal history record check" means information or circumstances exist that provide the commissioner with articulable suspicion that further pertinent information may exist concerning a background study subject that merits conducting a national criminal history record check on that subject. The commissioner has reasonable cause to require a national criminal history record check when:

(1) information from the Bureau of Criminal Apprehension indicates that the subject is a multistate offender;

(2) information from the Bureau of Criminal Apprehension indicates that multistate offender status is undetermined;

(3) the commissioner has received a report from the subject or a third party indicating that the subject has a criminal history in a jurisdiction other than Minnesota; or

(4) information from the Bureau of Criminal Apprehension for a state-based name and date of birth background study in which the subject is a minor that indicates that the subject has a criminal history.

(b) In addition to the circumstances described in paragraph (a), the commissioner has reasonable cause to require a national criminal history record check if the subject is not

currently residing in Minnesota or resided in a jurisdiction other than Minnesota during the previous five years.

Subd. 19. **Recurring maltreatment.** "Recurring maltreatment" means more than one incident of maltreatment for which there is a preponderance of evidence that the maltreatment occurred and that the subject was responsible for the maltreatment.

Subd. 20. **Results.** "Results" means a determination that a study subject is eligible, disqualified, set aside, granted a variance, or that more time is needed to complete the background study.

Subd. 21. **Roster.** (a) "Roster" means the electronic method used to identify the entity or entities required to conduct background studies under this chapter with which a background subject is affiliated. There are three types of rosters: active roster, inactive roster, and master roster.

(b) "Active roster" means the list of individuals specific to an entity who have been determined eligible under this chapter to provide services for the entity and who the entity has identified as affiliated. An individual shall remain on the entity's active roster and is considered affiliated until the commissioner determines the individual is ineligible or the entity removes the individual from the entity's active roster.

(c) "Inactive roster" means the list maintained by the commissioner of individuals who are eligible under this chapter to provide services and are not on an active roster. Individuals shall remain on the inactive roster for no more than 180 consecutive days, unless the individual submits a written request to the commissioner requesting to remain on the inactive roster for a longer period of time. Upon the commissioner's receipt of information that may cause an individual on the inactive roster to be disqualified under this chapter, the commissioner shall remove the individual from the inactive roster, and if the individual again seeks a position requiring a background study, the individual shall be required to complete a new background study.

(d) "Master roster" means the list maintained by the commissioner of all individuals who, as a result of a background study under this chapter, and regardless of affiliation with an entity, are determined by the commissioner to be eligible to provide services for one or more entities. The master roster includes all background study subjects on rosters under paragraphs (b) and (c).

Subd. 22. **Serious maltreatment.** (a) "Serious maltreatment" means sexual abuse, maltreatment resulting in death, neglect resulting in serious injury which reasonably requires the care of a physician or advanced practice registered nurse, whether or not the care of a

physician or advanced practice registered nurse was sought, or abuse resulting in serious injury.

(b) For purposes of this definition, "care of a physician or advanced practice registered nurse" is treatment received or ordered by a physician, physician assistant, advanced practice registered nurse, or nurse practitioner, but does not include:

(1) diagnostic testing, assessment, or observation;

(2) the application of, recommendation to use, or prescription solely for a remedy that is available over the counter without a prescription; or

(3) a prescription solely for a topical antibiotic to treat burns when there is no follow-up appointment.

(c) For purposes of this definition, "abuse resulting in serious injury" means: bruises, bites, skin laceration, or tissue damage; fractures; dislocations; evidence of internal injuries; head injuries with loss of consciousness; extensive second-degree or third-degree burns and other burns for which complications are present; extensive second-degree or third-degree frostbite and other frostbite for which complications are present; irreversible mobility or avulsion of teeth; injuries to the eyes; ingestion of foreign substances and objects that are harmful; near drowning; and heat exhaustion or sunstroke.

(d) Serious maltreatment includes neglect when it results in criminal sexual conduct against a child or vulnerable adult.

Subd. 23. **Subject of a background study.** "Subject of a background study" means an individual on whom a public law background study is required or completed.

Subd. 24. **Volunteer.** "Volunteer" means an individual who provides or seeks to provide services for an entity without compensation, is affiliated in NETStudy 2.0, and is subject to oversight by the entity, including but not limited to continuous, direct supervision and immediate removal from providing direct care services.

Sec. 34. **[245J.03] PUBLIC LAW BACKGROUND STUDY; INDIVIDUALS TO BE STUDIED.**

Subdivision 1. **Classification of public law background study data; access to information.** All data obtained by the commissioner for a background study completed under this chapter shall be classified as private data.

Subd. 2. **Minnesota Sex Offender Program.** The commissioner shall conduct a public law background study under this chapter for an employee having direct contact with persons

civilly committed to the Minnesota Sex Offender Program operated by the commissioner under chapters 246B and 253D.

Sec. 35. **[245J.04] WHEN BACKGROUND STUDY MUST OCCUR.**

Subdivision 1. **Initial studies.** (a) An entity in section 245J.03 shall initiate a background study:

(1) for an individual in NETStudy 2.0, upon application for initial license. All license holders must be on the entity's active roster with a status of eligible, set aside, or variance granted;

(2) for a current or prospective employee in NETStudy 2.0, before the individual will have direct contact with persons receiving services; and

(3) for a volunteer in NETStudy 2.0, before the volunteer will have direct contact with persons served by the program, if the contact is not under the continuous, direct supervision by an individual listed in clause (1) or (2).

(b) The commissioner is not required to conduct a study of an individual at the time of reapplication for a license if the individual's background study was completed by the commissioner of human services and the following conditions are met:

(1) a study of the individual was conducted either at the time of initial licensure or when the individual became affiliated with the license holder;

(2) the individual has been continuously affiliated with the license holder since the last study was conducted; and

(3) the last study of the individual was conducted on or after October 1, 1995.

(c) Applicants for licensure, license holders, and entities as provided in this chapter must submit completed background study requests to the commissioner using NETStudy 2.0 before individuals specified in section 245J.03, subdivision 1, begin positions allowing direct contact in the program.

(d) For an individual who is not on the entity's active roster, the entity must initiate a new background study through NETStudy 2.0 when:

(1) an individual returns to a position requiring a background study following an absence of 120 or more consecutive days; or

(2) a program that discontinued providing licensed direct contact services for 120 or more consecutive days begins to provide direct contact licensed services again.

The entity shall maintain a copy of the notification provided to the commissioner under this paragraph in the program's files. If the individual's disqualification was previously set aside for the license holder's program and the new background study results in no new information that indicates the individual may pose a risk of harm to persons receiving services from the entity, the previous set-aside shall remain in effect.

(e) For purposes of this section, a physician licensed under chapter 147 or an advanced practice registered nurse licensed under chapter 148 who is required to have a background study under this chapter is considered to be continuously affiliated upon the license holder's receipt from the commissioner of human services of the physician's or advanced practice registered nurse's background study results.

Subd. 2. **Public law background studies; electronic criminal case information updates; rosters; criteria for eliminating repeat background studies.** (a) The commissioner shall implement the electronic process in NETStudy 2.0 for the regular transfer of new criminal case information that is added to the Minnesota Court Information System. The commissioner's system must include for review only information that relates to individuals who are on the master roster.

(b) The commissioner shall develop and implement an online system as a part of NETStudy 2.0 for entities that initiate background studies under this chapter to access and maintain records of background studies initiated by that entity. The system must show all active background study subjects affiliated with that entity and the status of each individual's background study. Each entity that initiates background studies must use this system to notify the commissioner of discontinued affiliation for purposes of the processes required under paragraph (a).

Subd. 3. **New study required with legal name change.** (a) For a background study completed on an individual required to be studied under section 245J.03, the license holder or other entity that initiated the background study must initiate a new background study using NETStudy 2.0 when an individual who is affiliated with the license holder or other entity undergoes a legal name change.

(b) For background studies subject to a fee paid through NETStudy 2.0, the entity that initiated the study may initiate a new study under paragraph (a) or notify the commissioner of the name change through a notice to the commissioner.

(c) After an entity initiating a background study has paid the applicable fee for the study and has provided the individual with the privacy notice required under section 245J.05, subdivision 3, NETStudy 2.0 shall immediately inform the entity whether the individual

requires a background study or whether the individual is immediately eligible to provide services based on a previous background study. If the individual is immediately eligible, the entity initiating the background study shall be able to view the information previously supplied by the individual who is the subject of a background study as required under section 245J.05, subdivision 1, including the individual's photograph taken at the time the individual's fingerprints were recorded. The commissioner shall not provide any entity initiating a subsequent background study with information regarding the other entities that initiated background studies on the subject.

(d) Verification that an individual is eligible to provide services based on a previous background study is dependent on the individual voluntarily providing the individual's Social Security number to the commissioner at the time each background study is initiated. When an individual does not provide the individual's Social Security number for the background study, that study is not transferable and a repeat background study on that individual is required if the individual seeks a position requiring a background study under this chapter with another entity.

Sec. 36. **[245J.05] BACKGROUND STUDY; INFORMATION AND DATA PROVIDED TO COMMISSIONER.**

Subdivision 1. **Study submitted.** The entity with which the background study subject is seeking affiliation through employment, volunteering, or licensure shall initiate the background study in NETStudy 2.0.

Subd. 2. **Individual studied.** (a) The individual who is the subject of the background study must provide the applicant, license holder, or other entity under section 245J.04 with sufficient information to ensure an accurate study, including:

(1) the individual's first, middle, and last name and all other names by which the individual has been known;

(2) current home address, city, and state of residence;

(3) current zip code;

(4) sex;

(5) date of birth;

(6) driver's license number or state identification number; and

(7) the home address, city, county, and state of residence for the past five years.

(b) The subject of a background study shall provide fingerprints and a photograph as required in subdivision 6.

Subd. 3. **Entity.** (a) The entity initiating a background study as provided in this chapter shall verify that the information collected under subdivision 1 about an individual who is the subject of the background study is correct and must provide the information on forms or in a manner prescribed by the commissioner.

(b) The information collected under subdivision 1 about an individual who is the subject of a completed background study may only be viewable by an entity that initiates a subsequent background study on that individual under NETStudy 2.0 after the entity has paid the applicable fee for the study and has provided the individual with the privacy notice in subdivision 4.

Subd. 4. **Privacy notice to background study subject.** (a) Prior to initiating each background study, the entity initiating the study must provide the commissioner's privacy notice to the background study subject required under section 13.04, subdivision 2. The notice must be available through the commissioner's electronic NETStudy 2.0 system and shall include information that the individual has a disqualification that has been set aside for the entity that initiated the study.

(b) The background study subject must also be informed that:

(1) the subject's fingerprints collected for purposes of completing the background study under this chapter must not be retained by the Department of Public Safety, the Bureau of Criminal Apprehension, or the commissioner. The Federal Bureau of Investigation will not retain background study subjects' fingerprints;

(2) the subject's photograph will be retained by the commissioner, and if the subject has provided the subject's Social Security number for purposes of the background study, the photograph will be available to prospective employers and agencies initiating background studies under this chapter to verify the identity of the subject of the background study;

(3) the authorized fingerprint collection vendor or vendors shall, for purposes of verifying the identity of the background study subject, be able to view the identifying information entered into NETStudy 2.0 by the entity that initiated the background study, but shall not retain the subject's fingerprints, photograph, or information from NETStudy 2.0. The authorized fingerprint collection vendor or vendors shall retain no more than the subject's name and the date and time the subject's fingerprints were recorded and sent, only as necessary for auditing and billing activities;

(4) the commissioner shall provide the subject notice, as required in section 245J.15, subdivision 1, paragraph (a), when an entity initiates a background study on the individual;

(5) the subject may request in writing a report listing the entities that initiated a background study on the subject as provided in section 245J.15, subdivision 1, paragraph (b);

(6) the subject may request in writing that information used to complete the individual's background study in NETStudy 2.0 be destroyed if the requirements of section 245J.06, paragraph (a), are met; and

(7) notwithstanding clause (6), the commissioner shall destroy:

(i) the subject's photograph after a period of two years when the requirements of section 245J.06, paragraph (c), are met; and

(ii) any data collected on a subject under this chapter after a period of two years following the individual's death as provided in section 245J.06, paragraph (d).

Subd. 5. **Fingerprint data notification.** The commissioner of human services shall notify all background study subjects under this chapter that the Department of Human Services, Department of Public Safety, and the Bureau of Criminal Apprehension do not retain fingerprint data after a background study is completed, and that the Federal Bureau of Investigation does not retain background study subjects' fingerprints.

Subd. 6. **Electronic transmission.** (a) The commissioner shall implement a secure system for the electronic transmission of:

(1) background study information to the commissioner; and

(2) background study results to the license holder.

(b) Unless the commissioner has granted a hardship variance under paragraph (c), a license holder or an applicant must use the electronic transmission system known as NETStudy or NETStudy 2.0 to submit all requests for background studies to the commissioner as required by this chapter.

(c) A license holder or applicant whose program is located in an area in which high-speed Internet is inaccessible may request the commissioner to grant a variance to the electronic transmission requirement.

(d) Section 245J.08, subdivision 3, paragraph (c), applies to results transmitted under this subdivision.

Subd. 7. **Fingerprints and photograph.** (a) Except as provided in paragraph (f), every subject of a background study must provide the commissioner with a set of the background study subject's classifiable fingerprints and photograph. The photograph and fingerprints must be recorded at the same time by the authorized fingerprint collection vendor or vendors and sent to the commissioner through the commissioner's secure data system described in section 245J.29, subdivision 1a, paragraph (b).

(b) The fingerprints shall be submitted by the commissioner to the Bureau of Criminal Apprehension and, when specifically required by law, submitted to the Federal Bureau of Investigation for a national criminal history record check.

(c) The fingerprints must not be retained by the Department of Public Safety, the Bureau of Criminal Apprehension, or the commissioner. The Federal Bureau of Investigation will not retain background study subjects' fingerprints.

(d) The authorized fingerprint collection vendor or vendors shall, for purposes of verifying the identity of the background study subject, be able to view the identifying information entered into NETStudy 2.0 by the entity that initiated the background study, but shall not retain the subject's fingerprints, photograph, or information from NETStudy 2.0. The authorized fingerprint collection vendor or vendors shall retain no more than the name, date, and time the subject's fingerprints were recorded and sent, only as necessary for auditing and billing activities.

(e) For any background study conducted under this chapter, the subject shall provide the commissioner with a set of classifiable fingerprints when the commissioner has reasonable cause to require a national criminal history record check as defined in section 245J.02, subdivision 13.

(f) A study subject is not required to submit fingerprints and a photograph for a new study if they currently have an eligible background study status on an active roster or on the master roster. The entity initiating the new study shall have access to the eligible status upon completion of the initiation and payment process.

(g) The commissioner may inform the entity that initiated the background study under NETStudy 2.0 of the status of processing of the subject's fingerprints.

Subd. 8. **Applicant, license holder, and entity.** (a) The applicant, license holder, entity as provided in this chapter, Bureau of Criminal Apprehension, law enforcement agencies, commissioner of health, and county agencies shall help with the study by giving the commissioner criminal conviction data and reports about the maltreatment of adults

substantiated under section 626.557 and the maltreatment of minors substantiated under chapter 260E.

(b) If a background study is initiated by an applicant, license holder, or entity as provided in this chapter, and the applicant, license holder, or entity receives information about the possible criminal or maltreatment history of an individual who is the subject of the background study, the applicant, license holder, or entity must immediately provide the information to the commissioner.

(c) The applicant, license holder, entity, or county or other agency must provide written notice to the individual who is the subject of the background study of the requirements under this subdivision.

Subd. 9. **Probation officer and corrections agent.** (a) A probation officer or corrections agent shall notify the commissioner of an individual's conviction if the individual:

(1) has been affiliated with a program or facility regulated by the Department of Human Services or Department of Health, a facility serving children or youth licensed by the Department of Corrections, or any type of home care agency or provider of personal care assistance services within the preceding year; and

(2) has been convicted of a crime constituting a disqualification under section 245J.14.

(b) The commissioner, in consultation with the commissioner of corrections, shall develop forms and information necessary to implement this subdivision and shall provide the forms and information to the commissioner of corrections for distribution to local probation officers and corrections agents.

(c) The commissioner shall inform individuals subject to a background study that criminal convictions for disqualifying crimes shall be reported to the commissioner by the corrections system.

(d) A probation officer, corrections agent, or corrections agency is not civilly or criminally liable for disclosing or failing to disclose the information required by this subdivision.

(e) Upon receipt of disqualifying information, the commissioner shall provide the notice required under section 245J.17, as appropriate, to entities on whose active rosters the study subject is affiliated.

Sec. 37. **[245J.06] DESTRUCTION OF BACKGROUND STUDY SUBJECT INFORMATION.**

(a) A background study subject may request in writing to the commissioner that information used to complete the individual's study in NETStudy 2.0 be destroyed if the individual:

(1) has not been affiliated with any entity for the previous two years; and

(2) has no current disqualifying characteristic.

(b) After receiving the request and verifying the information in paragraph (a), the commissioner shall destroy the information used to complete the subject's background study and shall keep a record of the subject's name and a notation of the date that the information was destroyed.

(c) When a previously studied individual has not been on the master roster for two years, the commissioner shall destroy the photographic image of the individual obtained under section 245J.05, subdivision 7, paragraph (a).

(d) Any data collected on an individual under this chapter that is maintained by the commissioner that has not been destroyed according to paragraph (b) or (c) shall be destroyed when two years have elapsed from the individual's actual death that is reported to the commissioner or when 90 years have elapsed since the individual's birth except when readily available data indicate that the individual is still living.

Sec. 38. **[245J.07] STUDY SUBJECT AFFILIATED WITH MULTIPLE FACILITIES.**

(a) Subject to the conditions in paragraph (c), when a license holder, applicant, or other entity owns multiple programs or services that are licensed by the same agency, only one background study is required for an individual who provides direct contact services in one or more of the licensed programs or services if:

(1) the license holder designates one individual with one address and telephone number as the person to receive sensitive background study information for the multiple licensed programs or services that depend on the same background study; and

(2) the individual designated to receive the sensitive background study information is capable of determining, upon request of the department, whether a background study subject is providing direct contact services in one or more of the license holder's programs or services and, if so, at which location or locations.

(b) When a license holder maintains background study compliance for multiple licensed programs according to paragraph (a), and one or more of the licensed programs closes, the license holder shall immediately notify the commissioner which staff must be transferred to an active license so that the background studies can be electronically paired with the license holder's active program.

(c) For an entity operating under NETStudy 2.0, the entity's active roster must be the system used to document when a background study subject is affiliated with multiple entities. For a background study to be transferable:

(1) the background study subject must be on and moving to a roster for which the person designated to receive sensitive background study information is the same; and

(2) the same entity must own or legally control both the roster from which the transfer is occurring and the roster to which the transfer is occurring. For an entity that holds or controls multiple entities, there must be a common highest level entity that has a legally identifiable structure that can be verified through records available from the secretary of state.

Sec. 39. **[245J.08] BACKGROUND STUDY; COMMISSIONER REVIEWS.**

Subdivision 1. **Background studies conducted by Department of Human Services.** (a) For a background study conducted under this chapter, the commissioner shall review:

(1) information related to findings of maltreatment of vulnerable adults that has been received by the commissioner as required under section 626.557, subdivision 9c, paragraph (j);

(2) information related to findings of maltreatment of minors that has been received by the commissioner as required under chapter 260E;

(3) the commissioner's records relating to maltreatment in programs licensed by the Department of Human Services and the Department of Health;

(4) information from juvenile courts as required in subdivision 4 when there is reasonable cause;

(5) criminal history information from the Bureau of Criminal Apprehension, including information regarding a background study subject's registration in Minnesota as a predatory offender under section 243.166; and

(6) information received as a result of a national criminal history record check, as defined in section 245J.02, subdivision 13, when the commissioner has reasonable cause for a national criminal history record check as defined under section 245J.02, subdivision 16.

(b) Notwithstanding expungement by a court, the commissioner may consider information obtained under this section, unless the commissioner received notice of the petition for expungement and the court order for expungement is directed specifically to the commissioner.

(c) The commissioner shall also review criminal case information received according to section 245J.04, subdivision 2, from the Minnesota Court Information System or Minnesota Government Access that relates to individuals who are being studied or have already been studied under this chapter and who remain affiliated with the agency that initiated the background study.

Subd. 2. **Arrest and investigative information.** (a) For any background study completed under this chapter, if the commissioner has reasonable cause to believe the information is pertinent to the potential disqualification of an individual, the commissioner also may review arrest and investigative information from:

(1) the Bureau of Criminal Apprehension;

(2) the commissioners of health and human services;

(3) a county attorney;

(4) a county sheriff;

(5) a county agency;

(6) a local chief of police;

(7) other states;

(8) the courts;

(9) the Federal Bureau of Investigation;

(10) the National Criminal Records Repository; and

(11) criminal records from other states.

(b) Except when specifically required by law, the commissioner is not required to conduct more than one review of a subject's records from a national criminal history record check if a review of the subject's criminal history with the Federal Bureau of Investigation has

already been completed by the commissioner and there has been no break in the subject's affiliation with the entity that initiated the background study.

Subd. 3. **Juvenile court records.** (a) For a background study conducted by the Department of Human Services, the commissioner shall review records from the juvenile courts for an individual studied under this chapter when the commissioner has reasonable cause.

(b) The juvenile courts shall help with the study by giving the commissioner existing juvenile court records relating to delinquency proceedings held on individuals studied under this chapter when requested pursuant to this subdivision.

(c) For purposes of this chapter, a finding that a delinquency petition is proven in juvenile court shall be considered a conviction in state district court.

(d) Juvenile courts shall provide orders of involuntary and voluntary termination of parental rights under section 260C.301 to the commissioner upon request for purposes of conducting a background study under this chapter.

Sec. 40. **[245J.09] FAILURE OR REFUSAL TO COOPERATE WITH BACKGROUND STUDY.**

Subdivision 1. **Disqualification; licensing action.** An applicant's, license holder's, or other entity's failure or refusal to cooperate with the commissioner, including failure to provide additional information required under section 245J.05, is reasonable cause to disqualify a subject, deny a license application, or immediately suspend or revoke a license or registration.

Subd. 2. **Employment action.** An individual's failure or refusal to cooperate with the background study is just cause for denying or terminating employment of the individual if the individual's failure or refusal to cooperate could cause the applicant's application to be denied or the license holder's license to be immediately suspended or revoked.

Sec. 41. **[245J.10] BACKGROUND STUDY; FEES.**

Subdivision 1. **Expenses.** Section 181.645 does not apply to background studies completed under this chapter.

Subd. 2. **Background study fees.** (a) The commissioner shall recover the cost of background studies. Except as otherwise provided in subdivisions 3 and 4, the fees collected under this section shall be appropriated to the commissioner for the purpose of conducting

background studies under this chapter. Fees under this section are charges under section 16A.1283, paragraph (b), clause (3).

(b) Background study fees may include:

(1) a fee to compensate the commissioner's authorized fingerprint collection vendor or vendors for obtaining and processing a background study subject's classifiable fingerprints and photograph pursuant to subdivision 3; and

(2) a separate fee under subdivision 3 to complete a review of background-study-related records as authorized under this chapter.

(c) Fees charged under paragraph (b) may be paid in whole or in part when authorized by law by a state agency or board; by state court administration; by a service provider, employer, license holder, or other entity that initiates the background study; by the commissioner or other organization with duly appropriated money; by a background study subject; or by some combination of these sources.

Subd. 3. **Fingerprint and photograph processing fees.** The commissioner shall enter into a contract with a qualified vendor or vendors to obtain and process a background study subject's classifiable fingerprints and photograph as required by section 245J.05. The commissioner may, at their discretion, directly collect fees and reimburse the commissioner's authorized fingerprint collection vendor for the vendor's services or require the vendor to collect the fees. The authorized vendor is responsible for reimbursing the vendor's subcontractors at a rate specified in the contract with the commissioner.

Subd. 4. **National criminal history record check fees.** The commissioner may increase background study fees as necessary, commensurate with an increase in the national criminal history record check fee. The commissioner shall report any fee increase under this subdivision to the legislature during the legislative session following the fee increase, so that the legislature may consider adoption of the fee increase into statute. By July 1 of every year, background study fees shall be set at the amount adopted by the legislature under this section.

Subd. 5. **Minnesota Sex Offender Program.** The commissioner shall recover the cost of background studies for the Minnesota Sex Offender Program required under section 245J.03, subdivision 1, through a fee of no more than $42 per study charged to the entity submitting the study. The fees collected under this subdivision are appropriated to the commissioner for the purpose of conducting background studies.

Sec. 42. **[245J.11] BACKGROUND STUDY PROCESSING.**

Subdivision 1. **Completion of background study.** Upon receipt of the background study forms from an entity required to initiate a background study under this chapter, the commissioner shall complete the background study and provide the notice required under section 245J.15, subdivision 1.

Subd. 2. **Activities pending completion of background study.** (a) The subject of a background study may not perform any activity requiring a background study under paragraph (c) until the commissioner has issued one of the notices under paragraph (b).

(b) Notices from the commissioner required prior to activity under paragraph (c) include:

(1) a notice of the study results under section 245J.15 stating that:

(i) the individual is not disqualified; or

(ii) more time is needed to complete the study but the individual is not required to be removed from direct contact or access to people receiving services prior to completion of the study as provided under section 245J.15, subdivision 1, paragraph (b) or (c). The notice that more time is needed to complete the study must also indicate whether the individual is required to be under continuous direct supervision prior to completion of the background study;

(2) a notice that a disqualification has been set aside under section 245J.21; or

(3) a notice that a variance has been granted related to the individual under section 245J.27.

(c) Activities prohibited prior to receipt of notice under paragraph (b) include:

(1) being issued a license; or

(2) providing direct contact services to persons served by a program unless the subject is under continuous direct supervision.

Subd. 3. **Other state information.** If the commissioner has not received criminal, sex offender, or maltreatment information from another state that is required to be reviewed under this chapter within ten days of requesting the information, and the lack of the information is the only reason that a notice is issued under subdivision 2, paragraph (b), clause (1), item (ii), the commissioner may issue a notice under subdivision 2, paragraph (b), clause (1), item (i). The commissioner may take action on information received from other states after issuing a notice under subdivision 2, paragraph (b), clause (1), item (ii).

Sec. 43. **[245J.12] DISQUALIFICATION.**

Subdivision 1. **Disqualification from direct contact.** (a) The commissioner shall disqualify an individual who is the subject of a background study from any position allowing direct contact with persons receiving services from the entity identified in section 245J.03, upon receipt of information showing, or when a background study completed under this chapter shows any of the following:

(1) a conviction of, admission to, or Alford plea to one or more crimes listed in section 245J.13, regardless of whether the conviction or admission is a felony, gross misdemeanor, or misdemeanor level crime;

(2) a preponderance of the evidence indicates the individual has committed an act or acts that meet the definition of any of the crimes listed in section 245J.13, regardless of whether the preponderance of the evidence is for a felony, gross misdemeanor, or misdemeanor level crime;

(3) an investigation results in an administrative determination listed under section 245J.13, subdivision 4, paragraph (b); or

(4) involuntary termination of parental rights issued under subdivision 3 or section 260C.301, subdivision 1, paragraph (b).

(b) No individual who is disqualified following a background study under this chapter may be retained in a position involving direct contact with persons served by a program or entity identified in section 245J.03, unless the commissioner has provided written notice under section 245J.15 stating that:

(1) the individual may remain in direct contact during the period in which the individual may request reconsideration as provided in section 245J.19, subdivision 2;

(2) the commissioner has set aside the individual's disqualification for that entity as provided in section 245J.20, subdivision 4; or

(3) the license holder has been granted a variance for the disqualified individual under section 245J.27.

Subd. 2. **Disqualification from access.** (a) If an individual who is studied under this chapter is disqualified from direct contact under subdivision 1, the commissioner shall also disqualify the individual from access to a person receiving services from the entity.

(b) No individual who is disqualified following a background study under this chapter may be allowed access to persons served by the program unless the commissioner has provided written notice under section 245J.15 stating that:

(1) the individual may remain in direct contact during the period in which the individual may request reconsideration as provided in section 245J.19, subdivision 2;

(2) the commissioner has set aside the individual's disqualification for that entity as provided in section 245J.20, subdivision 4; or

(3) the license holder has been granted a variance for the disqualified individual under section 245J.27.

Sec. 44. **[245J.13] DISQUALIFYING CRIMES OR CONDUCT.**

Subdivision 1. **Permanent disqualification.** (a) An individual is disqualified under section 245J.12 if: (1) regardless of how much time has passed since the discharge of the sentence imposed, if any, for the offense; and (2) unless otherwise specified, regardless of the level of the offense, the individual has committed any of the following offenses: sections 243.166 (violation of predatory offender registration law); 609.185 (murder in the first degree); 609.19 (murder in the second degree); 609.195 (murder in the third degree); 609.20 (manslaughter in the first degree); 609.205 (manslaughter in the second degree); a felony offense under 609.221 or 609.222 (assault in the first or second degree); a felony offense under sections 609.2242 and 609.2243 (domestic assault), spousal abuse, child abuse or neglect, or a crime against children; 609.2247 (domestic assault by strangulation); 609.228 (great bodily harm caused by distribution of drugs); 609.245 (aggravated robbery); 609.25 (kidnapping); 609.2661 (murder of an unborn child in the first degree); 609.2662 (murder of an unborn child in the second degree); 609.2663 (murder of an unborn child in the third degree); 609.322 (solicitation, inducement, and promotion of prostitution); 609.324, subdivision 1 (other prohibited acts); 609.342 (criminal sexual conduct in the first degree); 609.343 (criminal sexual conduct in the second degree); 609.344 (criminal sexual conduct in the third degree); 609.345 (criminal sexual conduct in the fourth degree); 609.3451 (criminal sexual conduct in the fifth degree); 609.3453 (criminal sexual predatory conduct); 609.3458 (sexual extortion); 609.352 (solicitation of children to engage in sexual conduct); 609.365 (incest); a felony offense under 609.377 (malicious punishment of a child); a felony offense under 609.378 (neglect or endangerment of a child); 609.561 (arson in the first degree); 609.66, subdivision 1e (drive-by shooting); 609.749, subdivision 3, 4, or 5 (felony-level harassment or stalking); 609.855, subdivision 5 (shooting at or in a public transit vehicle or facility); 617.23, subdivision 2, clause (1), or subdivision 3, clause (1)

(indecent exposure involving a minor); 617.246 (use of minors in sexual performance prohibited); or 617.247 (possession of pictorial representations of minors).

(b) An individual's aiding and abetting, attempt, or conspiracy to commit any of the offenses listed in paragraph (a), as each of these offenses is defined in Minnesota Statutes, permanently disqualifies the individual under section 245J.12.

(c) An individual's offense in any other state or country, where the elements of the offense are substantially similar to any of the offenses listed in paragraph (a), permanently disqualifies the individual under section 245J.12.

(d) When a disqualification is based on a judicial determination other than a conviction, the disqualification period begins from the date of the court order. When a disqualification is based on an admission, the disqualification period begins from the date of an admission in court. When a disqualification is based on an Alford Plea, the disqualification period begins from the date the Alford Plea is entered in court. When a disqualification is based on a preponderance of evidence of a disqualifying act, the disqualification date begins from the date of the dismissal, the date of discharge of the sentence imposed for a conviction for a disqualifying crime of similar elements, or the date of the incident, whichever occurs last.

(e) If the individual studied commits one of the offenses listed in paragraph (a) that is specified as a felony-level only offense, but the sentence or level of offense is a gross misdemeanor or misdemeanor, the individual is disqualified, but the disqualification look-back period for the offense is the period applicable to gross misdemeanor or misdemeanor offenses.

Subd. 2. **15-year disqualification.** (a) An individual is disqualified under section 245J.12 if: (1) less than 15 years have passed since the discharge of the sentence imposed, if any, for the offense; and (2) the individual has committed a felony-level violation of any of the following offenses: sections 256.98 (wrongfully obtaining assistance); 268.182 (fraud); 393.07, subdivision 10, paragraph (c) (federal SNAP fraud); 609.165 (felon ineligible to possess firearm); 609.2112, 609.2113, or 609.2114 (criminal vehicular homicide or injury); 609.215 (suicide); 609.223 or 609.2231 (assault in the third or fourth degree); repeat offenses under 609.224 (assault in the fifth degree); 609.229 (crimes committed for benefit of a gang); 609.2325 (criminal abuse of a vulnerable adult); 609.2335 (financial exploitation of a vulnerable adult); 609.235 (use of drugs to injure or facilitate crime); 609.24 (simple robbery); 609.255 (false imprisonment); 609.2664 (manslaughter of an unborn child in the first degree); 609.2665 (manslaughter of an unborn child in the second degree); 609.267 (assault of an unborn child in the first degree); 609.2671 (assault of an unborn child in the

second degree); 609.268 (injury or death of an unborn child in the commission of a crime); 609.27 (coercion); 609.275 (attempt to coerce); 609.466 (medical assistance fraud); 609.495 (aiding an offender); 609.498, subdivision 1 or 1b (aggravated first-degree or first-degree tampering with a witness); 609.52 (theft); 609.521 (possession of shoplifting gear); 609.525 (bringing stolen goods into Minnesota); 609.527 (identity theft); 609.53 (receiving stolen property); 609.535 (issuance of dishonored checks); 609.562 (arson in the second degree); 609.563 (arson in the third degree); 609.582 (burglary); 609.59 (possession of burglary tools); 609.611 (insurance fraud); 609.625 (aggravated forgery); 609.63 (forgery); 609.631 (check forgery; offering a forged check); 609.635 (obtaining signature by false pretense); 609.66 (dangerous weapons); 609.67 (machine guns and short-barreled shotguns); 609.687 (adulteration); 609.71 (riot); 609.713 (terroristic threats); 609.82 (fraud in obtaining credit); 609.821 (financial transaction card fraud); 617.23 (indecent exposure), not involving a minor; repeat offenses under 617.241 (obscene materials and performances; distribution and exhibition prohibited; penalty); 624.713 (certain persons not to possess firearms); chapter 152 (drugs; controlled substance); or Minnesota Statutes 2012, section 609.21; or a felony-level conviction involving alcohol or drug use.

(b) An individual is disqualified under section 245J.12 if less than 15 years has passed since the individual's aiding and abetting, attempt, or conspiracy to commit any of the offenses listed in paragraph (a), as each of these offenses is defined in Minnesota Statutes.

(c) An individual is disqualified under section 245J.12 if less than 15 years has passed since the termination of the individual's parental rights under section 260C.301, subdivision 1, paragraph (b), or subdivision 3.

(d) An individual is disqualified under section 245J.12 if less than 15 years has passed since the discharge of the sentence imposed for an offense in any other state or country, the elements of which are substantially similar to the elements of the offenses listed in paragraph (a).

(e) If the individual studied commits one of the offenses listed in paragraph (a), but the sentence or level of offense is a gross misdemeanor or misdemeanor, the individual is disqualified but the disqualification look-back period for the offense is the period applicable to the gross misdemeanor or misdemeanor disposition.

(f) When a disqualification is based on a judicial determination other than a conviction, the disqualification period begins from the date of the court order. When a disqualification is based on an admission, the disqualification period begins from the date of an admission in court. When a disqualification is based on an Alford Plea, the disqualification period

begins from the date the Alford Plea is entered in court. When a disqualification is based on a preponderance of evidence of a disqualifying act, the disqualification date begins from the date of the dismissal, the date of discharge of the sentence imposed for a conviction for a disqualifying crime of similar elements, or the date of the incident, whichever occurs last.

Subd. 3. **Ten-year disqualification.** (a) An individual is disqualified under section 245J.12 if: (1) less than ten years have passed since the discharge of the sentence imposed, if any, for the offense; and (2) the individual has committed a gross misdemeanor-level violation of any of the following offenses: sections 256.98 (wrongfully obtaining assistance); 268.182 (fraud); 393.07, subdivision 10, paragraph (c) (federal SNAP fraud); 609.2112, 609.2113, or 609.2114 (criminal vehicular homicide or injury); 609.221 or 609.222 (assault in the first or second degree); 609.223 or 609.2231 (assault in the third or fourth degree); 609.224 (assault in the fifth degree); 609.224, subdivision 2, paragraph (c) (assault in the fifth degree by a caregiver against a vulnerable adult); 609.2242 and 609.2243 (domestic assault); 609.23 (mistreatment of persons confined); 609.231 (mistreatment of residents or patients); 609.2325 (criminal abuse of a vulnerable adult); 609.233 (criminal neglect of a vulnerable adult); 609.2335 (financial exploitation of a vulnerable adult); 609.234 (failure to report maltreatment of a vulnerable adult); 609.265 (abduction); 609.275 (attempt to coerce); 609.324, subdivision 1a (other prohibited acts; minor engaged in prostitution); 609.33 (disorderly house); 609.377 (malicious punishment of a child); 609.378 (neglect or endangerment of a child); 609.466 (medical assistance fraud); 609.52 (theft); 609.525 (bringing stolen goods into Minnesota); 609.527 (identity theft); 609.53 (receiving stolen property); 609.535 (issuance of dishonored checks); 609.582 (burglary); 609.59 (possession of burglary tools); 609.611 (insurance fraud); 609.631 (check forgery; offering a forged check); 609.66 (dangerous weapons); 609.71 (riot); 609.72, subdivision 3 (disorderly conduct against a vulnerable adult); repeat offenses under 609.746 (interference with privacy); 609.749, subdivision 2 (harassment); 609.82 (fraud in obtaining credit); 609.821 (financial transaction card fraud); 617.23 (indecent exposure), not involving a minor; 617.241 (obscene materials and performances); 617.243 (indecent literature, distribution); 617.293 (harmful materials; dissemination and display to minors prohibited); or Minnesota Statutes 2012, section 609.21; or violation of an order for protection under section 518B.01, subdivision 14.

(b) An individual is disqualified under section 245J.12 if less than ten years has passed since the individual's aiding and abetting, attempt, or conspiracy to commit any of the offenses listed in paragraph (a), as each of these offenses is defined in Minnesota Statutes.

(c) An individual is disqualified under section 245J.12 if less than ten years has passed since the discharge of the sentence imposed for an offense in any other state or country, the elements of which are substantially similar to the elements of any of the offenses listed in paragraph (a).

(d) If the individual studied commits one of the offenses listed in paragraph (a), but the sentence or level of offense is a misdemeanor disposition, the individual is disqualified but the disqualification lookback period for the offense is the period applicable to misdemeanors.

(e) When a disqualification is based on a judicial determination other than a conviction, the disqualification period begins from the date of the court order. When a disqualification is based on an admission, the disqualification period begins from the date of an admission in court. When a disqualification is based on an Alford Plea, the disqualification period begins from the date the Alford Plea is entered in court. When a disqualification is based on a preponderance of evidence of a disqualifying act, the disqualification date begins from the date of the dismissal, the date of discharge of the sentence imposed for a conviction for a disqualifying crime of similar elements, or the date of the incident, whichever occurs last.

Subd. 4. **Seven-year disqualification.** (a) An individual is disqualified under section 245J.12 if: (1) less than seven years has passed since the discharge of the sentence imposed, if any, for the offense; and (2) the individual has committed a misdemeanor-level violation of any of the following offenses: sections 256.98 (wrongfully obtaining assistance); 268.182 (fraud); 393.07, subdivision 10, paragraph (c) (federal SNAP fraud); 609.2112, 609.2113, or 609.2114 (criminal vehicular homicide or injury); 609.221 (assault in the first degree); 609.222 (assault in the second degree); 609.223 (assault in the third degree); 609.2231 (assault in the fourth degree); 609.224 (assault in the fifth degree); 609.2242 (domestic assault); 609.2335 (financial exploitation of a vulnerable adult); 609.234 (failure to report maltreatment of a vulnerable adult); 609.2672 (assault of an unborn child in the third degree); 609.27 (coercion); violation of an order for protection under 609.3232 (protective order authorized; procedures; penalties); 609.466 (medical assistance fraud); 609.52 (theft); 609.525 (bringing stolen goods into Minnesota); 609.527 (identity theft); 609.53 (receiving stolen property); 609.535 (issuance of dishonored checks); 609.611 (insurance fraud); 609.66 (dangerous weapons); 609.665 (spring guns); 609.746 (interference with privacy); 609.79 (obscene or harassing telephone calls); 609.795 (letter, telegram, or package; opening; harassment); 609.82 (fraud in obtaining credit); 609.821 (financial transaction card fraud); 617.23 (indecent exposure), not involving a minor; 617.293 (harmful materials; dissemination and display to minors prohibited); or Minnesota Statutes 2012, section 609.21; or violation of an order for protection under section 518B.01 (Domestic Abuse Act).

(b) An individual is disqualified under section 245J.12 if less than seven years has passed since a determination or disposition of the individual's:

(1) failure to make required reports under section 260E.06 or 626.557, subdivision 3, for incidents in which: (i) the final disposition under section 626.557 or chapter 260E was substantiated maltreatment, and (ii) the maltreatment was recurring or serious; or

(2) substantiated serious or recurring maltreatment of a minor under chapter 260E, a vulnerable adult under section 626.557, or serious or recurring maltreatment in any other state, the elements of which are substantially similar to the elements of maltreatment under section 626.557 or chapter 260E for which: (i) there is a preponderance of evidence that the maltreatment occurred, and (ii) the subject was responsible for the maltreatment.

(c) An individual is disqualified under section 245J.12 if less than seven years has passed since the individual's aiding and abetting, attempt, or conspiracy to commit any of the offenses listed in paragraphs (a) and (b), as each of these offenses is defined in Minnesota Statutes.

(d) An individual is disqualified under section 245J.12 if less than seven years has passed since the discharge of the sentence imposed for an offense in any other state or country, the elements of which are substantially similar to the elements of any of the offenses listed in paragraphs (a) and (b).

(e) When a disqualification is based on a judicial determination other than a conviction, the disqualification period begins from the date of the court order. When a disqualification is based on an admission, the disqualification period begins from the date of an admission in court. When a disqualification is based on an Alford Plea, the disqualification period begins from the date the Alford Plea is entered in court. When a disqualification is based on a preponderance of evidence of a disqualifying act, the disqualification date begins from the date of the dismissal, the date of discharge of the sentence imposed for a conviction for a disqualifying crime of similar elements, or the date of the incident, whichever occurs last.

(f) An individual is disqualified under section 245J.12 if less than seven years has passed since the individual was disqualified under section 256.98, subdivision 8.

Sec. 45. **[245J.14] DISQUALIFIED INDIVIDUAL'S RISK OF HARM.**

Subdivision 1. **Determining immediate risk of harm.** (a) If the commissioner determines that the individual studied has a disqualifying characteristic, the commissioner shall review the information immediately available and make a determination as to the subject's immediate

risk of harm to persons served by the program where the individual studied will have direct contact with, or access to, people receiving services.

(b) The commissioner shall consider all relevant information available, including the following factors in determining the immediate risk of harm:

(1) the recency of the disqualifying characteristic;

(2) the recency of discharge from probation for the crimes;

(3) the number of disqualifying characteristics;

(4) the intrusiveness or violence of the disqualifying characteristic;

(5) the vulnerability of the victim involved in the disqualifying characteristic;

(6) the similarity of the victim to the persons served by the program where the individual studied will have direct contact;

(7) whether the individual has a disqualification from a previous background study that has not been set aside;

(8) if the individual has a disqualification which may not be set aside because it is a permanent bar under section 245J.22, the commissioner may order the immediate removal of the individual from any position allowing direct contact with, or access to, persons receiving services from the entity; and

(c) If the commissioner has reason to believe, based on arrest information or an active maltreatment investigation, that an individual poses an imminent risk of harm to persons receiving services, the commissioner may order that the person be continuously supervised or immediately removed pending the conclusion of the maltreatment investigation or criminal proceedings.

Subd. 2. **Findings.** (a) After evaluating the information immediately available under subdivision 1, the commissioner may have reason to believe one of the following:

(1) the individual poses an imminent risk of harm to persons served by the program where the individual studied will have direct contact or access to persons served by the entity or where the individual studied will work;

(2) the individual poses a risk of harm requiring continuous, direct supervision while providing direct contact services during the period in which the subject may request a reconsideration; or

(3) the individual does not pose an imminent risk of harm or a risk of harm requiring continuous, direct supervision while providing direct contact services during the period in which the subject may request a reconsideration.

(b) After determining an individual's risk of harm under this section, the commissioner must notify the subject of the background study and the applicant or license holder as required under section 245J.15.

Sec. 46. **[245J.15] NOTICE OF BACKGROUND STUDY RESULTS.**

Subdivision 1. **Time frame for notice of study results and auditing system access.** (a) Within three working days after the commissioner's receipt of a request for a background study submitted through the commissioner's NETStudy 2.0 system, the commissioner shall notify the background study subject and the entity that submitted the study in writing or by electronic transmission of the results of the study or that more time is needed to complete the study. The notice to the individual shall include the identity of the entity that initiated the background study.

(b) Before being provided access to NETStudy 2.0, the entity shall sign an acknowledgment of responsibilities form developed by the commissioner that includes identifying the sensitive background study information person, who must be an employee of the entity. All queries to NETStudy 2.0 are electronically recorded and subject to audit by the commissioner. The electronic record shall identify the specific user. A background study subject may request in writing to the commissioner a report listing the entities that initiated a background study on the individual.

(c) When the commissioner has completed a prior background study on an individual that resulted in an order for immediate removal and more time is necessary to complete a subsequent study, the notice that more time is needed that is issued under paragraph (a) shall include an order for immediate removal of the individual from any position allowing direct contact with or access to people receiving services.

Subd. 2. **Disqualification notice sent to subject.** If the information in the study indicates the individual is disqualified from direct contact with, or from access to, persons served by the program, the commissioner shall disclose to the individual studied:

(1) the information causing disqualification;

(2) instructions on how to request a reconsideration of the disqualification;

(3) an explanation of any restrictions on the commissioner's discretion to set aside the disqualification under section 245J.22, when applicable to the individual; and

(4) a statement that when a subsequent background study is initiated on the individual following a set-aside of the individual's disqualification, and the commissioner makes a determination under section 245J.20, subdivision 5, paragraph (b), that the previous set-aside applies to the subsequent background study, the entity that initiated the background study will be informed that the individual's disqualification is set aside for that entity.

Subd. 3. **Disqualification notification.** (a) The commissioner shall notify the entity that submitted the study:

(1) that the commissioner has found information that disqualifies the individual studied from being in a position allowing direct contact with, or access to, people served by the entity; and

(2) the commissioner's determination of the individual's risk of harm under section 245J.14.

(b) If the commissioner determines under section 245J.14 that an individual studied poses an imminent risk of harm to persons served by the entity where the individual studied will have direct contact with, or access to, people served by the entity, the commissioner shall order the license holder to immediately remove the individual studied from any position allowing direct contact with, or access to, people served by the entity.

(c) If the commissioner determines under section 245J.14 that an individual studied poses a risk of harm that requires continuous, direct supervision, the commissioner shall order the entity to:

(1) immediately remove the individual studied from any position allowing direct contact with, or access to, people receiving services; or

(2) before allowing the disqualified individual to be in a position allowing direct contact with, or access to, people receiving services, the entity must:

(i) ensure that the individual studied is under continuous, direct supervision when in a position allowing direct contact with, or access to, people receiving services during the period in which the individual may request a reconsideration of the disqualification under section 245J.19; and

(ii) ensure that the disqualified individual requests reconsideration within 30 days of receipt of the notice of disqualification.

(d) If the commissioner determines under section 245J.14 that an individual studied does not pose a risk of harm that requires continuous, direct supervision, the commissioner shall order the entity to:

(1) immediately remove the individual studied from any position allowing direct contact with, or access to, people receiving services; or

(2) before allowing the disqualified individual to be in any position allowing direct contact with, or access to, people receiving services, the entity must ensure that the disqualified individual requests reconsideration within 15 days of receipt of the notice of disqualification.

(e) The commissioner shall not notify the entity of the information contained in the subject's background study unless:

(1) the basis for the disqualification is failure to cooperate with the background study or substantiated maltreatment under section 626.557 or chapter 260E;

(2) the Data Practices Act under chapter 13 provides for release of the information; or

(3) the individual studied provides the commissioner with written, informed consent authorizing the release of the information.

Sec. 47. **[245J.16] OBLIGATION TO REMOVE DISQUALIFIED INDIVIDUAL FROM DIRECT CONTACT OR ACCESS TO PEOPLE RECEIVING SERVICES.**

Upon receipt of notice from the commissioner, the entity must remove a disqualified individual from direct contact with or access to persons served by the entity if:

(1) the individual does not request reconsideration under section 245J.19 within the prescribed time;

(2) the individual submits a timely request for reconsideration, the commissioner does not set aside the disqualification under section 245J.20, subdivision 4, and the individual does not submit a timely request for a hearing under sections 245J.24 and 256.045, or 245J.25 and chapter 14; or

(3) the individual submits a timely request for a hearing under sections 245J.24 and 256.045, or 245J.25 and chapter 14, and the commissioner does not set aside or rescind the disqualification under section 245A.08, subdivision 5, or 256.045.

Sec. 48. **[245J.17] TERMINATION OF AFFILIATION BASED ON DISQUALIFICATION NOTICE.**

An applicant or license holder that terminates affiliation with persons studied under this chapter, when the termination is made in good faith reliance on a notice of disqualification provided by the commissioner, shall not be subject to civil liability.

Sec. 49. **[245J.18] ENTITY RECORD KEEPING.**

Subdivision 1. **Background studies initiated by entity.** The entity shall document the date the entity initiates a background study under this chapter and the date the subject of the study first has direct contact with persons served by the entity in the entity's personnel files. When a background study is completed under this chapter, an entity shall maintain a notice that the study was undertaken and completed in the entity's personnel files.

Subd. 2. **Background studies initiated by others; personnel pool agencies, temporary personnel agencies, supplemental nursing services agencies, or professional services agencies.** When a license holder relies on a background study initiated by a personnel pool agency, a temporary personnel agency, a supplemental nursing services agency, or a professional services agency for a person required to have a background study completed under this chapter, the entity must maintain a copy of the background study results in the entity's files.

Subd. 3. **Background studies initiated by others; educational programs.** When an entity relies on a background study initiated by an educational program for a person required to have a background study completed under this chapter and the person is on the educational program's active roster, the entity is responsible for ensuring that the background study has been completed. The entity may satisfy the documentation requirements through a written agreement with the educational program verifying that documentation of the background study may be provided upon request and that the educational program will inform the entity if there is a change in the person's background study status. The entity remains responsible for ensuring that all background study requirements are met.

Subd. 4. **Background studies identified on active rosters.** The requirements in subdivisions 1 and 2 are met for entities for which active rosters are implemented and for whom all individuals affiliated with the entity are recorded on the active roster.

Sec. 50. **[245J.19] REQUESTING RECONSIDERATION OF DISQUALIFICATION.**

Subdivision 1. **Who may request reconsideration.** An individual who is the subject of a disqualification may request a reconsideration of the disqualification pursuant to this section. The individual must submit the request for reconsideration to the commissioner in writing.

Subd. 2. **Submission of reconsideration request.** A reconsideration request shall be submitted within 30 days of the individual's receipt of the disqualification notice or the time frames specified in subdivision 3, whichever time frame is shorter.

Subd. 3. **Time frame for requesting reconsideration.** (a) When the commissioner sends an individual a notice of disqualification based on a finding under section 245J.14, subdivision 2, paragraph (a), clause (1) or (2), the disqualified individual must submit the request for a reconsideration within 30 calendar days of the individual's receipt of the notice of disqualification. If mailed, the request for reconsideration must be postmarked and sent to the commissioner within 30 calendar days of the individual's receipt of the notice of disqualification. If a request for reconsideration is made by personal service, it must be received by the commissioner within 30 calendar days after the individual's receipt of the notice of disqualification. Upon showing that the information under subdivision 3 cannot be obtained within 30 days, the disqualified individual may request additional time, not to exceed 30 days, to obtain the information.

(b) When the commissioner sends an individual a notice of disqualification based on a finding under section 245J.14, subdivision 2, paragraph (a), clause (3), the disqualified individual must submit the request for reconsideration within 15 calendar days of the individual's receipt of the notice of disqualification. If mailed, the request for reconsideration must be postmarked and sent to the commissioner within 15 calendar days of the individual's receipt of the notice of disqualification. If a request for reconsideration is made by personal service, it must be received by the commissioner within 15 calendar days after the individual's receipt of the notice of disqualification.

(c) An individual who was determined to have maltreated a child under chapter 260E or a vulnerable adult under section 626.557, and who is disqualified on the basis of serious or recurring maltreatment, may request a reconsideration of both the maltreatment and the disqualification determinations. The request must be submitted within 30 calendar days of the individual's receipt of the notice of disqualification. If mailed, the request for reconsideration must be postmarked and sent to the commissioner within 30 calendar days of the individual's receipt of the notice of disqualification. If a request for reconsideration is made by personal service, it must be received by the commissioner within 30 calendar days after the individual's receipt of the notice of disqualification.

(d) Reconsideration of a maltreatment determination under sections 260E.33 and 626.557, subdivision 9d, and reconsideration of a disqualification under section 245J.20, shall not be conducted when:

(1) a denial of a license under section 245A.05, or a licensing sanction under section 245A.07, is based on a determination that the license holder is responsible for maltreatment or the disqualification of a license holder based on serious or recurring maltreatment;

(2) the denial of a license or licensing sanction is issued at the same time as the maltreatment determination or disqualification; and

(3) the license holder appeals the maltreatment determination, disqualification, and denial of a license or licensing sanction. In such cases, a fair hearing under section 256.045 must not be conducted under sections 245J.24, 260E.33, and 626.557, subdivision 9d. Under section 245A.08, subdivision 2a, the scope of the consolidated contested case hearing must include the maltreatment determination, disqualification, and denial of a license or licensing sanction.

Notwithstanding clauses (1) to (3), if the license holder appeals the maltreatment determination or disqualification, but does not appeal the denial of a license or a licensing sanction, reconsideration of the maltreatment determination shall be conducted under sections 260E.33 and 626.557, subdivision 9d, and reconsideration of the disqualification shall be conducted under section 245J.20. In such cases, a fair hearing shall also be conducted as provided under sections 245J.24, 260E.33, and 626.557, subdivision 9d.

Subd. 4. **Disqualified individuals; information for reconsideration.** (a) The disqualified individual requesting reconsideration must submit information showing that:

(1) the information the commissioner relied upon in determining the underlying conduct that gave rise to the disqualification is incorrect;

(2) for maltreatment, the information the commissioner relied upon in determining that maltreatment was serious or recurring is incorrect; or

(3) the subject of the study does not pose a risk of harm to any person served by the entity as provided in this chapter, by addressing the information required under section 245J.20, subdivision 4.

(b) In order to determine the individual's risk of harm, the commissioner may require additional information from the disqualified individual as part of the reconsideration process. If the individual fails to provide the required information, the commissioner may deny the individual's request.

Subd. 5. **Notice of request for reconsideration.** Upon request, the commissioner may inform the entity as provided in this chapter who received a notice of the individual's disqualification under section 245J.15, subdivision 3, or has the consent of the disqualified individual, whether the disqualified individual has requested reconsideration.

Sec. 51. **[245J.20] REVIEW AND ACTION ON A RECONSIDERATION REQUEST.**

Subdivision 1. **Time frame; response to disqualification reconsideration requests.** (a) The commissioner shall respond in writing or by electronic transmission to all reconsideration requests for which the basis for the request is that the information the commissioner relied upon to disqualify is incorrect or inaccurate within 30 working days of receipt of a complete request and all required relevant information.

(b) If the basis for a disqualified individual's reconsideration request is that the individual does not pose a risk of harm, the commissioner shall respond to the request within 15 working days after receiving a complete request for reconsideration and all required relevant information.

(c) If the disqualified individual's reconsideration request is based on both the correctness or accuracy of the information the commissioner relied upon to disqualify the individual and the individual's risk of harm, the commissioner shall respond to the request within 45 working days after receiving a complete request for reconsideration and all required relevant information.

Subd. 2. **Incorrect information; rescission.** The commissioner shall rescind the disqualification if the commissioner finds that the information relied upon to disqualify the subject is incorrect.

Subd. 3. **Preeminent weight given to safety of persons being served.** In reviewing a request for reconsideration of a disqualification, the commissioner shall give preeminent weight to the safety of each person served by the entity as provided in this chapter over the interests of the disqualified individual or entity as provided in this chapter, and any single factor under subdivision 4, paragraph (b), may be determinative of the commissioner's decision whether to set aside the individual's disqualification.

Subd. 4. **Risk of harm; set aside.** (a) The commissioner may set aside the disqualification if the commissioner finds that the individual has submitted sufficient information to demonstrate that the individual does not pose a risk of harm to any person served by the entity as provided in this chapter.

(b) In determining whether the individual has met the burden of proof by demonstrating the individual does not pose a risk of harm, the commissioner shall consider:

(1) the nature, severity, and consequences of the event or events that led to the disqualification;

(2) whether there is more than one disqualifying event;

(3) the age and vulnerability of the victim at the time of the event;

(4) the harm suffered by the victim;

(5) vulnerability of persons served by the program;

(6) the similarity between the victim and persons served by the program;

(7) the time elapsed without a repeat of the same or similar event;

(8) documentation of successful completion by the individual studied of training or rehabilitation pertinent to the event; and

(9) any other information relevant to reconsideration.

(c) If the individual requested reconsideration on the basis that the information relied upon to disqualify the individual was incorrect or inaccurate and the commissioner determines that the information relied upon to disqualify the individual is correct, the commissioner must also determine if the individual poses a risk of harm to persons receiving services in accordance with paragraph (b).

Subd. 5. **Scope of set-aside.** (a) If the commissioner sets aside a disqualification under this section, the disqualified individual remains disqualified, but may hold a license and have direct contact with or access to persons receiving services. Except as provided in paragraph (b), the commissioner's set-aside of a disqualification is limited solely to the licensed program, applicant, or agency specified in the set aside notice under section 245J.21. For personal care provider organizations, the commissioner's set-aside may further be limited to a specific individual who is receiving services. For new background studies required under section 245J.04, subdivision 1, paragraph (c), if an individual's disqualification was previously set aside for the license holder's program and the new background study results in no new information that indicates the individual may pose a risk of harm to persons receiving services from the license holder, the previous set-aside shall remain in effect.

(b) If the commissioner has previously set aside an individual's disqualification for one or more entities, and the individual is the subject of a subsequent background study for a different entity, the commissioner shall determine whether the disqualification is set aside for the entity that initiated the subsequent background study. A notice of a set-aside under paragraph (c) shall be issued within 15 working days if all of the following criteria are met:

(1) the subsequent background study was initiated in connection with an entity licensed or regulated under the same provisions of law and rule for at least one entity for which the individual's disqualification was previously set aside by the commissioner;

(2) the individual is not disqualified for an offense specified in section 245J.13, subdivision 1 or 2;

(3) the commissioner has received no new information to indicate that the individual may pose a risk of harm to any person served by the program; and

(4) the previous set-aside was not limited to a specific person receiving services.

(c) When a disqualification is set aside under paragraph (b), the notice of background study results issued under section 245J.15, in addition to the requirements under section 245J.15, shall state that the disqualification is set aside for the program or agency that initiated the subsequent background study. The notice must inform the individual that the individual may request reconsideration of the disqualification under section 245J.19 on the basis that the information used to disqualify the individual is incorrect.

Subd. 6. **Rescission of set-aside.** The commissioner may rescind a previous set aside of a disqualification under this section based on new information that indicates the individual may pose a risk of harm to persons served by the applicant, license holder, or other entities as provided in this chapter. If the commissioner rescinds a set-aside of a disqualification under this subdivision, the appeal rights under sections 245J.19; 245J.24, subdivision 1; and 245J.25, subdivision 3, shall apply.

Sec. 52. **[245J.21] COMMISSIONER'S RECONSIDERATION NOTICE.**

Subdivision 1. **Disqualification that is rescinded or set aside.** (a) If the commissioner rescinds or sets aside a disqualification, the commissioner shall notify the entity in writing or by electronic transmission of the decision.

(b) In the notice from the commissioner that a disqualification has been rescinded, the commissioner must inform the entity that the information relied upon to disqualify the individual was incorrect.

Subd. 2. **Commissioner's notice of disqualification that is not set aside.** (a) The commissioner shall notify the entity of the disqualification and order the entity to immediately remove the individual from any position allowing direct contact with persons receiving services from the entity if:

(1) the individual studied does not submit a timely request for reconsideration under section 245J.19;

(2) the individual submits a timely request for reconsideration, but the commissioner does not set aside the disqualification for that entity under section 245J.20, unless the individual has a right to request a hearing under section 245J.24, 245J.25, or 256.045;

(3) an individual who has a right to request a hearing under sections 245J.24 and 256.045, or 245J.25 and chapter 14 for a disqualification that has not been set aside, does not request a hearing within the specified time; or

(4) an individual submitted a timely request for a hearing under sections 245J.24 and 256.045, or 245J.25 and chapter 14, but the commissioner does not set aside the disqualification under section 245A.08, subdivision 5, or 256.045.

(b) If the commissioner does not set aside the disqualification under section 245J.20, and the entity was previously ordered under section 245J.15 to immediately remove the disqualified individual from direct contact with persons receiving services or to ensure that the individual is under continuous, direct supervision when providing direct contact services, the order remains in effect pending the outcome of a hearing under sections 245J.24 and 256.045, or 245J.25 and chapter 14.

(c) If the commissioner does not set aside the disqualification under section 245J.20, and the entity was not previously ordered under section 245J.15 to immediately remove the disqualified individual from direct contact with persons receiving services or to ensure that the individual is under continuous direct supervision when providing direct contact services, the commissioner shall order the individual to remain under continuous direct supervision pending the outcome of a hearing under sections 245J.24 and 256.045, or 245J.25 and chapter 14.

Sec. 53. **[245J.22] DISQUALIFICATION; BAR TO SET ASIDE A DISQUALIFICATION.**

The commissioner may not set aside the disqualification of any individual disqualified pursuant to this chapter, regardless of how much time has passed, if the individual was disqualified for a crime or conduct listed in section 245J.13, subdivision 1.

Sec. 54. **[245J.23] CONSOLIDATED RECONSIDERATION OF MALTREATMENT DETERMINATION AND DISQUALIFICATION.**

If an individual is disqualified on the basis of a determination of maltreatment under section 626.557 or chapter 260E, which was serious and recurring, and the individual requests reconsideration of the maltreatment determination under section 260E.33 or 626.557,

subdivision 9d, and also requests reconsideration of the disqualification under section 245J.19, the commissioner shall consolidate the reconsideration of the maltreatment determination and the disqualification into a single reconsideration.

Sec. 55. **[245J.24] FAIR HEARING RIGHTS.**

Subdivision 1. **Fair hearing following a reconsideration decision.** (a) An individual who is disqualified on the basis of a preponderance of evidence that the individual committed an act or acts that meet the definition of any of the crimes listed in section 245J.13; for a determination under section 626.557 or chapter 260E of substantiated maltreatment that was serious or recurring under section 245J.13; or for failure to make required reports under section 260E.06, subdivision 1 or 2; 260E.11, subdivision 1; or 626.557, subdivision 3, pursuant to section 245J.13, subdivision 4, paragraph (b), clause (1), may request a fair hearing under section 256.045, following a reconsideration decision issued under section 245J.21, unless the disqualification is deemed conclusive under section 245J.26.

(b) The fair hearing is the only administrative appeal of the final agency determination for purposes of appeal by the disqualified individual. The disqualified individual does not have the right to challenge the accuracy and completeness of data under section 13.04.

(c) Except as provided under paragraph (e), if the individual was disqualified based on a conviction of, admission to, or Alford Plea to any crimes or conduct listed in section 245J.13, subdivisions 1 to 4, or for a disqualification under section 256.98, subdivision 8, the reconsideration decision under section 245J.20 is the final agency determination for purposes of appeal by the disqualified individual and is not subject to a hearing under section 256.045. If the individual was disqualified based on a judicial determination, that determination is treated the same as a conviction for purposes of appeal.

(d) This subdivision does not apply to a public employee's appeal of a disqualification under section 245J.25, subdivision 3.

(e) Notwithstanding paragraph (c), if the commissioner does not set aside a disqualification of an individual who was disqualified based on both a preponderance of evidence and a conviction or admission, the individual may request a fair hearing under section 256.045, unless the disqualifications are deemed conclusive under section 245J.26. The scope of the hearing conducted under section 256.045 with regard to the disqualification based on a conviction or admission shall be limited solely to whether the individual poses a risk of harm, according to section 256.045, subdivision 3b. In this case, the reconsideration decision under section 245J.20 is not the final agency decision for purposes of appeal by the disqualified individual.

Subd. 2. **Consolidated fair hearing following a reconsideration decision.** (a) If an individual who is disqualified on the bases of serious or recurring maltreatment requests a fair hearing on the maltreatment determination under section 260E.33 or 626.557, subdivision 9d, and requests a fair hearing under this section on the disqualification following a reconsideration decision under section 245J.21, the scope of the fair hearing under section 256.045 shall include the maltreatment determination and the disqualification.

(b) A fair hearing is the only administrative appeal of the final agency determination. The disqualified individual does not have the right to challenge the accuracy and completeness of data under section 13.04.

(c) This subdivision does not apply to a public employee's appeal of a disqualification under section 245J.25, subdivision 3.

Sec. 56. **[245J.25] CONTESTED CASE HEARING RIGHTS.**

Subdivision 1. **License holder.** (a) If a maltreatment determination or a disqualification for which reconsideration was timely requested and which was not set aside is the basis for a denial of a license under section 245A.05 or a licensing sanction under section 245A.07, the license holder has the right to a contested case hearing under chapter 14 and Minnesota Rules, parts 1400.8505 to 1400.8612. The license holder must submit the appeal under section 245A.05 or 245A.07, subdivision 3.

(b) As provided under section 245A.08, subdivision 2a, if the denial of a license or licensing sanction is based on a disqualification for which reconsideration was timely requested and was not set aside, the scope of the consolidated contested case hearing must include:

(1) the disqualification, to the extent the license holder otherwise has a hearing right on the disqualification under this chapter; and

(2) the licensing sanction or denial of a license.

(c) As provided for under section 245A.08, subdivision 2a, if the denial of a license or licensing sanction is based on a determination of maltreatment under section 626.557 or chapter 260E, or a disqualification for serious or recurring maltreatment which was not set aside, the scope of the contested case hearing must include:

(1) the maltreatment determination, if the maltreatment is not conclusive under section 245J.26;

(2) the disqualification, if the disqualification is not conclusive under section 245J.26; and

(3) the licensing sanction or denial of a license. In such cases, a fair hearing must not be conducted under section 256.045. If the disqualification was based on a determination of substantiated serious or recurring maltreatment under section 626.557 or chapter 260E, the appeal must be submitted under section 245A.07, subdivision 3, 260E.33, or 626.557, subdivision 9d.

(d) Except for family child care and child foster care, reconsideration of a maltreatment determination under sections 260E.33 and 626.557, subdivision 9d, and reconsideration of a disqualification under section 245J.20, must not be conducted when:

(1) a denial of a license under section 245A.05, or a licensing sanction under section 245A.07, is based on a determination that the license holder is responsible for maltreatment or the disqualification of a license holder based on serious or recurring maltreatment;

(2) the denial of a license or licensing sanction is issued at the same time as the maltreatment determination or disqualification; and

(3) the license holder appeals the maltreatment determination, disqualification, and denial of a license or licensing sanction. In such cases a fair hearing under section 256.045 must not be conducted under sections 245J.24, 260E.33, and 626.557, subdivision 9d. Under section 245A.08, subdivision 2a, the scope of the consolidated contested case hearing must include the maltreatment determination, disqualification, and denial of a license or licensing sanction.

Notwithstanding clauses (1) to (3), if the license holder appeals the maltreatment determination or disqualification, but does not appeal the denial of a license or a licensing sanction, reconsideration of the maltreatment determination shall be conducted under sections 260E.33 and 626.557, subdivision 9d, and reconsideration of the disqualification shall be conducted under section 245J.20. In such cases, a fair hearing shall also be conducted as provided under sections 245J.24, 260E.33, and 626.557, subdivision 9d.

Subd. 2. **Individual other than license holder.** If the basis for the commissioner's denial of a license under section 245A.05 or a licensing sanction under section 245A.07 is a maltreatment determination or disqualification that was not set aside under section 245J.20, and the disqualified subject is an individual other than the license holder and upon whom a background study must be conducted under this chapter, the hearing of all parties may be consolidated into a single contested case hearing upon consent of all parties and the administrative law judge.

Subd. 3. **Employees of public employer.** (a) A disqualified individual who is an employee of an employer, as defined in section 179A.03, subdivision 15, may request a contested case hearing under chapter 14, and specifically Minnesota Rules, parts 1400.8505 to 1400.8612, following a reconsideration decision under section 245J.21, unless the disqualification is deemed conclusive under section 245J.26. The request for a contested case hearing must be made in writing and must be postmarked and sent within 30 calendar days after the employee receives notice of the reconsideration decision. If the individual was disqualified based on a conviction or admission to any crimes listed in section 245J.13, the scope of the contested case hearing shall be limited solely to whether the individual poses a risk of harm pursuant to section 245J.20.

(b) When an individual is disqualified based on a maltreatment determination, the scope of the contested case hearing under paragraph (a), must include the maltreatment determination and the disqualification. In such cases, a fair hearing must not be conducted under section 256.045.

(c) Rules adopted under this chapter may not preclude an employee in a contested case hearing for a disqualification from submitting evidence concerning information gathered under this chapter.

(d) When an individual has been disqualified from multiple licensed programs, if at least one of the disqualifications entitles the person to a contested case hearing under this subdivision, the scope of the contested case hearing shall include all disqualifications from licensed programs.

(e) In determining whether the disqualification should be set aside, the administrative law judge shall consider all of the characteristics that cause the individual to be disqualified, as well as all the factors set forth in section 245J.20, in order to determine whether the individual has met the burden of demonstrating that the individual does not pose a risk of harm. The administrative law judge's recommendation and the commissioner's order to set aside a disqualification that is the subject of the hearing constitutes a determination that the individual does not pose a risk of harm and that the individual may provide direct contact services in the individual program specified in the set aside.

(f) An individual may not request a contested case hearing under this section if a contested case hearing has previously been held regarding the individual's disqualification on the same basis.

Subd. 4. **Final agency order.** The commissioner's final order under section 245A.08, subdivision 5, is conclusive on the issue of maltreatment and disqualification, including for

purposes of subsequent background studies. The contested case hearing under this section is the only administrative appeal of the final agency determination, specifically, including a challenge to the accuracy and completeness of data under section 13.04.

Sec. 57. **[245J.26] CONCLUSIVE DETERMINATIONS OR DISPOSITIONS.**

Subdivision 1. **Conclusive maltreatment determination or disposition.** Unless otherwise specified in statute, a maltreatment determination or disposition under section 626.557 or chapter 260E is conclusive, if:

(1) the commissioner has issued a final order in an appeal of that determination or disposition under section 245A.08, subdivision 5, or 256.045;

(2) the individual did not request reconsideration of the maltreatment determination or disposition under section 626.557 or chapter 260E; or

(3) the individual did not request a hearing of the maltreatment determination or disposition under section 256.045.

Subd. 2. **Conclusive disqualification determination.** (a) A disqualification is conclusive for purposes of current and future background studies if:

(1) the commissioner has issued a final order in an appeal of the disqualification under section 245A.08, subdivision 5; 245J.25, subdivision 3; or 256.045, or a court has issued a final decision;

(2) the individual did not request reconsideration of the disqualification under section 245J.19 on the basis that the information relied upon to disqualify the individual was incorrect; or

(3) the individual did not timely request a hearing on the disqualification under this chapter, chapter 14, or section 256.045 after previously being given the right to do so.

(b) If a disqualification is conclusive under this section, the individual has a right to request reconsideration on the risk of harm under section 245J.19 unless the commissioner is barred from setting aside the disqualification under section 245J.22. The commissioner's decision regarding the risk of harm shall be the final agency decision and is not subject to a hearing under this chapter, chapter 14, or section 256.045.

Sec. 58. **[245J.27] VARIANCE FOR A DISQUALIFIED INDIVIDUAL.**

Subdivision 1. **Entity variance.** (a) Except for any disqualification under section 245J.11, subdivision 1, when the commissioner has not set aside a background study subject's

disqualification, and there are conditions under which the disqualified individual may provide direct contact services or have access to people receiving services that minimize the risk of harm to people receiving services, the commissioner may grant a time-limited variance to an entity.

(b) The variance shall state the services that may be provided by the disqualified individual and state the conditions with which the entity must comply for the variance to remain in effect. The variance shall not state the reason for the disqualification.

Subd. 2. **Consequences for failing to comply with conditions of variance.** When an entity permits a disqualified individual to provide any services for which the subject is disqualified without complying with the conditions of the variance, the commissioner may terminate the variance effective immediately and subject the entity or license holder to a licensing action under sections 245A.06 and 245A.07.

Subd. 3. **Termination of a variance.** The commissioner may terminate a variance for a disqualified individual at any time for cause.

Subd. 4. **Final decision.** The commissioner's decision to grant or deny a variance is final and not subject to appeal under the provisions of chapter 14.

Sec. 59. **[245J.28] INDIVIDUAL REGULATED BY A HEALTH-RELATED LICENSING BOARD; DISQUALIFICATION BASED ON MALTREATMENT.**

(a) The commissioner has the authority to monitor the facility's compliance with any requirements that the health-related licensing board places on regulated individuals practicing in a facility either during the period pending a final decision on a disciplinary or corrective action or as a result of a disciplinary or corrective action. The commissioner has the authority to order the immediate removal of a regulated individual from direct contact or access when a board issues an order of temporary suspension based on a determination that the regulated individual poses an immediate risk of harm to persons receiving services in a licensed facility.

(b) A facility that allows a regulated individual to provide direct contact services while not complying with the requirements imposed by the health-related licensing board is subject to action by the commissioner as specified under sections 245A.06 and 245A.07.

(c) The commissioner shall notify a health-related licensing board immediately upon receipt of knowledge of a facility's or individual's noncompliance with requirements the board placed on a facility or upon an individual regulated by the board.

Sec. 60. **[245J.29] SYSTEMS AND RECORDS.**

Subdivision 1. **Establishment.** The commissioner may establish systems and records to fulfill the requirements of this chapter.

Subd. 2. **NETStudy 2.0 system.** (a) The NETStudy 2.0 system developed and implemented by the commissioner shall incorporate and meet all applicable data security standards and policies required by the Federal Bureau of Investigation (FBI), Department of Public Safety, Bureau of Criminal Apprehension, and Department of Information Technology Services. The system shall meet all required standards for encryption of data at the database level as well as encryption of data that travels electronically among agencies initiating background studies, the commissioner's authorized fingerprint collection vendor or vendors, the commissioner, the Bureau of Criminal Apprehension, and in cases involving national criminal record checks, the FBI.

(b) The data system developed and implemented by the commissioner shall incorporate a system of data security that allows the commissioner to control access to the data field level by the commissioner's employees. The commissioner shall establish that employees have access to the minimum amount of private data on any individual as is necessary to perform their duties under this chapter.

(c) The commissioner shall oversee regular quality and compliance audits of the authorized fingerprint collection vendor or vendors.

Subd. 3. **Use.** The commissioner may also use these systems and records to obtain and provide criminal history data from the Bureau of Criminal Apprehension, criminal history data held by the commissioner, and data about substantiated maltreatment under section 626.557 or chapter 260E, for other purposes, provided that the background study is specifically authorized in statute.

Subd. 4. **National records search.** (a) When specifically required by statute, the commissioner shall also obtain criminal history data from the National Criminal Records Repository.

(b) To obtain criminal history data from the National Criminal Records Repository, the commissioner shall require classifiable fingerprints of the data subject and must submit these fingerprint requests through the Bureau of Criminal Apprehension.

(c) The commissioner may require the background study subject to submit fingerprint images electronically. The commissioner may not require electronic fingerprint images until the electronic recording and transfer system is available for noncriminal justice purposes

and the necessary equipment is in use in the law enforcement agency in the background study subject's local community.

(d) The commissioner may recover the cost of obtaining and providing criminal history data from the National Criminal Records Repository by charging the individual or entity requesting the study a fee of no more than $30 per study. The fees collected under this subdivision are appropriated to the commissioner for the purpose of obtaining criminal history data from the National Criminal Records Repository.

Sec. 61. **REPEALER.**

(a) Minnesota Statutes 2022, sections 245C.02, subdivision 14b; 245C.032; and 245C.30, subdivision 1a, are repealed.

(b) Minnesota Statutes 2022, section 245C.11, subdivision 3, is repealed.

EFFECTIVE DATE. Paragraph (a) is effective August 1, 2023, and paragraph (b) is effective April 28, 2025.

ARTICLE 8
LICENSING

Section 1. Minnesota Statutes 2022, section 245.095, is amended to read:

245.095 LIMITS ON RECEIVING PUBLIC FUNDS.

Subdivision 1. **Prohibition.** (a) If a provider, vendor, or individual enrolled, licensed, receiving funds under a grant contract, or registered in any program administered by the commissioner, including under the commissioner's powers and authorities in section 256.01, is excluded from that program, the commissioner shall:

(1) prohibit the excluded provider, vendor, or individual from enrolling, becoming licensed, receiving grant funds, or registering in any other program administered by the commissioner; and

(2) disenroll, revoke or suspend a license, disqualify, or debar the excluded provider, vendor, or individual in any other program administered by the commissioner.

(b) If a provider, vendor, or individual enrolled, licensed, receiving funds under a grant contract, or registered in any program administered by the commissioner, including under the commissioner's powers and authorities in section 256.01, is excluded from that program, the commissioner may:

(1) prohibit any associated entities or associated individuals from enrolling, becoming licensed, receiving grant funds, or registering in any other program administered by the commissioner; and

(2) disenroll, revoke or suspend a license of, disqualify, or debar any associated entities or associated individuals in any other program administered by the commissioner.

(c) If a provider, vendor, or individual enrolled, licensed, or otherwise receiving funds under any contract or registered in any program administered by a Minnesota state or federal agency is excluded from that program, the commissioner of human services may:

(1) prohibit the excluded provider, vendor, individual, or any associated entities or associated individuals from enrolling, becoming licensed, receiving grant funds, or registering in any program administered by the commissioner; and

(2) disenroll, revoke or suspend a license of, disqualify, or debar the excluded provider, vendor, individual, or any associated entities or associated individuals in any program administered by the commissioner.

~~(b)~~ (d) The duration of ~~this~~ a prohibition, disenrollment, revocation, suspension, disqualification, or debarment under paragraph (a) must last for the longest applicable sanction or disqualifying period in effect for the provider, vendor, or individual permitted by state or federal law. The duration of a prohibition, disenrollment, revocation, suspension, disqualification, or debarment under paragraphs (b) and (c) may last until up to the longest applicable sanction or disqualifying period in effect for the provider, vendor, individual, associated entity, or associated individual as permitted by state or federal law.

Subd. 2. **Definitions.** (a) For purposes of this section, the following definitions have the meanings given ~~them~~.

(b) "Associated entity" means a provider or vendor owned or controlled by an excluded individual.

(c) "Associated individual" means an individual who owns or is an executive officer or board member of an excluded provider or vendor.

~~(b)~~ (d) "Excluded" means ~~disenrolled, disqualified, having a license that has been revoked or suspended under chapter 245A, or debarred or suspended under Minnesota Rules, part 1230.1150, or excluded pursuant to section 256B.064, subdivision 3~~ removed under other authorities from a program administered by a Minnesota state or federal agency, including a final determination to stop payments.

~~(c)~~ (e) "Individual" means a natural person providing products or services as a provider or vendor.

~~(d)~~ (f) "Provider" ~~includes any entity or individual receiving payment from a program administered by the Department of Human Services, and an owner, controlling individual, license holder, director, or managerial official of an entity receiving payment from a program administered by the Department of Human Services~~ means any entity, individual, owner, controlling individual, license holder, director, or managerial official of an entity receiving payment from a program administered by a Minnesota state or federal agency.

Subd. 3. **Notice.** Within five days of taking an action under subdivision (1), paragraph (a), (b), or (c), against a provider, vendor, individual, associated individual, or associated entity, the commissioner must send notice of the action to the provider, vendor, individual, associated individual, or associated entity. The notice must state:

(1) the basis for the action;

(2) the effective date of the action;

(3) the right to appeal the action; and

(4) the requirements and procedures for reinstatement.

Subd. 4. **Appeal.** Upon receipt of a notice under subdivision 3, a provider, vendor, individual, associated individual, or associated entity may request a contested case hearing, as defined in section 14.02, subdivision 3, by filing with the commissioner a written request of appeal. The scope of any contested case hearing is solely limited to action taken under this section. The commissioner must receive the appeal request no later than 30 days after the date the notice was mailed to the provider, vendor, individual, associated individual, or associated entity. The appeal request must specify:

(1) each disputed item and the reason for the dispute;

(2) the authority in statute or rule upon which the provider, vendor, individual, associated individual, or associated entity relies for each disputed item;

(3) the name and address of the person or entity with whom contacts may be made regarding the appeal; and

(4) any other information required by the commissioner.

Subd. 5. **Withholding of payments.** (a) Except as otherwise provided by state or federal law, the commissioner may withhold payments to a provider, vendor, individual, associated individual, or associated entity in any program administered by the commissioner, if the

commissioner determines there is a credible allegation of fraud for which an investigation is pending for a program administered by a Minnesota state or federal agency.

(b) For purposes of this subdivision, "credible allegation of fraud" means an allegation that has been verified by the commissioner from any source, including but not limited to:

(1) fraud hotline complaints;

(2) claims data mining;

(3) patterns identified through provider audits, civil false claims cases, and law enforcement investigations; and

(4) court filings and other legal documents, including but not limited to police reports, complaints, indictments, informations, affidavits, declarations, and search warrants.

(c) The commissioner must send notice of the withholding of payments within five days of taking such action. The notice must:

(1) state that payments are being withheld according to this subdivision;

(2) set forth the general allegations related to the withholding action, except the notice need not disclose specific information concerning an ongoing investigation;

(3) state that the withholding is for a temporary period and cite the circumstances under which the withholding will be terminated; and

(4) inform the provider, vendor, individual, associated individual, or associated entity of the right to submit written evidence to contest the withholding action for consideration by the commissioner.

(d) The commissioner shall stop withholding payments if the commissioner determines there is insufficient evidence of fraud by the provider, vendor, individual, associated individual, or associated entity or when legal proceedings relating to the alleged fraud are completed, unless the commissioner has sent notice under subdivision 3 to the provider, vendor, individual, associated individual, or associated entity.

(e) The withholding of payments is a temporary action and is not subject to appeal under section 256.045 or chapter 14.

Sec. 2. **[245.7351] PURPOSE AND ESTABLISHMENT.**

The certified community behavioral health clinic model is an integrated payment and service delivery model that uses evidence-based behavioral health practices to achieve better

outcomes for individuals experiencing behavioral health concerns while achieving sustainable rates for providers and economic efficiencies for payors.

EFFECTIVE DATE. This section is effective July 1, 2023, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 3. **[245.7352] DEFINITIONS.**

Subdivision 1. **Scope.** The definitions in this section apply to sections 245.7351 to 245.7357.

Subd. 2. **Care coordination.** "Care coordination" means the activities required to coordinate care across settings and providers for the people served to ensure seamless transitions across the full spectrum of health services. Care coordination includes: outreach and engagement; documenting a plan of care for medical, behavioral health, and social services and supports in the integrated treatment plan; assisting with obtaining appointments; confirming appointments are kept; developing a crisis plan; tracking medication; and implementing care coordination agreements with external providers. Care coordination may include psychiatric consultation to primary care practitioners and mental health clinical care consultation.

Subd. 3. **Certified community behavioral health clinic or CCBHC.** "Certified community behavioral health clinic" or "CCBHC" means a program or provider governed under sections 245.7351 to 245.7357.

Subd. 4. **Clinical responsibility.** "Clinical responsibility" means ensuring a designated collaborating organization meets all clinical parameters required of the CCBHC.

Subd. 5. **Commissioner.** "Commissioner" means the commissioner of human services.

Subd. 6. **Comprehensive evaluation.** "Comprehensive evaluation" means a person-centered, family-centered, trauma-informed evaluation completed for the purposes of diagnosis, treatment planning, and determination of client eligibility for services approved by a mental health professional.

Subd. 7. **Designated collaborating organization.** "Designated collaborating organization" means an entity with a formal agreement with a CCBHC to furnish CCBHC services.

Subd. 8. **Designated collaborating organization agreement.** "Designated collaborating organization agreement" means a purchase of services agreement between a CCBHC and

a designated collaborating organization as evidenced by a contract, memorandum of agreement, memorandum of understanding, or other such formal arrangement that describes specific CCBHC services to be purchased and provided by a designated collaborating organization on behalf of a CCBHC in accordance with federal and state requirements.

Subd. 9. **Functional assessment.** "Functional assessment" means the assessment of a client's current level of functioning relative to functioning that is appropriate for someone the client's age.

Subd. 10. **Financial responsibility.** "Financial responsibility" means the responsibility for billing CCBHC services rendered under contract by a designated collaborating organization.

Subd. 11. **Initial evaluation.** "Initial evaluation" means an evaluation that is designed to gather and document initial components of the comprehensive evaluation, allowing the assessor to formulate a preliminary diagnosis and the client to begin services.

Subd. 12. **Initial evaluation equivalents.** "Initial evaluation equivalents" means using a process that is approved by the commissioner as an alternative to the initial evaluation.

Subd. 13. **Integrated treatment plan.** "Integrated treatment plan" means a documented plan of care that is person- and family-centered and formulated to respond to a client's needs and goals. The integrated treatment plan must integrate prevention, medical needs, and behavioral health needs and service delivery. The CCBHC must develop the integrated treatment plan in collaboration with and receive endorsement from the client, the adult client's family to the extent the client wishes and a child or youth client's family or caregivers, and coordinate with staff or programs necessary to carry out the plan.

Subd. 14. **Outpatient withdrawal management.** "Outpatient withdrawal management" means a time-limited service delivered in an office setting, an outpatient behavioral health clinic, or a person's home by staff providing medically supervised evaluation and detoxification services to achieve safe and comfortable withdrawal from substances and facilitate transition into ongoing treatment and recovery. Outpatient withdrawal management services include assessment, withdrawal management, planning, medication prescribing and management, trained observation of withdrawal symptoms, and supportive services.

Subd. 15. **Preliminary screening and risk assessment.** "Preliminary screening and risk assessment" means a screening and risk assessment that is completed at the first contact with the prospective CCBHC service recipient and determines the acuity of recipient need.

Subd. 16. **Preliminary treatment plan.** "Preliminary treatment plan" means an initial plan of care that is written as a part of all initial evaluations, initial evaluation equivalents, or comprehensive evaluations.

Subd. 17. **Needs assessment.** "Needs assessment" means a systematic approach to identifying community needs and determining program capacity to address the needs of the population being served.

Subd. 18. **State-sanctioned crisis services.** "State-sanctioned crisis services" means adult and children's crisis response services conducted by an entity enrolled to provide crisis services under section 256B.0624.

EFFECTIVE DATE. This section is effective July 1, 2023, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 4. **[245.7353] APPLICABILITY.**

Subdivision 1. **Certification process.** (a) The commissioner must establish state certification and recertification processes for certified community behavioral health clinics that satisfy all federal and state requirements necessary for CCBHCs certified under sections 245.7351 to 245.7357 to be eligible for reimbursement under medical assistance, without service area limits based on geographic area or region. The commissioner must consult with CCBHC stakeholders before establishing and implementing changes in the certification or recertification process and requirements.

(b) The commissioner shall recertify a CCBHC provider entity every 36 months using the provider entity's certification anniversary or December 31. The commissioner may approve a recertification extension in the interest of sustaining services when a specific date for recertification is identified.

(c) The commissioner shall establish a process for decertification of a CCBHC provider entity and shall require corrective action, medical assistance repayment, or decertification of a provider entity that no longer meets the requirements in sections 245.7351 to 245.7357 or that fails to meet the clinical quality standards or administrative standards provided by the commissioner in the application and certification processes.

(d) The commissioner shall provide the following to CCBHC provider entities for the certification, recertification, and decertification processes:

(1) a structured listing of required provider entity certification criteria;

(2) a formal written letter with a determination of certification, recertification, or decertification, signed by the commissioner or the appropriate division director; and

(3) a formal written communication outlining the process for necessary corrective action and follow-up by the commissioner, if applicable, signed by the commissioner or the appropriate division director.

Subd. 2. **Certifications and licensures required.** In addition to all other requirements contained in sections 245.7351 to 245.7357, a CCBHC must:

(1) comply with the standards issued by the commissioner relating to CCBHC screenings, assessments, and evaluations;

(2) be certified as a mental health clinic under section 245I.20;

(3) be licensed to provide substance use disorder treatment under chapter 245G;

(4) be certified to provide children's therapeutic services and supports under section 256B.0943;

(5) be certified to provide adult rehabilitative mental health services under section 256B.0623;

(6) be enrolled to provide mental health crisis response services under section 256B.0624;

(7) be enrolled to provide mental health targeted case management under section 256B.0625, subdivision 20;

(8) comply with standards relating to mental health case management in Minnesota Rules, parts 9520.0900 to 9520.0926;

(9) comply with standards relating to peer services under sections 256B.0615, 256B.0616, and 245G.07, subdivision 2, clause (8), as applicable when peer services are provided; and

(10) directly employ, or through a formal arrangement utilize, a medically trained behavioral health care provider with independent authority under state law to prescribe and manage medications, including buprenorphine and other medications used to treat opioid and alcohol use disorders.

Subd. 3. **Variance authority.** When the standards listed in sections 245.7351 to 245.7357 or other applicable standards conflict or address similar issues in duplicative or incompatible ways, the commissioner may grant variances to state requirements if the variances do not conflict with federal requirements for services reimbursed under medical assistance. If standards overlap, the commissioner may substitute all or a part of a licensure or certification that is substantially the same as another licensure or certification. The commissioner must

consult with stakeholders as described in subdivision 1 before granting variances under this subdivision. For the CCBHC that is certified but not approved for prospective payment under section 256B.0625, subdivision 5m, the commissioner may grant a variance under this paragraph if the variance does not increase the state share of costs.

Subd. 4. **Notice and opportunity for correction.** If the commissioner finds that a prospective or certified CCBHC has failed to comply with an applicable law or rule and this failure does not imminently endanger health, safety, or rights of the persons served by the program, the commissioner may issue a notice ordering a correction. The notice ordering a correction must state the following in plain language:

(1) the conditions that constitute a violation of the law or rule;

(2) the specific law or rule violated; and

(3) the time allowed to correct each violation.

Subd. 5. **County letter of support.** A clinic that meets certification requirements for a CCBHC under sections 245.7351 to 245.7357 is not subject to any state law or rule that requires a county contract or other form of county approval as a condition for licensure or enrollment as a medical assistance provider. The commissioner must require evidence from the CCBHC that it has an ongoing relationship with the county or counties it serves to facilitate access and continuity of care, especially for individuals who are uninsured or who may go on and off medical assistance.

Subd. 6. **Decertification, denial of certification, or recertification request.** (a) The commissioner must establish a process for decertification and must require corrective action, medical assistance repayment, or decertification of a CCBHC that no longer meets the requirements in this section.

(b) The commissioner must provide the following to providers for the certification, recertification, and decertification process:

(1) a structured listing of required provider certification criteria;

(2) a formal written letter with a determination of certification, recertification, or decertification, signed by the commissioner or the appropriate division director; and

(3) a formal written communication outlining the process for necessary corrective action and follow-up by the commissioner if applicable.

EFFECTIVE DATE. This section is effective July 1, 2023, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 5. **[245.7354] MINIMUM STAFFING STANDARDS.**

(a) A CCBHC must meet minimum staffing requirements as identified in the certification process.

(b) A CCBHC must employ or contract for clinic staff who have backgrounds in diverse disciplines, including licensed mental health professionals, licensed alcohol and drug counselors, staff who are culturally and linguistically trained to meet the needs of the population the clinic serves, and staff who are trained to make accommodations to meet the needs of clients with disabilities.

EFFECTIVE DATE. This section is effective July 1, 2023, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 6. **[245.7355] REQUIRED SERVICES.**

Subdivision 1. **Generally.** CCBHCs must provide nine core services identified in subdivisions 2 and 3.

Subd. 2. **Required services to be provided directly.** Unless otherwise specified in sections 245.7351 to 245.7357 and approved by the commissioner, a CCBHC must directly provide the following:

(1) ambulatory withdrawal management services ASAM level 1.0;

(2) treatment planning;

(3) screening, assessment, diagnosis, and risk assessment;

(4) outpatient mental health treatment; and

(5) substance use disorder treatment services for both adult and adolescent populations.

Subd. 3. **Direct or contracted required services.** A CCBHC must provide the following services directly or via formal relationships with designated collaborating organizations:

(1) targeted case management;

(2) outpatient primary care screening and monitoring;

(3) community-based mental health care for veterans;

(4) peer, family support, and counselor services;

(5) psychiatric rehabilitation services; and

(6) crisis services conducted by a state-sanctioned provider.

Subd. 4. **Care coordination required.** A CCBHC must directly provide coordination of care across settings and providers to ensure seamless transitions for individuals being served across the full spectrum of health services, including acute, chronic, and behavioral needs.

Subd. 5. **Outreach and engagement required.** A CCBHC must provide outreach and engagement services to the community, including promoting accessibility and culturally and linguistically competent care, educating prospective CCBHC recipients about available services, and connecting prospective CCBHC recipients with needed services.

Subd. 6. **Initial evaluation; required elements.** (a) An initial evaluation must be completed by a mental health professional or clinical trainee and must contain all data elements listed in the commissioner's public clinical guidance.

(b) The timing of initial evaluation administration must be determined based on results of the preliminary screening and risk assessment. If a client is assessed to be experiencing a crisis-level behavioral health need, care must follow the timelines established in the CCBHC certification criteria published by the Substance Abuse and Mental Health Services Administration and the commissioner's published clinical guidance.

(c) Initial evaluation equivalents, as defined by the commissioner, may be completed to satisfy the requirement for the initial evaluation under this subdivision.

(d) The initial evaluation must include the following components:

(e) For programs governed by sections 245.7351 to 245.7357, the CCBHC initial evaluation requirements in this subdivision satisfy the requirements for:

(1) a brief diagnostic assessment under section 245I.10, subdivision 5;

(2) an individual family assessment summary under section 245.4881, subdivisions 3 and 4;

(3) an individual assessment summary under section 245.4711, subdivisions 3 and 4;

(4) a diagnostic assessment under Minnesota Rules, part 9520.0909, subpart 1;

(5) a local agency determination based on a diagnostic assessment under Minnesota Rules, part 9520.0910, subpart 1;

(6) an individual family community support plan and an individual community support plan under Minnesota Rules, part 9520.0914, subpart 2, items A and B;

(7) an individual family community support plan under Minnesota Rules, part 9520.0918, subparts 1 and 2; and

(8) an individual community support plan under Minnesota Rules, part 9520.0919, subparts 1 and 2.

Subd. 7. **Comprehensive evaluation; required elements.** (a) All new CCBHC clients must receive a comprehensive person-centered and family-centered diagnostic and treatment planning evaluation to be completed within 60 calendar days following the preliminary screening and risk assessment.

(b) The comprehensive evaluation must be completed by a mental health professional or clinical trainee and must contain all data elements listed in the commissioner's public clinical guidance.

(c) When a CCBHC client is engaged in substance use disorder services provided by the CCBHC, the comprehensive evaluation must also be approved by an alcohol and drug counselor.

(d) A CCBHC comprehensive evaluation completed according to the standards in subdivision 7 replaces the requirements for a comprehensive assessment in chapter 245G, if the comprehensive evaluation includes a diagnosis of a substance use disorder or a finding that the client does not meet the criteria for a substance use disorder.

(e) A comprehensive evaluation must be updated at least annually for all adult clients who continue to engage in behavioral health services, and:

(1) when the client's presentation does not appear to align with the current diagnostic formulation; or

(2) when the client or mental health professional suspect the emergence of a new diagnosis.

(f) A comprehensive evaluation update must contain the following components:

(1) a written update detailing all significant new or changed mental health symptoms, as well as a description of how the new or changed symptoms are impacting functioning;

(2) any diagnostic formulation updates, including rationale for new diagnoses as needed; and

(3) a rationale for removal of any existing diagnoses, as needed.

(g) When completing a comprehensive evaluation of a client who is five years of age or younger, the assessor must use the current edition of the DC: 0-5 Diagnostic Classification of Mental Health and Development Disorders of Infancy and Early Childhood published by Zero to Three. The comprehensive evaluation of children age five years and younger:

(1) must include an initial session without the client present and may include treatment to the parents or guardians along with inquiring about the child;

(2) may consist of three to five separate encounters;

(3) must incorporate the level of care assessment;

(4) must be completed prior to recommending additional CCBHC services; and

(5) must not contain scoring of the American Society of Addiction Medicine six dimensions.

(h) For programs governed by sections 245.7351 to 245.7357, the CCBHC comprehensive evaluation requirements in this subdivision satisfy the requirements for:

(1) a diagnostic assessment or crisis assessment under section 245I.10, subdivision 2, paragraph (a);

(2) a diagnostic assessment under section 245I.10, subdivisions 4 to 6;

(3) an initial services plan under section 245G.04, subdivision 1;

(4) a diagnostic assessment under section 245.4711, subdivision 2;

(5) a diagnostic assessment under section 245.4881, subdivision 2;

(6) a diagnostic assessment under Minnesota Rules, part 9520.0910, subpart 1;

(7) a diagnostic assessment under Minnesota Rules, part 9520.0909, subpart 1; and

(8) an individual family community support plan and an individual community support plan under Minnesota Rules, part 9520.0914, subpart 2, items A and B.

Subd. 8. **Integrated treatment plan; required elements.** (a) An integrated treatment plan must be approved by a mental health professional as defined in section 245I.04, subdivision 2.

(b) An integrated treatment plan must be completed within 60 calendar days following the completion of the preliminary screening and risk assessment.

(c) An integrated treatment plan must use a person- and family-centered planning process that includes the client, any family or client-identified natural supports, CCBHC service providers, and care coordination staff.

(d) An integrated treatment plan must be updated at least every six months or earlier based on changes in the client's circumstances.

(e) When a client is engaged in substance use disorder services at a CCBHC, the integrated treatment plan must also be approved by an alcohol and drug counselor as defined in section 245G.11, subdivision 5.

(f) The treatment plan must integrate prevention, medical and behavioral health needs, and service delivery and must be developed by the CCBHC in collaboration with and endorsed by the client, the adult client's family to the extent the client wishes, or family or caregivers of youth and children. The treatment plan must also be coordinated with staff or programs necessary to carry out the plan.

(g) The CCBHC integrated treatment plan requirements in this subdivision replace the requirements for:

(1) an individual treatment plan under section 245I.10, subdivisions 7 and 8;

(2) an individual treatment plan under section 245G.06, subdivision 1; and

(3) an individual treatment plan under section 245G.09, subdivision 3, clause (6).

(h) The CCBHC functional assessment requirements replace the requirements for:

(1) a functional assessment under section 256B.0623, subdivision 9;

(2) a functional assessment under section 245.4711, subdivision 3; and

(3) functional assessments under Minnesota Rules, part 9520.0914, subpart 2, items A and B.

Subd. 9. **Licensing and certification requirements.** The requirements for initial evaluations under subdivision 6, comprehensive evaluations under subdivision 7, and integrated treatment plans under subdivision 8 are part of the licensing requirements for substance use disorder treatment programs licensed according to chapter 245G and certification requirements for mental health clinics certified according to section 245I.20 if the program or clinic is part of a CCBHC. The Department of Human Services licensing division will review, inspect, and investigate for compliance with the requirements in subdivisions 6 to 8.

Sec. 7. **[245.7356] REQUIRED EVIDENCE-BASED SERVICES.**

Subdivision 1. **Generally.** A CCBHC must use evidence-based practices in all services. Treatments must be provided in a manner appropriate for each client's phase of life and development, specifically considering what is appropriate for children, adolescents, transition-age youth, and older adults, as distinct groups for whom life stage and functioning may affect treatment. Specifically, when treating children and adolescents, a CCHBC must provide evidence-based services that are developmentally appropriate, youth guided, and family and caregiver driven. When treating older adults, an individual client's desires and functioning must be considered, and appropriate evidence-based treatments must be provided. When treating individuals with developmental or other cognitive disabilities, level of functioning must be considered, and appropriate evidence-based treatments must be provided. The treatments referenced in this subdivision must be delivered by staff with specific training in treating the segment of the population being served.

Subd. 2. **Required evidence-based practices.** A CCBHC must use evidence-based practices, including the use of cognitive behavioral therapy, motivational interviewing, stages of change, and trauma treatment appropriate for populations being served.

Subd. 3. **Issuance of and amendments to evidence-based practices requirements.** The commissioner must issue a list of required evidence-based practices to be delivered by CCBHCs and may also provide a list of recommended evidence-based practices. The commissioner may update the list to reflect advances in outcomes research and medical services for persons living with mental illnesses or substance use disorders. The commissioner must take into consideration the adequacy of evidence to support the efficacy of the practice, the quality of workforce available, and the current availability of the practice in the state. At least 30 days before issuing the initial list and any revisions, the commissioner must provide stakeholders with an opportunity to comment.

EFFECTIVE DATE. This section is effective July 1, 2023, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 8. **[245.7357] DESIGNATED COLLABORATING ORGANIZATION.**

Subdivision 1. **Generally.** A CCBHC must directly provide a core set of services listed in section 245.7355, subdivision 2, and may directly provide or contract for the remainder of the services listed in section 245.7355, subdivision 3, with a designated collaborating organization as defined in section 245.7351, subdivision 10, that has the required authority

to provide that service and that meets the criteria as a designated collaborating organization under subdivision 2.

Subd. 2. **Designated collaborating organization requirements.** (a) A CCBHC providing CCBHC services via a designated collaborating organization agreement must:

(1) have a formal agreement, as defined in section 245.7351, subdivision 11, with the designated collaborating organization to furnish one or more of the allowable services listed under section 245.7355, subdivision 3;

(2) ensure that CCBHC services provided by a designated collaborating organization must be provided in accordance with CCBHC service standards and provider requirements;

(3) maintain responsibility for coordinating care and clinical and financial responsibility for the services provided by a designated collaborating organization;

(4) as applicable and necessary, ensure that a contracted designated collaborating organization participates in CCBHC care coordination activities, including utilizing health information technology to facilitate coordination and care transfers across organizations and arranging access to data necessary for quality and financial operations and reporting;

(5) ensure beneficiaries receiving CCBHC services at the designated collaborating organization have access to the CCBHC grievance process;

(6) submit all designated collaborating organization agreements for review and approval by the commissioner prior to the designated collaborating organization furnishing CCBHC services; and

(7) meet any additional requirements issued by the commissioner.

(b) Designated collaborating organization agreements must be submitted during the certification process. Adding new designated collaborating organization relationships after initial certification requires updates to the CCBHC certification. A CCBHC must update designated collaborating organization information and the designated collaborating organization agreement with the commissioner a minimum of 30 days prior to the execution of a designated collaborating organization agreement. The commissioner must review and approve or offer recommendations for designated collaborating organization agreement modifications

(c) Designated collaborating organizations furnishing services under an agreement with CCBHCs must meet all standards established in sections 245.7351 to 245.7357 for the service the designated collaborating organization is providing. CCBHCs maintain

responsibility for care coordination and are clinically and financially responsible for CCBHC services provided by a designated collaborating organization.

(d) Designated collaborating organization financial and payment processes must follow those outlined in section 256B.0625, subdivision 5m, paragraph (c), clause (10).

Subd. 3. **Designated collaborative organization agreements.** Designated collaborative organization agreements must include:

(1) the scope of CCBHC services to be furnished;

(2) the payment methodology and rates for purchased services;

(3) a requirement that the CCBHC maintains financial and clinical responsibility for services provided by the designated collaborating organization;

(4) a requirement that the CCBHC retains responsibility for care coordination;

(5) a requirement that the designated collaborating organization must have the necessary certifications, licenses, and enrollments to provide the services;

(6) a requirement that the staff providing CCBHC services within the designated collaborating organization must have the proper licensure for the services provided;

(7) a requirement that the designated collaborating organization meets CCBHC cultural competency and training requirements;

(8) a requirement that the designated collaborating organization must follow all federal, state, and CCBHC requirements for confidentiality and data privacy;

(9) a requirement that the designated collaborating organization must follow the grievance procedures of the CCBHC;

(10) a requirement that the designated collaborating organization must follow the CCBHC requirements for person- and family-centered, recovery-oriented care, being respectful of the individual person's needs, preferences, and values, and ensuring involvement by the person being served and self-direction of services received. Services for children and youth must be family-centered, youth-guided, and developmentally appropriate;

(11) a requirement that clients seeking services must have freedom of choice of providers;

(12) a requirement that the designated collaborating organization must be part of the CCBHCs health information technology system directly or through data integration;

(13) a requirement that the designated collaborating organization must provide all clinical and financial data necessary to support CCBHC required service and billing operations; and

(14) a requirement that the CCBHC and the designated collaborating organization have safeguards in place to ensure that the designated collaborating organization does not receive a duplicate payment for services that are included in the CCBHC's daily bundled rate.

EFFECTIVE DATE. This section is effective July 1, 2023, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 9. Minnesota Statutes 2022, section 245A.02, subdivision 2c, is amended to read:

Subd. 2c. **Annual or annually; family child care ~~training requirements~~.** For the purposes of sections 245A.50 to 245A.53, "annual" or "annually" means ~~the 12-month period beginning on the license effective date or the annual anniversary of the effective date and ending on the day prior to the annual anniversary of the license effective date~~ each calendar year.

Sec. 10. Minnesota Statutes 2022, section 245A.04, subdivision 1, is amended to read:

Subdivision 1. **Application for licensure.** (a) An individual, organization, or government entity that is subject to licensure under section 245A.03 must apply for a license. The application must be made on the forms and in the manner prescribed by the commissioner. The commissioner shall provide the applicant with instruction in completing the application and provide information about the rules and requirements of other state agencies that affect the applicant. An applicant seeking licensure in Minnesota with headquarters outside of Minnesota must have a program office located within 30 miles of the Minnesota border. An applicant who intends to buy or otherwise acquire a program or services licensed under this chapter that is owned by another license holder must apply for a license under this chapter and comply with the application procedures in this section and section 245A.03.

The commissioner shall act on the application within 90 working days after a complete application and any required reports have been received from other state agencies or departments, counties, municipalities, or other political subdivisions. The commissioner shall not consider an application to be complete until the commissioner receives all of the required information.

When the commissioner receives an application for initial licensure that is incomplete because the applicant failed to submit required documents or that is substantially deficient because the documents submitted do not meet licensing requirements, the commissioner shall provide the applicant written notice that the application is incomplete or substantially deficient. In the written notice to the applicant the commissioner shall identify documents that are missing or deficient and give the applicant 45 days to resubmit a second application that is substantially complete. An applicant's failure to submit a substantially complete application after receiving notice from the commissioner is a basis for license denial under section 245A.05.

(b) An application for licensure must identify all controlling individuals as defined in section 245A.02, subdivision 5a, and must designate one individual to be the authorized agent. The application must be signed by the authorized agent and must include the authorized agent's first, middle, and last name; mailing address; and email address. By submitting an application for licensure, the authorized agent consents to electronic communication with the commissioner throughout the application process. The authorized agent must be authorized to accept service on behalf of all of the controlling individuals. A government entity that holds multiple licenses under this chapter may designate one authorized agent for all licenses issued under this chapter or may designate a different authorized agent for each license. Service on the authorized agent is service on all of the controlling individuals. It is not a defense to any action arising under this chapter that service was not made on each controlling individual. The designation of a controlling individual as the authorized agent under this paragraph does not affect the legal responsibility of any other controlling individual under this chapter.

(c) An applicant or license holder must have a policy that prohibits license holders, employees, subcontractors, and volunteers, when directly responsible for persons served by the program, from abusing prescription medication or being in any manner under the influence of a chemical that impairs the individual's ability to provide services or care. The license holder must train employees, subcontractors, and volunteers about the program's drug and alcohol policy.

(d) An applicant and license holder must have a program grievance procedure that permits persons served by the program and their authorized representatives to bring a grievance to the highest level of authority in the program.

(e) The commissioner may limit communication during the application process to the authorized agent or the controlling individuals identified on the license application and for whom a background study was initiated under chapter 245C. Upon implementation of the

provider licensing and reporting hub, applicants and license holders must use the hub in the manner prescribed by the commissioner. The commissioner may require the applicant, except for child foster care, to demonstrate competence in the applicable licensing requirements by successfully completing a written examination. The commissioner may develop a prescribed written examination format.

(f) When an applicant is an individual, the applicant must provide:

(1) the applicant's taxpayer identification numbers including the Social Security number or Minnesota tax identification number, and federal employer identification number if the applicant has employees;

(2) at the request of the commissioner, a copy of the most recent filing with the secretary of state that includes the complete business name, if any;

(3) if doing business under a different name, the doing business as (DBA) name, as registered with the secretary of state;

(4) if applicable, the applicant's National Provider Identifier (NPI) number and Unique Minnesota Provider Identifier (UMPI) number; and

(5) at the request of the commissioner, the notarized signature of the applicant or authorized agent.

(g) When an applicant is an organization, the applicant must provide:

(1) the applicant's taxpayer identification numbers including the Minnesota tax identification number and federal employer identification number;

(2) at the request of the commissioner, a copy of the most recent filing with the secretary of state that includes the complete business name, and if doing business under a different name, the doing business as (DBA) name, as registered with the secretary of state;

(3) the first, middle, and last name, and address for all individuals who will be controlling individuals, including all officers, owners, and managerial officials as defined in section 245A.02, subdivision 5a, and the date that the background study was initiated by the applicant for each controlling individual;

(4) if applicable, the applicant's NPI number and UMPI number;

(5) the documents that created the organization and that determine the organization's internal governance and the relations among the persons that own the organization, have an interest in the organization, or are members of the organization, in each case as provided or authorized by the organization's governing statute, which may include a partnership

agreement, bylaws, articles of organization, organizational chart, and operating agreement, or comparable documents as provided in the organization's governing statute; and

(6) the notarized signature of the applicant or authorized agent.

(h) When the applicant is a government entity, the applicant must provide:

(1) the name of the government agency, political subdivision, or other unit of government seeking the license and the name of the program or services that will be licensed;

(2) the applicant's taxpayer identification numbers including the Minnesota tax identification number and federal employer identification number;

(3) a letter signed by the manager, administrator, or other executive of the government entity authorizing the submission of the license application; and

(4) if applicable, the applicant's NPI number and UMPI number.

(i) At the time of application for licensure or renewal of a license under this chapter, the applicant or license holder must acknowledge on the form provided by the commissioner if the applicant or license holder elects to receive any public funding reimbursement from the commissioner for services provided under the license that:

(1) the applicant's or license holder's compliance with the provider enrollment agreement or registration requirements for receipt of public funding may be monitored by the commissioner as part of a licensing investigation or licensing inspection; and

(2) noncompliance with the provider enrollment agreement or registration requirements for receipt of public funding that is identified through a licensing investigation or licensing inspection, or noncompliance with a licensing requirement that is a basis of enrollment for reimbursement for a service, may result in:

(i) a correction order or a conditional license under section 245A.06, or sanctions under section 245A.07;

(ii) nonpayment of claims submitted by the license holder for public program reimbursement;

(iii) recovery of payments made for the service;

(iv) disenrollment in the public payment program; or

(v) other administrative, civil, or criminal penalties as provided by law.

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

Sec. 11. Minnesota Statutes 2022, section 245A.04, subdivision 7a, is amended to read:

Subd. 7a. **Notification required.** (a) A license holder must notify the commissioner, in a manner prescribed by the commissioner, and obtain the commissioner's approval before making any change that would alter the license information listed under subdivision 7, paragraph (a).

(b) A license holder must also notify the commissioner, in a manner prescribed by the commissioner, before making any change:

(1) to the license holder's authorized agent as defined in section 245A.02, subdivision 3b;

(2) to the license holder's controlling individual as defined in section 245A.02, subdivision 5a;

(3) to the license holder information on file with the secretary of state;

(4) in the location of the program or service licensed under this chapter; and

(5) to the federal or state tax identification number associated with the license holder.

(c) When, for reasons beyond the license holder's control, a license holder cannot provide the commissioner with prior notice of the changes in paragraph (b), clauses (1) to (3), the license holder must notify the commissioner by the tenth business day after the change and must provide any additional information requested by the commissioner.

(d) When a license holder notifies the commissioner of a change to the license holder information on file with the secretary of state, the license holder must provide amended articles of incorporation and other documentation of the change.

(e) Upon implementation of the provider licensing and reporting hub, license holders must enter and update information in the hub in a manner prescribed by the commissioner.

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

Sec. 12. Minnesota Statutes 2022, section 245A.05, is amended to read:

245A.05 DENIAL OF APPLICATION.

(a) The commissioner may deny a license if an applicant or controlling individual:

(1) fails to submit a substantially complete application after receiving notice from the commissioner under section 245A.04, subdivision 1;

(2) fails to comply with applicable laws or rules;

(3) knowingly withholds relevant information from or gives false or misleading information to the commissioner in connection with an application for a license or during an investigation;

(4) has a disqualification that has not been set aside under section 245C.22 and no variance has been granted;

(5) has an individual living in the household who received a background study under section 245C.03, subdivision 1, paragraph (a), clause (2), who has a disqualification that has not been set aside under section 245C.22, and no variance has been granted;

(6) is associated with an individual who received a background study under section 245C.03, subdivision 1, paragraph (a), clause (6), who may have unsupervised access to children or vulnerable adults, and who has a disqualification that has not been set aside under section 245C.22, and no variance has been granted;

(7) fails to comply with section 245A.04, subdivision 1, paragraph (f) or (g);

(8) fails to demonstrate competent knowledge as required by section 245A.04, subdivision 6;

(9) has a history of noncompliance as a license holder or controlling individual with applicable laws or rules, including but not limited to this chapter and chapters 119B and 245C;

(10) is prohibited from holding a license according to section 245.095; or

(11) for a family foster setting, has nondisqualifying background study information, as described in section 245C.05, subdivision 4, that reflects on the individual's ability to safely provide care to foster children.

(b) An applicant whose application has been denied by the commissioner must be given notice of the denial, which must state the reasons for the denial in plain language. Notice must be given by certified mail ~~or~~, by personal service, or through the provider licensing and reporting hub. The notice must state the reasons the application was denied and must inform the applicant of the right to a contested case hearing under chapter 14 and Minnesota Rules, parts 1400.8505 to 1400.8612. The applicant may appeal the denial by notifying the commissioner in writing by certified mail ~~or~~, by personal service, or through the provider licensing and reporting hub. If mailed, the appeal must be postmarked and sent to the commissioner within 20 calendar days after the applicant received the notice of denial. If an appeal request is made by personal service, it must be received by the commissioner within 20 calendar days after the applicant received the notice of denial. If the order is issued

through the provider hub, the appeal must be received by the commissioner within 20 calendar days from the date the commissioner issued the order through the hub. Section 245A.08 applies to hearings held to appeal the commissioner's denial of an application.

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

Sec. 13. Minnesota Statutes 2022, section 245A.055, subdivision 2, is amended to read:

Subd. 2. **Reconsideration of closure.** If a license is closed, the commissioner must notify the license holder of closure by certified mail ~~or~~, by personal service, or through the provider licensing and reporting hub. If mailed, the notice of closure must be mailed to the last known address of the license holder and must inform the license holder why the license was closed and that the license holder has the right to request reconsideration of the closure. If the license holder believes that the license was closed in error, the license holder may ask the commissioner to reconsider the closure. The license holder's request for reconsideration must be made in writing and must include documentation that the licensed program has served a client in the previous 12 months. The request for reconsideration must be postmarked and sent to the commissioner or submitted through the provider licensing and reporting hub within 20 calendar days after the license holder receives the notice of closure. Upon implementation of the provider licensing and reporting hub, the provider must use the hub to request reconsideration. If the order is issued through the provider hub, the reconsideration must be received by the commissioner within 20 calendar days from the date the commissioner issued the order through the hub. A timely request for reconsideration stays imposition of the license closure until the commissioner issues a decision on the request for reconsideration.

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

Sec. 14. Minnesota Statutes 2022, section 245A.06, subdivision 1, is amended to read:

Subdivision 1. **Contents of correction orders and conditional licenses.** (a) If the commissioner finds that the applicant or license holder has failed to comply with an applicable law or rule and this failure does not imminently endanger the health, safety, or rights of the persons served by the program, the commissioner may issue a correction order and an order of conditional license to the applicant or license holder. When issuing a conditional license, the commissioner shall consider the nature, chronicity, or severity of the violation of law or rule and the effect of the violation on the health, safety, or rights of persons served by the program. The correction order or conditional license must state the following in plain language:

(1) the conditions that constitute a violation of the law or rule;

(2) the specific law or rule violated;

(3) the time allowed to correct each violation; and

(4) if a license is made conditional, the length and terms of the conditional license, and the reasons for making the license conditional.

(b) Nothing in this section prohibits the commissioner from proposing a sanction as specified in section 245A.07, prior to issuing a correction order or conditional license.

(c) The commissioner may issue a correction order and an order of conditional license to the applicant or license holder through the provider licensing and reporting hub.

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

Sec. 15. Minnesota Statutes 2022, section 245A.06, subdivision 2, is amended to read:

Subd. 2. **Reconsideration of correction orders.** (a) If the applicant or license holder believes that the contents of the commissioner's correction order are in error, the applicant or license holder may ask the Department of Human Services to reconsider the parts of the correction order that are alleged to be in error. The request for reconsideration must be made in writing and must be postmarked and sent to the commissioner within 20 calendar days after receipt of the correction order or submitted in the provider licensing and reporting hub within 20 calendar days from the date the commissioner issued the order through the hub by the applicant or license holder, and:

(1) specify the parts of the correction order that are alleged to be in error;

(2) explain why they are in error; and

(3) include documentation to support the allegation of error.

Upon implementation of the provider licensing and reporting hub, the provider must use the hub to request reconsideration. A request for reconsideration does not stay any provisions or requirements of the correction order. The commissioner's disposition of a request for reconsideration is final and not subject to appeal under chapter 14.

(b) This paragraph applies only to licensed family child care providers. A licensed family child care provider who requests reconsideration of a correction order under paragraph (a) may also request, on a form and in the manner prescribed by the commissioner, that the commissioner expedite the review if:

(1) the provider is challenging a violation and provides a description of how complying with the corrective action for that violation would require the substantial expenditure of funds or a significant change to their program; and

(2) describes what actions the provider will take in lieu of the corrective action ordered to ensure the health and safety of children in care pending the commissioner's review of the correction order.

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

Sec. 16. Minnesota Statutes 2022, section 245A.06, subdivision 4, is amended to read:

Subd. 4. **Notice of conditional license; reconsideration of conditional license.** (a) If a license is made conditional, the license holder must be notified of the order by certified mail ~~or~~, by personal service, or through the provider licensing and reporting hub. If mailed, the notice must be mailed to the address shown on the application or the last known address of the license holder. The notice must state the reasons the conditional license was ordered and must inform the license holder of the right to request reconsideration of the conditional license by the commissioner. The license holder may request reconsideration of the order of conditional license by notifying the commissioner by certified mail ~~or~~, by personal service, or through the provider licensing and reporting hub. The request must be made in writing. If sent by certified mail, the request must be postmarked and sent to the commissioner within ten calendar days after the license holder received the order. If a request is made by personal service, it must be received by the commissioner within ten calendar days after the license holder received the order. If the order is issued through the provider hub, the request must be received by the commissioner within ten calendar days from the date the commissioner issued the order through the hub. The license holder may submit with the request for reconsideration written argument or evidence in support of the request for reconsideration. A timely request for reconsideration shall stay imposition of the terms of the conditional license until the commissioner issues a decision on the request for reconsideration. If the commissioner issues a dual order of conditional license under this section and an order to pay a fine under section 245A.07, subdivision 3, the license holder has a right to a contested case hearing under chapter 14 and Minnesota Rules, parts 1400.8505 to 1400.8612. The scope of the contested case hearing shall include the fine and the conditional license. In this case, a reconsideration of the conditional license will not be conducted under this section. If the license holder does not appeal the fine, the license holder does not have a right to a contested case hearing and a reconsideration of the conditional license must be conducted under this subdivision.

(b) The commissioner's disposition of a request for reconsideration is final and not subject to appeal under chapter 14.

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

Sec. 17. Minnesota Statutes 2022, section 245A.07, subdivision 3, is amended to read:

Subd. 3. **License suspension, revocation, or fine.** (a) The commissioner may suspend or revoke a license, or impose a fine if:

(1) a license holder fails to comply fully with applicable laws or rules including but not limited to the requirements of this chapter and chapter 245C;

(2) a license holder, a controlling individual, or an individual living in the household where the licensed services are provided or is otherwise subject to a background study has been disqualified and the disqualification was not set aside and no variance has been granted;

(3) a license holder knowingly withholds relevant information from or gives false or misleading information to the commissioner in connection with an application for a license, in connection with the background study status of an individual, during an investigation, or regarding compliance with applicable laws or rules;

(4) a license holder is excluded from any program administered by the commissioner under section 245.095; or

(5) revocation is required under section 245A.04, subdivision 7, paragraph (d).

A license holder who has had a license issued under this chapter suspended, revoked, or has been ordered to pay a fine must be given notice of the action by certified mail ~~or~~, by personal service, or through the provider licensing and reporting hub. If mailed, the notice must be mailed to the address shown on the application or the last known address of the license holder. The notice must state in plain language the reasons the license was suspended or revoked, or a fine was ordered.

(b) If the license was suspended or revoked, the notice must inform the license holder of the right to a contested case hearing under chapter 14 and Minnesota Rules, parts 1400.8505 to 1400.8612. The license holder may appeal an order suspending or revoking a license. The appeal of an order suspending or revoking a license must be made in writing by certified mail ~~or~~, by personal service, or through the provider licensing and reporting hub. If mailed, the appeal must be postmarked and sent to the commissioner within ten calendar days after the license holder receives notice that the license has been suspended or revoked. If a request is made by personal service, it must be received by the commissioner

within ten calendar days after the license holder received the order. If the order is issued through the provider hub, the appeal must be received by the commissioner within ten calendar days from the date the commissioner issued the order through the hub. Except as provided in subdivision 2a, paragraph (c), if a license holder submits a timely appeal of an order suspending or revoking a license, the license holder may continue to operate the program as provided in section 245A.04, subdivision 7, paragraphs (f) and (g), until the commissioner issues a final order on the suspension or revocation.

(c)(1) If the license holder was ordered to pay a fine, the notice must inform the license holder of the responsibility for payment of fines and the right to a contested case hearing under chapter 14 and Minnesota Rules, parts 1400.8505 to 1400.8612. The appeal of an order to pay a fine must be made in writing by certified mail ~~or~~, by personal service, or through the provider licensing and reporting hub. If mailed, the appeal must be postmarked and sent to the commissioner within ten calendar days after the license holder receives notice that the fine has been ordered. If a request is made by personal service, it must be received by the commissioner within ten calendar days after the license holder received the order. If the order is issued through the provider hub, the appeal must be received by the commissioner within ten calendar days from the date the commissioner issued the order through the hub.

(2) The license holder shall pay the fines assessed on or before the payment date specified. If the license holder fails to fully comply with the order, the commissioner may issue a second fine or suspend the license until the license holder complies. If the license holder receives state funds, the state, county, or municipal agencies or departments responsible for administering the funds shall withhold payments and recover any payments made while the license is suspended for failure to pay a fine. A timely appeal shall stay payment of the fine until the commissioner issues a final order.

(3) A license holder shall promptly notify the commissioner of human services, in writing, when a violation specified in the order to forfeit a fine is corrected. If upon reinspection the commissioner determines that a violation has not been corrected as indicated by the order to forfeit a fine, the commissioner may issue a second fine. The commissioner shall notify the license holder by certified mail ~~or~~, by personal service, or through the provider licensing and reporting hub that a second fine has been assessed. The license holder may appeal the second fine as provided under this subdivision.

(4) Fines shall be assessed as follows:

(i) the license holder shall forfeit $1,000 for each determination of maltreatment of a child under chapter 260E or the maltreatment of a vulnerable adult under section 626.557 for which the license holder is determined responsible for the maltreatment under section 260E.30, subdivision 4, paragraphs (a) and (b), or 626.557, subdivision 9c, paragraph (c);

(ii) if the commissioner determines that a determination of maltreatment for which the license holder is responsible is the result of maltreatment that meets the definition of serious maltreatment as defined in section 245C.02, subdivision 18, the license holder shall forfeit $5,000;

(iii) for a program that operates out of the license holder's home and a program licensed under Minnesota Rules, parts 9502.0300 to 9502.0445, the fine assessed against the license holder shall not exceed $1,000 for each determination of maltreatment;

(iv) the license holder shall forfeit $200 for each occurrence of a violation of law or rule governing matters of health, safety, or supervision, including but not limited to the provision of adequate staff-to-child or adult ratios, and failure to comply with background study requirements under chapter 245C; and

(v) the license holder shall forfeit $100 for each occurrence of a violation of law or rule other than those subject to a $5,000, $1,000, or $200 fine in items (i) to (iv).

For purposes of this section, "occurrence" means each violation identified in the commissioner's fine order. Fines assessed against a license holder that holds a license to provide home and community-based services, as identified in section 245D.03, subdivision 1, and a community residential setting or day services facility license under chapter 245D where the services are provided, may be assessed against both licenses for the same occurrence, but the combined amount of the fines shall not exceed the amount specified in this clause for that occurrence.

(5) When a fine has been assessed, the license holder may not avoid payment by closing, selling, or otherwise transferring the licensed program to a third party. In such an event, the license holder will be personally liable for payment. In the case of a corporation, each controlling individual is personally and jointly liable for payment.

(d) Except for background study violations involving the failure to comply with an order to immediately remove an individual or an order to provide continuous, direct supervision, the commissioner shall not issue a fine under paragraph (c) relating to a background study violation to a license holder who self-corrects a background study violation before the commissioner discovers the violation. A license holder who has previously exercised the provisions of this paragraph to avoid a fine for a background study violation may not avoid

a fine for a subsequent background study violation unless at least 365 days have passed since the license holder self-corrected the earlier background study violation.

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

Sec. 18. Minnesota Statutes 2022, section 245A.16, is amended by adding a subdivision to read:

Subd. 10. **Licensing and reporting hub.** Upon implementation of the provider licensing and reporting hub, county staff who perform licensing functions must use the hub in the manner prescribed by the commissioner.

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

Sec. 19. Minnesota Statutes 2022, section 245A.50, subdivision 3, is amended to read:

Subd. 3. **First aid.** (a) Before initial licensure and before caring for a child, license holders, second adult caregivers, and substitutes must be trained in pediatric first aid. The first aid training must have been provided by an individual approved to provide first aid instruction. First aid training may be less than eight hours and persons qualified to provide first aid training include individuals approved as first aid instructors. License holders, second adult caregivers, and substitutes must repeat pediatric first aid training every two years. ~~When the training expires, it must be retaken no later than the day before the anniversary of the license holder's license effective date.~~ License holders, second adult caregivers, and substitutes must not let the training expire.

(b) Video training reviewed and approved by the county licensing agency satisfies the training requirement of this subdivision.

Sec. 20. Minnesota Statutes 2022, section 245A.50, subdivision 4, is amended to read:

Subd. 4. **Cardiopulmonary resuscitation.** (a) Before initial licensure and before caring for a child, license holders, second adult caregivers, and substitutes must be trained in pediatric cardiopulmonary resuscitation (CPR), including CPR techniques for infants and children, and in the treatment of obstructed airways. The CPR training must have been provided by an individual approved to provide CPR instruction. License holders, second adult caregivers, and substitutes must repeat pediatric CPR training at least once every two years and must document the training in the license holder's records. ~~When the training expires, it must be retaken no later than the day before the anniversary of the license holder's license effective date.~~ License holders, second adult caregivers, and substitutes must not let the training expire.

(b) Persons providing CPR training must use CPR training that has been developed:

(1) by the American Heart Association or the American Red Cross and incorporates psychomotor skills to support the instruction; or

(2) using nationally recognized, evidence-based guidelines for CPR training and incorporates psychomotor skills to support the instruction.

Sec. 21. Minnesota Statutes 2022, section 245A.50, subdivision 5, is amended to read:

Subd. 5. **Sudden unexpected infant death and abusive head trauma training.** (a) License holders must ensure and document that before the license holder, second adult caregivers, substitutes, and helpers assist in the care of infants, they are instructed on the standards in section 245A.1435 and receive training on reducing the risk of sudden unexpected infant death. In addition, license holders must ensure and document that before the license holder, second adult caregivers, substitutes, and helpers assist in the care of infants and children under school age, they receive training on reducing the risk of abusive head trauma from shaking infants and young children. The training in this subdivision may be provided as initial training under subdivision 1 or ongoing annual training under subdivision 7.

(b) Sudden unexpected infant death reduction training required under this subdivision must, at a minimum, address the risk factors related to sudden unexpected infant death, means of reducing the risk of sudden unexpected infant death in child care, and license holder communication with parents regarding reducing the risk of sudden unexpected infant death.

(c) Abusive head trauma training required under this subdivision must, at a minimum, address the risk factors related to shaking infants and young children, means of reducing the risk of abusive head trauma in child care, and license holder communication with parents regarding reducing the risk of abusive head trauma.

(d) Training for family and group family child care providers must be developed by the commissioner in conjunction with the Minnesota Sudden Infant Death Center and approved by the Minnesota Center for Professional Development. Sudden unexpected infant death reduction training and abusive head trauma training may be provided in a single course of no more than two hours in length.

(e) Sudden unexpected infant death reduction training and abusive head trauma training required under this subdivision must be completed in person or as allowed under subdivision 10, clause (1) or (2), at least once every two years. ~~When the training expires, it must be~~

~~retaken no later than the day before the anniversary of the license holder's license effective date.~~ On the years when the individual receiving training is not receiving training in person or as allowed under subdivision 10, clause (1) or (2), the individual receiving training in accordance with this subdivision must receive sudden unexpected infant death reduction training and abusive head trauma training through a video of no more than one hour in length. The video must be developed or approved by the commissioner.

(f) An individual who is related to the license holder as defined in section 245A.02, subdivision 13, and who is involved only in the care of the license holder's own infant or child under school age and who is not designated to be a second adult caregiver, helper, or substitute for the licensed program, is exempt from the sudden unexpected infant death and abusive head trauma training.

Sec. 22. Minnesota Statutes 2022, section 245A.50, subdivision 6, is amended to read:

Subd. 6. **Child passenger restraint systems; training requirement.** (a) A license holder must comply with all seat belt and child passenger restraint system requirements under section 169.685.

(b) Family and group family child care programs licensed by the Department of Human Services that serve a child or children under eight years of age must document training that fulfills the requirements in this subdivision.

(1) Before a license holder, second adult caregiver, substitute, or helper transports a child or children under age eight in a motor vehicle, the person placing the child or children in a passenger restraint must satisfactorily complete training on the proper use and installation of child restraint systems in motor vehicles. Training completed under this subdivision may be used to meet initial training under subdivision 1 or ongoing training under subdivision 7.

(2) Training required under this subdivision must be at least one hour in length, completed at initial training, and repeated at least once every five years. ~~When the training expires, it must be retaken no later than the day before the anniversary of the license holder's license effective date.~~ At a minimum, the training must address the proper use of child restraint systems based on the child's size, weight, and age, and the proper installation of a car seat or booster seat in the motor vehicle used by the license holder to transport the child or children.

(3) Training under this subdivision must be provided by individuals who are certified and approved by the Department of Public Safety, Office of Traffic Safety. License holders

may obtain a list of certified and approved trainers through the Department of Public Safety website or by contacting the agency.

(c) Child care providers that only transport school-age children as defined in section 245A.02, subdivision 19, paragraph (f), in child care buses as defined in section 169.448, subdivision 1, paragraph (e), are exempt from this subdivision.

Sec. 23. Minnesota Statutes 2022, section 245A.50, subdivision 9, is amended to read:

Subd. 9. **Supervising for safety; training requirement.** (a) Courses required by this subdivision must include the following health and safety topics:

(1) preventing and controlling infectious diseases;

(2) administering medication;

(3) preventing and responding to allergies;

(4) ensuring building and physical premises safety;

(5) handling and storing biological contaminants;

(6) preventing and reporting child abuse and maltreatment; and

(7) emergency preparedness.

(b) Before initial licensure and before caring for a child, all family child care license holders and each second adult caregiver shall complete and document the completion of the six-hour Supervising for Safety for Family Child Care course developed by the commissioner.

(c) The license holder must ensure and document that, before caring for a child, all substitutes have completed the four-hour Basics of Licensed Family Child Care for Substitutes course developed by the commissioner, which must include health and safety topics as well as child development and learning.

(d) The family child care license holder and each second adult caregiver shall complete and document:

(1) the annual completion of either:

(i) a two-hour active supervision course developed by the commissioner; or

(ii) any courses in the ensuring safety competency area under the health, safety, and nutrition standard of the Knowledge and Competency Framework that the commissioner has identified as an active supervision training course; and

(2) the completion at least once every five years of the two-hour courses Health and Safety I and Health and Safety II. ~~When the training is due for the first time or expires, it must be taken no later than the day before the anniversary of the license holder's license effective date.~~ A license holder's or second adult caregiver's completion of either training in a given year meets the annual active supervision training requirement in clause (1).

(e) At least once every three years, license holders must ensure and document that substitutes have completed the four-hour Basics of Licensed Family Child Care for Substitutes course. ~~When the training expires, it must be retaken no later than the day before the anniversary of the license holder's license effective date.~~

Sec. 24. Minnesota Statutes 2022, section 245G.03, subdivision 1, is amended to read:

Subdivision 1. **License requirements.** (a) An applicant for a license to provide substance use disorder treatment must comply with the general requirements in section 626.557; chapters 245A, 245C, and 260E; and Minnesota Rules, chapter 9544.

(b) The commissioner may grant variances to the requirements in this chapter that do not affect the client's health or safety if the conditions in section 245A.04, subdivision 9, are met.

(c) If a program is licensed according to this chapter and is part of a certified community behavioral health clinic under sections 245.7351 to 245.7357, the license holder must comply with the requirements in section 245.7355, subdivisions 6 to 9, as part of the licensing requirements under this chapter.

Sec. 25. Minnesota Statutes 2022, section 245H.03, subdivision 2, is amended to read:

Subd. 2. **Application submission.** The commissioner shall provide application instructions and information about the rules and requirements of other state agencies that affect the applicant. The certification application must be submitted in a manner prescribed by the commissioner. Upon implementation of the provider licensing and reporting hub, applicants must use the hub in the manner prescribed by the commissioner. The commissioner shall act on the application within 90 working days of receiving a completed application.

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

Sec. 26. Minnesota Statutes 2022, section 245H.03, subdivision 4, is amended to read:

Subd. 4. **Reconsideration of certification denial.** (a) The applicant may request reconsideration of the denial by notifying the commissioner by certified mail ~~or~~, by personal

service, or through the provider licensing and reporting hub. The request must be made in writing. If sent by certified mail, the request must be postmarked and sent to the commissioner within 20 calendar days after the applicant received the order. If a request is made by personal service, it must be received by the commissioner within 20 calendar days after the applicant received the order. If the order is issued through the provider hub, the request must be received by the commissioner within 20 calendar days from the date the commissioner issued the order through the hub. The applicant may submit with the request for reconsideration a written argument or evidence in support of the request for reconsideration.

(b) The commissioner's disposition of a request for reconsideration is final and not subject to appeal under chapter 14.

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

Sec. 27. Minnesota Statutes 2022, section 245H.06, subdivision 1, is amended to read:

Subdivision 1. **Correction order requirements.** (a) If the applicant or certification holder failed to comply with a law or rule, the commissioner may issue a correction order. The correction order must state:

(1) the condition that constitutes a violation of the law or rule;

(2) the specific law or rule violated; and

(3) the time allowed to correct each violation.

(b) The commissioner may issue a correction order to the applicant or certification holder through the provider licensing and reporting hub.

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

Sec. 28. Minnesota Statutes 2022, section 245H.06, subdivision 2, is amended to read:

Subd. 2. **Reconsideration request.** (a) If the applicant or certification holder believes that the commissioner's correction order is erroneous, the applicant or certification holder may ask the commissioner to reconsider the part of the correction order that is allegedly erroneous. A request for reconsideration must be made in writing~~,~~ and postmarked~~,~~ or submitted through the provider licensing and reporting hub, and sent to the commissioner within 20 calendar days after the applicant or certification holder received the correction order, and must:

(1) specify the part of the correction order that is allegedly erroneous;

(2) explain why the specified part is erroneous; and

(3) include documentation to support the allegation of error.

(b) A request for reconsideration does not stay any provision or requirement of the correction order. The commissioner's disposition of a request for reconsideration is final and not subject to appeal.

(c) Upon implementation of the provider licensing and reporting hub, the provider must use the hub to request reconsideration. If the order is issued through the provider hub, the request must be received by the commissioner within 20 calendar days from the date the commissioner issued the order through the hub.

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

Sec. 29. Minnesota Statutes 2022, section 245H.07, subdivision 1, is amended to read:

Subdivision 1. **Generally.** (a) The commissioner may decertify a center if a certification holder:

(1) failed to comply with an applicable law or rule;

(2) knowingly withheld relevant information from or gave false or misleading information to the commissioner in connection with an application for certification, in connection with the background study status of an individual, during an investigation, or regarding compliance with applicable laws or rules; or

(3) has authorization to receive child care assistance payments revoked pursuant to chapter 119B.

(b) When considering decertification, the commissioner shall consider the nature, chronicity, or severity of the violation of law or rule.

(c) When a center is decertified, the center is ineligible to receive a child care assistance payment under chapter 119B.

(d) The commissioner may issue a decertification order to a certification holder through the provider licensing and reporting hub.

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

Sec. 30. Minnesota Statutes 2022, section 245H.07, subdivision 2, is amended to read:

Subd. 2. **Reconsideration of decertification.** (a) The certification holder may request reconsideration of the decertification by notifying the commissioner by certified mail ~~or~~,

by personal service, or through the provider licensing and reporting hub. The request must be made in writing. If sent by certified mail, the request must be postmarked and sent to the commissioner within 20 calendar days after the certification holder received the order. If a request is made by personal service, it must be received by the commissioner within 20 calendar days after the certification holder received the order. If the order is issued through the provider hub, the request must be received by the commissioner within 20 calendar days from the date the commissioner issued the order through the hub. With the request for reconsideration, the certification holder may submit a written argument or evidence in support of the request for reconsideration.

(b) The commissioner's disposition of a request for reconsideration is final and not subject to appeal under chapter 14.

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

Sec. 31. Minnesota Statutes 2022, section 245I.011, subdivision 3, is amended to read:

Subd. 3. **Certification required.** (a) An individual, organization, or government entity that is exempt from licensure under section 245A.03, subdivision 2, paragraph (a), clause (19), and chooses to be identified as a certified mental health clinic must:

(1) be a mental health clinic that is certified under section 245I.20;

(2) comply with all of the responsibilities assigned to a license holder by this chapter except subdivision 1; and

(3) comply with all of the responsibilities assigned to a certification holder by chapter 245A.

(b) An individual, organization, or government entity described by this subdivision must obtain a criminal background study for each staff person or volunteer who provides direct contact services to clients.

(c) If a program is licensed according to this chapter and is part of a certified community behavioral health clinic under sections 245.7351 to 245.7357, the license holder must comply with the requirements in section 245.7355, subdivisions 6 to 9, as part of the licensing requirements under this chapter.

Sec. 32. Minnesota Statutes 2022, section 245I.20, subdivision 10, is amended to read:

Subd. 10. **Application procedures.** (a) The applicant for certification must submit any documents that the commissioner requires on forms approved by the commissioner. Upon

implementation of the provider licensing and reporting hub, applicants must use the hub in the manner prescribed by the commissioner.

(b) Upon submitting an application for certification, an applicant must pay the application fee required by section 245A.10, subdivision 3.

(c) The commissioner must act on an application within 90 working days of receiving a completed application.

(d) When the commissioner receives an application for initial certification that is incomplete because the applicant failed to submit required documents or is deficient because the submitted documents do not meet certification requirements, the commissioner must provide the applicant with written notice that the application is incomplete or deficient. In the notice, the commissioner must identify the particular documents that are missing or deficient and give the applicant 45 days to submit a second application that is complete. An applicant's failure to submit a complete application within 45 days after receiving notice from the commissioner is a basis for certification denial.

(e) The commissioner must give notice of a denial to an applicant when the commissioner has made the decision to deny the certification application. In the notice of denial, the commissioner must state the reasons for the denial in plain language. The commissioner must send or deliver the notice of denial to an applicant by certified mail ~~or~~, by personal service or through the provider licensing and reporting hub. In the notice of denial, the commissioner must state the reasons that the commissioner denied the application and must inform the applicant of the applicant's right to request a contested case hearing under chapter 14 and Minnesota Rules, parts 1400.8505 to 1400.8612. The applicant may appeal the denial by notifying the commissioner in writing by certified mail ~~or~~, by personal service, or through the provider licensing and reporting hub. If mailed, the appeal must be postmarked and sent to the commissioner within 20 calendar days after the applicant received the notice of denial. If an applicant delivers an appeal by personal service, the commissioner must receive the appeal within 20 calendar days after the applicant received the notice of denial. If the order is issued through the provider hub, the request must be received by the commissioner within 20 calendar days from the date the commissioner issued the order through the hub.

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

Sec. 33. Minnesota Statutes 2022, section 245I.20, subdivision 13, is amended to read:

Subd. 13. **Correction orders.** (a) If the applicant or certification holder fails to comply with a law or rule, the commissioner may issue a correction order. The correction order must state:

(1) the condition that constitutes a violation of the law or rule;

(2) the specific law or rule that the applicant or certification holder has violated; and

(3) the time that the applicant or certification holder is allowed to correct each violation.

(b) If the applicant or certification holder believes that the commissioner's correction order is erroneous, the applicant or certification holder may ask the commissioner to reconsider the part of the correction order that is allegedly erroneous. An applicant or certification holder must make a request for reconsideration in writing. The request must be postmarked and sent to the commissioner or submitted in the provider licensing and reporting hub within 20 calendar days after the applicant or certification holder received the correction order; and the request must:

(1) specify the part of the correction order that is allegedly erroneous;

(2) explain why the specified part is erroneous; and

(3) include documentation to support the allegation of error.

(c) A request for reconsideration does not stay any provision or requirement of the correction order. The commissioner's disposition of a request for reconsideration is final and not subject to appeal.

(d) If the commissioner finds that the applicant or certification holder failed to correct the violation specified in the correction order, the commissioner may decertify the certified mental health clinic according to subdivision 14.

(e) Nothing in this subdivision prohibits the commissioner from decertifying a mental health clinic according to subdivision 14.

(f) The commissioner may issue a correction order to the applicant or certification holder through the provider licensing and reporting hub. If the order is issued through the provider hub, the request must be received by the commissioner within 20 calendar days from the date the commissioner issued the order through the hub.

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

Sec. 34. Minnesota Statutes 2022, section 245I.20, subdivision 14, is amended to read:

Subd. 14. **Decertification.** (a) The commissioner may decertify a mental health clinic if a certification holder:

(1) failed to comply with an applicable law or rule; or

(2) knowingly withheld relevant information from or gave false or misleading information to the commissioner in connection with an application for certification, during an investigation, or regarding compliance with applicable laws or rules.

(b) When considering decertification of a mental health clinic, the commissioner must consider the nature, chronicity, or severity of the violation of law or rule and the effect of the violation on the health, safety, or rights of clients.

(c) If the commissioner decertifies a mental health clinic, the order of decertification must inform the certification holder of the right to have a contested case hearing under chapter 14 and Minnesota Rules, parts 1400.8505 to 1400.8612. The commissioner may issue the order through the provider licensing and reporting hub.The certification holder may appeal the decertification. The certification holder must appeal a decertification in writing and send or deliver the appeal to the commissioner by certified mail ~~or~~, by personal service, or through the provider licensing and reporting hub. If the certification holder mails the appeal, the appeal must be postmarked and sent to the commissioner within ten calendar days after the certification holder receives the order of decertification. If the certification holder delivers an appeal by personal service, the commissioner must receive the appeal within ten calendar days after the certification holder received the order. If the order is issued through the provider hub, the request must be received by the commissioner within 20 calendar days from the date the commissioner issued the order through the hub. If a certification holder submits a timely appeal of an order of decertification, the certification holder may continue to operate the program until the commissioner issues a final order on the decertification.

(d) If the commissioner decertifies a mental health clinic pursuant to paragraph (a), clause (1), based on a determination that the mental health clinic was responsible for maltreatment, and if the certification holder appeals the decertification according to paragraph (c), and appeals the maltreatment determination under section 260E.33, the final decertification determination is stayed until the commissioner issues a final decision regarding the maltreatment appeal.

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

Sec. 35. Minnesota Statutes 2022, section 245I.20, subdivision 16, is amended to read:

Subd. 16. **Notifications required and noncompliance.** (a) A certification holder must notify the commissioner, in a manner prescribed by the commissioner, and obtain the commissioner's approval before making any change to the name of the certification holder or the location of the mental health clinic. Upon implementation of the provider licensing and reporting hub, certification holders must enter and update information in the hub in a manner prescribed by the commissioner.

(b) Changes in mental health clinic organization, staffing, treatment, or quality assurance procedures that affect the ability of the certification holder to comply with the minimum standards of this section must be reported in writing by the certification holder to the commissioner within 15 days of the occurrence. Review of the change must be conducted by the commissioner. A certification holder with changes resulting in noncompliance in minimum standards must receive written notice and may have up to 180 days to correct the areas of noncompliance before being decertified. Interim procedures to resolve the noncompliance on a temporary basis must be developed and submitted in writing to the commissioner for approval within 30 days of the commissioner's determination of the noncompliance. Not reporting an occurrence of a change that results in noncompliance within 15 days, failure to develop an approved interim procedure within 30 days of the determination of the noncompliance, or nonresolution of the noncompliance within 180 days will result in immediate decertification.

(c) The mental health clinic may be required to submit written information to the department to document that the mental health clinic has maintained compliance with this section and mental health clinic procedures.

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

Sec. 36. Minnesota Statutes 2022, section 260E.09, is amended to read:

260E.09 REPORTING REQUIREMENTS.

(a) An oral report shall be made immediately by telephone or otherwise. An oral report made by a person required under section 260E.06, subdivision 1, to report shall be followed within 72 hours, exclusive of weekends and holidays, by a report in writing to the appropriate police department, the county sheriff, the agency responsible for assessing or investigating the report, or the local welfare agency.

(b) Any report shall be of sufficient content to identify the child, any person believed to be responsible for the maltreatment of the child if the person is known, the nature and

extent of the maltreatment, and the name and address of the reporter. The local welfare agency or agency responsible for assessing or investigating the report shall accept a report made under section 260E.06 notwithstanding refusal by a reporter to provide the reporter's name or address as long as the report is otherwise sufficient under this paragraph.

(c) Notwithstanding paragraph (a), upon implementation of the provider licensing and reporting hub, an individual who has an account with the provider licensing and reporting hub and is required to report suspected maltreatment at a licensed program under section 260E.06, subdivision 1, may submit a written report in the hub in a manner prescribed by the commissioner and is not required to make an oral report. A report submitted through the provider licensing and reporting hub must be made immediately.

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

Sec. 37. Minnesota Statutes 2022, section 270B.14, subdivision 1, is amended to read:

Subdivision 1. **Disclosure to commissioner of human services.** (a) On the request of the commissioner of human services, the commissioner shall disclose return information regarding taxes imposed by chapter 290, and claims for refunds under chapter 290A, to the extent provided in paragraph (b) and for the purposes set forth in paragraph (c).

(b) Data that may be disclosed are limited to data relating to the identity, whereabouts, employment, income, and property of a person owing or alleged to be owing an obligation of child support.

(c) The commissioner of human services may request data only for the purposes of carrying out the child support enforcement program and to assist in the location of parents who have, or appear to have, deserted their children. Data received may be used only as set forth in section 256.978.

(d) The commissioner shall provide the records and information necessary to administer the supplemental housing allowance to the commissioner of human services.

(e) At the request of the commissioner of human services, the commissioner of revenue shall electronically match the Social Security numbers and names of participants in the telephone assistance plan operated under sections 237.69 to 237.71, with those of property tax refund filers, and determine whether each participant's household income is within the eligibility standards for the telephone assistance plan.

(f) The commissioner may provide records and information collected under sections 295.50 to 295.59 to the commissioner of human services for purposes of the Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991, Public Law

102-234. Upon the written agreement by the United States Department of Health and Human Services to maintain the confidentiality of the data, the commissioner may provide records and information collected under sections 295.50 to 295.59 to the Centers for Medicare and Medicaid Services section of the United States Department of Health and Human Services for purposes of meeting federal reporting requirements.

(g) The commissioner may provide records and information to the commissioner of human services as necessary to administer the early refund of refundable tax credits.

(h) The commissioner may disclose information to the commissioner of human services as necessary for income verification for eligibility and premium payment under the MinnesotaCare program, under section 256L.05, subdivision 2, as well as the medical assistance program under chapter 256B.

(i) The commissioner may disclose information to the commissioner of human services necessary to verify whether applicants or recipients for the Minnesota family investment program, general assistance, the Supplemental Nutrition Assistance Program (SNAP), Minnesota supplemental aid program, and child care assistance have claimed refundable tax credits under chapter 290 and the property tax refund under chapter 290A, and the amounts of the credits.

(j) The commissioner may disclose information to the commissioner of human services necessary to verify income for purposes of calculating parental contribution amounts under section 252.27, subdivision 2a.

(k) The commissioner shall disclose information to the commissioner of human services to verify the income and tax identification information of:

(1) an applicant under section 245A.04, subdivision 1;

(2) an applicant under section 245I.20;

(3) an applicant under section 245H.03;

(4) a license holder; or

(5) a certification holder.

Sec. 38. **DIRECTION TO COMMISSIONER; LICENSING SYSTEM TRANSFORMATION.**

(a) The commissioner of human services must implement an integrated provider licensing hub for human services licensing that provides information about licensing, licensing

processes, and training to licensed providers and the public in multiple languages, including Spanish, Somali, and Hmong.

(b) The commissioner must establish a permanent cross-functional product team that includes staff from the Department of Human Services and MNIT services to implement the integrated provider licensing hub.

(c) The commissioner must execute a contract with an implementation contractor to configure the software and implement the provider licensing hub.

(d) The commissioner must execute a contract to implement an enterprise master data management solution that ensures that there is a single master record for each person, place, or program from across internal and external data sources and applications to promote accurate reporting, reduce data errors, remove redundancy, and facilitate data-driven decisions.

(e) The commissioner must develop a plan to create an enterprise single sign-on experience.

ARTICLE 9
BEHAVIORAL HEALTH

Section 1. **[245.0961] AFRICAN AMERICAN BEHAVIORAL HEALTH GRANT PROGRAM.**

Subdivision 1. **Establishment.** The commissioner of human services must establish an African American Behavioral Health grant program to offer culturally specific, comprehensive, trauma-informed, practice- and evidence-based, person- and family-centered mental health and substance use disorder treatment services.

Subd. 2. **Eligible applicants.** To be eligible for a grant under this section, applicants must be a nonprofit organization or a nongovernmental organization and must be a culturally specific mental health service provider that is a licensed community mental health center that specializes in services for African American children and families.

Subd. 3. **Application.** An organization seeking a grant under this section must apply to the commissioner at a time and in a manner specified by the commissioner.

Subd. 4. **Grant activities.** Grant money must be used to offer culturally specific, comprehensive, trauma-informed, practice- and evidence-based, person- and family-centered mental health and substance use disorder services. Grant money may also be used for

supervision and training, and care coordination regardless of a client's ability to pay or place of residence.

Subd. 5. **Reporting.** (a) The grantee must submit a report to the commissioner in a manner and on a timeline specified by the commissioner. The report must include how many clients were served with the grant money and, if grant money was used for supervision and training, how many providers were supervised or trained using the grant money.

(b) The commissioner must submit a report to the chairs and ranking minority members of the legislative committees with jurisdiction over behavioral health no later than six months after receiving the report under paragraph (a). The report submitted by the commissioner must include the information specified in paragraph (a).

Sec. 2. Minnesota Statutes 2022, section 245.4889, subdivision 1, is amended to read:

Subdivision 1. **Establishment and authority.** (a) The commissioner is authorized to make grants from available appropriations to assist:

(1) counties;

(2) Indian Tribes;

(3) children's collaboratives under section 124D.23 or 245.493; or

(4) mental health service providers.

(b) The following services are eligible for grants under this section:

(1) services to children with emotional disturbances as defined in section 245.4871, subdivision 15, and their families;

(2) transition services under section 245.4875, subdivision 8, for young adults under age 21 and their families;

(3) respite care services for children with emotional disturbances or severe emotional disturbances who are at risk of out-of-home placement or already in out-of-home placement in family foster settings as defined in chapter 245A and at risk of change in out-of-home placement or placement in a residential facility or other higher level of care. Allowable activities and expenses for respite care services are defined under subdivision 4. A child is not required to have case management services to receive respite care services;

(4) children's mental health crisis services;

(5) mental health services for people from cultural and ethnic minorities, including supervision of clinical trainees who are Black, indigenous, or people of color;

(6) children's mental health screening and follow-up diagnostic assessment and treatment;

(7) services to promote and develop the capacity of providers to use evidence-based practices in providing children's mental health services;

(8) school-linked mental health services under section 245.4901;

(9) building evidence-based mental health intervention capacity for children birth to age five;

(10) suicide prevention and counseling services that use text messaging statewide;

(11) mental health first aid training;

(12) training for parents, collaborative partners, and mental health providers on the impact of adverse childhood experiences and trauma and development of an interactive website to share information and strategies to promote resilience and prevent trauma;

(13) transition age services to develop or expand mental health treatment and supports for adolescents and young adults 26 years of age or younger;

(14) early childhood mental health consultation;

(15) evidence-based interventions for youth at risk of developing or experiencing a first episode of psychosis, and a public awareness campaign on the signs and symptoms of psychosis;

(16) psychiatric consultation for primary care practitioners; ~~and~~

(17) providers to begin operations and meet program requirements when establishing a new children's mental health program~~. These may be start-up grants~~, including start-up grants; and

(18) evidence-informed interventions for youth and young adults who are at risk of developing a mood disorder or are experiencing an emerging mood disorder, including major depression and bipolar disorders, and a public awareness campaign on the signs and symptoms of mood disorders in youth and young adults.

(c) Services under paragraph (b) must be designed to help each child to function and remain with the child's family in the community and delivered consistent with the child's treatment plan. Transition services to eligible young adults under this paragraph must be designed to foster independent living in the community.

(d) As a condition of receiving grant funds, a grantee shall obtain all available third-party reimbursement sources, if applicable.

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

Sec. 3. **[245.4903] CULTURAL AND ETHNIC MINORITY INFRASTRUCTURE GRANT PROGRAM.**

Subdivision 1. **Establishment.** The commissioner of human services must establish a cultural and ethnic minority infrastructure grant program to ensure that mental health and substance use disorder treatment supports and services are culturally specific and culturally responsive to meet the cultural needs of communities served.

Subd. 2. **Eligible applicants.** An eligible applicant is a licensed entity or provider from a cultural or ethnic minority population who:

(1) provides mental health or substance use disorder treatment services and supports to individuals from cultural and ethnic minority populations, including members of those populations who identify as lesbian, gay, bisexual, transgender, or queer;

(2) provides, or is qualified and has the capacity to provide, clinical supervision and support to members of culturally diverse and ethnic minority communities so they may become qualified mental health and substance use disorder treatment providers; or

(3) has the capacity and experience to provide training for mental health and substance use disorder treatment providers on cultural competency and cultural humility.

Subd. 3. **Allowable grant activities.** (a) Grantees must engage in activities and provide supportive services to ensure and increase equitable access to culturally specific and responsive care and build organizational and professional capacity for licensure and certification for the communities served. Allowable grant activities include but are not limited to:

(1) providing workforce development activities focused on recruiting, supporting, training, and supervising mental health and substance use disorder practitioners and professionals from diverse racial, cultural, and ethnic communities;

(2) helping members of racial and ethnic minority communities become qualified mental health and substance use disorder professionals, practitioners, clinical supervisors, recovery peer specialists, mental health certified peer specialists, and mental health certified family peer specialists;

(3) providing culturally specific outreach, early intervention, trauma-informed services, and recovery support in mental health and substance use disorder services;

(4) providing trauma-informed and culturally responsive mental health and substance use disorder supports and services to children and families, youth, or adults who are from cultural and ethnic minority backgrounds and are uninsured or underinsured;

(5) expanding mental health and substance use disorder services, particularly in greater Minnesota;

(6) training mental health and substance use disorder treatment providers on cultural competency and cultural humility; and

(7) providing activities that increase the availability of culturally responsive mental health and substance use disorder services for children and families, youth, or adults, or that increase the availability of substance use disorder services for individuals from cultural and ethnic minorities in the state.

(b) The commissioner must assist grantees with meeting third-party credentialing requirements, and grantees must obtain all available third-party reimbursement sources as a condition of receiving grant money. Grantees must serve individuals from cultural and ethnic minority communities regardless of health coverage status or ability to pay.

Subd. 4. **Program evaluation requirements.** The commissioner must consult with the commissioner of management and budget on program outcomes, evaluation metrics, and progress indicators for the grant program under this section. The commissioner must only implement program outcomes, evaluation metrics, and progress indicators that are determined through and agreed upon during the consultation with the commissioner of management and budget. The commissioner shall not implement the grant program under this section until the consultation with the commissioner of management and budget is completed. The commissioner must incorporate agreed-upon program outcomes, evaluation metrics, and progress indicators into grant applications, requests for proposals, and any reports to the legislature.

Sec. 4. **[245.4904] EMERGING MOOD DISORDER GRANT PROGRAM.**

Subdivision 1. **Creation.** (a) The emerging mood disorder grant program is established in the Department of Human Services to fund:

(1) evidence-informed interventions for youth and young adults who are at risk of developing a mood disorder or are experiencing an emerging mood disorder, including major depression and bipolar disorders; and

(2) a public awareness campaign on the signs and symptoms of mood disorders in youth and young adults.

(b) Emerging mood disorder services are eligible for children's mental health grants as specified in section 245.4889, subdivision 1, paragraph (b), clause (18).

Subd. 2. **Activities.** (a) All emerging mood disorder grant program recipients must:

(1) provide intensive treatment and support to adolescents and young adults experiencing or at risk of experiencing an emerging mood disorder. Intensive treatment and support includes medication management, psychoeducation for the individual and the individual's family, case management, employment support, education support, cognitive behavioral approaches, social skills training, peer support, crisis planning, and stress management;

(2) conduct outreach and provide training and guidance to mental health and health care professionals, including postsecondary health clinicians, on early symptoms of mood disorders, screening tools, and best practices;

(3) ensure access for individuals to emerging mood disorder services under this section, including ensuring access for individuals who live in rural areas; and

(4) use all available funding streams.

(b) Grant money may also be used to pay for housing or travel expenses for individuals receiving services or to address other barriers preventing individuals and their families from participating in emerging mood disorder services.

(c) Grant money may be used by the grantee to evaluate the efficacy of providing intensive services and supports to people with emerging mood disorders.

Subd. 3. **Eligibility.** Program activities must be provided to youth and young adults with early signs of an emerging mood disorder.

Subd. 4. **Program evaluation requirements.** The commissioner must consult with the commissioner of management and budget on program outcomes, evaluation metrics, and progress indicators for the grant program under this section. The commissioner must only implement program outcomes, evaluation metrics, and progress indicators that are determined through and agreed upon during the consultation with the commissioner of management and budget. The commissioner shall not implement the grant program under this section until the consultation with the commissioner of management and budget is completed. The commissioner must incorporate agreed-upon program outcomes, evaluation metrics, and progress indicators into grant applications, requests for proposals, and any reports to the legislature.

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

Sec. 5. Minnesota Statutes 2022, section 254B.02, subdivision 5, is amended to read:

Subd. 5. ~~**Administrative adjustment**~~ **Local agency allocation.** The commissioner may make payments to local agencies from money allocated under this section to support ~~administrative activities under sections 254B.03 and 254B.04~~ individuals with substance use disorders. The ~~administrative~~ payment must not ~~exceed the lesser of: (1) five percent of the first $50,000, four percent of the next $50,000, and three percent of the remaining payments for services from the special revenue account according to subdivision 1; or (2)~~ be less than 133 percent of the local agency ~~administrative~~ payment for the fiscal year ending June 30, 2009, adjusted in proportion to the statewide change in the appropriation for this chapter.

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

Sec. 6. Minnesota Statutes 2022, section 256B.0941, is amended by adding a subdivision to read:

Subd. 5. **Start-up and capacity-building grants.** (a) The commissioner shall establish start-up and capacity-building grants for psychiatric residential treatment facility sites. Start-up grants to prospective psychiatric residential treatment facility sites may be used for:

(1) administrative expenses;

(2) consulting services;

(3) Health Insurance Portability and Accountability Act of 1996 compliance;

(4) therapeutic resources, including evidence-based, culturally appropriate curriculums and training programs for staff and clients;

(5) allowable physical renovations to the property; and

(6) emergency workforce shortage uses, as determined by the commissioner.

(b) Start-up and capacity-building grants to prospective and current psychiatric residential treatment facilities may be used to support providers who treat and accept individuals with complex support needs, including but not limited to:

(1) neurocognitive disorders;

(2) co-occurring intellectual developmental disabilities;

(3) schizophrenia spectrum disorders;

(4) manifested or labeled aggressive behaviors; and

(5) manifested sexually inappropriate behaviors.

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

Sec. 7. **DIRECTION TO COMMISSIONER; CHANGES TO RESIDENTIAL ADULT MENTAL HEALTH PROGRAM LICENSING REQUIREMENTS.**

(a) The commissioner of human services must consult with stakeholders to determine the changes to residential adult mental health program licensing requirements in Minnesota Rules, parts 9520.0500 to 9520.0670, necessary to:

(1) update requirements for category I programs to align with current mental health practices, client rights for similar services, and health and safety needs of clients receiving services;

(2) remove category II classification and requirements; and

(3) add licensing requirements to the rule for the Forensic Mental Health Program.

(b) The commissioner must use existing authority in Minnesota Statutes, chapter 245A, to amend Minnesota Rules, parts 9520.0500 to 9520.0670, based on the stakeholder consultation in paragraph (a) and additional changes as determined by the commissioner.

Sec. 8. **LOCAL AGENCY SUBSTANCE USE DISORDER ALLOCATION.**

The commissioner of human services shall evaluate the ongoing need for local agency substance use disorder allocations under Minnesota Statutes, section 254B.02. The evaluation must include recommendations on whether local agency allocations should continue, and if so, must recommend what the purpose of the allocations should be and propose an updated allocation methodology that aligns with the purpose and person-centered outcomes for people experiencing substance use disorders and behavioral health conditions. The commissioner may contract with a vendor to support this evaluation through research and actuarial analysis.

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

Sec. 9. **MOBILE RESPONSE AND STABILIZATION SERVICES PILOT.**

The commissioner of human services shall establish a pilot to promote access to crisis response services and reduce psychiatric hospitalizations and out-of-home placement services for children, youth, and families. The pilot must incorporate a two-pronged approach to provide an immediate, face-to-face response within 60 minutes of a crisis as well as extended, longer-term supports for the family unit. The pilot must aim to help families respond to

children's behavioral health crises while bolstering resiliency and recovery within the family unit. The commissioner must consult with a qualified expert entity to assist in the formulation of measurable outcomes and explore and position the state to submit a Medicaid state plan amendment to scale the model statewide.

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

Sec. 10. **RATE INCREASE FOR MENTAL HEALTH ADULT DAY TREATMENT.**

The commissioner of human services must increase the reimbursement rate for adult day treatment under Minnesota Statutes, section 256B.0671, subdivision 3, by 50 percent over the reimbursement rate in effect as of June 30, 2023.

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

ARTICLE 10
ADDRESSING DEEP POVERTY

Section 1. Minnesota Statutes 2022, section 256D.01, subdivision 1a, is amended to read:

Subd. 1a. **Standards.** (a) A principal objective in providing general assistance is to provide for single adults, childless couples, or children as defined in section 256D.02, subdivision 6, ineligible for federal programs who are unable to provide for themselves. The minimum standard of assistance determines the total amount of the general assistance grant without separate standards for shelter, utilities, or other needs.

(b) The ~~commissioner shall set the~~ standard of assistance for an assistance unit consisting of ~~an adult~~ a recipient who is childless and unmarried or living apart from children and spouse and who does not live with a parent or parents or a legal custodian is the cash portion of the MFIP transitional standard for a single adult under section 256J.24, subdivision 5. ~~When the other standards specified in this subdivision increase, this standard must also be increased by the same percentage.~~

(c) For an assistance unit consisting of a single adult who lives with a parent or parents, the general assistance standard of assistance ~~is the amount that the aid to families with dependent children standard of assistance, in effect on July 16, 1996, would increase if the recipient were added as an additional minor child to an assistance unit consisting of the recipient's parent and all of that parent's family members, except that the standard may not exceed the standard for a general assistance recipient living alone~~ is the cash portion of the

MFIP transitional standard for a single adult under section 256J.24, subdivision 5. Benefits received by a responsible relative of the assistance unit under the Supplemental Security Income program, a workers' compensation program, the Minnesota supplemental aid program, or any other program based on the responsible relative's disability, and any benefits received by a responsible relative of the assistance unit under the Social Security retirement program, may not be counted in the determination of eligibility or benefit level for the assistance unit. Except as provided below, the assistance unit is ineligible for general assistance if the available resources or the countable income of the assistance unit and the parent or parents with whom the assistance unit lives are such that a family consisting of the assistance unit's parent or parents, the parent or parents' other family members and the assistance unit as the only or additional minor child would be financially ineligible for general assistance. For the purposes of calculating the countable income of the assistance unit's parent or parents, the calculation methods must follow the provisions under section 256P.06.

(d) For an assistance unit consisting of a childless couple, the standards of assistance are the same as the first and second adult standards of the aid to families with dependent children program in effect on July 16, 1996. If one member of the couple is not included in the general assistance grant, the standard of assistance for the other is the second adult standard of the aid to families with dependent children program as of July 16, 1996.

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

Sec. 2. Minnesota Statutes 2022, section 256D.024, subdivision 1, is amended to read:

Subdivision 1. **Person convicted of drug offenses.** (a) ~~If~~ An ~~applicant or recipient~~ individual who has been convicted of a felony-level drug offense ~~after July 1, 1997, the assistance unit is ineligible for benefits under this chapter until five years after the applicant has completed terms of the court-ordered sentence, unless the person is participating in a drug treatment program, has successfully completed a drug treatment program, or has been assessed by the county and determined not to be in need of a drug treatment program. Persons subject to the limitations of this subdivision who become eligible for assistance under this chapter shall~~ during the previous ten years from the date of application or recertification may be subject to random drug testing ~~as a condition of continued eligibility and shall lose eligibility for benefits for five years beginning the month following:~~. The county must provide information about substance use disorder treatment programs to a person who tests positive for an illegal controlled substance.

~~(1) Any positive test result for an illegal controlled substance; or~~

~~(2) discharge of sentence after conviction for another drug felony.~~

(b) For the purposes of this subdivision, "drug offense" means a conviction that occurred ~~after July 1, 1997,~~ during the previous ten years from the date of application or recertification of sections 152.021 to 152.025, 152.0261, 152.0262, or 152.096. Drug offense also means a conviction in another jurisdiction of the possession, use, or distribution of a controlled substance, or conspiracy to commit any of these offenses, if the ~~offense~~ conviction occurred ~~after July 1, 1997,~~ during the previous ten years from the date of application or recertification and the conviction is a felony offense in that jurisdiction, or in the case of New Jersey, a high misdemeanor.

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

Sec. 3. Minnesota Statutes 2022, section 256D.06, subdivision 5, is amended to read:

Subd. 5. **Eligibility; requirements.** (a) Any applicant, otherwise eligible for general assistance and possibly eligible for maintenance benefits from any other source shall (1) make application for those benefits within ~~30~~ 90 days of the general assistance application; and (2) execute an interim assistance agreement on a form as directed by the commissioner.

(b) The commissioner shall review a denial of an application for other maintenance benefits and may require a recipient of general assistance to file an appeal of the denial if appropriate. If found eligible for benefits from other sources, and a payment received from another source relates to the period during which general assistance was also being received, the recipient shall be required to reimburse the county agency for the interim assistance paid. Reimbursement shall not exceed the amount of general assistance paid during the time period to which the other maintenance benefits apply and shall not exceed the state standard applicable to that time period.

(c) The commissioner may contract with the county agencies, qualified agencies, organizations, or persons to provide advocacy and support services to process claims for federal disability benefits for applicants or recipients of services or benefits supervised by the commissioner using money retained under this section.

(d) The commissioner may provide methods by which county agencies shall identify, refer, and assist recipients who may be eligible for benefits under federal programs for people with a disability.

(e) The total amount of interim assistance recoveries retained under this section for advocacy, support, and claim processing services shall not exceed 35 percent of the interim assistance recoveries in the prior fiscal year.

Sec. 4. Minnesota Statutes 2022, section 256D.44, subdivision 5, is amended to read:

Subd. 5. **Special needs.** (a) In addition to the state standards of assistance established in subdivisions 1 to 4, payments are allowed for the following special needs of recipients of Minnesota supplemental aid who are not residents of a nursing home, a regional treatment center, or a setting authorized to receive housing support payments under chapter 256I.

(b) The county agency shall pay a monthly allowance for medically prescribed diets if the cost of those additional dietary needs cannot be met through some other maintenance benefit. The need for special diets or dietary items must be prescribed by a licensed physician, advanced practice registered nurse, or physician assistant. Costs for special diets shall be determined as percentages of the allotment for a one-person household under the thrifty food plan as defined by the United States Department of Agriculture. The types of diets and the percentages of the thrifty food plan that are covered are as follows:

(1) high protein diet, at least 80 grams daily, 25 percent of thrifty food plan;

(2) controlled protein diet, 40 to 60 grams and requires special products, 100 percent of thrifty food plan;

(3) controlled protein diet, less than 40 grams and requires special products, 125 percent of thrifty food plan;

(4) low cholesterol diet, 25 percent of thrifty food plan;

(5) high residue diet, 20 percent of thrifty food plan;

(6) pregnancy and lactation diet, 35 percent of thrifty food plan;

(7) gluten-free diet, 25 percent of thrifty food plan;

(8) lactose-free diet, 25 percent of thrifty food plan;

(9) antidumping diet, 15 percent of thrifty food plan;

(10) hypoglycemic diet, 15 percent of thrifty food plan; or

(11) ketogenic diet, 25 percent of thrifty food plan.

(c) Payment for nonrecurring special needs must be allowed for necessary home repairs or necessary repairs or replacement of household furniture and appliances using the payment standard of the AFDC program in effect on July 16, 1996, for these expenses, as long as other funding sources are not available.

(d) A fee for guardian or conservator service is allowed at a reasonable rate negotiated by the county or approved by the court. This rate shall not exceed five percent of the

assistance unit's gross monthly income up to a maximum of $100 per month. If the guardian or conservator is a member of the county agency staff, no fee is allowed.

(e) The county agency shall continue to pay a monthly allowance of $68 for restaurant meals for a person who was receiving a restaurant meal allowance on June 1, 1990, and who eats two or more meals in a restaurant daily. The allowance must continue until the person has not received Minnesota supplemental aid for one full calendar month or until the person's living arrangement changes and the person no longer meets the criteria for the restaurant meal allowance, whichever occurs first.

(f) A fee ~~of ten percent of the recipient's gross income or $25, whichever is less,~~ equal to the maximum monthly amount allowed by the Social Security Administration is allowed for representative payee services provided by an agency that meets the requirements under SSI regulations to charge a fee for representative payee services. This special need is available to all recipients of Minnesota supplemental aid regardless of their living arrangement.

(g)(1) Notwithstanding the language in this subdivision, an amount equal to one-half of the maximum federal Supplemental Security Income payment amount for a single individual which is in effect on the first day of July of each year will be added to the standards of assistance established in subdivisions 1 to 4 for adults under the age of 65 who qualify as in need of housing assistance and are:

(i) relocating from an institution, a setting authorized to receive housing support under chapter 256I, or an adult mental health residential treatment program under section 256B.0622;

(ii) eligible for personal care assistance under section 256B.0659; or

(iii) home and community-based waiver recipients living in their own home or rented or leased apartment.

(2) Notwithstanding subdivision 3, paragraph (c), an individual eligible for the shelter needy benefit under this paragraph is considered a household of one. An eligible individual who receives this benefit prior to age 65 may continue to receive the benefit after the age of 65.

(3) "Housing assistance" means that the assistance unit incurs monthly shelter costs that exceed 40 percent of the assistance unit's gross income before the application of this special needs standard. "Gross income" for the purposes of this section is the applicant's or recipient's income as defined in section 256D.35, subdivision 10, or the standard specified in subdivision 3, paragraph (a) or (b), whichever is greater. A recipient of a federal or state housing subsidy,

that limits shelter costs to a percentage of gross income, shall not be considered in need of housing assistance for purposes of this paragraph.

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

Sec. 5. Minnesota Statutes 2022, section 256I.03, subdivision 7, is amended to read:

Subd. 7. **Countable income.** (a) "Countable income" means all income received by an applicant or recipient as described under section 256P.06, less any applicable exclusions or disregards. ~~For a recipient of any cash benefit from the SSI program, countable income means the SSI benefit limit in effect at the time the person is a recipient of housing support, less the medical assistance personal needs allowance under section 256B.35. If the SSI limit or benefit is reduced for a person due to events other than receipt of additional income, countable income means actual income less any applicable exclusions and disregards.~~

(b) For a recipient of any cash benefit from the SSI program who does not live in a setting described in section 256I.04, subdivision 2a, paragraph (b), clause (2), countable income equals the SSI benefit limit in effect at the time the person is a recipient of housing support, less the personal needs allowance under section 256B.35. If the SSI limit or benefit is reduced for a person due to events other than receipt of additional income, countable income equals actual income less any applicable exclusions and disregards.

(c) For a recipient of any cash benefit from the SSI program who lives in a setting as described in section 256I.04, subdivision 2a, paragraph (b), clause (2), countable income equals 30 percent of the SSI benefit limit in effect at the time a person is a recipient of housing support. If the SSI limit or benefit is reduced for a person due to events other than receipt of additional income, countable income equals 30 percent of the actual income less any applicable exclusions and disregards. For recipients under this paragraph, the personal needs allowance described in section 256B.35 does not apply.

(d) Notwithstanding the earned income disregard described in section 256P.03, for a recipient of unearned income as defined in section 256P.06, subdivision 3, clause (2), other than SSI and the general assistance personal needs allowance who lives in a setting described in section 256I.04, subdivision 2a, paragraph (b), clause (2), countable income equals 30 percent of the recipient's total income after applicable exclusions and disregards. Total income includes any unearned income as defined in section 256P.06 and any earned income in the month the person is a recipient of housing support. For recipients under this paragraph, the personal needs allowance described in section 256B.35 does not apply.

(e) For a recipient who lives in a setting as described in section 256I.04, subdivision 2a, paragraph (b), clause (2), and receives general assistance, the personal needs allowance described in section 256B.35 is not countable unearned income.

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

Sec. 6. Minnesota Statutes 2022, section 256J.26, subdivision 1, is amended to read:

Subdivision 1. **Person convicted of drug offenses.** (a) An individual who has been convicted of a felony level drug offense ~~committed~~ during the previous ten years from the date of application or recertification is subject to the following:

(1) Benefits for the entire assistance unit must be paid in vendor form for shelter and utilities during any time the applicant is part of the assistance unit.

(2) The convicted applicant or participant ~~shall~~ may be subject to random drug testing ~~as a condition of continued eligibility and~~. Following any positive test for an illegal controlled substance ~~is subject to the following sanctions:~~, the county must provide information about substance use disorder treatment programs to the applicant or participant.

~~(i) for failing a drug test the first time, the residual amount of the participant's grant after making vendor payments for shelter and utility costs, if any, must be reduced by an amount equal to 30 percent of the MFIP standard of need for an assistance unit of the same size. When a sanction under this subdivision is in effect, the job counselor must attempt to meet with the person face-to-face. During the face-to-face meeting, the job counselor must explain the consequences of a subsequent drug test failure and inform the participant of the right to appeal the sanction under section 256J.40. If a face-to-face meeting is not possible, the county agency must send the participant a notice of adverse action as provided in section 256J.31, subdivisions 4 and 5, and must include the information required in the face-to-face meeting; or~~

~~(ii) for failing a drug test two times, the participant is permanently disqualified from receiving MFIP assistance, both the cash and food portions. The assistance unit's MFIP grant must be reduced by the amount which would have otherwise been made available to the disqualified participant. Disqualification under this item does not make a participant ineligible for the Supplemental Nutrition Assistance Program (SNAP). Before a disqualification under this provision is imposed, the job counselor must attempt to meet with the participant face-to-face. During the face-to-face meeting, the job counselor must identify other resources that may be available to the participant to meet the needs of the family and inform the participant of the right to appeal the disqualification under section~~

~~256J.40. If a face-to-face meeting is not possible, the county agency must send the participant a notice of adverse action as provided in section 256J.31, subdivisions 4 and 5, and must include the information required in the face-to-face meeting.~~

~~(3) A participant who fails a drug test the first time and is under a sanction due to other MFIP program requirements is considered to have more than one occurrence of noncompliance and is subject to the applicable level of sanction as specified under section 256J.46, subdivision 1, paragraph (d).~~

(b) Applicants requesting only SNAP benefits or participants receiving only SNAP benefits, who have been convicted of a felony-level drug offense ~~that occurred after July 1, 1997,~~ during the previous ten years from the date of application or recertification may, if otherwise eligible, receive SNAP benefits ~~if~~. The convicted applicant or participant ~~is~~ may be subject to random drug testing ~~as a condition of continued eligibility~~. Following a positive test for an illegal controlled substance, the ~~applicant is subject to the following sanctions:~~ county must provide information about substance use disorder treatment programs to the applicant or participant.

~~(1) for failing a drug test the first time, SNAP benefits shall be reduced by an amount equal to 30 percent of the applicable SNAP benefit allotment. When a sanction under this clause is in effect, a job counselor must attempt to meet with the person face-to-face. During the face-to-face meeting, a job counselor must explain the consequences of a subsequent drug test failure and inform the participant of the right to appeal the sanction under section 256J.40. If a face-to-face meeting is not possible, a county agency must send the participant a notice of adverse action as provided in section 256J.31, subdivisions 4 and 5, and must include the information required in the face-to-face meeting; and~~

~~(2) for failing a drug test two times, the participant is permanently disqualified from receiving SNAP benefits. Before a disqualification under this provision is imposed, a job counselor must attempt to meet with the participant face-to-face. During the face-to-face meeting, the job counselor must identify other resources that may be available to the participant to meet the needs of the family and inform the participant of the right to appeal the disqualification under section 256J.40. If a face-to-face meeting is not possible, a county agency must send the participant a notice of adverse action as provided in section 256J.31, subdivisions 4 and 5, and must include the information required in the face-to-face meeting.~~

(c) For the purposes of this subdivision, "drug offense" means ~~an offense~~ a conviction that occurred during the previous ten years from the date of application or recertification of sections 152.021 to 152.025, 152.0261, 152.0262, 152.096, or 152.137. Drug offense

also means a conviction in another jurisdiction of the possession, use, or distribution of a controlled substance, or conspiracy to commit any of these offenses, if the ~~offense~~ conviction occurred during the previous ten years from the date of application or recertification and the conviction is a felony offense in that jurisdiction, or in the case of New Jersey, a high misdemeanor.

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

Sec. 7. Minnesota Statutes 2022, section 256P.01, is amended by adding a subdivision to read:

Subd. 5a. **Lived-experience engagement.** "Lived-experience engagement" means an intentional engagement of people with lived experience by a federal, Tribal, state, county, municipal, or nonprofit human services agency funded in part or in whole by federal, state, local government, Tribal Nation, public, private, or philanthropic money to gather and share feedback on the impact of human services programs.

Sec. 8. Minnesota Statutes 2022, section 256P.02, is amended by adding a subdivision to read:

Subd. 4. **Health and human services recipient engagement income.** Income received from lived-experience engagement, as defined in section 256P.01, subdivision 6, shall be excluded when determining the equity value of personal property.

Sec. 9. Minnesota Statutes 2022, section 256P.06, is amended by adding a subdivision to read:

Subd. 4. **Recipient engagement income.** Income received from lived-experience engagement, as defined in section 256P.01, subdivision 5a, must not be counted as income for purposes of determining or redetermining eligibility or benefits.

Sec. 10. Minnesota Statutes 2022, section 609B.425, subdivision 2, is amended to read:

Subd. 2. **Benefit eligibility.** (a) For general assistance benefits and Minnesota supplemental aid under chapter 256D, a person convicted of a felony-level drug offense ~~after July 1, 1997, is ineligible for general assistance benefits and Supplemental Security Income under chapter 256D until:~~ during the previous ten years from the date of application or recertification may be subject to random drug testing. The county must provide information about substance use disorder treatment programs to a person who tests positive for an illegal controlled substance.

~~(1) five years after completing the terms of a court-ordered sentence; or~~

~~(2) unless the person is participating in a drug treatment program, has successfully completed a program, or has been determined not to be in need of a drug treatment program.~~

~~(b) A person who becomes eligible for assistance under chapter 256D is subject to random drug testing and shall lose eligibility for benefits for five years beginning the month following:~~

~~(1) any positive test for an illegal controlled substance; or~~

~~(2) discharge of sentence for conviction of another drug felony.~~

~~(c)~~ (b) Parole violators and fleeing felons are ineligible for benefits and persons fraudulently misrepresenting eligibility are also ineligible to receive benefits for ten years.

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

Sec. 11. Minnesota Statutes 2022, section 609B.435, subdivision 2, is amended to read:

Subd. 2. **Drug offenders; random testing; sanctions.** A person who is an applicant for benefits from the Minnesota family investment program or MFIP, the vehicle for temporary assistance for needy families or TANF, and who has been convicted of a felony-level drug offense ~~shall~~ may be subject to ~~certain conditions, including~~ random drug testing~~, in order to receive MFIP benefits~~. Following any positive test for a controlled substance, the ~~convicted applicant or participant is subject to the following sanctions:~~ county must provide information about substance use disorder treatment programs to the applicant or participant.

~~(1) a first time drug test failure results in a reduction of benefits in an amount equal to 30 percent of the MFIP standard of need; and~~

~~(2) a second time drug test failure results in permanent disqualification from receiving MFIP assistance.~~

~~A similar disqualification sequence occurs if the applicant is receiving Supplemental Nutrition Assistance Program (SNAP) benefits.~~

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

ARTICLE 11

ECONOMIC ASSISTANCE

Section 1. Minnesota Statutes 2022, section 119B.025, subdivision 4, is amended to read:

Subd. 4. **Changes in eligibility.** (a) The county shall process a change in eligibility factors according to paragraphs (b) to (g).

(b) A family is subject to the reporting requirements in section 256P.07, subdivision 6.

(c) If a family reports a change or a change is known to the agency before the family's regularly scheduled redetermination, the county must act on the change. The commissioner shall establish standards for verifying a change.

(d) A change in income occurs on the day the participant received the first payment reflecting the change in income.

(e) During a family's 12-month eligibility period, if the family's income increases and remains at or below 85 percent of the state median income, adjusted for family size, there is no change to the family's eligibility. The county shall not request verification of the change. The co-payment fee shall not increase during the remaining portion of the family's 12-month eligibility period.

(f) During a family's 12-month eligibility period, if the family's income increases and exceeds 85 percent of the state median income, adjusted for family size, the family is not eligible for child care assistance. The family must be given 15 calendar days to provide verification of the change. If the required verification is not returned or confirms ineligibility, the family's eligibility ends following a subsequent 15-day adverse action notice.

(g) Notwithstanding Minnesota Rules, parts 3400.0040, subpart 3, and 3400.0170, subpart 1, if an applicant or participant reports that employment ended, the agency may accept a signed statement from the applicant or participant as verification that employment ended.

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

Sec. 2. Minnesota Statutes 2022, section 256D.03, is amended by adding a subdivision to read:

Subd. 2b. **Budgeting and reporting.** Every county agency shall determine eligibility and calculate benefit amounts for general assistance according to chapter 256P.

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

Sec. 3. Minnesota Statutes 2022, section 256D.63, subdivision 2, is amended to read:

Subd. 2. **SNAP reporting requirements.** The commissioner of human services shall implement simplified reporting as permitted under the Food and Nutrition Act of 2008, as amended, and the SNAP regulations in Code of Federal Regulations, title 7, part 273. SNAP benefit recipient households required to report periodically shall not be required to report more often than one time every six months. ~~This provision shall not apply to households receiving food benefits under the Minnesota family investment program waiver.~~

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

Sec. 4. Minnesota Statutes 2022, section 256E.34, subdivision 4, is amended to read:

Subd. 4. **Use of money.** At least 96 percent of the money distributed to Hunger Solutions under this section must be distributed to food shelf programs to purchase, transport, and coordinate the distribution of nutritious food to needy individuals and families. The money distributed to food shelf programs may also be used to purchase personal hygiene products, including but not limited to diapers and toilet paper. No more than four percent of the money may be expended for other expenses, such as rent, salaries, and other administrative expenses of Hunger Solutions.

Sec. 5. **[256E.342] AMERICAN INDIAN FOOD SOVEREIGNTY FUNDING PROGRAM.**

Subdivision 1. **Establishment.** The American Indian food sovereignty funding program is established to improve access and equity to food security programs within Tribal and American Indian communities. The program shall assist Tribal Nations and American Indian communities in achieving self-determination and improve collaboration and partnership building between American Indian communities and the state. The commissioner of human services shall administer the program and provide outreach, technical assistance, and program development support to increase food security for American Indians.

Subd. 2. **Distribution of funding.** (a) The commissioner shall provide funding to support food system changes and provide equitable access to existing and new methods of food support for American Indian communities. The commissioner shall determine the timing and form of the application for the program.

(b) Eligible recipients of funding under this section include:

(1) federally recognized American Indian Tribes or bands in Minnesota as defined in section 10.65; or

(2) nonprofit organizations or fiscal sponsors with a majority American Indian board of directors.

(c) Funding for American Indian Tribes or Bands must be allocated by a formula determined by the commissioner. Funding for nonprofit organizations or fiscal sponsors must be awarded through a competitive grant process.

Subd. 3. **Allowable uses of money.** Recipients shall use money provided under this section to promote food security for American Indian communities by:

(1) planning for sustainable food systems;

(2) implementing food security programs, including but not limited to technology to facilitate no-contact or low-contact food distribution and outreach models;

(3) providing culturally relevant training for building food access;

(4) purchasing, producing, processing, transporting, storing, and coordinating the distribution of food, including culturally relevant food; and

(5) purchasing seeds, plants, equipment, or materials to preserve, procure, or grow food.

Subd. 4. **Reporting.** Recipients shall report on the use of American Indian food sovereignty funding program money under this section to the commissioner.

The commissioner shall determine the timing and form required for the reports.

Sec. 6. Minnesota Statutes 2022, section 256E.35, subdivision 1, is amended to read:

Subdivision 1. **Establishment.** The Minnesota family assets for independence initiative is established to provide incentives for low-income families to accrue assets for education, housing, vehicles, emergencies, and economic development purposes.

Sec. 7. Minnesota Statutes 2022, section 256E.35, subdivision 2, is amended to read:

Subd. 2. **Definitions.** (a) The definitions in this subdivision apply to this section.

(b) "Eligible educational institution" means the following:

(1) an institution of higher education described in section 101 or 102 of the Higher Education Act of 1965; or

(2) an area vocational education school, as defined in subparagraph (C) or (D) of United States Code, title 20, chapter 44, section 2302 (3) (the Carl D. Perkins Vocational and Applied Technology Education Act), which is located within any state, as defined in United

States Code, title 20, chapter 44, section 2302 (30). This clause is applicable only to the extent section 2302 is in effect on August 1, 2008.

(c) "Family asset account" means a savings account opened by a household participating in the Minnesota family assets for independence initiative.

(d) "Fiduciary organization" means:

(1) a community action agency that has obtained recognition under section 256E.31;

(2) a federal community development credit union ~~serving the seven-county metropolitan area~~; ~~or~~

(3) a women-oriented economic development agency ~~serving the seven-county metropolitan area.~~;

(4) a federally recognized Tribal Nation; or

(5) a nonprofit organization as defined under section 501(c)(3) of the Internal Revenue Code.

(e) "Financial coach" means a person who:

(1) has completed an intensive financial literacy training workshop that includes curriculum on budgeting to increase savings, debt reduction and asset building, building a good credit rating, and consumer protection;

(2) participates in ongoing statewide family assets for independence in Minnesota (FAIM) network training meetings under FAIM program supervision; and

(3) provides financial coaching to program participants under subdivision 4a.

(f) "Financial institution" means a bank, bank and trust, savings bank, savings association, or credit union, the deposits of which are insured by the Federal Deposit Insurance Corporation or the National Credit Union Administration.

(g) "Household" means all individuals who share use of a dwelling unit as primary quarters for living and eating separate from other individuals.

(h) "Permissible use" means:

(1) postsecondary educational expenses at an eligible educational institution as defined in paragraph (b), including books, supplies, and equipment required for courses of instruction;

(2) acquisition costs of acquiring, constructing, or reconstructing a residence, including any usual or reasonable settlement, financing, or other closing costs;

(3) business capitalization expenses for expenditures on capital, plant, equipment, working capital, and inventory expenses of a legitimate business pursuant to a business plan approved by the fiduciary organization;

(4) acquisition costs of a principal residence within the meaning of section 1034 of the Internal Revenue Code of 1986 which do not exceed 100 percent of the average area purchase price applicable to the residence determined according to section 143(e)(2) and (3) of the Internal Revenue Code of 1986; ~~and~~

(5) acquisition costs of a personal vehicle only if approved by the fiduciary organization~~.~~;

(6) contributions to an emergency savings account; and

(7) contributions to a Minnesota 529 savings plan.

Sec. 8. Minnesota Statutes 2022, section 256E.35, subdivision 3, is amended to read:

Subd. 3. **Grants awarded.** The commissioner shall allocate funds to participating fiduciary organizations to provide family asset services. Grant awards must be based on a plan submitted by a statewide organization representing fiduciary organizations. The statewide organization must ensure that any interested unrepresented fiduciary organization have input into the development of the plan. The plan must equitably distribute funds to achieve geographic balance and document the capacity of participating fiduciary organizations to manage the program. A portion of funds appropriated for this section may be expended on evaluation of the Minnesota family assets for independence initiative.

Sec. 9. Minnesota Statutes 2022, section 256E.35, subdivision 4a, is amended to read:

Subd. 4a. **Financial coaching.** A financial coach shall provide the following to program participants:

(1) financial education relating to budgeting, debt reduction, asset-specific training, credit building, and financial stability activities;

(2) asset-specific training related to buying a home or vehicle, acquiring postsecondary education, ~~or~~ starting or expanding a small business, saving for emergencies, or saving for a child's education; and

(3) financial stability education and training to improve and sustain financial security.

Sec. 10. Minnesota Statutes 2022, section 256E.35, subdivision 6, is amended to read:

Subd. 6. **Withdrawal; matching; permissible uses.** (a) To receive a match, a participating household must transfer funds withdrawn from a family asset account to its matching fund custodial account held by the fiscal agent, according to the family asset agreement. The fiscal agent must determine if the match request is for a permissible use consistent with the household's family asset agreement.

(b) The fiscal agent must ensure the household's custodial account contains the applicable matching funds to match the balance in the household's account, including interest, on at least a quarterly basis and at the time of an approved withdrawal. Matches must be a contribution of $3 from state grant or TANF funds for every $1 of funds withdrawn from the family asset account not to exceed a ~~$6,000~~ $12,000 lifetime limit.

(c) Notwithstanding paragraph (b), if funds are appropriated for the Federal Assets for Independence Act of 1998, and a participating fiduciary organization is awarded a grant under that act, participating households with that fiduciary organization must be provided matches as follows:

(1) from state grant and TANF funds, a matching contribution of $1.50 for every $1 of funds withdrawn from the family asset account not to exceed a ~~$3,000~~ $6,000 lifetime limit; and

(2) from nonstate funds, a matching contribution of not less than $1.50 for every $1 of funds withdrawn from the family asset account not to exceed a ~~$3,000~~ $6,000 lifetime limit.

(d) Upon receipt of transferred custodial account funds, the fiscal agent must make a direct payment to the vendor of the goods or services for the permissible use.

Sec. 11. Minnesota Statutes 2022, section 256E.35, subdivision 7, is amended to read:

Subd. 7. **Program reporting.** The fiscal agent on behalf of each fiduciary organization participating in a family assets for independence initiative must report quarterly to the commissioner of human services identifying the participants with accounts~~,~~; the number of accounts~~,~~; the amount of savings and matches for each participant's account~~,~~; the uses of the account~~, and~~; the number of businesses, homes, vehicles, and educational services paid for with money from the account~~,~~; and the amount of contributions to Minnesota 529 savings plans and emergency savings accounts, as well as other information that may be required for the commissioner to administer the program and meet federal TANF reporting requirements.

Sec. 12. Minnesota Statutes 2022, section 256I.03, subdivision 13, is amended to read:

Subd. 13. **Prospective budgeting.** "Prospective budgeting" ~~means estimating the amount of monthly income a person will have in the payment month~~ has the meaning given in section 256P.01, subdivision 9.

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

Sec. 13. Minnesota Statutes 2022, section 256I.06, subdivision 6, is amended to read:

Subd. 6. **Reports.** Recipients must report changes in circumstances according to section 256P.07 ~~that affect eligibility or housing support payment amounts, other than changes in earned income, within ten days of the change~~. Recipients with countable earned income must complete a household report form ~~at least~~ once every six months according to section 256P.10. ~~If the report form is not received before the end of the month in which it is due, the county agency must terminate eligibility for housing support payments. The termination shall be effective on the first day of the month following the month in which the report was due. If a complete report is received within the month eligibility was terminated, the individual is considered to have continued an application for housing support payment effective the first day of the month the eligibility was terminated.~~

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

Sec. 14. Minnesota Statutes 2022, section 256I.06, is amended by adding a subdivision to read:

Subd. 6a. **When to terminate assistance.** An agency must terminate benefits when the assistance unit fails to submit the household report form before the end of the month in which it is due. The termination shall be effective on the first day of the month following the month in which the report was due. If the assistance unit submits the household report form within 30 days of the termination of benefits and remains eligible, benefits must be reinstated and made available retroactively for the full benefit month.

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

Sec. 15. Minnesota Statutes 2022, section 256I.06, subdivision 8, is amended to read:

Subd. 8. **Amount of housing support payment.** (a) The amount of a room and board payment to be made on behalf of an eligible individual is determined by subtracting the individual's countable income under section 256I.04, subdivision 1, for a whole calendar month from the room and board rate for that same month. The housing support payment is

determined by multiplying the housing support rate times the period of time the individual was a resident or temporarily absent under section 256I.05, subdivision 2a.

(b) For an individual with earned income under paragraph (a), prospective budgeting according to section 256P.09 must be used ~~to determine the amount of the individual's payment for the following six-month period. An increase in income shall not affect an individual's eligibility or payment amount until the month following the reporting month. A decrease in income shall be effective the first day of the month after the month in which the decrease is reported~~.

(c) For an individual who receives housing support payments under section 256I.04, subdivision 1, paragraph (c), the amount of the housing support payment is determined by multiplying the housing support rate times the period of time the individual was a resident.

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

Sec. 16. Minnesota Statutes 2022, section 256J.08, subdivision 71, is amended to read:

Subd. 71. **Prospective budgeting.** "Prospective budgeting" ~~means a method of determining the amount of the assistance payment in which the budget month and payment month are the same~~ has the meaning given in section 256P.01, subdivision 9.

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

Sec. 17. Minnesota Statutes 2022, section 256J.08, subdivision 79, is amended to read:

Subd. 79. **Recurring income.** "Recurring income" means a form of income which is:

(1) received periodically, and may be received irregularly when receipt can be anticipated even though the date of receipt cannot be predicted; and

(2) from the same source or of the same type that is received and budgeted in a prospective month ~~and is received in one or both of the first two retrospective months~~.

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

Sec. 18. Minnesota Statutes 2022, section 256J.11, subdivision 1, is amended to read:

Subdivision 1. **General citizenship requirements.** (a) To be eligible for MFIP, a member of the assistance unit must be a citizen of the United States, a qualified noncitizen as defined in section 256J.08, or a noncitizen who is otherwise residing lawfully in the United States.

(b) A qualified noncitizen who entered the United States on or after August 22, 1996, is eligible for MFIP. However, TANF dollars cannot be used to fund the MFIP benefits for

an individual under this paragraph for a period of five years after the date of entry unless the qualified noncitizen meets one of the following criteria:

(1) was admitted to the United States as a refugee under United States Code, title 8, section 1157;

(2) was granted asylum under United States Code, title 8, section 1158;

(3) was granted withholding of deportation under the United States Code, title 8, section 1253(h);

(4) is a veteran of the United States armed forces with an honorable discharge for a reason other than noncitizen status, or is a spouse or unmarried minor dependent child of the same; or

(5) is an individual on active duty in the United States armed forces, other than for training, or is a spouse or unmarried minor dependent child of the same.

(c) A person who is not a qualified noncitizen but who is otherwise residing lawfully in the United States is eligible for MFIP. However, TANF dollars cannot be used to fund the MFIP benefits for an individual under this paragraph.

(d) For purposes of this subdivision, a nonimmigrant in one or more of the classes listed in United States Code, title 8, section 1101(a)(15)(A)-(S) and (V), or an undocumented immigrant who resides in the United States without the approval or acquiescence of the United States Citizenship and Immigration Services, is not eligible for MFIP.

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

Sec. 19. Minnesota Statutes 2022, section 256J.21, subdivision 3, is amended to read:

Subd. 3. **Initial income test.** (a) The agency shall determine initial eligibility by considering all earned and unearned income as defined in section 256P.06. To be eligible for MFIP, the assistance unit's countable income minus the earned income disregards in paragraph (a) and section 256P.03 must be below the family wage level according to section 256J.24, subdivision 7, for that size assistance unit.

~~(a)~~ (b) The initial eligibility determination must disregard the following items:

(1) the earned income disregard as determined in section 256P.03;

(2) dependent care costs must be deducted from gross earned income for the actual amount paid for dependent care up to a maximum of $200 per month for each child less than two years of age, and $175 per month for each child two years of age and older;

(3) all payments made according to a court order for spousal support or the support of children not living in the assistance unit's household shall be disregarded from the income of the person with the legal obligation to pay support; and

(4) an allocation for the unmet need of an ineligible spouse or an ineligible child under the age of 21 for whom the caregiver is financially responsible and who lives with the caregiver according to section 256J.36.

~~(b) After initial eligibility is established,~~ (c) The income test is for a six-month period. The assistance payment calculation is based on ~~the monthly income test~~ prospective budgeting according to section 256P.09.

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

Sec. 20. Minnesota Statutes 2022, section 256J.21, subdivision 4, is amended to read:

Subd. 4. ~~**Monthly**~~ **Income test and determination of assistance payment.** ~~The county agency shall determine ongoing eligibility and the assistance payment amount according to the monthly income test.~~ To be eligible for MFIP, the result of the computations in paragraphs (a) to (e) applied to prospective budgeting must be at least $1.

(a) Apply an income disregard as defined in section 256P.03, to gross earnings and subtract this amount from the family wage level. If the difference is equal to or greater than the MFIP transitional standard, the assistance payment is equal to the MFIP transitional standard. If the difference is less than the MFIP transitional standard, the assistance payment is equal to the difference. The earned income disregard in this paragraph must be deducted every month there is earned income.

(b) All payments made according to a court order for spousal support or the support of children not living in the assistance unit's household must be disregarded from the income of the person with the legal obligation to pay support.

(c) An allocation for the unmet need of an ineligible spouse or an ineligible child under the age of 21 for whom the caregiver is financially responsible and who lives with the caregiver must be made according to section 256J.36.

(d) Subtract unearned income dollar for dollar from the MFIP transitional standard to determine the assistance payment amount.

(e) When income is both earned and unearned, the amount of the assistance payment must be determined by first treating gross earned income as specified in paragraph (a). After determining the amount of the assistance payment under paragraph (a), unearned income must be subtracted from that amount dollar for dollar to determine the assistance payment amount.

~~(f) When the monthly income is greater than the MFIP transitional standard after deductions and the income will only exceed the standard for one month, the county agency must suspend the assistance payment for the payment month.~~

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

Sec. 21. Minnesota Statutes 2022, section 256J.33, subdivision 1, is amended to read:

Subdivision 1. **Determination of eligibility.** (a) A county agency must determine MFIP eligibility prospectively ~~for a payment month~~ based on ~~retrospectively~~ assessing income and the county agency's best estimate of the circumstances that will exist in the payment month.

(b) ~~Except as described in section 256J.34, subdivision 1, when prospective eligibility exists,~~ A county agency must calculate the amount of the assistance payment using ~~retrospective~~ prospective budgeting. To determine MFIP eligibility and the assistance payment amount, a county agency must apply countable income, described in sections 256P.06 and 256J.37, subdivisions 3 to ~~10~~ 9, received by members of an assistance unit or by other persons whose income is counted for the assistance unit, described under sections 256J.37, subdivisions 1 to 2, and 256P.06, subdivision 1.

(c) This income must be applied to the MFIP standard of need or family wage level subject to this section and sections 256J.34 to 256J.36. Countable income as described in section 256P.06, subdivision 3, received ~~in a calendar month~~ must be applied to the needs of an assistance unit.

(d) An assistance unit is not eligible when the countable income equals or exceeds the MFIP standard of need or the family wage level for the assistance unit.

EFFECTIVE DATE. This section is effective March 1, 2025, except that the amendment to paragraph (b) striking "10" and inserting "9" is effective July 1, 2024.

Sec. 22. Minnesota Statutes 2022, section 256J.33, subdivision 2, is amended to read:

Subd. 2. **Prospective eligibility.** An agency must determine whether the eligibility requirements that pertain to an assistance unit, including those in sections 256J.11 to 256J.15

and 256P.02, will be met prospectively for the payment ~~month~~ period. ~~Except for the provisions in section 256J.34, subdivision 1,~~ The income test will be applied ~~retrospectively~~ prospectively.

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

Sec. 23. Minnesota Statutes 2022, section 256J.35, is amended to read:

256J.35 AMOUNT OF ASSISTANCE PAYMENT.

Except as provided in paragraphs (a) to ~~(d)~~ (e), the amount of an assistance payment is equal to the difference between the MFIP standard of need or the Minnesota family wage level in section 256J.24 and countable income.

(a) Beginning July 1, 2015, MFIP assistance units are eligible for an MFIP housing assistance grant of $110 per month, unless:

(1) the housing assistance unit is currently receiving public and assisted rental subsidies provided through the Department of Housing and Urban Development (HUD) and is subject to section 256J.37, subdivision 3a; or

(2) the assistance unit is a child-only case under section 256J.88.

(b) On October 1 of each year, the commissioner shall adjust the MFIP housing assistance grant in paragraph (a) for inflation based on the CPI-U for the prior calendar year.

(c) When MFIP eligibility exists for the month of application, the amount of the assistance payment for the month of application must be prorated from the date of application or the date all other eligibility factors are met for that applicant, whichever is later. This provision applies when an applicant loses at least one day of MFIP eligibility.

~~(c)~~ (d) MFIP overpayments to an assistance unit must be recouped according to section 256P.08, subdivision 6.

~~(d)~~ (e) An initial assistance payment must not be made to an applicant who is not eligible on the date payment is made.

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

Sec. 24. Minnesota Statutes 2022, section 256J.37, subdivision 3, is amended to read:

Subd. 3. **Earned income of wage, salary, and contractual employees.** The agency must include gross earned income less any disregards in the initial ~~and monthly~~ income test. Gross earned income received by persons employed on a contractual basis must be

prorated over the period covered by the contract even when payments are received over a lesser period of time.

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

Sec. 25. Minnesota Statutes 2022, section 256J.37, subdivision 3a, is amended to read:

Subd. 3a. **Rental subsidies; unearned income.** (a) Effective July 1, 2003, the agency shall count $50 of the value of public and assisted rental subsidies provided through the Department of Housing and Urban Development (HUD) as unearned income to the cash portion of the MFIP grant. The full amount of the subsidy must be counted as unearned income when the subsidy is less than $50. The income from this subsidy shall be budgeted according to section ~~256J.34~~ 256P.09.

(b) The provisions of this subdivision shall not apply to an MFIP assistance unit which includes a participant who is:

(1) age 60 or older;

(2) a caregiver who is suffering from an illness, injury, or incapacity that has been certified by a qualified professional when the illness, injury, or incapacity is expected to continue for more than 30 days and severely limits the person's ability to obtain or maintain suitable employment; or

(3) a caregiver whose presence in the home is required due to the illness or incapacity of another member in the assistance unit, a relative in the household, or a foster child in the household when the illness or incapacity and the need for the participant's presence in the home has been certified by a qualified professional and is expected to continue for more than 30 days.

(c) The provisions of this subdivision shall not apply to an MFIP assistance unit where the parental caregiver is an SSI participant.

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

Sec. 26. Minnesota Statutes 2022, section 256J.425, subdivision 1, is amended to read:

Subdivision 1. **Eligibility.** (a) To be eligible for a hardship extension, a participant in an assistance unit subject to the time limit under section 256J.42, subdivision 1, must ~~be in compliance in the participant's 60th counted month. For purposes of determining eligibility for a hardship extension, a participant is in compliance in any month that the participant has not been sanctioned. In order to maintain eligibility for any of the hardship extension~~

~~categories a participant shall~~ develop and comply with either an employment plan or a family stabilization services plan, whichever is appropriate.

(b) If one participant in a two-parent assistance unit is determined to be ineligible for a hardship extension, the county shall give the assistance unit the option of disqualifying the ineligible participant from MFIP. In that case, the assistance unit shall be treated as a one-parent assistance unit.

~~(c) Prior to denying an extension, the county must review the sanction status and determine whether the sanction is appropriate or if good cause exists under section 256J.57. If the sanction was inappropriately applied or the participant is granted a good cause exception before the end of month 60, the participant shall be considered for an extension.~~

EFFECTIVE DATE. This section is effective May 1, 2026.

Sec. 27. Minnesota Statutes 2022, section 256J.425, subdivision 4, is amended to read:

Subd. 4. **Employed participants.** (a) An assistance unit subject to the time limit under section 256J.42, subdivision 1, is eligible to receive assistance under a hardship extension if the participant who reached the time limit belongs to:

(1) a one-parent assistance unit in which the participant is participating in work activities for at least 30 hours per week, of which an average of at least 25 hours per week every month are spent participating in employment;

(2) a two-parent assistance unit in which the participants are participating in work activities for at least 55 hours per week, of which an average of at least 45 hours per week every month are spent participating in employment; or

(3) an assistance unit in which a participant is participating in employment for fewer hours than those specified in clause (1), and the participant submits verification from a qualified professional, in a form acceptable to the commissioner, stating that the number of hours the participant may work is limited due to illness or disability, as long as the participant is participating in employment for at least the number of hours specified by the qualified professional. The participant must be following the treatment recommendations of the qualified professional providing the verification. The commissioner shall develop a form to be completed and signed by the qualified professional, documenting the diagnosis and any additional information necessary to document the functional limitations of the participant that limit work hours. If the participant is part of a two-parent assistance unit, the other parent must be treated as a one-parent assistance unit for purposes of meeting the work requirements under this subdivision.

(b) For purposes of this section, employment means:

(1) unsubsidized employment under section 256J.49, subdivision 13, clause (1);

(2) subsidized employment under section 256J.49, subdivision 13, clause (2);

(3) on-the-job training under section 256J.49, subdivision 13, clause (2);

(4) an apprenticeship under section 256J.49, subdivision 13, clause (1);

(5) supported work under section 256J.49, subdivision 13, clause (2);

(6) a combination of clauses (1) to (5); or

(7) child care under section 256J.49, subdivision 13, clause (7), if it is in combination with paid employment.

(c) If a participant is complying with a child protection plan under chapter 260C, the number of hours required under the child protection plan count toward the number of hours required under this subdivision.

(d) The county shall provide the opportunity for subsidized employment to participants needing that type of employment within available appropriations.

~~(e) To be eligible for a hardship extension for employed participants under this subdivision, a participant must be in compliance for at least ten out of the 12 months the participant received MFIP immediately preceding the participant's 61st month on assistance. If ten or fewer months of eligibility for TANF assistance remain at the time the participant from another state applies for assistance, the participant must be in compliance every month.~~

~~(f)~~ (e) The employment plan developed under section 256J.521, subdivision 2, for participants under this subdivision must contain at least the minimum number of hours specified in paragraph (a) for the purpose of meeting the requirements for an extension under this subdivision. The job counselor and the participant must sign the employment plan to indicate agreement between the job counselor and the participant on the contents of the plan.

~~(g)~~ (f) Participants who fail to meet the requirements in paragraph (a), without eligibility for another hardship extension or good cause under section 256J.57, shall be ~~sanctioned~~ subject to sanction or ~~permanently disqualified under subdivision 6. Good cause may only be granted for that portion of the month for which the good cause reason applies~~ case closure. Participants must meet all remaining requirements in the approved employment plan or be subject to sanction or ~~permanent disqualification~~ case closure.

~~(h)~~ (g) If the noncompliance with an employment plan is due to the involuntary loss of employment, the participant is exempt from the hourly employment requirement under this subdivision for one month. Participants must meet all remaining requirements in the approved employment plan or be subject to sanction or ~~permanent disqualification~~ case closure if ineligible for another hardship extension.

EFFECTIVE DATE. This section is effective May 1, 2026.

Sec. 28. Minnesota Statutes 2022, section 256J.425, subdivision 5, is amended to read:

Subd. 5. **Accrual of certain exempt months.** (a) Participants who are not eligible for assistance under a hardship extension under this section shall be eligible for a hardship extension for a period of time equal to the number of months that were counted toward the 60-month time limit while the participant was a caregiver with a child or an adult in the household who meets the disability or medical criteria for home care services under section 256B.0651, subdivision 1, paragraph (c), or a home and community-based waiver services program under chapter 256B, or meets the criteria for severe emotional disturbance under section 245.4871, subdivision 6, or for serious and persistent mental illness under section 245.462, subdivision 20, paragraph (c), and who was subject to the requirements in section 256J.561, subdivision 2.

(b) A participant who received MFIP assistance that counted toward the 60-month time limit while the participant met the state time limit exemption criteria under section 256J.42, subdivision 4 or 5, is eligible for assistance under a hardship extension for a period of time equal to the number of months that were counted toward the 60-month time limit while the participant met the state time limit exemption criteria under section 256J.42, subdivision 4 or 5.

(c) After the accrued months have been exhausted, the county agency must determine if the assistance unit is eligible for an extension under another extension category in subdivision 2, 3, or 4.

(d) At the time of the case review, a county agency must explain to the participant the basis for receiving a hardship extension based on the accrual of exempt months. The participant must provide documentation necessary to enable the county agency to determine whether the participant is eligible to receive a hardship extension based on the accrual of exempt months or authorize a county agency to verify the information.

~~(e) While receiving extended MFIP assistance under this subdivision, a participant is subject to the MFIP policies that apply to participants during the first 60 months of MFIP,~~

~~unless the participant is a member of a two-parent family in which one parent is extended under subdivision 3 or 4. For two-parent families in which one parent is extended under subdivision 3 or 4, the sanction provisions in subdivision 6 shall apply.~~

EFFECTIVE DATE. This section is effective May 1, 2026.

Sec. 29. Minnesota Statutes 2022, section 256J.425, subdivision 7, is amended to read:

Subd. 7. **Status of ~~disqualified participants~~ closed cases.** (a) An assistance unit that ~~is disqualified~~ has its case closed under ~~subdivision 6, paragraph (a),~~ section 256J.46 may be approved for MFIP if the participant complies with MFIP program requirements and demonstrates compliance for up to one month. No assistance shall be paid during this period.

(b) An assistance unit that ~~is disqualified~~ has its case closed under ~~subdivision 6, paragraph (a),~~ section 256J.46 and that reapplies under paragraph (a) is subject to sanction under section 256J.46, subdivision 1, paragraph (c)~~, clause (1), for a first occurrence of noncompliance. A subsequent occurrence of noncompliance results in a permanent disqualification~~.

~~(c) If one participant in a two-parent assistance unit receiving assistance under a hardship extension under subdivision 3 or 4 is determined to be out of compliance with the employment and training services requirements under sections 256J.521 to 256J.57, the county shall give the assistance unit the option of disqualifying the noncompliant participant from MFIP. In that case, the assistance unit shall be treated as a one-parent assistance unit for the purposes of meeting the work requirements under subdivision 4. An applicant who is disqualified from receiving assistance under this paragraph may reapply under paragraph (a). If a participant is disqualified from MFIP under this subdivision a second time, the participant is permanently disqualified from MFIP.~~

~~(d)~~ (c) Prior to a ~~disqualification~~ case closure under this subdivision, a county agency must review the participant's case to determine if the employment plan is still appropriate and attempt to meet with the participant face-to-face. If a face-to-face meeting is not conducted, the county agency must send the participant a notice of adverse action as provided in section 256J.31. During the face-to-face meeting, the county agency must:

(1) determine whether the continued noncompliance can be explained and mitigated by providing a needed preemployment activity, as defined in section 256J.49, subdivision 13, clause (9);

(2) determine whether the participant qualifies for a good cause exception under section 256J.57;

(3) inform the participant of the family violence waiver criteria and make appropriate referrals if the waiver is requested;

(4) inform the participant of the participant's sanction status and explain the consequences of continuing noncompliance;

(5) identify other resources that may be available to the participant to meet the needs of the family; and

(6) inform the participant of the right to appeal under section 256J.40.

EFFECTIVE DATE. This section is effective May 1, 2026.

Sec. 30. Minnesota Statutes 2022, section 256J.46, subdivision 1, is amended to read:

Subdivision 1. **Participants not complying with program requirements.** (a) A participant who fails without good cause under section 256J.57 to comply with the requirements ~~of this chapter~~ for orientation under section 256J.45, or employment and training services under sections 256J.515 to 256J.57, and who is not subject to a sanction under subdivision 2, shall be subject to a sanction or case closure as provided in this ~~subdivision~~ section. Good cause may only be granted for the month for which the good cause reason applies. Prior to the imposition of a sanction, a county agency shall provide a notice of intent to sanction under section 256J.57, subdivision 2, and, when applicable, a notice of adverse action as provided in section 256J.31, subdivision 5.

(b) A sanction under this subdivision becomes effective the month following the month in which a required notice is given. A sanction must not be imposed when a participant comes into compliance ~~with the requirements for orientation under section 256J.45~~ prior to the effective date of the sanction. ~~A sanction must not be imposed when a participant comes into compliance with the requirements for employment and training services under sections 256J.515 to 256J.57 ten days prior to the effective date of the sanction.~~ For purposes of this subdivision, each month that a participant fails to comply with a requirement of this chapter shall be considered a separate occurrence of noncompliance. If both participants in a two-parent assistance unit are out of compliance at the same time, it is considered one occurrence of noncompliance.

(c) Sanctions for noncompliance ~~shall be imposed as follows:~~

~~(1) For the first occurrence of noncompliance by a participant in an assistance unit, the assistance unit's grant shall be reduced by ten percent of the MFIP standard of need for an assistance unit of the same size with the residual grant paid to the participant. The reduction~~

~~in the grant amount must be in effect for a minimum of one month and shall be removed in the month following the month that the participant returns to compliance.~~

~~(2)~~ for ~~a~~ the first, second, third, fourth, fifth, or sixth consecutive occurrence of noncompliance by a participant in an assistance unit~~, the assistance unit's shelter costs shall be vendor paid up to the amount of the cash portion of the MFIP grant for which the assistance unit is eligible. At county option, the assistance unit's utilities may also be vendor paid up to the amount of the cash portion of the MFIP grant remaining after vendor payment of the assistance unit's shelter costs. The residual amount of the grant after vendor payment, if any, must be reduced by an amount~~ are equal to ~~30~~ a reduction of five percent of the cash portion of the MFIP ~~standard of need for an~~ grant received by the assistance unit ~~of the same size before the residual grant is paid to the assistance unit~~. The reduction in the grant amount must be in effect for a minimum of one month and shall be removed in the month following the month that the participant in a one-parent assistance unit returns to compliance, unless the requirements in paragraph (h) are met. In a two-parent assistance unit, the grant reduction must be in effect for a minimum of one month and shall be removed in the month following the month both participants return to compliance, unless the requirements in paragraph (h) are met. ~~The vendor payment of shelter costs and, if applicable, utilities shall be removed six months after the month in which the participant or participants return to compliance.~~ When an assistance unit comes into compliance with the requirements in section 256.741, or shows good cause under section 256.741, subdivision 10, or 256J.57, the sanction occurrences for that assistance unit shall be equal to zero sanctions. If an assistance unit is sanctioned under this clause, the participant's case file must be reviewed to determine if the employment plan is still appropriate.

(d) For a seventh consecutive occurrence of noncompliance by a participant in an assistance unit, ~~or when the participants in a two-parent assistance unit have a total of seven occurrences of noncompliance,~~ the county agency shall close the MFIP assistance unit's financial assistance case, ~~both~~ including the cash and food portions, and redetermine the family's ~~continued~~ eligibility for Supplemental Nutrition Assistance Program (SNAP) payments. The MFIP case must remain closed for a minimum of one full month. Before the case is closed, the county agency must review the participant's case to determine if the employment plan is still appropriate and attempt to meet with the participant face-to-face. The participant may bring an advocate to the face-to-face meeting. If a face-to-face meeting is not conducted, the county agency must send the participant a written notice that includes the information required under clause (1).

(1) During the face-to-face meeting, the county agency must:

(i) determine whether the continued noncompliance can be explained and mitigated by providing a needed preemployment activity, as defined in section 256J.49, subdivision 13, clause (9);

(ii) determine whether the participant qualifies for a good cause exception under section 256J.57, or if the sanction is for noncooperation with child support requirements, determine if the participant qualifies for a good cause exemption under section 256.741, subdivision 10;

(iii) determine whether the work activities in the employment plan are appropriate based on the criteria in section 256J.521, subdivision 2 or 3;

(iv) determine whether the participant qualifies for the family violence waiver;

(v) inform the participant of the participant's sanction status and explain the consequences of continuing noncompliance;

(vi) identify other resources that may be available to the participant to meet the needs of the family; and

(vii) inform the participant of the right to appeal under section 256J.40.

(2) If the lack of an identified activity or service can explain the noncompliance, the county must work with the participant to provide the identified activity.

(3) The grant must be restored to the full amount for which the assistance unit is eligible retroactively to the first day of the month in which the participant was found to lack preemployment activities or to qualify for a family violence waiver or for a good cause exemption under section 256.741, subdivision 10, or 256J.57.

(e) For the purpose of applying sanctions under this section, only consecutive occurrences of noncompliance that occur ~~after July 1, 2003~~ on or after May 1, 2026, shall be considered when counting the number of sanction occurrences under this subdivision. Active cases under sanction on May 1, 2026, shall be considered to have one sanction occurrence. If the participant ~~is in 30 percent sanction in the month this section takes effect, that month counts as the first occurrence for purposes of applying the sanctions under this section, but the sanction shall remain at 30 percent for that month~~ comes into compliance, the assistance unit is considered to have zero sanctions.

(f) An assistance unit whose case is closed under paragraph (d) or (g), may reapply for MFIP using a form prescribed by the commissioner and shall be eligible if the participant complies with MFIP program requirements and demonstrates compliance for up to one month. No assistance shall be paid during this period. The county agency shall not start a

new certification period for a participant who has submitted the reapplication form within 30 calendar days of case closure. The county agency must process the form according to section 256P.04, except that the county agency shall not require additional verification of information in the case file unless the information is inaccurate, questionable, or no longer current. If a participant does not reapply for MFIP within 30 calendar days of case closure, a new application must be completed.

(g) An assistance unit whose case has been closed for noncompliance~~,~~ that reapplies under paragraph (f)~~,~~ is subject to sanction under paragraph (c)~~, clause (2), for a first occurrence of noncompliance. Any subsequent occurrence of noncompliance shall result in~~ and case closure under paragraph (d).

(h) If an assistance unit is in compliance by the 15th of the month in which the assistance unit has a sanction imposed, the reduction to the assistance unit's cash grant shall be restored retroactively for the current month and the sanction occurrences shall be equal to zero.

EFFECTIVE DATE. This section is effective May 1, 2026.

Sec. 31. Minnesota Statutes 2022, section 256J.46, subdivision 2, is amended to read:

Subd. 2. **Sanctions for refusal to cooperate with support requirements.** The grant of an MFIP caregiver who refuses to cooperate, as determined by the child support enforcement agency, with support requirements under section 256.741, shall be subject to sanction as specified in this subdivision and subdivision 1~~. For a first occurrence of noncooperation, the assistance unit's grant must be reduced by 30 percent of the applicable MFIP standard of need. Subsequent occurrences of noncooperation shall be subject to sanction under subdivision 1, paragraphs (c), clause (2), and (d).~~, paragraphs (b) to (h), except the assistance unit's cash portion of the grant must be reduced by 25 percent of the MFIP cash received by the assistance unit. The residual amount of the grant, if any, must be paid to the caregiver. A sanction under this subdivision becomes effective the first month following the month in which a required notice is given. A sanction must not be imposed when a caregiver comes into compliance with the requirements under section 256.741 prior to the effective date of the sanction. The sanction shall be removed in the month following the month that the caregiver cooperates with the support requirements, unless the requirements in subdivision 1, paragraph (h), are met. Each month that an MFIP caregiver fails to comply with the requirements of section 256.741 must be considered a separate occurrence of noncompliance for the purpose of applying sanctions under subdivision 1, paragraphs (c)~~, clause (2),~~ and (d).

EFFECTIVE DATE. This section is effective May 1, 2026.

Sec. 32. Minnesota Statutes 2022, section 256J.46, subdivision 2a, is amended to read:

Subd. 2a. **Dual sanctions.** (a) Notwithstanding the provisions of subdivisions 1 and 2, for a participant subject to a sanction for refusal to comply with child support requirements under subdivision 2 and subject to a concurrent sanction for refusal to cooperate with other program requirements under subdivision 1, sanctions shall be imposed in the manner prescribed in this subdivision.

~~Any vendor payment of shelter costs or utilities under this subdivision must remain in effect for six months after the month in which the participant is no longer subject to sanction under subdivision 1.~~

~~(b) If the participant was subject to sanction for:~~

~~(1) noncompliance under subdivision 1 before being subject to sanction for noncooperation under subdivision 2; or~~

~~(2) noncooperation under subdivision 2 before being subject to sanction for noncompliance under subdivision 1, the participant is considered to have a second occurrence of noncompliance and shall be sanctioned as provided in subdivision 1, paragraph (c), clause (2). Each subsequent occurrence of noncompliance shall be considered one additional occurrence and shall be subject to the applicable level of sanction under subdivision 1. The requirement that the county conduct a review as specified in subdivision 1, paragraph (d), remains in effect.~~

~~(c)~~ (b) A participant who ~~first~~ becomes subject to sanction under both subdivisions 1 and 2 in the same month is subject to sanction as follows:

(1) in the first month of noncompliance and noncooperation, the participant's cash portion of the grant must be reduced by ~~30~~ 25 percent of the ~~applicable~~ MFIP ~~standard of need~~ cash received by the assistance unit, with any residual amount paid to the participant;

(2) in the second and subsequent months of noncompliance and noncooperation, the participant shall be subject to the applicable level of sanction under subdivision 1.

The requirement that the county conduct a review as specified in subdivision 1, paragraph (d), remains in effect.

~~(d)~~ (c) A participant remains subject to sanction under subdivision 2 if the participant:

(1) returns to compliance and is no longer subject to sanction for noncompliance with section 256J.45 or sections 256J.515 to 256J.57; or

(2) has the sanction for noncompliance with section 256J.45 or sections 256J.515 to 256J.57 removed upon completion of the review under subdivision 1, paragraph (e).

A participant remains subject to the applicable level of sanction under subdivision 1 if the participant cooperates and is no longer subject to sanction under subdivision 2.

EFFECTIVE DATE. This section is effective May 1, 2026.

Sec. 33. Minnesota Statutes 2022, section 256J.95, subdivision 19, is amended to read:

Subd. 19. **DWP overpayments and underpayments.** DWP benefits are subject to overpayments and underpayments. Anytime an overpayment or an underpayment is determined for DWP, the correction shall be calculated using prospective budgeting. Corrections shall be determined based on the policy in section ~~256J.34, subdivision 1, paragraphs (a), (b), and (c)~~ 256P.09, subdivisions 1 to 4. ATM errors must be recovered as specified in section 256P.08, subdivision 7. Cross program recoupment of overpayments cannot be assigned to or from DWP.

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

Sec. 34. Minnesota Statutes 2022, section 256P.01, is amended by adding a subdivision to read:

Subd. 9. **Prospective budgeting.** "Prospective budgeting" means estimating the amount of monthly income that an assistance unit will have in the payment month.

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

Sec. 35. Minnesota Statutes 2022, section 256P.02, subdivision 2, is amended to read:

Subd. 2. **Personal property limitations.** The equity value of an assistance unit's personal property listed in clauses (1) to (5) must not exceed $10,000 for applicants and participants. For purposes of this subdivision, personal property is limited to:

(1) cash not excluded under subdivision 4;

(2) bank accounts not excluded under subdivision 5;

(3) liquid stocks and bonds that can be readily accessed without a financial penalty;

(4) vehicles not excluded under subdivision 3; and

(5) the full value of business accounts used to pay expenses not related to the business.

Sec. 36. Minnesota Statutes 2022, section 256P.02, is amended by adding a subdivision to read:

Subd. 5. **Account exception.** Family asset accounts under section 256E.35 and individual development accounts authorized under the Assets for Independence Act, Title IV of the Community Opportunities, Accountability, and Training and Educational Services Human Services Reauthorization Act of 1998, Public Law 105-285, shall be excluded when determining the equity value of personal property.

Sec. 37. Minnesota Statutes 2022, section 256P.04, subdivision 4, is amended to read:

Subd. 4. **Factors to be verified.** (a) The agency shall verify the following at application:

(1) identity of adults;

(2) age, if necessary to determine eligibility;

(3) immigration status;

(4) income;

(5) spousal support and child support payments made to persons outside the household;

(6) vehicles;

(7) checking and savings accounts, including but not limited to any business accounts used to pay expenses not related to the business;

(8) inconsistent information, if related to eligibility;

(9) residence; and

(10) Social Security number~~; and~~.

~~(11) use of nonrecurring income under section 256P.06, subdivision 3, clause (2), item (ix), for the intended purpose for which it was given and received.~~

(b) Applicants who are qualified noncitizens and victims of domestic violence as defined under section 256J.08, subdivision 73, clauses (8) and (9), are not required to verify the information in paragraph (a), clause (10). When a Social Security number is not provided to the agency for verification, this requirement is satisfied when each member of the assistance unit cooperates with the procedures for verification of Social Security numbers, issuance of duplicate cards, and issuance of new numbers which have been established jointly between the Social Security Administration and the commissioner.

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

Sec. 38. Minnesota Statutes 2022, section 256P.04, subdivision 8, is amended to read:

Subd. 8. **Recertification.** The agency shall recertify eligibility annually. During recertification and reporting under section 256P.10, the agency shall verify the following:

(1) income, unless excluded, including self-employment earnings;

(2) assets when the value is within $200 of the asset limit; and

(3) inconsistent information, if related to eligibility.

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

Sec. 39. Minnesota Statutes 2022, section 256P.06, subdivision 3, is amended to read:

Subd. 3. **Income inclusions.** The following must be included in determining the income of an assistance unit:

(1) earned income; and

(2) unearned income, which includes:

(i) interest and dividends from investments and savings;

(ii) capital gains as defined by the Internal Revenue Service from any sale of real property;

(iii) proceeds from rent and contract for deed payments in excess of the principal and interest portion owed on property;

(iv) income from trusts, excluding special needs and supplemental needs trusts;

(v) interest income from loans made by the participant or household;

(vi) cash prizes and winnings;

(vii) unemployment insurance income that is received by an adult member of the assistance unit unless the individual receiving unemployment insurance income is:

(A) 18 years of age and enrolled in a secondary school; or

(B) 18 or 19 years of age, a caregiver, and is enrolled in school at least half-time;

(viii) for the purposes of programs under chapters 256D and 256I, retirement, survivors, and disability insurance payments;

(ix) ~~nonrecurring income over $60 per quarter unless the nonrecurring income is: (A) from tax refunds, tax rebates, or tax credits; (B) a reimbursement, rebate, award, grant, or refund of personal or real property or costs or losses incurred when these payments are made by: a public agency; a court; solicitations through public appeal; a federal, state, or~~

~~local unit of government; or a disaster assistance organization; (C) provided as an in-kind benefit; or (D) earmarked and used for the purpose for which it was intended, subject to verification requirements under section 256P.04;~~

~~(x)~~ retirement benefits;

~~(xi)~~ (x) cash assistance benefits, as defined by each program in chapters 119B, 256D, 256I, and 256J;

~~(xii) Tribal per capita payments unless excluded by federal and state law;~~

~~(xiii)~~ (xi) income from members of the United States armed forces unless excluded from income taxes according to federal or state law;

~~(xiv)~~ (xii) for the purposes of programs under chapters 119B, 256D, and 256I, all child support payments ~~for programs under chapters 119B, 256D, and 256I~~;

~~(xv)~~ (xiii) for the purposes of programs under chapter 256J, the amount of child support received that exceeds $100 for assistance units with one child and $200 for assistance units with two or more children ~~for programs under chapter 256J~~;

~~(xvi)~~ (xiv) spousal support; ~~and~~

~~(xvii)~~ (xv) workers' compensation~~.~~; and

(xvi) for the purposes of programs under chapters 119B and 256J, the amount of retirement, survivors, and disability insurance payments that exceeds the applicable monthly federal maximum Supplemental Security Income payments.

Sec. 40. Minnesota Statutes 2022, section 256P.07, subdivision 1, is amended to read:

Subdivision 1. **Exempted programs.** Participants who receive Supplemental Security Income and qualify for Minnesota supplemental aid under chapter 256D ~~and~~ or for housing support under chapter 256I ~~on the basis of eligibility for Supplemental Security Income~~ are exempt from ~~this section~~ reporting income under this chapter.

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

Sec. 41. Minnesota Statutes 2022, section 256P.07, is amended by adding a subdivision to read:

Subd. 1a. **Child care assistance programs.** Participants who qualify for child care assistance programs under chapter 119B are exempt from this section except the reporting requirements in subdivision 6.

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

Sec. 42. Minnesota Statutes 2022, section 256P.07, subdivision 2, is amended to read:

Subd. 2. **Reporting requirements.** An applicant or participant must provide information on an application and any subsequent reporting forms about the assistance unit's circumstances that affect eligibility or benefits. An applicant or assistance unit must report changes that affect eligibility or benefits as identified in ~~subdivision~~ subdivisions 3, 4, 5, 7, 8, and 9 during the application period or by the tenth of the month following the month the assistance unit's circumstances changed. When information is not accurately reported, both an overpayment and a referral for a fraud investigation may result. When information or documentation is not provided, the receipt of any benefit may be delayed or denied, depending on the type of information required and its effect on eligibility.

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

Sec. 43. Minnesota Statutes 2022, section 256P.07, subdivision 3, is amended to read:

Subd. 3. **Changes that must be reported.** ~~An assistance unit must report the changes or anticipated changes specified in clauses (1) to (12) within ten days of the date they occur, at the time of recertification of eligibility under section 256P.04, subdivisions 8 and 9, or within eight calendar days of a reporting period, whichever occurs first. An assistance unit must report other changes at the time of recertification of eligibility under section 256P.04, subdivisions 8 and 9, or at the end of a reporting period, as applicable. When an agency could have reduced or terminated assistance for one or more payment months if a delay in reporting a change specified under clauses (1) to (12) had not occurred, the agency must determine whether a timely notice could have been issued on the day that the change occurred. When a timely notice could have been issued, each month's overpayment subsequent to that notice must be considered a client error overpayment under section 119B.11, subdivision 2a, or 256P.08. Changes in circumstances that must be reported within ten days must also be reported for the reporting period in which those changes occurred. Within ten days, an assistance unit must report:~~

~~(1) a change in earned income of $100 per month or greater with the exception of a program under chapter 119B;~~

~~(2) a change in unearned income of $50 per month or greater with the exception of a program under chapter 119B;~~

~~(3) a change in employment status and hours with the exception of a program under chapter 119B;~~

~~(4) a change in address or residence;~~

~~(5) a change in household composition with the exception of programs under chapter 256I;~~

~~(6) a receipt of a lump-sum payment with the exception of a program under chapter 119B;~~

~~(7) an increase in assets if over $9,000 with the exception of programs under chapter 119B;~~

~~(8) a change in citizenship or immigration status;~~

~~(9) a change in family status with the exception of programs under chapter 256I;~~

~~(10) a change in disability status of a unit member, with the exception of programs under chapter 119B;~~

~~(11) a new rent subsidy or a change in rent subsidy with the exception of a program under chapter 119B; and~~

~~(12) a sale, purchase, or transfer of real property with the exception of a program under chapter 119B.~~

(a) An assistance unit must report changes or anticipated changes as described in this section.

(b) An assistance unit must report:

(1) a change in eligibility for Supplemental Security Income, Retirement Survivors Disability Insurance, or another federal income support;

(2) a change in address or residence;

(3) a change in household composition with the exception of programs under chapter 256I;

(4) cash prizes and winnings according to guidance provided for the Supplemental Nutrition Assistance Program;

(5) a change in citizenship or immigration status;

(6) a change in family status with the exception of programs under chapter 256I; and

(7) a change that makes the value of the unit's assets at or above the asset limit.

(c) When an agency could have reduced or terminated assistance for one or more payment months if a delay in reporting a change specified under paragraph (b) had not occurred, the agency must determine whether the agency could have issued a timely notice on the day that the change occurred. When a timely notice could have been issued, each month's overpayment subsequent to the notice must be considered a client error overpayment under section 256P.08.

EFFECTIVE DATE. This section is effective March 1, 2025, except that the amendment striking clause (6) is effective July 1, 2024.

Sec. 44. Minnesota Statutes 2022, section 256P.07, subdivision 4, is amended to read:

Subd. 4. **MFIP-specific reporting.** In addition to subdivision 3, an assistance unit under chapter 256J~~, within ten days of the change,~~ must report:

(1) a pregnancy not resulting in birth when there are no other minor children; ~~and~~

(2) a change in school attendance of a parent under 20 years of age ~~or of an employed child.~~; and

(3) an individual in the household who is 18 or 19 years of age attending high school who graduates or drops out of school.

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

Sec. 45. Minnesota Statutes 2022, section 256P.07, subdivision 6, is amended to read:

Subd. 6. **Child care assistance programs-specific reporting.** (a) ~~In addition to subdivision 3,~~ An assistance unit under chapter 119B, within ten days of the change, must report:

(1) a change in a parentally responsible individual's custody schedule for any child receiving child care assistance program benefits;

(2) a permanent end in a parentally responsible individual's authorized activity; ~~and~~

(3) if the unit's family's annual included income exceeds 85 percent of the state median income, adjusted for family size~~.~~;

(4) a change in address or residence;

(5) a change in household composition;

(6) a change in citizenship or immigration status; and

(7) a change in family status.

(b) An assistance unit subject to section 119B.095, subdivision 1, paragraph (b), must report a change in the unit's authorized activity status.

(c) An assistance unit must notify the county when the unit wants to reduce the number of authorized hours for children in the unit.

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

Sec. 46. Minnesota Statutes 2022, section 256P.07, subdivision 7, is amended to read:

Subd. 7. **Minnesota supplemental aid-specific reporting.** (a) In addition to subdivision 3, an assistance unit participating in the Minnesota supplemental aid program under ~~section 256D.44, subdivision 5, paragraph (g), within ten days of the change,~~ chapter 256D and not receiving Supplemental Security Income must report ~~shelter expenses.~~:

(1) a change in unearned income of $50 per month or greater; and

(2) a change in earned income of $100 per month or greater.

(b) An assistance unit receiving housing assistance under section 256D.44, subdivision 5, paragraph (g), including assistance units that also receive Supplemental Security Income, must report:

(1) a change in shelter expenses; and

(2) a new rent subsidy or a change in rent subsidy.

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

Sec. 47. Minnesota Statutes 2022, section 256P.07, is amended by adding a subdivision to read:

Subd. 8. **Housing support-specific reporting.** (a) In addition to subdivision 3, an assistance unit participating in the housing support program under chapter 256I and not receiving Supplemental Security Income must report:

(1) a change in unearned income of $50 per month or greater; and

(2) a change in earned income of $100 per month or greater, unless the assistance unit is already subject to six-month reporting requirements in section 256P.10.

(b) Notwithstanding the exemptions in subdivisions 1 and 3, an assistance unit receiving housing support under chapter 256I, including an assistance unit that receives Supplemental Security Income, must report:

(1) a new rent subsidy or a change in rent subsidy;

(2) a change in the disability status of a unit member; and

(3) a change in household composition if the assistance unit is a participant in housing support under section 256I.04, subdivision 3, paragraph (a), clause (3).

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

Sec. 48. Minnesota Statutes 2022, section 256P.07, is amended by adding a subdivision to read:

Subd. 9. **General assistance-specific reporting.** In addition to subdivision 3, an assistance unit participating in the general assistance program under chapter 256D must report:

(1) a change in unearned income of $50 per month or greater;

(2) a change in earned income of $100 per month or greater, unless the assistance unit is already subject to six-month reporting requirements in section 256P.10; and

(3) changes in any condition that would result in the loss of basis for eligibility in section 256D.05, subdivision 1, paragraph (a).

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

Sec. 49. **[256P.09] PROSPECTIVE BUDGETING OF BENEFITS.**

Subdivision 1. **Exempted programs.** Assistance units that qualify for child care assistance programs under chapter 119B and assistance units that receive housing support under chapter 256I are not subject to reporting under section 256P.10, and assistance units that qualify for Minnesota supplemental aid under chapter 256D are exempt from this section.

Subd. 2. **Prospective budgeting of benefits.** An agency subject to this chapter must use prospective budgeting to calculate the assistance payment amount.

Subd. 3. **Initial income.** For the purpose of determining an assistance unit's level of benefits, an agency must take into account the income already received by the assistance unit during or anticipated to be received during the application period. Income anticipated to be received only in the initial month of eligibility must only be counted in the initial month.

Subd. 4. **Income determination.** An agency must use prospective budgeting to determine the amount of the assistance unit's benefit for the eligibility period based on the best information available at the time of approval. An agency shall only count anticipated income

when the participant and the agency are reasonably certain of the amount of the payment and the month in which the payment will be received. If the exact amount of the income is not known, the agency shall consider only the amounts that can be anticipated as income.

Subd. 5. **Income changes.** An increase in income shall not affect an assistance unit's eligibility or benefit amount until the next review unless otherwise required to be reported in section 256P.07. A decrease in income shall be effective on the date that the change occurs if the change is reported by the tenth of the month following the month when the change occurred. If the assistance unit does not report the change in income by the tenth of the month following the month when the change occurred, the change in income shall be effective on the date the change was reported.

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

Sec. 50. **[256P.10] SIX-MONTH REPORTING.**

Subdivision 1. **Exempted programs.** Assistance units that qualify for child care assistance programs under chapter 119B, assistance units that qualify for Minnesota supplemental aid under chapter 256D, and assistance units that qualify for housing support under chapter 256I and also receive Supplemental Security Income are exempt from this section.

Subd. 2. **Reporting.** (a) Every six months, an assistance unit that qualifies for the Minnesota family investment program under chapter 256J, an assistance unit that qualifies for general assistance under chapter 256D with an earned income of $100 per month or greater, or an assistance unit that qualifies for housing support under chapter 256I with an earned income of $100 per month or greater is subject to six-month reviews. The initial reporting period may be shorter than six months in order to align with other programs' reporting periods.

(b) An assistance unit that qualifies for the Minnesota family investment program or an assistance unit that qualifies for general assistance with an earned income of $100 per month or greater must complete household report forms as required by the commissioner for redetermination of benefits.

(c) An assistance unit that qualifies for housing support with an earned income of $100 per month or greater must complete household report forms as prescribed by the commissioner to provide information about earned income.

(d) An assistance unit that qualifies for housing support and also receives assistance through the Minnesota family investment program shall be subject to requirements of this section for purposes of the Minnesota family investment program but not for housing support.

(e) An assistance unit covered by this section must submit a household report form in compliance with the provisions in section 256P.04, subdivision 11.

(f) An assistance unit covered by this section may choose to report changes under this section at any time.

Subd. 3. **When to terminate assistance.** (a) An agency must terminate benefits when the assistance unit fails to submit the household report form before the end of the six-month review period. If the assistance unit submits the household report form within 30 days of the termination of benefits and remains eligible, benefits must be reinstated and made available retroactively for the full benefit month.

(b) When an assistance unit is determined to be ineligible for assistance according to this section and chapter 256D, 256I, or 256J, the agency must terminate assistance.

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

Sec. 51. **COUNTY WORKER TRAINING PROGRAM PILOT.**

(a) To the extent permitted under federal law, and subject to any necessary federal approval, the commissioner of human services must permit Anoka, Dakota, St. Louis, and Wright Counties to operate a 12-month pilot to provide the four-day mandated training under Minnesota Statutes, section 256.01, subdivision 2, paragraph (a), clause (1), for the MAXIS eligibility system and Supplemental Nutrition Assistance Program (SNAP) in-house. Counties shall be permitted to provide their own training under this section starting 30 days after receipt of necessary federal approval and only after receiving and agreeing to use the commissioner's training materials.

(b) The commissioner must provide oversight of the training program to ensure county training is consistent with current curriculum. The commissioner shall determine what oversight activities will be utilized. If there are changes in state or federal law governing SNAP or changes are made to MAXIS, counties must not provide training until they have received and agreed to use the updated curriculum provided by the commissioner.

(c) Counties must comply with all applicable state and federal training requirements, including but not limited to reporting requirements. In addition, no later than 120 days following completion of the pilot, each county permitted to conduct their own training under this section must report to the commissioner the following data:

(1) the number of classes offered during the pilot period;

(2) the number of workers trained during the pilot period; and

(3) the number of county staff who provided training during the pilot period.

(d) Nothing in this section shall prevent the commissioner from requiring the employees of the counties participating in the pilot from receiving mandatory training provided by the commissioner on subjects relating to data privacy and security awareness. Prior to receiving any in-house training provided for in paragraph (a), any county employee must first receive all training the commissioner requires pursuant to this section.

Sec. 52. **REPEALER.**

(a) Minnesota Statutes 2022, sections 256.9864; 256J.08, subdivisions 10, 53, 61, 62, 81, and 83; 256J.30, subdivisions 5, 7, and 8; 256J.33, subdivisions 3, 4, and 5; 256J.34, subdivisions 1, 2, 3, and 4; and 256J.37, subdivision 10, are repealed.

(b) Minnesota Statutes 2022, section 256.8799, is repealed.

EFFECTIVE DATE. Paragraph (a) is effective March 1, 2025, except the repeal of Minnesota Statutes 2022, sections 256J.08, subdivisions 53 and 62, and 256J.37, subdivision 10, is effective July 1, 2024. Paragraph (b) is effective May 1, 2026.

ARTICLE 12
HOUSING AND HOMELESSNESS

Section 1. Minnesota Statutes 2022, section 145.4716, subdivision 3, is amended to read:

Subd. 3. **Youth eligible for services.** Youth 24 years of age or younger ~~shall be~~ are eligible for all services, support, and programs provided under this section and section 145.4717, and all shelter, housing beds, and services provided by the commissioner of human services to sexually exploited youth and youth at risk of sexual exploitation under section 256K.47.

Sec. 2. **[245.0963] CONTINUUM OF CARE GRANT PROGRAM.**

Subdivision 1. **Establishment.** The commissioner of human services must establish a grant program to maintain funding for shelters and services provided to individuals experiencing homelessness.

Subd. 2. **Eligible applicants.** To be eligible for a grant under this section, applicants must be a nonprofit organization or a county. An eligible applicant must have experience

providing continuum of care services to individuals experiencing homelessness and operating a community-wide partnership committed to ending homelessness.

Subd. 3. **Application.** An organization seeking a grant under this section must apply to the commissioner in the time and manner specified by the commissioner.

Subd. 4. **Grant activities.** (a) Grant money must be used for:

(1) maintaining funding for a 100-bed family shelter;

(2) maintaining funding to provide shelter and services for single adults, including an expanded shelter for women;

(3) developing and operating a familiar faces pilot program for high-frequency unhoused clients with intensive, 24-hours-a-day, seven-days-a-week staffing;

(4) maintaining current day shelter programming; and

(5) providing outreach, support services, single point of entry, infrastructure, and extreme weather support.

(b) A grantee may contract with eligible nonprofit organizations and local and Tribal governmental agencies to provide the services listed under paragraph (a).

Subd. 5. **Reporting.** (a) The grantee must submit a report to the commissioner in the time and manner specified by the commissioner. The report must include how the grant money was used and how many individuals were served.

(b) The commissioner must submit a report to the chairs and ranking minority members of the legislative committees with jurisdiction over homelessness no later than six months after receiving the report under paragraph (a). The report submitted by the commissioner must include the information specified in paragraph (a).

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

Sec. 3. **[245.0965] OLMSTED COUNTY HOMELESSNESS GRANT PROGRAM.**

Subdivision 1. **Establishment.** The commissioner of human services must establish a grant program to fund and support shelters and services for persons experiencing homelessness in Olmsted County.

Subd. 2. **Eligible applicants.** To be eligible for a grant under this section, applicants must be a nonprofit organization or a county that provides shelter and services to persons experiencing homelessness in Olmsted County. An eligible applicant must have experience

with services that house persons experiencing homelessness and aid transitions to permanent stable housing.

Subd. 3. **Application.** An organization seeking a grant under this section must apply to the commissioner in the time and manner specified by the commissioner.

Subd. 4. **Grant activities.** (a) Eligible uses of grant money include:

(1) operations and services to maintain daytime and overnight shelter;

(2) recuperative care shelter;

(3) housing-focused case management for persons experiencing homelessness;

(4) shelter diversion services;

(5) hotel and motel vouchers;

(6) shelter for youth, including host homes;

(7) transitional housing programs;

(8) supportive staffing; and

(9) outreach services.

(b) The grantee may contract with eligible nonprofit organizations and local and Tribal governmental agencies to provide the services specified under paragraph (a).

Subd. 5. **Reporting.** (a) The grantee must submit a report to the commissioner in the time and manner specified by the commissioner. The report must include the number of persons experiencing homelessness that were served and what the grant money was used for.

(b) The commissioner must submit a report to the chairs and ranking minority members of the legislative committees with jurisdiction over homelessness no later than six months after receiving the report under paragraph (a). The report submitted by the commissioner must include the information specified in paragraph (a).

Sec. 4. **[245.0966] HENNEPIN COUNTY HOMELESSNESS GRANT PROGRAM.**

Subdivision 1. **Establishment.** The commissioner of human services must establish a grant program to maintain funding for shelters and services provided to individuals experiencing homelessness in Hennepin County.

Subd. 2. **Eligible applicants.** To be eligible for a grant under this section, applicants must be a nonprofit organization or a county that provides shelter and services to persons

experiencing homelessness in Hennepin County. An eligible applicant must have experience with services that house persons experiencing homelessness and aid transitions to permanent, stable housing.

Subd. 3. **Application.** An organization seeking a grant under this section must apply to the commissioner in the time and manner specified by the commissioner.

Subd. 4. **Grant activities.** (a) Grant money must be used for:

(1) maintaining current shelter and homeless response programming;

(2) maintaining shelter operations and services at Avivo Village, including the shelter comprised of 100 private dwellings and the American Indian Community Development Corporation Homeward Bound 50-bed shelter;

(3) maintaining shelter operations and services at 24-hours-a-day, seven-days-a-week shelters;

(4) providing housing-focused case management; and

(5) providing shelter diversion services.

(b) A grantee may contract with eligible nonprofit organizations and local and Tribal governmental agencies to provide the services listed under paragraph (a).

Subd. 5. **Reporting.** (a) The grantee must submit a report to the commissioner in the time and manner specified by the commissioner. The report must include how the grant money was used and how many persons experiencing homelessness were served.

(b) The commissioner must submit a report to the chairs and ranking minority members of the legislative committees with jurisdiction over homelessness no later than six months after receiving the report under paragraph (a). The report submitted by the commissioner must include the information specified in paragraph (a).

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

Sec. 5. Minnesota Statutes 2022, section 256I.04, subdivision 1, is amended to read:

Subdivision 1. **Individual eligibility requirements.** An individual is eligible for and entitled to a housing support payment to be made on the individual's behalf if the agency has approved the setting where the individual will receive housing support and the individual meets the requirements in paragraph (a), (b), ~~or~~ (c), or (d).

(a) The individual is aged, blind, or is over 18 years of age with a disability as determined under the criteria used by the title II program of the Social Security Act, and meets the

resource restrictions and standards of section 256P.02, and the individual's countable income after deducting the (1) exclusions and disregards of the SSI program, (2) the medical assistance personal needs allowance under section 256B.35, and (3) an amount equal to the income actually made available to a community spouse by an elderly waiver participant under the provisions of sections 256B.0575, paragraph (a), clause (4), and 256B.058, subdivision 2, is less than the monthly rate specified in the agency's agreement with the provider of housing support in which the individual resides.

(b) The individual meets a category of eligibility under section 256D.05, subdivision 1, paragraph (a), clauses (1), (3), (4) to (8), and (13), and paragraph (b), if applicable, and the individual's resources are less than the standards specified by section 256P.02, and the individual's countable income as determined under section 256P.06, less the medical assistance personal needs allowance under section 256B.35 is less than the monthly rate specified in the agency's agreement with the provider of housing support in which the individual resides.

(c) The individual lacks a fixed, adequate, nighttime residence upon discharge from a residential behavioral health treatment program, as determined by treatment staff from the residential behavioral health treatment program. An individual is eligible under this paragraph for up to three months, including a full or partial month from the individual's move-in date at a setting approved for housing support following discharge from treatment, plus two full months.

(d) The individual meets the criteria related to establishing a certified disability or disabling condition in paragraph (a) or (b) and lacks a fixed, adequate, nighttime residence upon discharge from a correctional facility, as determined by an authorized representative from a Minnesota-based correctional facility. An individual is eligible under this paragraph for up to three months, including a full or partial month from the individual's move-in date at a setting approved for housing support following release, plus two full months. People who meet the disabling condition criteria established in paragraph (a) or (b) will not have any countable income for the duration of eligibility under this paragraph.

Sec. 6. **[256K.47] SAFE HARBOR SHELTER AND HOUSING.**

Subdivision 1. **Grant program established.** The commissioner of human services must establish a safe harbor shelter and housing grant program. Under this grant program, the commissioner must award grants to providers who are committed to serving sexually exploited youth and youth at risk of sexual exploitation. Grantees must use grant money to provide street and community outreach programs, emergency shelter programs, or supportive

housing programs consistent with the program descriptions in this section to address the specialized outreach, shelter, and housing needs of sexually exploited youth and youth at risk of sexual exploitation.

Subd. 2. **Youth eligible services.** Youth 24 years of age or younger are eligible for all shelter, housing beds, and services provided under this section and all services, support, and programs provided by the commissioner of health to sexually exploited youth and youth at risk of sexual exploitation under sections 145.4716 and 145.4717.

Subd. 3. **Street and community outreach.** (a) Street and community outreach programs must locate, contact, and provide information, referrals, and services to eligible youth.

(b) Information, referrals, and services provided by street and community outreach programs may include but are not limited to:

(1) family reunification services;

(2) conflict resolution or mediation counseling;

(3) assistance in obtaining temporary emergency shelter;

(4) assistance in obtaining food, clothing, medical care, or mental health counseling;

(5) counseling regarding violence, sexual exploitation, substance use, sexually transmitted infections, and pregnancy;

(6) referrals to other agencies that provide support services to sexually exploited youth and youth at risk of sexual exploitation;

(7) assistance with education, employment, and independent living skills;

(8) aftercare services;

(9) specialized services for sexually exploited youth and youth at risk of sexual exploitation, including youth experiencing homelessness and youth with mental health needs; and

(10) services to address the prevention of sexual exploitation and homelessness.

Subd. 4. **Emergency shelter program.** (a) Emergency shelter programs must provide eligible youth with referral and walk-in access to emergency short-term residential care. The program shall provide eligible youth with safe and dignified shelter that includes private shower facilities, beds, and meals each day and must assist eligible youth with reunification with that youth's family or legal guardian when required or appropriate.

(b) The services provided at emergency shelters may include but are not limited to:

(1) specialized services to address the trauma of sexual exploitation;

(2) family reunification services;

(3) individual, family, and group counseling;

(4) assistance obtaining clothing;

(5) access to medical and dental care and mental health counseling;

(6) counseling regarding violence, sexual exploitation, substance use, sexually transmitted infections, and pregnancy;

(7) education and employment services;

(8) recreational activities;

(9) advocacy and referral services;

(10) independent living skills training;

(11) aftercare and follow-up services;

(12) transportation; and

(13) services to address the prevention of sexual exploitation and homelessness.

Subd. 5. **Supportive housing programs.** (a) Supportive housing programs must help eligible youth find and maintain safe and dignified housing and provide related supportive services and referrals. Supportive housing programs may also provide rental assistance.

(b) The services provided in supportive housing programs may include but are not limited to:

(1) specialized services to address the trauma of sexual exploitation;

(2) education and employment services;

(3) budgeting and money management;

(4) assistance in securing housing appropriate to needs and income;

(5) counseling regarding violence, sexual exploitation, substance use, sexually transmitted infections, and pregnancy;

(6) referral for medical services or chemical dependency treatment;

(7) parenting skills;

(8) self-sufficiency support services and independent living skills training;

(9) aftercare and follow-up services; and

(10) services to address the prevention of sexual exploitation and homelessness prevention.

Subd. 6. **Funding.** Money appropriated for this section may be expended on programs described in subdivisions 3 to 5, technical assistance, and capacity building to meet the greatest need on a statewide basis.

Sec. 7. **[256K.50] FAMILY SUPPORTIVE HOUSING.**

Subdivision 1. **Definitions.** (a) The definitions in this subdivision apply to this section.

(b) "Family" means a nontemporary household unit that includes at least one child and one parent or legal guardian.

(c) "Family permanent supportive housing" means housing that:

(1) is not time limited;

(2) is affordable for those at or below 30 percent of the area median income;

(3) offers specialized support services to residents tailored to the needs of children and families; and

(4) is available to families with multiple barriers to obtaining and maintaining housing, including but not limited to those who are homeless or at risk of homelessness; those with mental illness, substance use disorders, and other disabilities; and those referred by child protection services.

(d) "Resident" means a resident of family permanent supportive housing.

Subd. 2. **Specialized family support services.** Specialized family support services are nonmandatory, trauma-informed, and culturally appropriate services designed to help family residents maintain secure, dignified housing and provide a safe, stable environment for children. Services provided may include but are not limited to:

(1) age-appropriate child-centric services for education and enrichment;

(2) stabilization services such as:

(i) educational assessments and referrals to educational programs;

(ii) career planning, work skill training, job placement, and employment retention;

(iii) budgeting and money management;

(iv) referrals for counseling regarding violence and sexual exploitation;

(v) referrals for medical or psychiatric services or substance use disorder treatment;

(vi) parenting skills training;

(vii) self-sufficiency support services or life skill training, including tenant education and support to sustain housing; and

(viii) aftercare and follow-up services; and

(3) 24-hour-a-day, seven-days-a-week on-site staffing, including but not limited to front desk and security.

Subd. 3. **Funding.** Money appropriated for this section may be expended on programs described under subdivision 2, technical assistance, and capacity building to meet the greatest need on a statewide basis. The commissioner must provide outreach, technical assistance, and program development support to increase capacity to new and existing service providers to better meet needs statewide.

Sec. 8. Laws 2021, First Special Session chapter 7, article 17, section 5, subdivision 1, is amended to read:

Subdivision 1. **Housing transition cost.** (a) This act includes $682,000 in fiscal year 2022 and $1,637,000 in fiscal year 2023 for a onetime payment per transition of up to $3,000 to cover costs associated with moving to a community setting that are not covered by other sources. Covered costs include: (1) lease or rent deposits; (2) security deposits; (3) utilities setup costs, including telephone and Internet services; and (4) essential furnishings and supplies. The commissioner of human services shall seek an amendment to the medical assistance state plan to allow for these payments as a housing stabilization service under Minnesota Statutes, section 256B.051. The general fund base in this act for this purpose is $1,227,000 in fiscal year 2024 and $0 in fiscal year 2025.

~~(b) This subdivision expires March 31, 2024.~~

(b) An individual is only eligible for a housing transition cost payment if the individual is moving from an institution or provider-controlled setting into their own home.

EFFECTIVE DATE. This section is effective upon federal approval.

Sec. 9. **HOMELESS YOUTH CASH STIPEND PILOT PROJECT.**

Subdivision 1. **Pilot project established.** The commissioner of human services shall establish a homeless youth cash stipend pilot project to provide a direct cash stipend to

homeless youth in Hennepin and St. Louis Counties. The pilot project must be designed to meet the needs of underserved communities.

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

(b) "Commissioner" means the commissioner of human services.

(c) "Homeless youth" means a person 18 to 24 years of age who lacks a fixed, regular, and adequate nighttime residence. The following are not fixed, regular, or adequate nighttime residences:

(1) a supervised publicly or privately operated shelter designed to provide temporary living accommodations;

(2) an institution or a publicly or privately operated shelter designed to provide temporary living accommodations;

(3) transitional housing;

(4) a temporary placement with a peer, friend, or family member that has not offered permanent residence, a residential lease, or temporary lodging for more than 30 days; or

(5) a public or private place not designed for, nor ordinarily used as, a regular sleeping accommodation for human beings.

Subd. 3. **Administration.** The commissioner, as authorized by Minnesota Statutes, section 256.01, subdivision 2, paragraph (a), clause (6), shall contract with Youthprise to:

(1) identify eligible homeless youth under this section;

(2) provide technical assistance to cash stipend recipients;

(3) engage with cash stipend recipients to develop youth-designed optional services;

(4) evaluate the efficacy and cost-effectiveness of the pilot program;

(5) collaborate with youth leaders of each county to identify and contract with the appropriate service providers to offer financial coaching, housing navigation, employment, education services, and trauma-informed mentoring and support; and

(6) submit annual updates and a final report to the commissioner.

Subd. 4. **Eligibility.** Homeless youth who are 18 to 24 years of age and who live in Hennepin or St. Louis County at the time of initial enrollment are eligible to participate in the pilot project.

Subd. 5. **Cash stipend.** The commissioner, in consultation with Youthprise and Hennepin and St. Louis Counties, shall establish a stipend amount for eligible homeless youth who participate in the pilot project.

Subd. 6. **Stipends not to be considered income.** (a) Notwithstanding any law to the contrary, cash stipends under this section must not be considered income, assets, or personal property for purposes of determining eligibility or recertifying eligibility for:

(1) child care assistance programs under Minnesota Statutes, chapter 119B;

(2) general assistance, Minnesota supplemental aid, and food support under Minnesota Statutes, chapter 256D;

(3) housing support under Minnesota Statutes, chapter 256I;

(4) the Minnesota family investment program and diversionary work program under Minnesota Statutes, chapter 256J; and

(5) economic assistance programs under Minnesota Statutes, chapter 256P.

(b) The commissioner must not consider cash stipends under this section as income or assets for medical assistance under Minnesota Statutes, section 256B.056, subdivision 1a, paragraph (a); 3; or 3c.

Subd. 7. **Report.** The commissioner, in cooperation with Youthprise and Hennepin and St. Louis Counties, shall submit an annual report on Youthprise's findings regarding the efficacy and cost-effectiveness of the homeless youth cash stipend pilot project to the chairs and ranking minority members of the legislative committees with jurisdiction over homeless youth policy and finance by January 15, 2024, and each January 15 thereafter.

Subd. 8. **Expiration.** This section expires June 30, 2027.

Sec. 10. **HOUSING STABILIZATION SERVICES INFLATIONARY ADJUSTMENT.**

The commissioner of human services shall seek federal approval to apply biennial inflationary updates to housing stabilization services rates based on the consumer price index. Beginning January 1, 2024, the commissioner must update rates using the most recently available data from the consumer price index.

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

ARTICLE 13
CHILDREN AND FAMILIES

Section 1. Minnesota Statutes 2022, section 4.045, is amended to read:

4.045 CHILDREN'S CABINET.

The Children's Cabinet shall consist of the commissioners of education~~,~~; human services~~,~~; employment and economic development~~,~~; public safety~~,~~; corrections~~,~~; management and budget~~,~~; health~~,~~; administration~~,~~; Housing Finance Agency~~, and~~; transportation~~,~~; and ~~the director of the Office of Strategic and Long-Range Planning~~ children, youth, and families. The governor shall designate one member to serve as cabinet chair. The chair is responsible for ensuring that the duties of the Children's Cabinet are performed.

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

Sec. 2. Minnesota Statutes 2022, section 10.65, subdivision 2, is amended to read:

Subd. 2. **Definitions.** (a) As used in this section, the following terms have the meanings given:

(1) "agency" means the Department of Administration~~,~~; Department of Agriculture~~,~~; Department of Children, Youth, and Families; Department of Commerce~~,~~; Department of Corrections~~,~~; Department of Education~~,~~; Department of Employment and Economic Development~~,~~; Department of Health~~,~~; Office of Higher Education~~,~~; Housing Finance Agency~~,~~; Department of Human Rights~~,~~; Department of Human Services~~,~~; Department of Information Technology Services~~,~~; Department of Iron Range Resources and Rehabilitation~~,~~; Department of Labor and Industry~~,~~; Minnesota Management and Budget~~,~~; Bureau of Mediation Services~~,~~; Department of Military Affairs~~,~~; Metropolitan Council~~,~~; Department of Natural Resources~~,~~; Pollution Control Agency~~,~~; Department of Public Safety~~,~~; Department of Revenue~~,~~; Department of Transportation~~,~~; Department of Veterans Affairs~~,~~; Gambling Control Board~~,~~; Racing Commission~~,~~; the Minnesota Lottery~~,~~; the Animal Health Board~~,~~; and the Board of Water and Soil Resources;

(2) "consultation" means the direct and interactive involvement of the Minnesota Tribal governments in the development of policy on matters that have Tribal implications. Consultation is the proactive, affirmative process of identifying and seeking input from appropriate Tribal governments and considering their interest as a necessary and integral part of the decision-making process. This definition adds to statutorily mandated notification procedures. During a consultation, the burden is on the agency to show that it has made a good faith effort to elicit feedback. Consultation is a formal engagement between agency

officials and the governing body or bodies of an individual Minnesota Tribal government that the agency or an individual Tribal government may initiate. Formal meetings or communication between top agency officials and the governing body of a Minnesota Tribal government is a necessary element of consultation;

(3) "matters that have Tribal implications" means rules, legislative proposals, policy statements, or other actions that have substantial direct effects on one or more Minnesota Tribal governments, or on the distribution of power and responsibilities between the state and Minnesota Tribal governments;

(4) "Minnesota Tribal governments" means the federally recognized Indian Tribes located in Minnesota including: Bois Forte Band; Fond Du Lac Band; Grand Portage Band; Leech Lake Band; Mille Lacs Band; White Earth Band; Red Lake Nation; Lower Sioux Indian Community; Prairie Island Indian Community; Shakopee Mdewakanton Sioux Community; and Upper Sioux Community; and

(5) "timely and meaningful" means done or occurring at a favorable or useful time that allows the result of consultation to be included in the agency's decision-making process for a matter that has Tribal implications.

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

Sec. 3. Minnesota Statutes 2022, section 15.01, is amended to read:

15.01 DEPARTMENTS OF THE STATE.

The following agencies are designated as the departments of the state government: the Department of Administration; the Department of Agriculture; the Department of Children, Youth, and Families; the Department of Commerce; the Department of Corrections; the Department of Education; the Department of Employment and Economic Development; the Department of Health; the Department of Human Rights; the Department of Information Technology Services; the Department of Iron Range Resources and Rehabilitation; the Department of Labor and Industry; the Department of Management and Budget; the Department of Military Affairs; the Department of Natural Resources; the Department of Public Safety; the Department of Human Services; the Department of Revenue; the Department of Transportation; the Department of Veterans Affairs; and their successor departments.

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

Sec. 4. Minnesota Statutes 2022, section 15.06, subdivision 1, is amended to read:

Subdivision 1. **Applicability.** This section applies to the following departments or agencies: the Departments of Administration~~,~~; Agriculture~~,~~; Children, Youth, and Families; Commerce~~,~~; Corrections~~,~~; Education~~,~~; Employment and Economic Development~~,~~; Health~~,~~; Human Rights~~,~~; Labor and Industry~~,~~; Management and Budget~~,~~; Natural Resources~~,~~; Public Safety~~,~~; Human Services~~,~~; Revenue~~,~~; Transportation~~,~~; and Veterans Affairs; the Housing Finance and Pollution Control Agencies; the Office of Commissioner of Iron Range Resources and Rehabilitation; the Department of Information Technology Services; the Bureau of Mediation Services; and their successor departments and agencies. The heads of the foregoing departments or agencies are "commissioners."

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

Sec. 5. Minnesota Statutes 2022, section 15A.0815, subdivision 2, is amended to read:

Subd. 2. **Group I salary limits.** The salary for a position listed in this subdivision shall not exceed 133 percent of the salary of the governor. This limit must be adjusted annually on January 1. The new limit must equal the limit for the prior year increased by the percentage increase, if any, in the Consumer Price Index for all urban consumers from October of the second prior year to October of the immediately prior year. The commissioner of management and budget must publish the limit on the department's website. This subdivision applies to the following positions:

Commissioner of administration;

Commissioner of agriculture;

Commissioner of education;

Commissioner of children, youth, and families;

Commissioner of commerce;

Commissioner of corrections;

Commissioner of health;

Commissioner, Minnesota Office of Higher Education;

Commissioner, Housing Finance Agency;

Commissioner of human rights;

Commissioner of human services;

Commissioner of labor and industry;

Commissioner of management and budget;

Commissioner of natural resources;

Commissioner, Pollution Control Agency;

Commissioner of public safety;

Commissioner of revenue;

Commissioner of employment and economic development;

Commissioner of transportation; and

Commissioner of veterans affairs.

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

Sec. 6. Minnesota Statutes 2022, section 43A.08, subdivision 1a, is amended to read:

Subd. 1a. **Additional unclassified positions.** Appointing authorities for the following agencies may designate additional unclassified positions according to this subdivision: the Departments of Administration; Agriculture; Children, Youth, and Families; Commerce; Corrections; Education; Employment and Economic Development; Explore Minnesota Tourism; Management and Budget; Health; Human Rights; Labor and Industry; Natural Resources; Public Safety; Human Services; Revenue; Transportation; and Veterans Affairs; the Housing Finance and Pollution Control Agencies; the State Lottery; the State Board of Investment; the Office of Administrative Hearings; the Department of Information Technology Services; the Offices of the Attorney General, Secretary of State, and State Auditor; the Minnesota State Colleges and Universities; the Minnesota Office of Higher Education; the Perpich Center for Arts Education; and the Minnesota Zoological Board.

A position designated by an appointing authority according to this subdivision must meet the following standards and criteria:

(1) the designation of the position would not be contrary to other law relating specifically to that agency;

(2) the person occupying the position would report directly to the agency head or deputy agency head and would be designated as part of the agency head's management team;

(3) the duties of the position would involve significant discretion and substantial involvement in the development, interpretation, and implementation of agency policy;

(4) the duties of the position would not require primarily personnel, accounting, or other technical expertise where continuity in the position would be important;

(5) there would be a need for the person occupying the position to be accountable to, loyal to, and compatible with, the governor and the agency head, the employing statutory board or commission, or the employing constitutional officer;

(6) the position would be at the level of division or bureau director or assistant to the agency head; and

(7) the commissioner has approved the designation as being consistent with the standards and criteria in this subdivision.

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

Sec. 7. Minnesota Statutes 2022, section 119B.011, subdivision 2, is amended to read:

Subd. 2. **Applicant.** "Child care fund applicants" means all parents~~,~~; stepparents~~,~~; legal guardians~~, or~~; eligible relative caregivers ~~who are~~; relative custodians who accepted a transfer of permanent legal and physical custody of a child under section 260C.515, subdivision 4, or similar permanency disposition in Tribal code; successor custodians or guardians as established by section 256N.22, subdivision 10; or foster parents providing care to a child placed in a family foster home under section 260C.007, subdivision 16b. Applicants must be members of the family and reside in the household that applies for child care assistance under the child care fund.

EFFECTIVE DATE. This section is effective August 25, 2024.

Sec. 8. Minnesota Statutes 2022, section 119B.011, subdivision 5, is amended to read:

Subd. 5. **Child care.** "Child care" means the care of a child by someone other than a parent~~,~~; stepparent~~,~~; legal guardian~~,~~; eligible relative caregiver~~,~~; relative custodian who accepted a transfer of permanent legal and physical custody of a child under section 260C.515, subdivision 4, or similar permanency disposition in Tribal code; successor custodian or guardian as established according to section 256N.22, subdivision 10; foster parent providing care to a child placed in a family foster home under section 260C.007, subdivision 16b; or ~~the spouses~~ spouse of any of the foregoing in or outside the child's own home for gain or otherwise, on a regular basis, for any part of a 24-hour day.

EFFECTIVE DATE. This section is effective August 25, 2024.

Sec. 9. Minnesota Statutes 2022, section 119B.011, subdivision 13, is amended to read:

Subd. 13. **Family.** "Family" means parents~~,~~; stepparents~~,~~; guardians and their spouses~~,~~ ~~or~~; other eligible relative caregivers and their spouses~~,~~; relative custodians who accepted a transfer of permanent legal and physical custody of a child under section 260C.515, subdivision 4, or similar permanency disposition in Tribal code, and their spouses; successor custodians or guardians as established by section 256N.22, subdivision 10, and their spouses; foster parents providing care to a child placed in a family foster home under section 260C.007, subdivision 16b, and their spouses; and ~~their blood related~~ the blood-related dependent children and adoptive siblings under the age of 18 years living in the same home ~~including~~ as any of the above. Family includes children temporarily absent from the household in settings such as schools, foster care, and residential treatment facilities ~~or parents, stepparents, guardians and their spouses, or other relative caregivers and their spouses~~ and adults temporarily absent from the household in settings such as schools, military service, or rehabilitation programs. An adult family member who is not in an authorized activity under this chapter may be temporarily absent for up to 60 days. When a minor parent or parents and his, her, or their child or children are living with other relatives, and the minor parent or parents apply for a child care subsidy, "family" means only the minor parent or parents and their child or children. An adult age 18 or older who meets this definition of family and is a full-time high school or postsecondary student may be considered a dependent member of the family unit if 50 percent or more of the adult's support is provided by the parents~~,~~; stepparents~~,~~; guardians and their spouses; relative custodians who accepted a transfer of permanent legal and physical custody of a child under section 260C.515, subdivision 4, or similar permanency disposition in Tribal code, and their spouses; successor custodians or guardians as established by section 256N.22, subdivision 10, and their spouses; foster parents providing care to a child placed in a family foster home under section 260C.007, subdivision 16b, and their spouses; or eligible relative caregivers and their spouses residing in the same household.

EFFECTIVE DATE. This section is effective August 25, 2024.

Sec. 10. Minnesota Statutes 2022, section 119B.03, subdivision 4a, is amended to read:

Subd. 4a. ~~**Temporary reprioritization**~~ **Funding priorities.** (a) ~~Notwithstanding subdivision 4~~ In the event that inadequate funding necessitates the use of waiting lists, priority for child care assistance under the basic sliding fee assistance program shall be determined according to this subdivision ~~beginning July 1, 2021, through May 31, 2024~~.

(b) First priority must be given to eligible non-MFIP families who do not have a high school diploma or commissioner of education-selected high school equivalency certification or who need remedial and basic skill courses in order to pursue employment or to pursue education leading to employment and who need child care assistance to participate in the education program. This includes student parents as defined under section 119B.011, subdivision 19b. Within this priority, the following subpriorities must be used:

(1) child care needs of minor parents;

(2) child care needs of parents under 21 years of age; and

(3) child care needs of other parents within the priority group described in this paragraph.

(c) Second priority must be given to families in which at least one parent is a veteran, as defined under section 197.447.

(d) Third priority must be given to eligible families who do not meet the specifications of paragraph (b), (c), (e), or (f).

(e) Fourth priority must be given to families who are eligible for portable basic sliding fee assistance through the portability pool under subdivision 9.

(f) Fifth priority must be given to eligible families receiving services under section 119B.011, subdivision 20a, if the parents have completed their MFIP or DWP transition year, or if the parents are no longer receiving or eligible for DWP supports.

(g) Families under paragraph (f) must be added to the basic sliding fee waiting list on the date they complete their transition year under section 119B.011, subdivision 20.

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

Sec. 11. Minnesota Statutes 2022, section 119B.13, subdivision 1, is amended to read:

Subdivision 1. **Subsidy restrictions.** (a) Beginning ~~November 15, 2021~~ October 30, 2023, the maximum rate paid for child care assistance in any county or county price cluster under the child care fund shall be~~:~~

~~(1) for all infants and toddlers,~~ the greater of the ~~40th~~ 75th percentile of the 2021 child care provider rate survey or the rates in effect at the time of the update~~; and~~.

~~(2) for all preschool and school-age children, the greater of the 30th percentile of the 2021 child care provider rate survey or the rates in effect at the time of the update.~~

(b) Beginning the first full service period on or after January 1, 2025, and every three years thereafter, the maximum rate paid for child care assistance in a county or county price cluster under the child care fund shall be~~:~~

~~(1) for all infants and toddlers,~~ the greater of the ~~40th~~ 75th percentile of the ~~2024~~ most recent child care provider rate survey or the rates in effect at the time of the update~~; and~~.

~~(2) for all preschool and school-age children, the greater of the 30th percentile of the 2024 child care provider rate survey or the rates in effect at the time of the update.~~

The rates under paragraph (a) continue until the rates under this paragraph go into effect.

(c) For a child care provider located within the boundaries of a city located in two or more of the counties of Benton, Sherburne, and Stearns, the maximum rate paid for child care assistance shall be equal to the maximum rate paid in the county with the highest maximum reimbursement rates or the provider's charge, whichever is less. The commissioner may: (1) assign a county with no reported provider prices to a similar price cluster; and (2) consider county level access when determining final price clusters.

(d) A rate which includes a special needs rate paid under subdivision 3 may be in excess of the maximum rate allowed under this subdivision.

(e) The department shall monitor the effect of this paragraph on provider rates. The county shall pay the provider's full charges for every child in care up to the maximum established. The commissioner shall determine the maximum rate for each type of care on an hourly, full-day, and weekly basis, including special needs and disability care.

(f) If a child uses one provider, the maximum payment for one day of care must not exceed the daily rate. The maximum payment for one week of care must not exceed the weekly rate.

(g) If a child uses two providers under section 119B.097, the maximum payment must not exceed:

(1) the daily rate for one day of care;

(2) the weekly rate for one week of care by the child's primary provider; and

(3) two daily rates during two weeks of care by a child's secondary provider.

(h) Child care providers receiving reimbursement under this chapter must not be paid activity fees or an additional amount above the maximum rates for care provided during nonstandard hours for families receiving assistance.

(i) If the provider charge is greater than the maximum provider rate allowed, the parent is responsible for payment of the difference in the rates in addition to any family co-payment fee.

(j) Beginning October 30, 2023, the maximum registration fee paid for child care assistance in any county or county price cluster under the child care fund shall be ~~set as follows: (1) beginning November 15, 2021,~~ the greater of the ~~40th~~ 75th percentile of the ~~2021~~ most recent child care provider rate survey or the registration fee in effect at the time of the update~~; and (2) beginning the first full service period on or after January 1, 2025, the maximum registration fee shall be the greater of the 40th percentile of the 2024 child care provider rate survey or the registration fee in effect at the time of the update. The registration fees under clause (1) continue until the registration fees under clause (2) go into effect~~.

(k) Maximum registration fees must be set for licensed family child care and for child care centers. For a child care provider located in the boundaries of a city located in two or more of the counties of Benton, Sherburne, and Stearns, the maximum registration fee paid for child care assistance shall be equal to the maximum registration fee paid in the county with the highest maximum registration fee or the provider's charge, whichever is less.

Sec. 12. **[119B.196] FAMILY, FRIEND, AND NEIGHBOR GRANT PROGRAM.**

Subdivision 1. **Establishment.** The commissioner of human services shall establish a family, friend, and neighbor (FFN) grant program to promote children's social-emotional learning and healthy development, early literacy, and other skills to succeed as learners and to foster community partnerships that will help children thrive when they enter school.

Subd. 2. **Grant awards.** The commissioner may award grants under this section to the following entities working with FFN caregivers: community-based organizations, nonprofit organizations, local or regional libraries, local public health agencies, and Indian Tribes and Tribal organizations. Grantees may use grant money received under this section to:

(1) provide culturally and linguistically appropriate training, support, and resources to FFN caregivers and children's families to improve and promote children's health, safety, nutrition, and learning;

(2) connect FFN caregivers and children's families with community resources that support the families' physical and mental health and economic and developmental needs;

(3) connect FFN caregivers and children's families to early childhood screening programs and facilitate referrals to state and local agencies, schools, community organizations, and medical providers, as appropriate;

(4) provide FFN caregivers and children's families with information about high-quality, community-based early care and learning programs and financial assistance available to the families, including but not limited to child care assistance under this chapter and early learning scholarships under section 124D.165;

(5) provide FFN caregivers with information about registering as a legal nonlicensed child care provider as defined in section 119B.011, subdivision 16, and establishing a licensed family or group family child care program;

(6) provide transportation for FFN caregivers and children's families to educational and other early childhood training activities;

(7) translate materials for FFN caregivers and children's families and provide translation services to FFN caregivers and children's families;

(8) develop and disseminate social-emotional learning, health and safety, and early learning kits to FFN caregivers; and

(9) establish play and learning groups for FFN caregivers.

Subd. 3. **Administration.** Applicants must apply for the grants using the forms and according to timelines established by the commissioner.

Subd. 4. **Reporting requirements.** (a) Grantees shall provide data and program outcomes to the commissioner in a form and manner specified by the commissioner for the purpose of evaluating the grant program.

(b) Beginning February 1, 2024, and every two years thereafter, the commissioner shall report to the legislature on program outcomes.

Sec. 13. **[143.01] DEFINITIONS.**

Subdivision 1. **Application.** The definitions in this section apply to this chapter.

Subd. 2. **Commissioner.** "Commissioner" means the commissioner of children, youth, and families.

Subd. 3. **Department.** "Department" means the Department of Children, Youth, and Families.

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

Sec. 14. **[143.02] CREATION OF THE DEPARTMENT OF CHILDREN, YOUTH, AND FAMILIES.**

Subdivision 1. **Department.** The Department of Children, Youth, and Families is established.

Subd. 2. **Transfer and restructuring provisions.** The restructuring of agencies under this act must be conducted in accordance with sections 15.039 and 43A.045.

Subd. 3. **Successor and employee protection clause.** (a) Personnel relating to the functions assigned to the commissioner in section 143.03 are transferred to the department effective 30 days after approval by the commissioner.

(b) Before the commissioner's appointment, personnel relating to the functions in this section may be transferred beginning July 1, 2024, with 30 days' notice from the commissioner of management and budget.

(c) All employees transferred to the department remain in the same employment status, bargaining unit, and civil service protection as the employees had before the transfer. All collective bargaining agreements that cover any employee of the Departments of Human Services, Education, Health, or Public Safety who is transferred to the Department of Children, Youth, and Families remain in effect.

(d) To the extent that departmental changes affect the operations of any school district or charter school, employers have the obligation to bargain about any changes affecting or relating to employees' terms and conditions of employment if such changes are necessary during or after the term of an existing collective bargaining agreement.

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

Sec. 15. **[143.03] COMMISSIONER.**

Subdivision 1. **General.** The department is under the administrative control of the commissioner. The commissioner is appointed by the governor with the advice and consent of the senate. The commissioner has the general powers provided in section 15.06, subdivision 6. The commissioner's salary must be established according to the procedure in section 15A.0815, subdivision 5, in the same range as specified for the commissioner of management and budget.

Subd. 2. **Duties of the commissioner.** (a) The commissioner may apply for and accept on behalf of the state any grants, bequests, gifts, or contributions for the purpose of carrying out the duties and responsibilities of the commissioner. Any money received under this

paragraph is appropriated and dedicated for the purpose for which the money is granted. The commissioner must biennially report to the chairs and ranking minority members of relevant legislative committees and divisions by January 15 of each even-numbered year a list of all grants and gifts received under this subdivision.

(b) Pursuant to law, the commissioner may apply for and receive money made available from federal sources for the purpose of carrying out the duties and responsibilities of the commissioner.

(c) The commissioner may make contracts with and grants to Tribal Nations, public and private agencies and for-profit and nonprofit organizations, and individuals using appropriated money.

(d) The commissioner must develop program objectives and performance measures for evaluating progress toward achieving the objectives. The commissioner must identify the objectives, performance measures, and current status of achieving the measures in a biennial report to the chairs and ranking minority members of relevant legislative committees and divisions. The report is due no later than January 15 each even-numbered year. The report must include, when possible, the following objectives:

(1) centering and including the lived experiences of children and youth, including those with disabilities and mental illness and their families, in all aspects of the department's work;

(2) increasing the effectiveness of the department's programs in addressing the needs of children and youth facing racial, economic, or geographic inequities;

(3) increasing coordination and reducing inefficiencies among the department's programs and the funding sources that support the programs;

(4) increasing the alignment and coordination of family access to child care and early learning programs and improving systems of support for early childhood and learning providers and services;

(5) improving the connection between the department's programs and the kindergarten through grade 12 and higher education systems; and

(6) minimizing and streamlining the effort required of youth and families to receive services to which the youth and families are entitled.

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

Sec. 16. **[143.04] STATE AND COUNTY SYSTEMS.**

Subdivision 1. **Establishment of systems.** (a) The commissioner shall establish and enhance computer systems necessary for the efficient operation of the programs the commissioner supervises, including:

(1) management and administration of the Supplemental Nutrition Assistance Program (SNAP) and income maintenance program, including the electronic distribution of benefits; and

(2) management and administration of the child support enforcement program.

(b) The commissioner's development costs incurred by computer systems for statewide programs administered with that computer system and mandated by state or federal law must not be assessed against county agencies. The commissioner may charge a county for development and operating costs incurred by computer systems for functions requested by the county and not mandated by state or federal law for programs administered by the computer system incurring the cost.

(c) The commissioner shall distribute the nonfederal share of the costs of operating and maintaining the systems to the commissioner and to the counties participating in the system in a manner that reflects actual system usage, except that the nonfederal share of the costs of the MAXIS computer system and child support enforcement systems for statewide programs administered by those systems and mandated by state or federal law shall be borne entirely by the commissioner.

(d) The commissioner may enter into contractual agreements with federally recognized Indian Tribes with a reservation in Minnesota to participate in state-operated computer systems related to the management and administration of the SNAP, income maintenance, and child support enforcement programs to the extent necessary for the Tribe to operate a federally approved family assistance program or any other program under the supervision of the commissioner.

Subd. 2. **State systems account created.** A state systems account for the Department of Children, Youth, and Families is created in the state treasury. Money collected by the commissioner for the programs in subdivision 1 must be deposited in the account. Money in the state systems account and federal matching money are appropriated to the commissioner for purposes of this section.

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

Sec. 17. **[143.05] RULEMAKING.**

(a) The commissioner may use the procedure in section 14.386, paragraph (a), to adopt rules necessary to implement the responsibilities transferred under this article or through section 16B.37. Section 14.386, paragraph (b), does not apply to these rules.

(b) The commissioner must amend Minnesota Rules to make conforming changes related to the transfer of responsibilities under this act or through section 16B.37. The commissioner must obtain the approval of the commissioners of human services, education, health, and public safety for any amendments to or repeal of rules in existence on the effective date of this section and administered under the authority of those agencies.

(c) The time limit in section 14.125 is extended to 36 months for rulemaking under paragraphs (a) and (b). The commissioner must publish a notice of intent to adopt rules or a notice of hearing within 36 months of the effective date reported under section 143.05, subdivision 1, paragraph (c).

(d) The commissioner may adopt rules for the administration of activities related to the department. Rules adopted under this paragraph are subject to the rulemaking requirements of chapter 14.

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

Sec. 18. **[145.9285] COMMUNITY SOLUTIONS FOR HEALTHY CHILD DEVELOPMENT GRANT PROGRAM.**

Subdivision 1. **Establishment.** The commissioner of health shall establish the community solutions for healthy child development grant program. The purpose of the program is to:

(1) improve child development outcomes as related to the well-being of children of color and American Indian children from prenatal to grade 3 and their families, including but not limited to the goals outlined by the Department of Human Services' early childhood systems reform effort for: early learning; health and well-being; economic security; and safe, stable, nurturing relationships and environments by funding community-based solutions for challenges that are identified by the affected community;

(2) reduce racial disparities in children's health and development from prenatal to grade 3; and

(3) promote racial and geographic equity.

Subd. 2. **Commissioner's duties.** The commissioner shall:

(1) develop a request for proposals for the healthy child development grant program in consultation with the Community Solutions Advisory Council;

(2) provide outreach, technical assistance, and program development support to increase capacity for new and existing service providers in order to better meet statewide needs, particularly in greater Minnesota and areas where services to reduce health disparities have not been established;

(3) review responses to requests for proposals, in consultation with the Community Solutions Advisory Council, and award grants under this section;

(4) ensure communication with the ethnic councils, Minnesota Indian Affairs Council, and the state advisory council on early childhood education and care on the request for proposal process;

(5) establish a transparent and objective accountability process, in consultation with the Community Solutions Advisory Council, that is focused on outcomes that grantees agree to achieve;

(6) provide grantees with access to data to assist grantees in establishing and implementing effective community-led solutions;

(7) maintain data on outcomes reported by grantees; and

(8) contract with an independent third-party entity to evaluate the success of the grant program and to build the evidence base for effective community solutions in reducing health disparities of children of color and American Indian children from prenatal to grade 3.

Subd. 3. **Community Solutions Advisory Council; establishment; duties; compensation.** (a) The commissioner, in consultation with the three ethnic councils under section 15.0145 and the Indian Affairs Council under section 3.922, shall appoint a 13-member Community Solutions Advisory Council, as follows:

(1) three members representing Black Minnesotans of African heritage, one of whom is a parent with a child under the age of eight years at the time of the appointment;

(2) three members representing Latino and Latina Minnesotans with an ethnic heritage from Mexico, a country in Central or South America, Cuba, the Dominican Republic, or Puerto Rico, one of whom is a parent with a child under the age of eight years at the time of the appointment;

(3) three members representing Asian-Pacific Minnesotans with Asian-Pacific heritage, one of whom is a parent with a child under the age of eight years at the time of the appointment;

(4) three members representing the American Indian community, one of whom is a parent of a child under the age of eight years at the time of the appointment; and

(5) one member with research or academic expertise in racial equity and healthy child development.

(b) The commissioner must include representation from organizations with expertise in advocacy on behalf of communities of color and Indigenous communities in areas related to the grant program.

(c) At least three of the 13 members appointed under paragraph (a), clauses (1) to (4), of the advisory council must come from outside the seven-county metropolitan area.

(d) The Community Solutions Advisory Council shall:

(1) advise the commissioner on the development of the request for proposals for community solutions healthy child development grants. In advising the commissioner, the council must consider how to build on the capacity of communities to promote child and family well-being and address social determinants of healthy child development;

(2) review responses to requests for proposals and advise the commissioner on the selection of grantees and grant awards;

(3) advise the commissioner on the establishment of a transparent and objective accountability process focused on outcomes the grantees agree to achieve;

(4) advise the commissioner on ongoing oversight and necessary support in the implementation of the program; and

(5) support the commissioner on other racial equity and early childhood grant efforts.

(e) Member terms, compensation, and removal shall be as provided in section 15.059, subdivisions 2 to 4.

(f) The commissioner must convene meetings of the advisory council at least four times per year.

(g) The advisory council shall expire upon expiration or repeal of the healthy childhood development program.

(h) The commissioner of health must provide meeting space and administrative support for the advisory council.

Subd. 4. **Eligible grantees.** Organizations eligible to receive grant funding under this section include:

(1) organizations or entities that work with communities of color and American Indian communities;

(2) Tribal Nations and Tribal organizations as defined in section 658P of the Child Care and Development Block Grant Act of 1990; and

(3) organizations or entities focused on supporting healthy child development.

Subd. 5. **Strategic consideration and priority of proposals; eligible populations; grant awards.** (a) The commissioner, in consultation with the Community Solutions Advisory Council, shall develop a request for proposals for healthy child development grants. In developing the proposals and awarding the grants, the commissioner shall consider building on the capacity of communities to promote child and family well-being and address social determinants of healthy child development. Proposals must focus on increasing racial equity and healthy child development and reducing health disparities experienced by children of color and American Indian children from prenatal to grade 3 and their families.

(b) In awarding the grants, the commissioner shall provide strategic consideration and give priority to proposals from:

(1) organizations or entities led by people of color and serving communities of color;

(2) organizations or entities led by American Indians and serving American Indians, including Tribal Nations and Tribal organizations;

(3) organizations or entities with proposals focused on healthy development from prenatal to grade 3;

(4) organizations or entities with proposals focusing on multigenerational solutions;

(5) organizations or entities located in or with proposals to serve communities located in counties that are moderate to high risk according to the Wilder Research Risk and Reach Report; and

(6) community-based organizations that have historically served communities of color and American Indians and have not traditionally had access to state grant funding.

The advisory council may recommend additional strategic considerations and priorities to the commissioner.

(c) The first round of grants must be awarded no later than April 15, 2024. Grants must be awarded annually thereafter. Grants are awarded for a period of three years.

Subd. 6. **Geographic distribution of grants.** The commissioner and the advisory council shall ensure that grant money is prioritized and awarded to organizations and entities that are within counties that have a higher proportion of people of color and American Indians than the state average, to the extent possible.

Subd. 7. **Report.** Grantees must report grant program outcomes to the commissioner on the forms and according to the timelines established by the commissioner.

Sec. 19. Minnesota Statutes 2022, section 256.014, subdivision 1, is amended to read:

Subdivision 1. **Establishment of systems.** (a) The commissioner of human services shall establish and enhance computer systems necessary for the efficient operation of ~~the~~ medical assistance and other programs the commissioner supervises~~, including:~~.

~~(1) management and administration of the Supplemental Nutrition Assistance Program (SNAP) and income maintenance program, including the electronic distribution of benefits;~~

~~(2) management and administration of the child support enforcement program; and~~

~~(3) administration of medical assistance.~~

(b) The commissioner's development costs incurred by computer systems for statewide programs administered by that computer system and mandated by state or federal law must not be assessed against county agencies. The commissioner may charge a county for development and operating costs incurred by computer systems for functions requested by the county and not mandated by state or federal law for programs administered by the computer system incurring the cost.

(c) The commissioner shall distribute the nonfederal share of the costs of operating and maintaining the systems to the commissioner and to the counties participating in the system in a manner that reflects actual system usage, except that the nonfederal share of the costs of the MAXIS computer system ~~and child support enforcement systems~~ for statewide programs administered by ~~those systems~~ that system and mandated by state or federal law shall be borne entirely by the commissioner.

The commissioner may enter into contractual agreements with federally recognized Indian Tribes with a reservation in Minnesota to participate in state-operated computer systems related to the management and administration of the ~~SNAP, income maintenance, child support enforcement, and~~ medical assistance ~~programs~~ program to the extent necessary

for the Tribe to operate ~~a federally approved family~~ the medical assistance program or any other program under the supervision of the commissioner.

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

Sec. 20. Minnesota Statutes 2022, section 256.014, subdivision 2, is amended to read:

Subd. 2. **State systems account created.** A state systems account for the Department of Human Services is created in the state treasury. Money collected by the commissioner of human services for the programs in subdivision 1 must be deposited in the account. Money in the state systems account and federal matching money is appropriated to the commissioner of human services for purposes of this section.

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

Sec. 21. **[256E.341] PREPARED MEALS FOOD RELIEF GRANTS.**

Subdivision 1. **Establishment.** The commissioner of human services shall establish a prepared meals grant program to provide hunger relief to Minnesotans experiencing food insecurity and who have difficulty preparing meals due to limited mobility, disability, age, or limited resources to prepare their own meal.

Subd. 2. **Eligible grantees.** Eligible grantees are nonprofit organizations and federally recognized American Indian Tribes or Bands located in Minnesota as defined in section 10.65, with a demonstrated history of providing and distributing prepared meals customized for the population that they serve, including tailoring meals to the cultural, religious, and dietary needs of the population served. Eligible grantees must prepare meals in a licensed commercial kitchen and distribute meals according to ServSafe guidelines.

Subd. 3. **Application.** Applicants for grant money under this section shall apply to the commissioner on the forms and in the time and manner established by the commissioner.

Subd. 4. **Allowable uses of grant funds.** (a) Eligible grantees must use grant money awarded under this section to fund a prepared meals program that primarily targets individuals between 18 and 60 years of age, and their dependents, experiencing food insecurity. Grantees must avoid duplication with existing state and federal meal programs.

(b) Grant money must supplement, but not supplant, any state or federal funding used to provide prepared meals to Minnesotans experiencing food insecurity.

Subd. 5. **Duties of the commissioner.** (a) The commissioner shall develop a process for determining eligible grantees under this section.

(b) In granting money, the commissioner shall prioritize applicants that:

(1) have demonstrated ability to provide prepared meals to racially and geographically diverse populations at greater risk for food insecurity;

(2) work with external community partners to distribute meals targeting nontraditional meal sites reaching those most in need; and

(3) have a demonstrated history of sourcing at least 50 percent of the prepared meal ingredients from:

(i) Minnesota food producers and processors; or

(ii) food that is donated or would otherwise be waste.

(c) The commissioner shall consider geographic distribution to ensure statewide coverage when awarding grants and minimize the number of grantees to simplify administrative burdens and costs.

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

Sec. 22. **[256E.38] DIAPER DISTRIBUTION GRANT PROGRAM.**

Subdivision 1. **Establishment; purpose.** The commissioner of human services shall establish a diaper distribution program to award competitive grants to eligible applicants to provide diapers to underresourced families statewide.

Subd. 2. **Eligibility.** To be eligible for a grant under this section, an applicant must demonstrate its capacity to distribute diapers statewide by having:

(1) a network of well-established partners for diaper distribution;

(2) the infrastructure needed to efficiently manage diaper procurement and distribution statewide;

(3) relationships with national organizations that support and enhance the work of addressing diaper need;

(4) the ability to engage in building community awareness of diaper need and advocate for diaper need at local, state, and federal levels;

(5) a commitment to and demonstration of working with organizations across ideological and political spectrums;

(6) the ability to address diaper need for children from birth through early childhood; and

(7) a commitment to working within an equity framework by ensuring access to organizations that provide culturally specific services or are located in communities with high concentrations of poverty.

Subd. 3. **Application.** Applicants must apply to the commissioner in a form and manner prescribed by the commissioner. Applications must be filed at the times and for the periods determined by the commissioner.

Subd. 4. **Eligible uses of grant money.** An eligible applicant that receives grant money under this section shall use the money to purchase diapers and wipes and may use up to four percent of the money for administrative costs.

Subd. 5. **Enforcement.** (a) An eligible applicant that receives grant money under this section must:

(1) retain records documenting expenditure of the grant money;

(2) report to the commissioner on the use of the grant money; and

(3) comply with any additional requirements imposed by the commissioner.

(b) The commissioner may require that a report submitted under this subdivision include an independent audit.

Sec. 23. **DIRECTION TO COMMISSIONER; ALLOCATING BASIC SLIDING FEE MONEY.**

Notwithstanding Minnesota Statutes, section 119B.03, subdivisions 6, 6a, and 6b, the commissioner of human services must allocate additional basic sliding fee child care money for calendar year 2025 to counties and Tribes to account for the change in the definition of family in Minnesota Statutes, section 119B.011, in this article. In allocating the additional money, the commissioner shall consider:

(1) the number of children in the county or Tribe who receive care from a relative custodian who accepted a transfer of permanent legal and physical custody of a child under Minnesota Statutes, section 260C.515, subdivision 4, or similar permanency disposition in Tribal code; successor custodian or guardian as established according to Minnesota Statutes, section 256N.22, subdivision 10; or foster parents in a family foster home under Minnesota Statutes, section 260C.007, subdivision 16b; and

(2) the average basic sliding fee cost of care in the county or Tribe.

Sec. 24. **DIRECTION TO COMMISSIONER; COST ESTIMATION MODEL FOR EARLY CARE AND LEARNING PROGRAMS.**

(a) The commissioner of human services shall develop a cost estimation model for providing early care and learning in the state. In developing the model, the commissioner shall consult with relevant entities and stakeholders, including but not limited to the State Advisory Council on Early Childhood Education and Care under Minnesota Statutes, section 124D.141; county administrators; child care resource and referral organizations under Minnesota Statutes, section 119B.19, subdivision 1; and organizations representing caregivers, teachers, and directors.

(b) The commissioner shall contract with an organization with experience and expertise in early care and learning cost estimation modeling to conduct the work outlined in this section. If practicable, the commissioner shall contract with First Children's Finance.

(c) The commissioner shall ensure that the model can estimate variation in the cost of early care and learning by:

(1) quality of care;

(2) geographic area;

(3) type of child care provider and associated licensing standards;

(4) age of child;

(5) whether the early care and learning is inclusive, including caring for children with disabilities alongside children without disabilities;

(6) provider and staff compensation, including benefits such as professional development stipends, health care benefits, and retirement benefits;

(7) a provider's fixed costs, including rent and mortgage payments, property taxes, and business-related insurance payments;

(8) a provider's operating expenses, including expenses for training and substitutes; and

(9) a provider's hours of operation.

(d) By January 30, 2025, the commissioner must submit a report to the legislative committees with jurisdiction over early childhood programs on the development of the cost estimation model. The report shall include:

(1) recommendations for how the model could be used in conjunction with a child care and early education professional wage scale to set provider payment rates for child care

assistance under Minnesota Statutes, chapter 119B, and great start scholarships under Minnesota Statutes, section 119C.01; and

(2) a plan to seek federal approval to use the model for provider payment rates for child care assistance.

Sec. 25. **DIRECTION TO COMMISSIONER; INCREASE FOR MAXIMUM CHILD CARE ASSISTANCE RATES.**

Notwithstanding Minnesota Statutes, section 119B.03, subdivisions 6, 6a, and 6b, the commissioner must allocate the additional basic sliding fee child care money for calendar year 2024 to counties for updated maximum rates based on relative need to cover maximum rate increases. In distributing the additional money, the commissioner shall consider the following factors by county:

(1) the number of children;

(2) the provider type;

(3) the age of children served; and

(4) the amount of the increase in maximum rates.

Sec. 26. **DIRECTION TO COMMISSIONER; INTEGRATED SERVICES FOR CHILDREN AND FAMILIES.**

(a) The commissioner must increase staffing to eliminate the backlog of technology improvements for the Minnesota electronic child care system and MAXIS.

(b) The commissioner must increase staffing to sustain the Minnesota electronic child care system, MAXIS, and property record information system of Minnesota (PRISM) for five to ten years.

(c) The commissioner must address the social services information system (SSIS) performance and sustainability work group to ensure significant improvements in the performance of SSIS.

(d) The commissioner must modernize the state's child support system by refactoring, replatforming, and transforming the participant portal to increase the capacity to update information for participants.

(e) The commissioner must contract with an independent consultant to complete a thorough examination of SSIS to determine a proper platform for future development to perform the functions of SSIS.

(f) The commissioner must implement bidirectional data exchanges with the commissioner of education and the Minnesota judicial branch and improve data exchange with the state's Medicaid management information system. Also, the commissioner must plan and implement a process for data collaboration and exchange with child welfare contributing agencies.

(g) The commissioner must develop an enterprise approach to communicating with program participants, including by incorporating text messaging technology, and improve notices to program participants to make them easier to understand.

(h) The commissioner must increase staffing capacity to analyze the next steps toward implementing sustainable technology solutions that improve the experience of program participants, enhance program integrity, and reduce workloads. The commissioner must include community engagement and staff training in the analysis.

(i) The commissioner must contract with an independent consultant to perform a thorough evaluation of the SSIS, which supports the child protection system in Minnesota. The consultant must make recommendations for improving the current system for usability, system performance, and federal Comprehensive Child Welfare Information System compliance, and must address technical problems and identify any unnecessary or unduly burdensome data entry requirements that have contributed to system capacity issues. The consultant must assist the commissioner with selecting a platform for future development of an information technology system for child protection.

(j) The commissioner of human services must conduct a study and develop recommendations to streamline and reduce SSIS data entry requirements for child protection cases. The study must be completed in partnership with local social services agencies and others, as determined by the commissioner. The study must review all input fields required on current reporting forms and determine which input fields and information are required under state or federal law. By June 30, 2024, the commissioner must provide a status report and an implementation timeline to the chairs and ranking minority members of the legislative committees with jurisdiction over child protection. The status report must include information about procedures for soliciting ongoing user input from stakeholders, progress on solicitation and hiring of a consultant to conduct the system evaluation required under paragraph (a), and a report on progress and completed efforts to streamline data entry requirements and improve user experience.

Sec. 27. **DIRECTION TO COMMISSIONER; SERVICE DELIVERY TRANSFORMATION.**

(a) The commissioner must expand the MNbenefits application to streamline the application process and reduce processing time.

(b) The commissioner must create two additional product teams to expand the adoption of Agile to support progress on client-centered outcomes for integrated service delivery.

(c) The commissioner must continue implementation of enterprise architecture, change management, community and stakeholder engagement, evaluation and performance measurement, and management of enterprise applications, systems, and processes.

(d) The commissioner must implement an enterprise data management strategy, standards, and policies, and advanced analytics capacity.

(e) The commissioner may maintain existing systems to the extent necessary to support the service delivery transformation projects in this section.

Sec. 28. **FIRST APPOINTMENTS AND TERMS FOR THE COMMUNITY SOLUTIONS ADVISORY COUNCIL.**

The commissioner of health must appoint members to the Community Solutions Advisory Council under Minnesota Statutes, section 145.9285, by July 1, 2023, and must convene the first meeting by September 15, 2023. The commissioner must designate half of the members appointed under Minnesota Statutes, section 145.9285, subdivision 3, paragraph (a), clauses (1) to (4), to serve a two-year term and the remaining members will serve a four-year term. The commissioner may appoint people who are serving on or who have served on the council established under Laws 2019, First Special Session chapter 9, article 11, section 107, subdivision 3.

Sec. 29. **APPOINTMENT OF COMMISSIONER OF CHILDREN, YOUTH, AND FAMILIES.**

The governor shall appoint a commissioner-designee of the Department of Children, Youth, and Families. The person appointed becomes the governor's appointee as the commissioner of children, youth, and families on July 1, 2024.

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

Sec. 30. **DATA PRACTICES.**

(a) To the extent not prohibited by state or federal law, and notwithstanding the data's classification under Minnesota Statutes, chapter 13:

(1) the commissioner of children, youth, and families may access data maintained by the commissioners of education, health, human services, and public safety related to the responsibilities transferred under section 31; and

(2) the commissioners of education, health, human services, and public safety may access data maintained by the commissioner of children, youth, and families related to each department's respective responsibilities transferred under section 31.

(b) Data sharing authorized by this section includes only the data necessary to coordinate department activities and services transferred under section 31.

(c) Any data shared under this section retain their classification from the agency holding the data.

(d) Existing limitations and legal requirements under Minnesota Statutes, chapter 13, including but not limited to any applicable data subject consent requirements, apply to any data accessed, transferred, disseminated, or shared under this section.

(e) This section expires July 1, 2027.

Sec. 31. **TRANSFERS FROM OTHER AGENCIES.**

Subdivision 1. **General.** (a) Between July 1, 2024, and July 1, 2025, the Departments of Human Services, Education, Health, and Public Safety must transition all of the responsibilities held by these departments and described in this section to the Department of Children, Youth, and Families.

(b) Notwithstanding paragraph (a), any programs identified in paragraph (a) that require federal approval to move to the Department of Children, Youth, and Families must be transferred on or after July 1, 2024, and upon the federal government granting transfer authority to the commissioner of children, youth, and families.

(c) The commissioner of children, youth, and families must report an effective date of the transfer of each responsibility identified in this section to the commissioners of administration, management and budget, and other relevant departments along with the secretary of the senate, the chief clerk of the house of representatives, and the chairs and ranking minority members of relevant legislative committees and divisions. The reported

date is the effective date of transfer of responsibilities under Minnesota Statutes, section 15.039.

(d) The requirement in Minnesota Statutes, section 16B.37, subdivision 1, that a state agency must have been in existence for at least one year before being eligible for receiving a transfer of personnel, powers, or duties does not apply to the Department of Children, Youth, and Families.

(e) Notwithstanding Minnesota Statutes, section 15.039, subdivision 6, for the transfer of responsibilities conducted under this chapter, the unexpended balance of any appropriation to an agency for the purposes of any responsibilities that are transferred to the Department of Children, Youth, and Families, along with the operational functions to support the responsibilities transferred, including administrative, legal, information technology, and personnel support, and a proportional share of base funding, are reappropriated under the same conditions as the original appropriation to the Department of Children, Youth, and Families effective on the date of the transfer of responsibilities and related elements. The commissioner of management and budget shall identify and allocate any unexpended appropriations and base funding.

(f) The commissioner of children, youth, and families or management and budget may request an extension to transfer any responsibility listed in this section. The commissioner of children, youth, and families or management and budget may request that the transfer of any responsibility listed in this section be canceled if an effective date has not been reported under paragraph (c). Any request under this paragraph must be made in writing to the governor. Upon approval from the governor, the transfer may be delayed or canceled. Within ten days after receiving the approval of the governor, the commissioner who requested the transfer shall submit to the chairs and ranking minority members of relevant legislative committees and divisions a notice of any extensions or cancellations granted under this paragraph.

(g) The commissioner of children, youth, and families must provide four successive quarterly reports to relevant legislative committees on the status of transferring programs, responsibilities, and personnel under this section. The first report must cover the quarter starting July 1, 2024, and each report must be submitted by the 15th of the month following the quarter end.

Subd. 2. **Department of Human Services.** The powers and duties of the Department of Human Services with respect to the following responsibilities and related elements are

transferred to the Department of Children, Youth, and Families according to Minnesota Statutes, section 15.039:

(1) family services and community-based collaboratives under Minnesota Statutes, section 124D.23;

(2) child care programs under Minnesota Statutes, chapter 119B;

(3) the Parent Aware quality rating and improvement system under Minnesota Statutes, section 124D.142;

(4) migrant child care services under Minnesota Statutes, section 256M.50;

(5) early childhood and school-age professional development training under Laws 2007, chapter 147, article 2, section 56;

(6) licensure of family child care and child care centers, child foster care, and private child placing agencies under Minnesota Statutes, chapter 245A;

(7) certification of license-exempt child care centers under Minnesota Statutes, chapter 245H;

(8) program integrity and fraud related to the Child Care Assistance Program (CCAP), the Minnesota Family Investment Program (MFIP), and the Supplemental Nutrition Assistance Program (SNAP) under Minnesota Statutes, chapters 119B and 245E;

(9) SNAP under Minnesota Statutes, sections 256D.60 to 256D.63;

(10) electronic benefit transactions under Minnesota Statutes, sections 256.9862, 256.9863, 256.9865, 256.987, 256.9871, 256.9872, and 256J.77;

(11) Minnesota food assistance program under Minnesota Statutes, section 256D.64;

(12) Minnesota food shelf program under Minnesota Statutes, section 256E.34;

(13) MFIP and Temporary Assistance for Needy Families (TANF) under Minnesota Statutes, sections 256.9864 and 256.9865 and chapters 256J and 256P;

(14) Diversionary Work Program (DWP) under Minnesota Statutes, section 256J.95;

(15) resettlement programs under Minnesota Statutes, section 256B.06, subdivision 6;

(16) child abuse under Minnesota Statutes, chapter 256E;

(17) reporting of the maltreatment of minors under Minnesota Statutes, chapter 260E;

(18) children in voluntary foster care for treatment under Minnesota Statutes, chapter 260D;

(19) juvenile safety and placement under Minnesota Statutes, chapter 260C;

(20) the Minnesota Indian Family Preservation Act under Minnesota Statutes, sections 260.751 to 260.835;

(21) the Interstate Compact for Juveniles under Minnesota Statutes, section 260.515, and the Interstate Compact on the Placement of Children under Minnesota Statutes, sections 260.851 to 260.93;

(22) adoption under Minnesota Statutes, sections 259.20 to 259.89;

(23) Northstar Care for Children under Minnesota Statutes, chapter 256N;

(24) child support under Minnesota Statutes, chapters 13, 13B, 214, 256, 256J, 257, 259, 518, 518A, 518C, 551, 552, 571, and 588 and section 609.375;

(25) community action programs under Minnesota Statutes, sections 256E.30 to 256E.32; and

(26) Family Assets for Independence in Minnesota under Minnesota Statutes, section 256E.35.

Subd. 3. **Department of Education.** The powers and duties of the Department of Education with respect to the following responsibilities and related elements are transferred to the Department of Children, Youth, and Families according to Minnesota Statutes, section 15.039:

(1) Head Start Program and Early Head Start under Minnesota Statutes, sections 119A.50 to 119A.545;

(2) the early childhood screening program under Minnesota Statutes, sections 121A.16 to 121A.19;

(3) early learning scholarships under Minnesota Statutes, section 124D.165;

(4) the interagency early childhood intervention system under Minnesota Statutes, sections 125A.259 to 125A.48;

(5) voluntary prekindergarten programs and school readiness plus programs under Minnesota Statutes, section 124D.151;

(6) early childhood family education programs under Minnesota Statutes, sections 124D.13 to 124D.135;

(7) school readiness under Minnesota Statutes, sections 124D.15 to 124D.16; and

(8) after-school community learning programs under Minnesota Statutes, section 124D.2211.

Subd. 4. **Department of Public Safety.** The powers and duties of the Department of Public Safety with respect to the following responsibilities and related elements are transferred to the Department of Children, Youth, and Families according to Minnesota Statutes, section 15.039:

(1) the juvenile justice program under Minnesota Statutes, section 299A.72; and

(2) grants-in-aid to youth intervention programs under Minnesota Statutes, section 299A.73.

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

Sec. 32. **TRANSITION REPORT TO THE LEGISLATURE.**

By March 1, 2024, the commissioner of management and budget must report to the legislature on the status of work related to establishing and setting up the Department of Children, Youth, and Families. The report must address, at a minimum:

(1) the completed, ongoing, and anticipated work related to the transfer of programs, responsibilities, and personnel to the department;

(2) the development of interagency agreements for services that will be shared across agencies;

(3) a description of efforts to secure needed federal approvals for the transfer of programs and responsibilities;

(4) engagement with leaders and staff of state agencies; Tribal governments; local service providers, including but not limited to county agencies, Tribal organizations, and school districts; families; and relevant stakeholders about the creation of the department and the transfer of programs, responsibilities, and personnel to the department; and

(5) plans and timelines related to the items referenced in clauses (1) through (4).

Sec. 33. **REVISOR INSTRUCTION.**

The revisor of statutes must identify, in consultation with the commissioners of management and budget; human services; education; health; and public safety and with nonpartisan legislative offices, any changes to Minnesota Statutes and Minnesota Rules necessary to facilitate the transfer of responsibilities under this act, the authority to fulfill the responsibilities under this act, and the related operational functions needed to implement

the necessary legal changes and responsibilities under this act. By February 1, 2024, the revisor of statutes must submit to the chairs and ranking minority members of relevant legislative committees and divisions draft legislation with the statutory changes necessary to implement this act.

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

Sec. 34. **REPEALER.**

Minnesota Statutes 2022, section 119B.03, subdivision 4, is repealed.

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

ARTICLE 14
CHILD CARE WORKFORCE

Section 1. Minnesota Statutes 2022, section 119B.011, subdivision 19a, is amended to read:

Subd. 19a. **Registration.** "Registration" means the process used by ~~a county~~ the commissioner to determine whether the provider selected by a family applying for or receiving child care assistance to care for that family's children meets the requirements necessary for payment of child care assistance for care provided by that provider. The commissioner shall create a process for statewide registration by April 28, 2025.

EFFECTIVE DATE. This section is effective April 28, 2025.

Sec. 2. Minnesota Statutes 2022, section 119B.125, subdivision 1, is amended to read:

Subdivision 1. **Authorization.** ~~A county or~~ The commissioner must authorize the provider chosen by an applicant or a participant before the county can authorize payment for care provided by that provider. The commissioner must establish the requirements necessary for authorization of providers. A provider must be reauthorized every two years. ~~A legal, nonlicensed family child care provider also must be reauthorized when another person over the age of 13 joins the household, a current household member turns 13, or there is reason to believe that a household member has a factor that prevents authorization. The provider is required to report all family changes that would require reauthorization. When a provider has been authorized for payment for providing care for families in more than one county, the county responsible for reauthorization of that provider is the county of the family with a current authorization for that provider and who has used the provider for the longest length of time.~~

EFFECTIVE DATE. This section is effective April 28, 2025.

Sec. 3. Minnesota Statutes 2022, section 119B.125, subdivision 1a, is amended to read:

Subd. 1a. **Background study required.** (a) This subdivision only applies to legal, nonlicensed family child care providers.

(b) Prior to authorization, ~~and as part of each reauthorization required in subdivision 1, the county~~ the commissioner shall perform a background study on ~~every member of the provider's household who is age 13 and older. The county shall also perform a background study on an individual who has reached age ten but is not yet age 13 and is living in the household where the nonlicensed child care will be provided when the county has reasonable cause as defined under section 245C.02, subdivision 15~~ individuals identified under section 245C.02, subdivision 6a.

(c) After authorization, a background study shall also be performed when an individual identified under section 245C.02, subdivision 6a, joins the household. The provider must report all family changes that would require a new background study.

(d) At each reauthorization, the commissioner shall ensure that a background study through NETStudy 2.0 has been performed on all individuals in the provider's household for whom a background study is required under paragraphs (b) and (c).

(e) Prior to a background study through NETStudy 2.0 expiring, another background study shall be completed on all individuals for whom the background study is expiring.

EFFECTIVE DATE. This section is effective April 28, 2025.

Sec. 4. Minnesota Statutes 2022, section 119B.125, subdivision 1b, is amended to read:

Subd. 1b. **Training required.** (a) ~~Effective November 1, 2011,~~ Prior to initial authorization as required in subdivision 1, a legal nonlicensed family child care provider must complete first aid and CPR training and provide the verification of first aid and CPR training to the ~~county~~ commissioner. The training documentation must have valid effective dates as of the date the registration request is submitted to the ~~county~~ commissioner. The training must have been provided by an individual approved to provide first aid and CPR instruction and have included CPR techniques for infants and children.

~~(b) Legal nonlicensed family child care providers with an authorization effective before November 1, 2011, must be notified of the requirements before October 1, 2011, or at authorization, and must meet the requirements upon renewal of an authorization that occurs on or after January 1, 2012.~~

~~(c)~~ (b) Upon each reauthorization after the authorization period when the initial first aid and CPR training requirements are met, a legal nonlicensed family child care provider must provide verification of at least eight hours of additional training listed in the Minnesota Center for Professional Development Registry.

~~(d)~~ (c) This subdivision only applies to legal nonlicensed family child care providers.

EFFECTIVE DATE. This section is effective April 28, 2025.

Sec. 5. Minnesota Statutes 2022, section 119B.125, subdivision 2, is amended to read:

Subd. 2. **Persons who cannot be authorized.** (a) The provider seeking authorization under this section shall collect the information required under section 245C.05~~, subdivision 1,~~ and forward the information to the ~~county agency~~ commissioner. The background study must include a review of the information required under section 245C.08, ~~subdivisions 2,~~ subdivision 3~~, and 4, paragraph (b)~~.

(b) A legal nonlicensed family child care provider is not authorized under this section if:

(1) the commissioner determines that any household member who is the subject of a background study is ~~determined to have a disqualifying characteristic under paragraphs (b) to (e) or under section 245C.14 or 245C.15. If a county has determined that a provider is able to be authorized in that county, and a family in another county later selects that provider, the provider is able to be authorized in the second county without undergoing a new background investigation unless one of the following conditions exists:~~ disqualified from direct contact with, or from access to, persons served by the program and that disqualification has not been set aside or a variance has not been granted under chapter 245C;

~~(1) two years have passed since the first authorization;~~

~~(2) another person age 13 or older has joined the provider's household since the last authorization;~~

~~(3) a current household member has turned 13 since the last authorization; or~~

~~(4) there is reason to believe that a household member has a factor that prevents authorization.~~

~~(b)~~ (2) the person has refused to give written consent for disclosure of criminal history records~~.~~;

~~(c)~~ (3) the person has been denied a family child care license ~~or has received a fine or a sanction as a licensed child care provider that has not been reversed on appeal.~~;

~~(d)~~ (4) the person has a family child care licensing disqualification that has not been set aside~~.~~; or

~~(e)~~ (5) the person has admitted or a county has found that there is a preponderance of evidence that fraudulent information was given to the county for child care assistance application purposes or was used in submitting child care assistance bills for payment.

EFFECTIVE DATE. This section is effective April 28, 2025.

Sec. 6. Minnesota Statutes 2022, section 119B.125, subdivision 3, is amended to read:

Subd. 3. **Authorization exception.** When ~~a county~~ the commissioner denies a person authorization as a legal nonlicensed family child care provider under subdivision 2, the ~~county~~ commissioner later may authorize that person as a provider if the following conditions are met:

(1) after receiving notice of the denial of the authorization, the person applies for and obtains a valid child care license issued under chapter 245A, issued by a Tribe, or issued by another state;

(2) the person maintains the valid child care license; and

(3) the person is providing child care in the state of licensure or in the area under the jurisdiction of the licensing Tribe.

EFFECTIVE DATE. This section is effective April 28, 2025.

Sec. 7. Minnesota Statutes 2022, section 119B.125, subdivision 4, is amended to read:

Subd. 4. **Unsafe care.** ~~A county~~ The commissioner may deny authorization as a child care provider to any applicant or rescind authorization of any provider when ~~the~~ a county or commissioner knows or has reason to believe that the provider is unsafe or that the circumstances of the chosen child care arrangement are unsafe. The ~~county must include the conditions under which a provider or care arrangement will be determined to be unsafe in the county's child care fund plan under section 119B.08, subdivision 3~~ commissioner shall introduce statewide criteria for unsafe care by April 28, 2025.

EFFECTIVE DATE. This section is effective April 28, 2025.

Sec. 8. Minnesota Statutes 2022, section 119B.125, subdivision 6, is amended to read:

Subd. 6. **Record-keeping requirement.** (a) As a condition of payment, all providers receiving child care assistance payments must:

(1) keep accurate and legible daily attendance records at the site where services are delivered for children receiving child care assistance; and

(2) make those records available immediately to the county or the commissioner upon request. Any records not provided to a county or the commissioner at the date and time of the request are deemed inadmissible if offered as evidence by the provider in any proceeding to contest an overpayment or disqualification of the provider.

(b) As a condition of payment, attendance records must be completed daily and include the date, the first and last name of each child in attendance, and the times when each child is dropped off and picked up. To the extent possible, the times that the child was dropped off to and picked up from the child care provider must be entered by the person dropping off or picking up the child. The daily attendance records must be retained at the site where services are delivered for six years after the date of service.

(c) ~~A county or the commissioner may deny or revoke a provider's authorization to receive child care assistance payments under section 119B.13, subdivision 6, paragraph (d), pursue a fraud disqualification under section 256.98, take an action against the provider under chapter 245E, or establish an attendance record overpayment under paragraph (d) against a current or former provider,~~ When the county or the commissioner knows or has reason to believe that ~~the~~ a current or former provider has not complied with the record-keeping requirement in this subdivision~~.~~:

(1) the commissioner may:

(i) deny or revoke a provider's authorization to receive child care assistance payments under section 119B.13, subdivision 6, paragraph (d);

(ii) pursue an administrative disqualification under sections 256.046, subdivision 3, and 256.98; or

(iii) take an action against the provider under chapter 245E; or

(2) a county or the commissioner may establish an attendance record overpayment under paragraph (d).

(d) To calculate an attendance record overpayment under this subdivision, the commissioner or county agency shall subtract the maximum daily rate from the total amount paid to a provider for each day that a child's attendance record is missing, unavailable, incomplete, inaccurate, or otherwise inadequate.

(e) The commissioner shall develop criteria for a county to determine an attendance record overpayment under this subdivision.

EFFECTIVE DATE. This section is effective April 28, 2025.

Sec. 9. Minnesota Statutes 2022, section 119B.125, subdivision 7, is amended to read:

Subd. 7. **Failure to comply with attendance record requirements.** (a) In establishing an overpayment claim for failure to provide attendance records in compliance with subdivision 6, the county or commissioner is limited to the six years prior to the date the county or the commissioner requested the attendance records.

(b) The commissioner or county may periodically audit child care providers to determine compliance with subdivision 6.

(c) When the commissioner or county establishes an overpayment claim against a current or former provider, the commissioner or county must provide notice of the claim to the provider. A notice of overpayment claim must specify the reason for the overpayment, the authority for making the overpayment claim, the time period in which the overpayment occurred, the amount of the overpayment, and the provider's right to appeal.

(d) The commissioner or county shall seek to recoup or recover overpayments paid to a current or former provider.

(e) When a provider has been disqualified or convicted of fraud under section 256.98, theft under section 609.52, or a federal crime relating to theft of state funds or fraudulent billing for a program administered by the commissioner or a county, recoupment or recovery must be sought regardless of the amount of overpayment.

EFFECTIVE DATE. This section is effective April 28, 2025.

Sec. 10. Minnesota Statutes 2022, section 119B.13, subdivision 6, is amended to read:

Subd. 6. **Provider payments.** (a) A provider shall bill only for services documented according to section 119B.125, subdivision 6. The provider shall bill for services provided within ten days of the end of the service period. Payments under the child care fund shall be made within 21 days of receiving a complete bill from the provider. Counties or the state may establish policies that make payments on a more frequent basis.

(b) If a provider has received an authorization of care and been issued a billing form for an eligible family, the bill must be submitted within 60 days of the last date of service on the bill. A bill submitted more than 60 days after the last date of service must be paid if the county determines that the provider has shown good cause why the bill was not submitted within 60 days. Good cause must be defined in the county's child care fund plan under section 119B.08, subdivision 3, and the definition of good cause must include county error.

Any bill submitted more than a year after the last date of service on the bill must not be paid.

(c) If a provider provided care for a time period without receiving an authorization of care and a billing form for an eligible family, payment of child care assistance may only be made retroactively for a maximum of three months from the date the provider is issued an authorization of care and a billing form. For a family at application, if a provider provided child care during a time period without receiving an authorization of care and a billing form, a county may only make child care assistance payments to the provider retroactively from the date that child care began, or from the date that the family's eligibility began under section 119B.09, subdivision 7, or from the date that the family meets authorization requirements, not to exceed six months from the date that the provider is issued an authorization of care and a billing form, whichever is later.

(d) ~~A county or~~ The commissioner may refuse to issue a child care authorization to a certified, licensed, or legal nonlicensed provider, revoke an existing child care authorization to a certified, licensed, or legal nonlicensed provider, stop payment issued to a certified, licensed, or legal nonlicensed provider, or refuse to pay a bill submitted by a certified, licensed, or legal nonlicensed provider if:

(1) the provider admits to intentionally giving the county materially false information on the provider's billing forms;

(2) ~~a county or~~ the commissioner finds by a preponderance of the evidence that the provider intentionally gave the county materially false information on the provider's billing forms, or provided false attendance records to a county or the commissioner;

(3) the provider is in violation of child care assistance program rules, until the agency determines those violations have been corrected;

(4) the provider is operating after:

(i) an order of suspension of the provider's license issued by the commissioner;

(ii) an order of revocation of the provider's license issued by the commissioner; or

(iii) an order of decertification issued to the provider;

(5) the provider submits false attendance reports or refuses to provide documentation of the child's attendance upon request;

(6) the provider gives false child care price information; or

(7) the provider fails to report decreases in a child's attendance as required under section 119B.125, subdivision 9.

(e) For purposes of paragraph (d), clauses (3), (5), (6), and (7), ~~the county or~~ the commissioner may withhold the provider's authorization or payment for a period of time not to exceed three months beyond the time the condition has been corrected.

(f) A county's payment policies must be included in the county's child care plan under section 119B.08, subdivision 3. If payments are made by the state, in addition to being in compliance with this subdivision, the payments must be made in compliance with section 16A.124.

(g) If the commissioner ~~or responsible county agency~~ suspends or refuses payment to a provider under paragraph (d), clause (1) or (2), or chapter 245E and the provider has:

(1) a disqualification for wrongfully obtaining assistance under section 256.98, subdivision 8, paragraph (c);

(2) an administrative disqualification under section 256.046, subdivision 3; or

(3) a termination under section 245E.02, subdivision 4, paragraph (c), clause (4), or 245E.06;

then the provider forfeits the payment to the commissioner or the responsible county agency, regardless of the amount assessed in an overpayment, charged in a criminal complaint, or ordered as criminal restitution.

EFFECTIVE DATE. This section is effective April 28, 2025.

Sec. 11. Minnesota Statutes 2022, section 119B.16, subdivision 1c, is amended to read:

Subd. 1c. **Notice to providers.** (a) Before taking an action appealable under subdivision 1a, paragraph (b), a county agency or the commissioner must mail written notice to the provider against whom the action is being taken. Unless otherwise specified under this chapter, chapter 245E, or Minnesota Rules, chapter 3400, a county agency or the commissioner must mail the written notice at least 15 calendar days before the adverse action's effective date.

(b) The notice shall state (1) the factual basis for the county agency or department's determination, (2) the action the county agency or department intends to take, (3) the dollar amount of the monetary recovery or recoupment, if known, and (4) the provider's right to appeal the department's proposed action.

EFFECTIVE DATE. This section is effective April 28, 2025.

Sec. 12. Minnesota Statutes 2022, section 119B.16, subdivision 3, is amended to read:

Subd. 3. **Fair hearing stayed.** (a) If ~~a county agency or~~ the commissioner denies or revokes a provider's authorization based on a licensing action under section 245A.07, and the provider appeals, the provider's fair hearing must be stayed until the commissioner issues an order as required under section 245A.08, subdivision 5.

(b) If the commissioner denies or revokes a provider's authorization based on decertification under section 245H.07, and the provider appeals, the provider's fair hearing must be stayed until the commissioner issues a final order as required under section 245H.07.

EFFECTIVE DATE. This section is effective April 28, 2025.

Sec. 13. Minnesota Statutes 2022, section 119B.161, subdivision 2, is amended to read:

Subd. 2. **Notice.** (a) ~~A county agency or~~ The commissioner must mail written notice to a provider within five days of suspending payment or denying or revoking the provider's authorization under subdivision 1.

(b) The notice must:

(1) state the provision under which ~~a county agency or~~ the commissioner is denying, revoking, or suspending the provider's authorization or suspending payment to the provider;

(2) set forth the general allegations leading to the denial, revocation, or suspension of the provider's authorization. The notice need not disclose any specific information concerning an ongoing investigation;

(3) state that the denial, revocation, or suspension of the provider's authorization is for a temporary period and explain the circumstances under which the action expires; and

(4) inform the provider of the right to submit written evidence and argument for consideration by the commissioner.

(c) Notwithstanding Minnesota Rules, part 3400.0185, if ~~a county agency or~~ the commissioner suspends payment to a provider under chapter 245E or denies or revokes a provider's authorization under section 119B.13, subdivision 6, paragraph (d), clause (1) or (2), a county agency or the commissioner must send notice of service authorization closure to each affected family. The notice sent to an affected family is effective on the date the notice is created.

EFFECTIVE DATE. This section is effective April 28, 2025.

Sec. 14. Minnesota Statutes 2022, section 119B.161, subdivision 3, is amended to read:

Subd. 3. **Duration.** If a provider's payment is suspended under chapter 245E or a provider's authorization is denied or revoked under section 119B.13, subdivision 6, paragraph (d), clause (1) or (2), the provider's denial, revocation, temporary suspension, or payment suspension remains in effect until:

(1) the commissioner or a law enforcement authority determines that there is insufficient evidence warranting the action and ~~a county agency or~~ the commissioner does not pursue an additional administrative remedy under chapter 245E or section 256.98; or

(2) all criminal, civil, and administrative proceedings related to the provider's alleged misconduct conclude and any appeal rights are exhausted.

EFFECTIVE DATE. This section is effective April 28, 2025.

Sec. 15. Minnesota Statutes 2022, section 119B.19, subdivision 7, is amended to read:

Subd. 7. **Child care resource and referral programs.** Within each region, a child care resource and referral program must:

(1) maintain one database of all existing child care resources and services and one database of family referrals;

(2) provide a child care referral service for families;

(3) develop resources to meet the child care service needs of families;

(4) increase the capacity to provide culturally responsive child care services;

(5) coordinate professional development opportunities for child care and school-age care providers;

(6) administer and award child care services grants;

(7) cooperate with the Minnesota Child Care Resource and Referral Network and its member programs to develop effective child care services and child care resources; ~~and~~

(8) assist in fostering coordination, collaboration, and planning among child care programs and community programs such as school readiness, Head Start, early childhood family education, local interagency early intervention committees, early childhood screening, special education services, and other early childhood care and education services and programs that provide flexible, family-focused services to families with young children to the extent possible~~.~~;

(9) administer the child care one-stop regional assistance network to assist child care providers and individuals interested in becoming child care providers with establishing and sustaining a licensed family child care or group family child care program or a child care center; and

(10) provide supports that enable economically challenged individuals to obtain the jobs skills training, career counseling, and job placement assistance necessary to begin a career path in child care.

Sec. 16. **[119B.252] EARLY CHILDHOOD REGISTERED APPRENTICESHIP GRANT PROGRAM.**

Subdivision 1. **Establishment.** The commissioner of human services shall, in coordination with the commissioner of labor and industry, establish an apprenticeship grant program to provide employment-based training and mentoring opportunities for early childhood workers.

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

(b) "Apprentice" means an employee participating in an early childhood registered apprenticeship program.

(c) "Early childhood registered apprenticeship program" means an organization registered with the Department of Labor and Industry under chapter 178, registered with the Office of Apprenticeship within the United States Department of Labor, or registered with a recognized state apprenticeship agency under Code of Federal Regulations, title 29, parts 29 and 30, and who is:

(1) a licensed child care center under Minnesota Rules, chapter 9503;

(2) a licensed family and group family child care provider under Minnesota Rules, chapter 9502;

(3) a public prekindergarten program under section 124D.13, 124D.135, 124D.15 to 124D.16, 125A.01 to 125A.05, or 125A.26 to 125A.48, or Laws 2017, First Special Session chapter 5, article 8, section 9;

(4) a Head Start program under sections 119A.50 to 119A.54; or

(5) a certified, license-exempt child care center under chapter 245H.

(d) "Mentor" means an early childhood registered apprenticeship program journeyworker under section 178.011, subdivision 9, and who has a career lattice step of nine or higher.

Subd. 3. **Program components.** The organization holding the TEACH license with the Department of Human Services shall distribute the grant and must use the grant for:

(1) tuition scholarships for apprentices for courses leading to a higher education degree in early childhood;

(2) stipends for mentors; or

(3) stipends for early childhood registered apprenticeship programs.

Subd. 4. **Grants to apprentices.** An apprentice may receive a higher education scholarship of up to $10,000 for up to 24 months under this section, provided the apprentice:

(1) enrolls in an early childhood registered apprenticeship program;

(2) is a current participant in good standing in the TEACH scholarship program under section 119B.251;

(3) participates in monthly meetings with a mentor;

(4) works toward meeting early childhood competencies identified in Minnesota's Knowledge and Competency Framework for early childhood professionals, as observed by a mentor; and

(5) works toward the attainment of a higher education degree in early childhood.

Subd. 5. **Allowable uses.** Grant recipients may use grant money for personal expenses.

Subd. 6. **Stipends for mentors.** A mentor shall receive up to $4,000 for each apprentice mentored under this section, provided the mentor complies with the requirements in the apprenticeship program standard and completes eight weeks of mentor training and additional training on observation. The training must be free of charge to mentors.

Subd. 7. **Stipends for early childhood registered apprenticeship programs.** (a) An early childhood registered apprenticeship program shall receive up to $5,000 for the first apprentice and up to $2,500 for each additional apprentice employed under this section, provided the early childhood registered apprenticeship program complies with the requirements in the apprenticeship program standard and the following requirements:

(1) sponsor each apprentice's TEACH scholarship under section 119B.251; and

(2) provide each apprentice at least three hours a week of paid release time for coursework.

(b) An early childhood program may not host more than three apprentices at one site in a 12-month period.

Sec. 17. **[119B.27] CHILD CARE RETENTION PROGRAM.**

Subdivision 1. **Establishment.** A child care retention program is established to provide eligible child care programs with payments to improve access to child care in Minnesota and to strengthen the ability of child care programs to recruit and retain qualified early educators to work in child care programs. The child care retention program shall be administered by the commissioner of human services.

Subd. 2. **Eligible programs.** (a) The following programs are eligible to receive child care retention payments under this section:

(1) family and group family child care homes licensed under Minnesota Rules, chapter 9502;

(2) child care centers licensed under Minnesota Rules, chapter 9503;

(3) certified license-exempt child care centers under chapter 245H;

(4) Tribally licensed child care programs; and

(5) other programs as determined by the commissioner.

(b) To be eligible, programs must not be:

(1) the subject of a finding of fraud for which the program or individual is currently serving a penalty or exclusion;

(2) the subject of suspended, denied, or terminated payments to a provider under section 256.98, subdivision 1; 119B.13, subdivision 6, paragraph (d), clauses (1) and (2); or 245E.02, subdivision 4, paragraph (c), clause (4), regardless of whether the action is under appeal;

(3) prohibited from receiving public funds under section 245.095, regardless of whether the action is under appeal; or

(4) under license revocation, suspension, temporary immediate suspension, or decertification, regardless of whether the action is under appeal.

Subd. 3. **Requirements.** (a) As a condition of payment, all providers receiving retention payments under this section must:

(1) complete an application developed by the commissioner for each payment period for which the eligible program applies for funding;

(2) attest and agree in writing that the program was open and operating and served a minimum number of children, as determined by the commissioner, during the funding period, with the exceptions of:

(i) service disruptions that are necessary to protect the safety and health of children and child care programs based on public health guidance issued by the Centers for Disease Control and Prevention, the commissioner of health, the commissioner of human services, or a local public health agency; and

(ii) planned temporary closures for provider vacation and holidays during each payment period. The maximum allowed duration of vacations and holidays must be established by the commissioner; and

(3) submit data on child enrollment and attendance to the commissioner in the form and manner prescribed by the commissioner.

(b) Money received under this section must be expended by a provider no later than six months after the date the payment was received.

(c) Recipients must comply with all requirements listed in the application under this section. Methods for demonstrating that requirements have been met shall be determined by the commissioner.

(d) Recipients must keep accurate and legible records of the following at the site where services are delivered:

(1) use of money;

(2) attendance records. Daily attendance records must be completed every day and include the date, the first and last name of each child in attendance, and the times when each child is dropped off and picked up. To the extent possible, the times that the child was dropped off and picked up from the child care provider must be entered by the person dropping off or picking up the child; and

(3) staff employment, compensation, and benefits records. Employment, compensation, and benefits records must include time sheets or other records of daily hours worked; documentation of compensation and benefits; documentation of written changes to employees' rate or rates of pay and basis thereof as a result of retention payments, as required under section 181.032, paragraphs (d) to (f); and any other records required to be maintained under section 177.30.

(e) The requirement to document compensation and benefits only applies to family child care providers if retention payment money are used for employee compensation and benefits.

(f) All records must be retained at the site where services are delivered for six years after the date of receipt of payment and be made immediately available to the commissioner upon request. Any records not provided to the commissioner at the date and time of the request

are deemed inadmissible if offered as evidence by a provider in any proceeding to contest an overpayment or disqualification of the provider.

(g) Recipients that fail to meet the requirements under this section are subject to discontinuation of future installment payments, recovery of overpayments, and actions under chapter 245E. Except when based on a finding of fraud, actions to establish an overpayment must be made within six years of receipt of the payments. Once an overpayment is established, collection may continue until money has been repaid in full. The appeal process under section 119B.16 applies to actions taken for failure to meet the requirements of this section.

Subd. 4. **Providing payments.** (a) The commissioner shall provide retention payments under this section to all eligible programs on a noncompetitive basis.

(b) The commissioner shall award retention payments to all eligible programs. The payment amounts shall be based on the number of full-time equivalent staff who regularly care for children in the program, including any employees, sole proprietors, or independent contractors.

(c) One full-time equivalent is defined as an individual caring for children 32 hours per week. An individual can count as more or less than one full-time equivalent staff, but as no more than two full-time equivalent staff.

(d) The amount awarded per full-time equivalent individual caring for children for each payment type must be established by the commissioner.

(e) Payments must be increased by 25 percent for providers receiving payments through the child care assistance programs under section 119B.03 or 119B.05 or early learning scholarships under section 124D.165 or whose program is located in a child care access equity area. Child care access equity areas are areas with low access to child care, high poverty rates, high unemployment rates, low home ownership rates, and low median household incomes. The commissioner must develop a method for establishing child care access equity areas.

(f) The commissioner shall make payments to eligible programs under this section in the form, frequency, and manner established by the commissioner.

Subd. 5. **Eligible uses of money.** (a) Recipients that are child care centers licensed under Minnesota Rules, chapter 9503; certified license-exempt child care centers under chapter 245H; or Tribally licensed child care centers must use money provided under this section to pay for increases in compensation, benefits, premium pay, or additional federal taxes

assessed on the compensation of employees as a result of paying increased compensation or premium pay to all paid employees or independent contractors regularly caring for children. The increases in this paragraph must occur no less frequently than once per year.

(b) Recipients that are family and group family child care homes licensed under Minnesota Rules, chapter 9502, or are Tribally licensed family child care homes shall use money provided under this section for one or more of the following uses:

(1) paying personnel costs, such as payroll, salaries, or similar compensation; employee benefits; premium pay; or financial incentives for recruitment and retention for an employee, a sole proprietor, or an independent contractor;

(2) paying rent, including rent under a lease agreement, or making payments on any mortgage obligation, utilities, facility maintenance or improvements, property taxes, or insurance;

(3) purchasing or updating equipment, supplies, goods, or services;

(4) providing mental health supports for children; or

(5) purchasing training or other professional development.

Subd. 6. **Legal nonlicensed child care provider payments.** (a) Legal nonlicensed child care providers, as defined in section 119B.011, subdivision 16, may be eligible to apply for a payment of up to $500 for costs incurred before the first month when payments from the child care assistance program are issued.

(b) Payments must be used on one or more of the following eligible activities to meet child care assistance program requirements under sections 119B.03 and 119B.05:

(1) purchasing or updating equipment, supplies, goods, or services; or

(2) purchasing training or other professional development.

(c) The commissioner shall determine the form and manner of the application for a payment under this subdivision.

Subd. 7. **Carryforward authority.** Money appropriated under this section are available until expended.

Subd. 8. **Report.** By January 1 each year, the commissioner must report to the chairs and ranking minority members of the legislative committees with jurisdiction over child care the number of payments provided to recipients and outcomes of the retention payment program since the last report. This subdivision expires January 31, 2033.

Sec. 18. **[119B.28] SHARED SERVICES GRANTS.**

(a) The commissioner of human services shall establish a grant program to distribute money for the planning, establishment, expansion, improvement, or operation of shared services alliances to allow family child care providers to achieve economies of scale. The commissioner must develop a process to fund organizations to operate shared services alliances that includes application forms, timelines, and standards for renewal. For purposes of this section, "shared services alliances" means networks of licensed family child care providers that share services to reduce costs and achieve efficiencies.

(b) Programs eligible to be a part of the shared services alliances supported through this grant program include:

(1) family child care or group family child care homes licensed under Minnesota Rules, chapter 9502;

(2) Tribally licensed family child care or group family child care; and

(3) individuals in the process of starting a family child care or group family child care home.

(c) Eligible applicants include public entities and private for-profit and nonprofit organizations.

(d) Grantees shall use the grant money to deliver one or more of the following services:

(1) pooling the management of payroll and benefits, banking, janitorial services, food services, and other operations;

(2) shared administrative staff for tasks such as record keeping and reporting for programs such as the child care assistance program, Head Start, the child and adult care food program, and early learning scholarships;

(3) coordination of bulk purchasing;

(4) management of a substitute pool;

(5) support for implementing shared curriculum and assessments;

(6) mentoring child care provider participants to improve business practices;

(7) provision of and training in child care management software to simplify processes such as enrollment, billing, and tracking expenditures;

(8) support for a group of providers sharing one or more physical spaces within a larger building; or

(9) other services as determined by the commissioner.

(e) The commissioner must consult with the commissioner of management and budget on program outcomes, evaluation metrics, and progress indicators for the grant program under this section. The commissioner must only implement program outcomes, evaluation metrics, and progress indicators that are determined through and agreed upon during the consultation with the commissioner of management and budget. The commissioner shall not implement the grant program under this section until the consultation with the commissioner of management and budget is completed. The commissioner must incorporate agreed upon program outcomes, evaluation metrics, and progress indicators into grant applications, requests for proposals, and any reports to the legislature.

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

Sec. 19. **[119B.29] CHILD CARE PROVIDER ACCESS TO TECHNOLOGY GRANTS.**

(a) The commissioner of human services shall distribute money provided by this section through grants to one or more organizations to offer grants or other supports to child care providers for technology intended to improve the providers' business practices. The commissioner must develop a process to fund organizations to provide technology supports that includes application forms, timelines, reporting requirements, and standards for renewal.

(b) Programs eligible to be supported through this grant program include:

(1) child care centers licensed under Minnesota Rules, chapter 9503;

(2) family or group family child care homes licensed under Minnesota Rules, chapter 9502; and

(3) Tribally licensed centers, family child care, and group family child care.

(c) Eligible applicants include public entities and private for-profit and nonprofit organizations with the ability to develop technology products for child care business management or offer training, technical assistance, coaching, or other supports for child care providers to use technology products for child care business management.

(d) Grantees shall use the grant money, either directly or through grants to providers, for one or more of the following purposes:

(1) the purchase of computers or mobile devices for use in business management;

(2) access to the Internet through the provision of necessary hardware such as routers or modems or by covering the costs of monthly fees for Internet access;

(3) covering the costs of subscription to child care management software;

(4) covering the costs of training in the use of technology for business management purposes; and

(5) other services as determined by the commissioner.

Sec. 20. Minnesota Statutes 2022, section 256.046, subdivision 3, is amended to read:

Subd. 3. **Administrative disqualification of child care providers caring for children receiving child care assistance.** (a) The department ~~or local agency~~ shall pursue an administrative disqualification, if the child care provider is accused of committing an intentional program violation, in lieu of a criminal action when it has not been pursued. Intentional program violations include intentionally making false or misleading statements; intentionally misrepresenting, concealing, or withholding facts; and repeatedly and intentionally violating program regulations under chapters 119B and 245E. Intent may be proven by demonstrating a pattern of conduct that violates program rules under chapters 119B and 245E.

(b) To initiate an administrative disqualification, ~~a local agency or~~ the commissioner must mail written notice by certified mail to the provider against whom the action is being taken. Unless otherwise specified under chapter 119B or 245E or Minnesota Rules, chapter 3400, ~~a local agency or~~ the commissioner must mail the written notice at least 15 calendar days before the adverse action's effective date. The notice shall state (1) the factual basis for the agency's determination, (2) the action the agency intends to take, (3) the dollar amount of the monetary recovery or recoupment, if known, and (4) the provider's right to appeal the agency's proposed action.

(c) The provider may appeal an administrative disqualification by submitting a written request to the Department of Human Services, Appeals Division. A provider's request must be received by the Appeals Division no later than 30 days after the date ~~a local agency or~~ the commissioner mails the notice.

(d) The provider's appeal request must contain the following:

(1) each disputed item, the reason for the dispute, and, if applicable, an estimate of the dollar amount involved for each disputed item;

(2) the computation the provider believes to be correct, if applicable;

(3) the statute or rule relied on for each disputed item; and

(4) the name, address, and telephone number of the person at the provider's place of business with whom contact may be made regarding the appeal.

(e) On appeal, the issuing agency bears the burden of proof to demonstrate by a preponderance of the evidence that the provider committed an intentional program violation.

(f) The hearing is subject to the requirements of sections 256.045 and 256.0451. The human services judge may combine a fair hearing and administrative disqualification hearing into a single hearing if the factual issues arise out of the same or related circumstances and the provider receives prior notice that the hearings will be combined.

(g) A provider found to have committed an intentional program violation and is administratively disqualified shall be disqualified, for a period of three years for the first offense and permanently for any subsequent offense, from receiving any payments from any child care program under chapter 119B.

(h) Unless a timely and proper appeal made under this section is received by the department, the administrative determination of the department is final and binding.

EFFECTIVE DATE. This section is effective April 28, 2025.

Sec. 21. Minnesota Statutes 2022, section 256.983, subdivision 5, is amended to read:

Subd. 5. **Child care providers; financial misconduct.** (a) A county or Tribal agency may conduct investigations of financial misconduct by child care providers as described in chapter 245E. Prior to opening an investigation, a county or Tribal agency must contact the commissioner to determine whether an investigation under this chapter may compromise an ongoing investigation.

(b) If, upon investigation, a preponderance of evidence shows a provider committed an intentional program violation, intentionally gave the county or Tribe materially false information on the provider's billing forms, provided false attendance records to a county, Tribe, or the commissioner, or committed financial misconduct as described in section 245E.01, subdivision 8, the county or Tribal agency may recommend that the commissioner suspend a provider's payment pursuant to chapter 245E, or deny or revoke a provider's authorization pursuant to section 119B.13, subdivision 6, paragraph (d), clause (2), prior to pursuing other available remedies. ~~The county or tribe must send notice in accordance with the requirements of section 119B.161, subdivision 2. If a provider's payment is suspended under this section, the payment suspension shall remain in effect until: (1) the commissioner, county, tribe, or a law enforcement authority determines that there is insufficient evidence warranting the action and a county, tribe, or the commissioner does not pursue an additional~~

~~administrative remedy under chapter 119B or 245E, or section 256.046 or 256.98; or (2) all criminal, civil, and administrative proceedings related to the provider's alleged misconduct conclude and any appeal rights are exhausted.~~

~~(c) For the purposes of this section, an intentional program violation includes intentionally making false or misleading statements; intentionally misrepresenting, concealing, or withholding facts; and repeatedly and intentionally violating program regulations under chapters 119B and 245E.~~

~~(d) A provider has the right to administrative review under section 119B.161 if: (1) payment is suspended under chapter 245E; or (2) the provider's authorization was denied or revoked under section 119B.13, subdivision 6, paragraph (d), clause (2).~~

EFFECTIVE DATE. This section is effective April 28, 2025.

Sec. 22. **DIRECTION TO COMMISSIONER; CHILD CARE AND EARLY EDUCATION PROFESSIONAL WAGE SCALE.**

(a) The commissioner of human services shall develop, in consultation with the commissioner of employment and economic development, the commissioner of education, the Children's Cabinet, and relevant stakeholders, a child care and early education professional wage scale that:

(1) provides recommended wages that are equivalent to elementary school educators with similar credentials and experience;

(2) provides recommended levels of compensation and benefits, such as professional development stipends, health care benefits, and retirement benefits, that vary based on child care and early education professional roles and qualifications, and other criteria established by the commissioner; and

(3) is applicable to the following types of child care and early education programs:

(i) licensed family and group family child care under Minnesota Rules, chapter 9502;

(ii) licensed child care centers under Minnesota Rules, chapter 9503;

(iii) certified, license-exempt child care centers under Minnesota Statutes, chapter 245H;

(iv) voluntary prekindergarten and school readiness plus programs;

(v) school readiness programs;

(vi) early childhood family education programs;

(vii) programs for children who are eligible for Part B or Part C of the Individuals with Disabilities Education Act (Public Law 108-446); and

(viii) Head Start programs.

(b) By January 30, 2025, the commissioner must submit a report to the legislative committees with jurisdiction over early childhood programs on the development of the wage scale and make recommendations for how the wage scale could be used to inform payment rates for child care assistance under Minnesota Statutes, chapter 119B, and great start scholarships under Minnesota Statutes, section 119C.01.

Sec. 23. **DIRECTION TO COMMISSIONER; TRANSITION CHILD CARE STABILIZATION GRANTS.**

(a) The commissioner of human services must continue providing child care stabilization grants under Laws 2021, First Special Session chapter 7, article 14, section 21, from July 1, 2023, through no later than December 31, 2023.

(b) The commissioner shall award transition child care stabilization grant amounts to all eligible programs. The transition month grant amounts must be based on the number of full-time equivalent staff who regularly care for children in the program, including employees, sole proprietors, or independent contractors. One full-time equivalent staff is defined as an individual caring for children 32 hours per week. An individual can count as more, or less, than one full-time equivalent staff, but as no more than two full-time equivalent staff.

Sec. 24. **RECOGNIZING COMPARABLE COMPETENCIES TO ACHIEVE COMPARABLE COMPENSATION TASK FORCE.**

Subdivision 1. **Establishment.** The Recognizing Comparable Competencies to Achieve Comparable Compensation Task Force is established to develop methods for incorporating competencies and experiences, as well as educational attainment, into a compensation model for the early childhood workforce.

Subd. 2. **Membership.** (a) The task force shall consist of the following members, appointed by the governor:

(1) two individuals who are directors of a licensed child care center, one from greater Minnesota and one from the seven-county metropolitan area;

(2) two individuals who are license holders of family child care programs, one from greater Minnesota and one from the seven-county metropolitan area;

(3) four individuals who are early childhood educators, one who works in a licensed child care center, one who works in a public-school-based early childhood program, one who works in a Head Start program or a community education program, and one who works in a licensed family child care setting;

(4) one representative of a federally recognized Tribe who has expertise in the early care and education system;

(5) one representative from the Children's Cabinet;

(6) two parents of children under five years of age, one parent whose child attends a private early care and education program and one parent whose child attends a public program. One parent under this clause must be from greater Minnesota, and the other parent must be from the seven-county metropolitan area; and

(7) four individuals who have expertise in early childhood workforce issues.

(b) The governor must select a chair or cochairs for the task force from among the members. The first task force meeting must be convened by the chair or cochairs and held no later than September 1, 2023. Thereafter, the chair or cochairs shall convene the task force at least monthly and may convene other meetings as necessary. The chair or cochairs shall convene meetings in a manner to allow for access from diverse geographic locations in Minnesota.

(c) Compensation of task force members, filling of task force vacancies, and removal of task force members are governed by Minnesota Statutes, section 15.059.

Subd. 3. **Duties.** (a) The task force must develop a compensation framework for the early childhood workforce that incorporates competencies and experiences, as well as educational attainment.

(b) In developing the compensation framework required under this subdivision, the task force must:

(1) identify competencies and experiences to incorporate into the framework, including but not limited to multilingualism and previous work experience in a direct care setting; and

(2) propose mechanisms for including the compensation framework in the state's early childhood programs and services.

Subd. 4. **Administration.** (a) The commissioner of management and budget shall provide staff and administrative services for the task force.

(b) The task force expires upon submission of the final report required under subdivision 5.

(c) The task force is subject to Minnesota Statutes, chapter 13D.

Subd. 5. **Required reports.** By December 1, 2024, the task force must submit its preliminary findings to the governor and the chairs and ranking minority members of the legislative committees with jurisdiction over early childhood programs. By January 15, 2025, the task force must submit the compensation framework and proposed mechanisms for incorporating the framework into the state's early childhood programs and services to the governor and the chairs and ranking minority members of the legislative committees with jurisdiction over early childhood programs.

ARTICLE 15
CHILD SUPPORT, SAFETY, AND PERMANENCY

Section 1. **[245.0962] QUALITY PARENTING INITIATIVE GRANT PROGRAM.**

Subdivision 1. **Establishment.** The commissioner of human services must establish a quality parenting initiative grant program to implement quality parenting initiative principles and practices to support children and families experiencing foster care placements.

Subd. 2. **Eligible applicants.** To be eligible for a grant under this section, applicants must be a nonprofit organization or a nongovernmental organization and must have experience providing training and technical assistance on how to implement quality parenting initiative principles and practices.

Subd. 3. **Application.** An organization seeking a grant under this section must apply to the commissioner in the time and manner specified by the commissioner.

Subd. 4. **Grant activities.** Grant money must be used to provide training and technical assistance to county and Tribal agencies, community-based agencies, and other stakeholders on:

(1) conducting initial foster care telephone calls under section 260C.219, subdivision 6;

(2) supporting practices that create birth family to foster family partnerships; and

(3) informing child welfare practices by supporting youth leadership and the participation of individuals with experience in the foster care system.

Sec. 2. Minnesota Statutes 2022, section 256N.26, subdivision 12, is amended to read:

Subd. 12. **Treatment of Supplemental Security Income.** ~~If a child placed in foster care receives benefits through Supplemental Security Income (SSI) at the time of foster care placement or subsequent to placement in foster care, the financially responsible agency may apply to be the payee for the child for the duration of the child's placement in foster care.~~ If a child continues to be eligible for ~~SSI~~ Supplemental Security Income benefits after finalization of the adoption or transfer of permanent legal and physical custody and is determined to be eligible for a payment under Northstar Care for Children, a permanent caregiver may choose to receive payment from both programs simultaneously. The permanent caregiver is responsible to report the amount of the payment to the Social Security Administration and the ~~SSI~~ Supplemental Security Income payment will be reduced as required by the Social Security Administration.

Sec. 3. **[256N.262] FOSTER CHILDREN BENEFITS TRUST.**

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

(b) "Beneficiary" means a current or former child in foster care who is or was entitled to cash benefits.

(c) "Cash benefits" means all sources of income a child in foster care is entitled to, including death benefits; survivor benefits; crime victim impact payments; federal cash benefits from programs administered by the Social Security Administration, including from the Supplemental Security Income and the Retirement, Survivors, Disability Insurance programs; and any other eligible income as determined by the Office of the Foster Youth Ombudsperson.

Subd. 2. **Establishment.** (a) The foster children benefits trust is established. The trust must be funded by appropriations to the Office of the Foster Youth Ombudsperson to compensate beneficiaries for cash benefits taken by a financially responsible agency to pay for the beneficiaries' care. The trust must be managed to ensure the stability and growth of the trust.

(b) All assets of the trust are held in trust for the exclusive benefit of beneficiaries. Assets must be held in a separate account in the state treasury to be known as the foster children benefits trust account or in accounts with the third-party provider selected pursuant to subdivision 9.

Subd. 3. **Requirements of financially responsible agencies.** (a) A financially responsible agency must assess whether each child the agency is responsible for is eligible to receive any cash benefits as soon as the custody of the child is transferred to a child placing agency or responsible social services agency pursuant to section 260C.201, subdivision 1, or custody of the child is otherwise transferred to the state.

(b) If a child placed in foster care is eligible to receive cash benefits, the financially responsible agency must:

(1) apply to be the payee for the child for the duration of the child's placement in foster care;

(2) at least monthly, transfer all cash benefits received on behalf of a beneficiary to the Office of the Foster Youth Ombudsperson to be deposited in the trust;

(3) at least annually, notify the Office of the Foster Youth Ombudsperson of all cash benefits received for each beneficiary along with documentation identifying the beneficiary and amounts received for the child;

(4) notify each beneficiary 18 years of age or older that the beneficiary may be entitled to disbursements pursuant to the foster children benefits trust and inform the child how to contact the Office of the Foster Youth Ombudsperson about the trust; and

(5) retain all documentation related to cash benefits received for a beneficiary for at least five years after the agency is no longer the beneficiary's financially responsible agency.

(c) The financially responsible agency is liable to a beneficiary for any benefit payment that the agency receives as payee for a beneficiary that is not included in the documentation sent to the Office of the Foster Youth Ombudsperson as required by this subdivision.

Subd. 4. **Deposits.** The Office of the Foster Youth Ombudsperson must deposit an amount equal to the cash benefits received by a financially responsible agency in a separate account for each beneficiary.

Subd. 5. **Ombudsperson's duties.** (a) The Office of the Foster Youth Ombudsperson must keep a record of the amounts deposited pursuant to subdivision 4 and all disbursements for each beneficiary's account.

(b) Annually, the Office of the Foster Youth Ombudsperson must determine the annual interest earnings of the trust, which include realized capital gains and losses.

(c) The Office of the Foster Youth Ombudsperson must apportion any annual capital gains earnings to the separate beneficiaries' accounts. The rate to be used in this

apportionment, computed to the last full quarter percent, must be determined by dividing the capital gains earnings by the total invested assets of the trust.

(d) For each beneficiary between the ages of 14 and 18, the Office of the Foster Youth Ombudsperson must notify the beneficiary of the amount of cash benefits received on the beneficiary's behalf in the prior calendar year and the tax implications of those benefits by February 1 of each year.

(e) Account owner data, account data, and data on beneficiaries of accounts are private data on individuals or nonpublic data as defined in section 13.02.

Subd. 6. **Account protections.** (a) Trust assets are not subject to claims by creditors of the state, are not part of the general fund, and are not subject to appropriation by the state.

(b) Trust assets may not be used as collateral, as a part of a structured settlement, or in any way contracted to be paid to anyone who is not the beneficiary.

(c) Trust assets are not subject to seizure or garnishment as assets or income of the beneficiary.

Subd. 7. **Reports.** (a) By December 1, 2024, the Office of the Foster Youth Ombudsperson must submit a report to the legislative committees with jurisdiction over human services on the potential tax and state and federal benefit impacts of the trust and disbursements on beneficiaries and include recommendations on how best to minimize any increased tax burden or benefit reduction due to the trust.

(b) By December 1 of each year, the Office of the Foster Youth Ombudsperson must submit a report to the legislative committees with jurisdiction over foster youth on the cost of depositing into the trust pursuant to subdivision 4 and a projection for future costs.

Subd. 8. **Disbursements.** (a) Once a beneficiary has reached 18 years of age, the Office of the Foster Youth Ombudsperson must disburse $700 each month to the beneficiary until the beneficiary's account is depleted. If the total amount remaining in a beneficiary's account is less than $700, the Office of the Foster Youth Ombudsperson must disburse that total amount remaining to the beneficiary.

(b) With each disbursement, the Office of the Foster Youth Ombudsperson must include information about the potential tax and benefits consequences of the disbursement.

(c) On petition of a minor beneficiary who is 14 years of age or older, a court may order the Office of the Foster Youth Ombudsperson to deliver or pay to the beneficiary or expend for the beneficiary's benefit the amount of the beneficiary's trust account as the court considers advisable for the use and benefit of the beneficiary.

Subd. 9. **Administration.** The Office of the Foster Youth Ombudsperson must administer the program pursuant to this section. The Office of the Foster Youth Ombudsperson may contract with one or more third parties to carry out some or all of these administrative duties, including managing the assets of the trust and ensuring that records are maintained.

Subd. 10. **Repayment program.** (a) No later than January 1, 2025, the Office of the Foster Youth Ombudsperson must identify every person for whom a financially responsible agency received cash benefits as the person's representative payee between August 1, 2018, and July 31, 2023, and the amount of money diverted to the financially responsible agency during that time. The Office of the Foster Youth Ombudsperson must attempt to notify every individual identified in this paragraph of the individual's potential eligibility for repayment pursuant to this subdivision no later than July 1, 2025.

(b) No later than January 1, 2026, the Office of the Foster Youth Ombudsperson must begin accepting applications for individuals described in paragraph (a) to receive compensation for cash benefits diverted to the individual's financially responsible agency between August 1, 2018, and July 31, 2023. The Office of the Foster Youth Ombudsperson must develop a system to process the applications and approve all applications that can show that the applicant had cash benefits diverted to a financially responsible agency between August 1, 2018, and July 31, 2023.

(c) For every beneficiary already enrolled in the foster youth benefits trust that the Office of the Foster Youth Ombudsperson determines had cash benefits diverted to a financially responsible agency between August 1, 2018, and July 31, 2023, the Office of the Foster Youth Ombudsperson must deposit an amount equal to the cash benefits diverted to a financially responsible agency between August 1, 2018, and July 31, 2023, into the beneficiary's trust account. The Office of the Foster Youth Ombudsperson must screen beneficiaries for eligibility under this paragraph automatically without requiring an application from the beneficiaries.

(d) For every applicant under paragraph (b) who is not already enrolled in the foster youth benefits trust, the Office of the Foster Youth Ombudsperson must directly award the applicant an amount equal to the cash benefits diverted to a financially responsible agency between August 1, 2018, and July 31, 2023.

(e) No later than January 31, 2025, the Office of the Foster Youth Ombudsperson must issue a report to the chairs and ranking minority members of the legislative committees with jurisdiction over foster youth. The report must include:

(1) the number of persons identified for whom a financially responsible agency received cash benefits as the person's representative payee between August 1, 2018, and July 31, 2023; and

(2) the Office of the Foster Youth Ombudsperson's plan for notifying eligible persons described in paragraph (a).

Subd. 11. **Rulemaking authority.** The Office of the Foster Youth Ombudsperson is authorized, subject to the provisions of chapter 14, to make rules necessary to the operation of the foster youth benefits trust and repayment program and to aid in performing its administrative duties and ensuring an equitable result for beneficiaries and former foster youths.

Sec. 4. **[260.014] FAMILY FIRST PREVENTION AND EARLY INTERVENTION ALLOCATION PROGRAM.**

Subdivision 1. **Authorization.** The commissioner shall establish a program that allocates money to counties and federally recognized Tribes in Minnesota to provide prevention and early intervention services.

Subd. 2. **Uses.** (a) Money allocated to counties and Tribes may be used for the following purposes:

(1) to implement or expand any Family First Prevention Services Act service or program that is included in the state's prevention plan;

(2) to implement or expand any proposed Family First Prevention Services Act service or program;

(3) to implement or expand any existing Family First Prevention Services Act service or programming; and

(4) any other use approved by the commissioner.

A county or a Tribe must use at least ten percent of the allocation to provide services and supports directly to families.

Subd. 3. **Payments.** (a) The commissioner shall allocate state money appropriated under this section to each county board or Tribe on a calendar-year basis using a formula established by the commissioner.

(b) Notwithstanding this subdivision, to the extent that money is available, no county or Tribe shall be allocated less than:

(1) $25,000 in calendar year 2024;

(2) $50,000 in calendar year 2025; and

(3) $75,000 in calendar year 2026 and each year thereafter.

(c) A county agency or an initiative Tribe must submit a plan and report the use of money as determined by the commissioner.

(d) The commissioner may distribute money under this section for a two-year period.

Subd. 4. **Prohibition on supplanting existing money.** Money received under this section must be used to address prevention and early intervention staffing, programming, and other activities as determined by the commissioner. Money must not be used to supplant current county or Tribal expenditures for these purposes.

Sec. 5. Minnesota Statutes 2022, section 260.761, subdivision 2, is amended to read:

Subd. 2. **Agency and court notice to Tribes.** (a) When a local social services agency has information that a family assessment ~~or~~, investigation, or noncaregiver sex trafficking assessment being conducted may involve an Indian child, the local social services agency shall notify the Indian child's Tribe of the family assessment ~~or~~, investigation, or noncaregiver sex trafficking assessment according to section 260E.18. The local social services agency shall provide initial notice ~~shall be provided~~ by telephone and by email or facsimile. The local social services agency shall request that the Tribe or a designated Tribal representative participate in evaluating the family circumstances, identifying family and Tribal community resources, and developing case plans.

(b) When a local social services agency has information that a child receiving services may be an Indian child, the local social services agency shall notify the Tribe by telephone and by email or facsimile of the child's full name and date of birth, the full names and dates of birth of the child's biological parents, and, if known, the full names and dates of birth of the child's grandparents and of the child's Indian custodian. This notification must be provided ~~so~~ for the Tribe ~~can~~ to determine if the child is enrolled in the Tribe or eligible for Tribal membership, and ~~must be provided~~ the agency must provide this notification to the Tribe within seven days of receiving information that the child may be an Indian child. If information regarding the child's grandparents or Indian custodian is not available within the seven-day period, the local social services agency shall continue to request this information and shall notify the Tribe when it is received. Notice shall be provided to all Tribes to which the child may have any Tribal lineage. If the identity or location of the child's parent or Indian custodian and Tribe cannot be determined, the local social services

agency shall provide the notice required in this paragraph to the United States secretary of the interior.

(c) In accordance with sections 260C.151 and 260C.152, when a court has reason to believe that a child placed in emergency protective care is an Indian child, the court administrator or a designee shall, as soon as possible and before a hearing takes place, notify the Tribal social services agency by telephone and by email or facsimile of the date, time, and location of the emergency protective case hearing. The court shall make efforts to allow appearances by telephone for Tribal representatives, parents, and Indian custodians.

(d) A local social services agency must provide the notices required under this subdivision at the earliest possible time to facilitate involvement of the Indian child's Tribe. Nothing in this subdivision is intended to hinder the ability of the local social services agency and the court to respond to an emergency situation. Lack of participation by a Tribe shall not prevent the Tribe from intervening in services and proceedings at a later date. A Tribe may participate in a case at any time. At any stage of the local social services agency's involvement with an Indian child, the agency shall provide full cooperation to the Tribal social services agency, including disclosure of all data concerning the Indian child. Nothing in this subdivision relieves the local social services agency of satisfying the notice requirements in the Indian Child Welfare Act.

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

Sec. 6. **[260.786] CHILD WELFARE STAFF ALLOCATION FOR TRIBES.**

Subdivision 1. **Allocations.** The commissioner shall allocate $80,000 annually to each of Minnesota's federally recognized Tribes that, at the beginning of the fiscal year, have not joined the American Indian Child welfare initiative under section 256.01, subdivision 14b. Tribes not participating in or planning to join the initiative as of July 1, 2023, are: Bois Fort Band of Chippewa, Fond du Lac Band of Lake Superior Chippewa, Grand Portage Band of Lake Superior Chippewa, Lower Sioux Indian Community, Prairie Island Indian Community, and Upper Sioux Indian Community.

Subd. 2. **Purposes.** Money must be used to address staffing for responding to notices under the Indian Child Welfare Act under United States Code, title 25, sections 1901 to 1963 and 260.751 to 260.835, to the extent necessary, or providing other child protection and child welfare services. Money must not be used to supplant current Tribal expenditures for these purposes.

Subd. 3. **Reporting.** By June 1 each year, Tribes receiving this money shall provide a report to the commissioner. The report shall be written in a manner prescribed by the commissioner and must include an accounting of money spent, staff hired, job duties, and other information as required by the commissioner.

Subd. 4. **Redistribution of money.** If a Tribe joins the American Indian child welfare initiative, the payment for that Tribe shall be distributed equally among the remaining Tribes receiving an allocation under this section.

Sec. 7. Minnesota Statutes 2022, section 260C.007, subdivision 6, is amended to read:

Subd. 6. **Child in need of protection or services.** "Child in need of protection or services" means a child who is in need of protection or services because the child:

(1) is abandoned or without parent, guardian, or custodian;

(2)(i) has been a victim of physical or sexual abuse as defined in section 260E.03, subdivision 18 or 20, (ii) resides with or has resided with a victim of child abuse as defined in subdivision 5 or domestic child abuse as defined in subdivision 13, (iii) resides with or would reside with a perpetrator of domestic child abuse as defined in subdivision 13 or child abuse as defined in subdivision 5 or 13, or (iv) is a victim of emotional maltreatment as defined in subdivision 15;

(3) is without necessary food, clothing, shelter, education, or other required care for the child's physical or mental health or morals because the child's parent, guardian, or custodian is unable or unwilling to provide that care;

(4) is without the special care made necessary by a physical, mental, or emotional condition because the child's parent, guardian, or custodian is unable or unwilling to provide that care. Parents of children reported to be in an emergency department or hospital setting due to mental health or a disability who cannot be safely discharged to their family and are unable to access necessary services must not be viewed as unable or unwilling to provide care unless there are other factors present;

(5) is medically neglected, which includes, but is not limited to, the withholding of medically indicated treatment from an infant with a disability with a life-threatening condition. The term "withholding of medically indicated treatment" means the failure to respond to the infant's life-threatening conditions by providing treatment, including appropriate nutrition, hydration, and medication which, in the treating physician's, advanced practice registered nurse's, or physician assistant's reasonable medical judgment, will be most likely to be effective in ameliorating or correcting all conditions, except that the term

does not include the failure to provide treatment other than appropriate nutrition, hydration, or medication to an infant when, in the treating physician's, advanced practice registered nurse's, or physician assistant's reasonable medical judgment:

(i) the infant is chronically and irreversibly comatose;

(ii) the provision of the treatment would merely prolong dying, not be effective in ameliorating or correcting all of the infant's life-threatening conditions, or otherwise be futile in terms of the survival of the infant; or

(iii) the provision of the treatment would be virtually futile in terms of the survival of the infant and the treatment itself under the circumstances would be inhumane;

(6) is one whose parent, guardian, or other custodian for good cause desires to be relieved of the child's care and custody, including a child who entered foster care under a voluntary placement agreement between the parent and the responsible social services agency under section 260C.227;

(7) has been placed for adoption or care in violation of law;

(8) is without proper parental care because of the emotional, mental, or physical disability, or state of immaturity of the child's parent, guardian, or other custodian;

(9) is one whose behavior, condition, or environment is such as to be injurious or dangerous to the child or others. An injurious or dangerous environment may include, but is not limited to, the exposure of a child to criminal activity in the child's home;

(10) is experiencing growth delays, which may be referred to as failure to thrive, that have been diagnosed by a physician and are due to parental neglect;

(11) is a sexually exploited youth;

(12) has committed a delinquent act or a juvenile petty offense before becoming ten years old;

(13) is a runaway;

(14) is a habitual truant;

(15) has been found incompetent to proceed or has been found not guilty by reason of mental illness or mental deficiency in connection with a delinquency proceeding, a certification under section 260B.125, an extended jurisdiction juvenile prosecution, or a proceeding involving a juvenile petty offense; or

(16) has a parent whose parental rights to one or more other children were involuntarily terminated or whose custodial rights to another child have been involuntarily transferred to a relative and there is a case plan prepared by the responsible social services agency documenting a compelling reason why filing the termination of parental rights petition under section 260C.503, subdivision 2, is not in the best interests of the child.

Sec. 8. Minnesota Statutes 2022, section 260C.007, subdivision 14, is amended to read:

Subd. 14. **Egregious harm.** "Egregious harm" means the infliction of bodily harm to a child or neglect of a child which demonstrates a grossly inadequate ability to provide minimally adequate parental care. The egregious harm need not have occurred in the state or in the county where a termination of parental rights action ~~is otherwise properly venued~~ has proper venue. Egregious harm includes, but is not limited to:

(1) conduct ~~towards~~ toward a child that constitutes a violation of sections 609.185 to 609.2114, 609.222, subdivision 2, 609.223, or any other similar law of any other state;

(2) the infliction of "substantial bodily harm" to a child, as defined in section 609.02, subdivision 7a;

(3) conduct ~~towards~~ toward a child that constitutes felony malicious punishment of a child under section 609.377;

(4) conduct ~~towards~~ toward a child that constitutes felony unreasonable restraint of a child under section 609.255, subdivision 3;

(5) conduct ~~towards~~ toward a child that constitutes felony neglect or endangerment of a child under section 609.378;

(6) conduct ~~towards~~ toward a child that constitutes assault under section 609.221, 609.222, or 609.223;

(7) conduct ~~towards~~ toward a child that constitutes sex trafficking, solicitation, inducement, ~~or~~ promotion of, or receiving profit derived from prostitution under section 609.322;

(8) conduct ~~towards~~ toward a child that constitutes murder or voluntary manslaughter as defined by United States Code, title 18, section 1111(a) or 1112(a);

(9) conduct ~~towards~~ toward a child that constitutes aiding or abetting, attempting, conspiring, or soliciting to commit a murder or voluntary manslaughter that constitutes a violation of United States Code, title 18, section 1111(a) or 1112(a); or

(10) conduct toward a child that constitutes criminal sexual conduct under sections 609.342 to 609.345 or sexual extortion under section 609.3458.

Sec. 9. Minnesota Statutes 2022, section 260C.80, subdivision 1, is amended to read:

Subdivision 1. **Office of the Foster Youth Ombudsperson.** The Office of the Foster Youth Ombudsperson is hereby created. The ombudsperson ~~serves at the pleasure of the governor in the unclassified service,~~ must be selected without regard to political affiliation, and must be a person highly competent and qualified to work to improve the lives of youth in the foster care system, while understanding the administration and public policy related to youth in the foster care system. The ombudsperson may be removed only for just cause. No person may serve as the foster youth ombudsperson while holding any other public office. The foster youth ombudsperson is accountable to the governor and may investigate decisions, acts, and other matters related to the health, safety, and welfare of youth in foster care to promote the highest attainable standards of competence, efficiency, and justice for youth who are in the care of the state.

Sec. 10. Minnesota Statutes 2022, section 260E.01, is amended to read:

260E.01 POLICY.

(a) The legislature hereby declares that the public policy of this state is to protect children whose health or welfare may be jeopardized through maltreatment. While it is recognized that most parents want to keep their children safe, sometimes circumstances or conditions interfere with their ability to do so. When this occurs, the health and safety of the children must be of paramount concern. Intervention and prevention efforts must address immediate concerns for child safety and the ongoing risk of maltreatment and should engage the protective capacities of families. In furtherance of this public policy, it is the intent of the legislature under this chapter to:

(1) protect children and promote child safety;

(2) strengthen the family;

(3) make the home, school, and community safe for children by promoting responsible child care in all settings; and

(4) provide, when necessary, a safe temporary or permanent home environment for maltreated children.

(b) In addition, it is the policy of this state to:

(1) require the reporting of maltreatment of children in the home, school, and community settings;

(2) provide for ~~the~~ voluntary reporting of maltreatment of children;

(3) require an investigation when the report alleges sexual abuse or substantial child endangerment, except when the report alleges sex trafficking by a noncaregiver sex trafficker;

(4) provide a family assessment, if appropriate, when the report does not allege sexual abuse or substantial child endangerment; ~~and~~

(5) provide a noncaregiver sex trafficking assessment when the report alleges sex trafficking by a noncaregiver sex trafficker; and

(6) provide protective, family support, and family preservation services when needed in appropriate cases.

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

Sec. 11. Minnesota Statutes 2022, section 260E.02, subdivision 1, is amended to read:

Subdivision 1. **Establishment of team.** A county shall establish a multidisciplinary child protection team that may include, but is not ~~be~~ limited to, the director of the local welfare agency or designees, the county attorney or designees, the county sheriff or designees, representatives of health and education, representatives of mental health, representatives of agencies providing specialized services or responding to youth who experience or are at risk of experiencing sex trafficking or sexual exploitation, or other appropriate human services or community-based agencies, and parent groups. As used in this section, a "community-based agency" may include, but is not limited to, schools, social services agencies, family service and mental health collaboratives, children's advocacy centers, early childhood and family education programs, Head Start, or other agencies serving children and families. A member of the team must be designated as the lead person of the team responsible for the planning process to develop standards for the team's activities with battered women's and domestic abuse programs and services.

Sec. 12. Minnesota Statutes 2022, section 260E.03, is amended by adding a subdivision to read:

Subd. 15a. **Noncaregiver sex trafficker.** "Noncaregiver sex trafficker" means an individual who is alleged to have engaged in the act of sex trafficking a child and who is not a person responsible for the child's care, who does not have a significant relationship

with the child as defined in section 609.341, and who is not a person in a current or recent position of authority as defined in section 609.341, subdivision 10.

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

Sec. 13. Minnesota Statutes 2022, section 260E.03, is amended by adding a subdivision to read:

Subd. 15b. **Noncaregiver sex trafficking assessment.** "Noncaregiver sex trafficking assessment" is a comprehensive assessment of child safety, the risk of subsequent child maltreatment, and strengths and needs of the child and family. The local welfare agency shall only perform a noncaregiver sex trafficking assessment when a maltreatment report alleges sex trafficking of a child by someone other than the child's caregiver. A noncaregiver sex trafficking assessment does not include a determination of whether child maltreatment occurred. A noncaregiver sex trafficking assessment includes a determination of a family's need for services to address the safety of the child or children, the safety of family members, and the risk of subsequent child maltreatment.

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

Sec. 14. Minnesota Statutes 2022, section 260E.03, subdivision 22, is amended to read:

Subd. 22. **Substantial child endangerment.** "Substantial child endangerment" means that a person responsible for a child's care, by act or omission, commits or attempts to commit an act against a child ~~under their~~ in the person's care that constitutes any of the following:

(1) egregious harm under subdivision 5;

(2) abandonment under section 260C.301, subdivision 2;

(3) neglect under subdivision 15, paragraph (a), clause (2), that substantially endangers the child's physical or mental health, including a growth delay, which may be referred to as failure to thrive, that has been diagnosed by a physician and is due to parental neglect;

(4) murder in the first, second, or third degree under section 609.185, 609.19, or 609.195;

(5) manslaughter in the first or second degree under section 609.20 or 609.205;

(6) assault in the first, second, or third degree under section 609.221, 609.222, or 609.223;

(7) sex trafficking, solicitation, inducement, ~~and~~ or promotion of prostitution under section 609.322;

(8) criminal sexual conduct under sections 609.342 to 609.3451;

(9) sexual extortion under section 609.3458;

(10) solicitation of children to engage in sexual conduct under section 609.352;

(11) malicious punishment or neglect or endangerment of a child under section 609.377 or 609.378;

(12) use of a minor in sexual performance under section 617.246; or

(13) parental behavior, status, or condition ~~that mandates that~~ requiring the county attorney to file a termination of parental rights petition under section 260C.503, subdivision 2.

Sec. 15. Minnesota Statutes 2022, section 260E.14, subdivision 2, is amended to read:

Subd. 2. **Sexual abuse.** (a) The local welfare agency is the agency responsible for investigating an allegation of sexual abuse if the alleged offender is the parent, guardian, sibling, or an individual functioning within the family unit as a person responsible for the child's care, or a person with a significant relationship to the child if that person resides in the child's household.

(b) The local welfare agency is also responsible for assessing or investigating when a child is identified as a victim of sex trafficking.

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

Sec. 16. Minnesota Statutes 2022, section 260E.14, subdivision 5, is amended to read:

Subd. 5. **Law enforcement.** (a) The local law enforcement agency is the agency responsible for investigating a report of maltreatment if a violation of a criminal statute is alleged.

(b) Law enforcement and the responsible agency must coordinate their investigations or assessments as required under this chapter when ~~the~~: (1) a report alleges maltreatment that is a violation of a criminal statute by a person who is a parent, guardian, sibling, person responsible for the child's care ~~functioning~~ within the family unit, or by a person who lives in the child's household and who has a significant relationship to the child~~,~~ in a setting other than a facility as defined in section 260E.03; or (2) a report alleges sex trafficking of a child.

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

Sec. 17. Minnesota Statutes 2022, section 260E.17, subdivision 1, is amended to read:

Subdivision 1. **Local welfare agency.** (a) Upon receipt of a report, the local welfare agency shall determine whether to conduct a family assessment ~~or~~, an investigation, or a noncaregiver sex trafficking assessment as appropriate to prevent or provide a remedy for maltreatment.

(b) The local welfare agency shall conduct an investigation when the report involves sexual abuse, except as indicated in paragraph (f), or substantial child endangerment.

(c) The local welfare agency shall begin an immediate investigation ~~if,~~ at any time when the local welfare agency is ~~using~~ responding with a family assessment ~~response,~~ and the local welfare agency determines that there is reason to believe that sexual abuse ~~or~~, substantial child endangerment, or a serious threat to the child's safety exists.

(d) The local welfare agency may conduct a family assessment for reports that do not allege sexual abuse, except as indicated in paragraph (f), or substantial child endangerment. In determining that a family assessment is appropriate, the local welfare agency may consider issues of child safety, parental cooperation, and the need for an immediate response.

(e) The local welfare agency may conduct a family assessment ~~on~~ for a report that was initially screened and assigned for an investigation. In determining that a complete investigation is not required, the local welfare agency must document the reason for terminating the investigation and notify the local law enforcement agency if the local law enforcement agency is conducting a joint investigation.

(f) The local welfare agency shall conduct a noncaregiver sex trafficking assessment when a maltreatment report alleges sex trafficking of a child and the alleged offender is a noncaregiver sex trafficker as defined by section 260E.03, subdivision 15a.

(g) During a noncaregiver sex trafficking assessment, the local welfare agency shall initiate an immediate investigation if there is reason to believe that a child's parent, caregiver, or household member allegedly engaged in the act of sex trafficking a child or was alleged to have engaged in any conduct requiring the agency to conduct an investigation.

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

Sec. 18. Minnesota Statutes 2022, section 260E.18, is amended to read:

260E.18 NOTICE TO CHILD'S TRIBE.

The local welfare agency shall provide immediate notice, according to section 260.761, subdivision 2, to an Indian child's Tribe when the agency has reason to believe that the

family assessment ~~or,~~ investigation, or noncaregiver sex trafficking assessment may involve an Indian child. For purposes of this section, "immediate notice" means notice provided within 24 hours.

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

Sec. 19. Minnesota Statutes 2022, section 260E.20, subdivision 2, is amended to read:

Subd. 2. **Face-to-face contact.** (a) Upon receipt of a screened in report, the local welfare agency shall ~~conduct a~~ have face-to-face contact with the child reported to be maltreated and with the child's primary caregiver sufficient to complete a safety assessment and ensure the immediate safety of the child. When it is possible and the report alleges substantial child endangerment or sexual abuse, the local welfare agency is not required to provide notice before conducting the initial face-to-face contact with the child and the child's primary caregiver.

(b) Except in a noncaregiver sex trafficking assessment, the local welfare agency shall have face-to-face contact with the child and primary caregiver ~~shall occur~~ immediately after the agency screens in a report if sexual abuse or substantial child endangerment is alleged and within five calendar days of a screened in report for all other reports. If the alleged offender was not already interviewed as the primary caregiver, the local welfare agency shall also conduct a face-to-face interview with the alleged offender in the early stages of the assessment or investigation, except in a noncaregiver sex trafficking assessment. Face-to-face contact with the child and primary caregiver in response to a report alleging sexual abuse or substantial child endangerment may be postponed for no more than five calendar days if the child is residing in a location that is confirmed to restrict contact with the alleged offender as established in guidelines issued by the commissioner, or if the local welfare agency is pursuing a court order for the child's caregiver to produce the child for questioning under section 260E.22, subdivision 5.

(c) At the initial contact with the alleged offender, the local welfare agency or the agency responsible for assessing or investigating the report must inform the alleged offender of the complaints or allegations made against the individual in a manner consistent with laws protecting the rights of the person who made the report. The interview with the alleged offender may be postponed if it would jeopardize an active law enforcement investigation. In a noncaregiver sex trafficking assessment, the local child welfare agency is not required to inform or interview the alleged offender.

(d) The local welfare agency or the agency responsible for assessing or investigating the report must provide the alleged offender with an opportunity to make a statement, except

in a noncaregiver sex trafficking assessment. The alleged offender may submit supporting documentation relevant to the assessment or investigation.

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

Sec. 20. Minnesota Statutes 2022, section 260E.24, subdivision 2, is amended to read:

Subd. 2. **Determination after family assessment or a noncaregiver sex trafficking assessment.** After conducting a family assessment or a noncaregiver sex trafficking assessment, the local welfare agency shall determine whether child protective services are needed to address the safety of the child and other family members and the risk of subsequent maltreatment. The local welfare agency must document the information collected under section 260E.20, subdivision 3, related to the completed family assessment in the child's or family's case notes.

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

Sec. 21. Minnesota Statutes 2022, section 260E.24, subdivision 7, is amended to read:

Subd. 7. **Notification at conclusion of family assessment or a noncaregiver sex trafficking assessment.** Within ten working days of the conclusion of a family assessment or a noncaregiver sex trafficking assessment, the local welfare agency shall notify the parent or guardian of the child of the need for services to address child safety concerns or significant risk of subsequent maltreatment. The local welfare agency and the family may also jointly agree that family support and family preservation services are needed.

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

Sec. 22. Minnesota Statutes 2022, section 260E.33, subdivision 1, is amended to read:

Subdivision 1. **Following a family assessment or a noncaregiver sex trafficking assessment.** Administrative reconsideration is not applicable to a family assessment or noncaregiver sex trafficking assessment since no determination concerning maltreatment is made.

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

Sec. 23. Minnesota Statutes 2022, section 260E.35, subdivision 6, is amended to read:

Subd. 6. **Data retention.** (a) Notwithstanding sections 138.163 and 138.17, a record maintained or a record derived from a report of maltreatment by a local welfare agency, agency responsible for assessing or investigating the report, court services agency, or school

under this chapter shall be destroyed as provided in paragraphs (b) to (e) by the responsible authority.

(b) For a report alleging maltreatment that was not accepted for an assessment or an investigation, a family assessment case, a noncaregiver sex trafficking assessment case, and a case where an investigation results in no determination of maltreatment or the need for child protective services, the record must be maintained for a period of five years after the date that the report was not accepted for assessment or investigation or the date of the final entry in the case record. A record of a report that was not accepted must contain sufficient information to identify the subjects of the report, the nature of the alleged maltreatment, and the reasons ~~as to~~ why the report was not accepted. Records under this paragraph may not be used for employment, background checks, or purposes other than to assist in future screening decisions and risk and safety assessments.

(c) All records relating to reports that, upon investigation, indicate ~~either~~ maltreatment or a need for child protective services shall be maintained for ten years after the date of the final entry in the case record.

(d) All records regarding a report of maltreatment, including a notification of intent to interview that was received by a school under section 260E.22, subdivision 7, shall be destroyed by the school when ordered to do so by the agency conducting the assessment or investigation. The agency shall order the destruction of the notification when other records relating to the report under investigation or assessment are destroyed under this subdivision.

(e) Private or confidential data released to a court services agency under subdivision 3, paragraph (d), must be destroyed by the court services agency when ordered to do so by the local welfare agency that released the data. The local welfare agency or agency responsible for assessing or investigating the report shall order destruction of the data when other records relating to the assessment or investigation are destroyed under this subdivision.

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

Sec. 24. Minnesota Statutes 2022, section 518A.31, is amended to read:

518A.31 SOCIAL SECURITY OR VETERANS' BENEFIT PAYMENTS RECEIVED ON BEHALF OF THE CHILD.

(a) The amount of the monthly Social Security benefits or apportioned veterans' benefits provided for a joint child shall be included in the gross income of the parent on whose eligibility the benefits are based.

(b) The amount of the monthly survivors' and dependents' educational assistance provided for a joint child shall be included in the gross income of the parent on whose eligibility the benefits are based.

(c) If Social Security or apportioned veterans' benefits are provided for a joint child based on the eligibility of the obligor, and are received by the obligee as a representative payee for the child or by the child attending school, then the amount of the benefits shall also be subtracted from the obligor's net child support obligation as calculated pursuant to section 518A.34.

(d) If the survivors' and dependents' educational assistance is provided for a joint child based on the eligibility of the obligor, and is received by the obligee as a representative payee for the child or by the child attending school, then the amount of the assistance shall also be subtracted from the obligor's net child support obligation as calculated under section 518A.34.

(e) Upon a motion to modify child support, any regular or lump sum payment of Social Security or apportioned veterans' benefit received by the obligee for the benefit of the joint child based upon the obligor's disability prior to filing the motion to modify may be used to satisfy arrears that remain due for the period of time for which the benefit was received. This paragraph applies only if the derivative benefit was not considered in the guidelines calculation of the previous child support order.

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

Sec. 25. Minnesota Statutes 2022, section 518A.32, subdivision 3, is amended to read:

Subd. 3. **Parent not considered voluntarily unemployed, underemployed, or employed on a less than full-time basis.** A parent is not considered voluntarily unemployed, underemployed, or employed on a less than full-time basis upon a showing by the parent that:

(1) the unemployment, underemployment, or employment on a less than full-time basis is temporary and will ultimately lead to an increase in income;

(2) the unemployment, underemployment, or employment on a less than full-time basis represents a bona fide career change that outweighs the adverse effect of that parent's diminished income on the child; ~~or~~

(3) the unemployment, underemployment, or employment on a less than full-time basis is because a parent is physically or mentally incapacitated or due to incarceration~~.~~; or

(4) a governmental agency authorized to determine eligibility for general assistance or supplemental Social Security income has determined that the individual is eligible to receive general assistance or supplemental Social Security income. Actual income earned by the parent may be considered for the purpose of calculating child support.

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

Sec. 26. Minnesota Statutes 2022, section 518A.32, subdivision 4, is amended to read:

Subd. 4. **TANF or MFIP recipient.** If the parent of a joint child is a recipient of a temporary assistance to a needy family (TANF) cash grant, or comparable state-funded Minnesota family investment program (MFIP) benefits, no potential income is to be imputed to that parent.

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

Sec. 27. Minnesota Statutes 2022, section 518A.34, is amended to read:

518A.34 COMPUTATION OF CHILD SUPPORT OBLIGATIONS.

(a) To determine the presumptive child support obligation of a parent, the court shall follow the procedure set forth in this section.

(b) To determine the obligor's basic support obligation, the court shall:

(1) determine the gross income of each parent under section 518A.29;

(2) calculate the parental income for determining child support (PICS) of each parent, by subtracting from the gross income the credit, if any, for each parent's nonjoint children under section 518A.33;

(3) determine the percentage contribution of each parent to the combined PICS by dividing the combined PICS into each parent's PICS;

(4) determine the combined basic support obligation by application of the guidelines in section 518A.35;

(5) determine each parent's share of the combined basic support obligation by multiplying the percentage figure from clause (3) by the combined basic support obligation in clause (4); and

(6) apply the parenting expense adjustment formula provided in section 518A.36 to determine the obligor's basic support obligation.

(c) If the parents have split custody of joint children, child support must be calculated for each joint child as follows:

(1) the court shall determine each parent's basic support obligation under paragraph (b) and include the amount of each parent's obligation in the court order. If the basic support calculation results in each parent owing support to the other, the court shall offset the higher basic support obligation with the lower basic support obligation to determine the amount to be paid by the parent with the higher obligation to the parent with the lower obligation. For the purpose of the cost-of-living adjustment required under section 518A.75, the adjustment must be based on each parent's basic support obligation prior to offset. For the purposes of this paragraph, "split custody" means that there are two or more joint children and each parent has at least one joint child more than 50 percent of the time;

(2) if each parent pays all child care expenses for at least one joint child, the court shall calculate child care support for each joint child as provided in section 518A.40. The court shall determine each parent's child care support obligation and include the amount of each parent's obligation in the court order. If the child care support calculation results in each parent owing support to the other, the court shall offset the higher child care support obligation with the lower child care support obligation to determine the amount to be paid by the parent with the higher obligation to the parent with the lower obligation; and

(3) if each parent pays all medical or dental insurance expenses for at least one joint child, medical support shall be calculated for each joint child as provided in section 518A.41. The court shall determine each parent's medical support obligation and include the amount of each parent's obligation in the court order. If the medical support calculation results in each parent owing support to the other, the court shall offset the higher medical support obligation with the lower medical support obligation to determine the amount to be paid by the parent with the higher obligation to the parent with the lower obligation. Unreimbursed and uninsured medical expenses are not included in the presumptive amount of support owed by a parent and are calculated and collected as provided in section 518A.41.

(d) The court shall determine the child care support obligation for the obligor as provided in section 518A.40.

(e) The court shall determine the medical support obligation for each parent as provided in section 518A.41. Unreimbursed and uninsured medical expenses are not included in the presumptive amount of support owed by a parent and are calculated and collected as described in section 518A.41.

(f) The court shall determine each parent's total child support obligation by adding together each parent's basic support, child care support, and health care coverage obligations as provided in this section.

(g) If Social Security benefits or veterans' benefits are received by one parent as a representative payee for a joint child based on the other parent's eligibility, the court shall subtract the amount of benefits from the other parent's net child support obligation, if any. Any benefit received by the obligee for the benefit of the joint child based upon the obligor's disability or past earnings in any given month in excess of the child support obligation must not be treated as an arrearage payment or a future payment.

(h) The final child support order shall separately designate the amount owed for basic support, child care support, and medical support. If applicable, the court shall use the self-support adjustment and minimum support adjustment under section 518A.42 to determine the obligor's child support obligation.

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

Sec. 28. Minnesota Statutes 2022, section 518A.41, is amended to read:

518A.41 MEDICAL SUPPORT.

Subdivision 1. **Definitions.** The definitions in this subdivision apply to this chapter and chapter 518.

(a) "Health care coverage" means ~~medical, dental, or other health care benefits that are provided by one or more health plans. Health care coverage does not include any form of public coverage~~ private health care coverage, including fee for service, health maintenance organization, preferred provider organization, and other types of private health care coverage. Health care coverage also means public health care coverage under which medical or dental services could be provided to a dependent child.

~~(b) "Health carrier" means a carrier as defined in sections 62A.011, subdivision 2, and 62L.02, subdivision 16.~~

~~(c) "Health plan"~~ (b) "Private health care coverage" means a health plan~~, other than any form of public coverage,~~ that provides medical, dental, or other health care benefits and is:

(1) provided on an individual or group basis;

(2) provided by an employer or union;

(3) purchased in the private market; ~~or~~

(4) provided through MinnesotaCare under chapter 256L; or

~~(4)~~ (5) available to a person eligible to carry insurance for the joint child, including a party's spouse or parent.

~~Health plan~~ Private health care coverage includes, but is not limited to, a health plan meeting the definition under section 62A.011, subdivision 3, except that the exclusion of coverage designed solely to provide dental or vision care under section 62A.011, subdivision 3, clause (6), does not apply to the definition of ~~health plan~~ private health care coverage under this section; a group health plan governed under the federal Employee Retirement Income Security Act of 1974 (ERISA); a self-insured plan under sections 43A.23 to 43A.317 and 471.617; and a policy, contract, or certificate issued by a community-integrated service network licensed under chapter 62N.

(c) "Public health care coverage" means health care benefits provided by any form of medical assistance under chapter 256B. Public health care coverage does not include MinnesotaCare or health plans subsidized by federal premium tax credits or federal cost-sharing reductions.

(d) "Medical support" means providing health care coverage for a joint child ~~by carrying health care coverage for the joint child or~~ by contributing to the cost of health care coverage, ~~public coverage,~~ unreimbursed ~~medical~~ health-related expenses, and uninsured ~~medical~~ health-related expenses of the joint child.

(e) "National medical support notice" means an administrative notice issued by the public authority to enforce health insurance provisions of a support order in accordance with Code of Federal Regulations, title 45, section 303.32, in cases where the public authority provides support enforcement services.

~~(f) "Public coverage" means health care benefits provided by any form of medical assistance under chapter 256B. Public coverage does not include MinnesotaCare or health plans subsidized by federal premium tax credits or federal cost-sharing reductions.~~

~~(g)~~ (f) "Uninsured ~~medical~~ health-related expenses" means a joint child's reasonable and necessary ~~health-related~~ medical and dental expenses if the joint child is not covered by ~~a health plan or public coverage~~ private health insurance care when the expenses are incurred.

~~(h)~~ (g) "Unreimbursed ~~medical~~ health-related expenses" means a joint child's reasonable and necessary ~~health-related~~ medical and dental expenses if a joint child is covered by ~~a health plan or public coverage~~ health care coverage and ~~the plan or~~ health care coverage does not pay for the total cost of the expenses when the expenses are incurred. Unreimbursed

~~medical~~ health-related expenses do not include the cost of premiums. Unreimbursed ~~medical~~ health-related expenses include, but are not limited to, deductibles, co-payments, and expenses for orthodontia, and prescription eyeglasses and contact lenses, but not over-the-counter medications if ~~coverage is under a health plan~~ provided through health care coverage.

Subd. 2. **Order.** (a) A completed national medical support notice issued by the public authority or a court order that complies with this section is a qualified medical child support order under the federal Employee Retirement Income Security Act of 1974 (ERISA), United States Code, title 29, section 1169(a).

(b) Every order addressing child support must state:

(1) the names, last known addresses, and Social Security numbers of the parents and the joint child that is a subject of the order unless the court prohibits the inclusion of an address or Social Security number and orders the parents to provide the address and Social Security number to the administrator of the health plan;

(2) ~~if a joint child is not presently enrolled in health care coverage,~~ whether appropriate health care coverage for the joint child is available and, if so, state:

(i) the parents' responsibilities for carrying health care coverage;

(ii) the cost of premiums and how the cost is allocated between the parents; ~~and~~

(iii) the circumstances, if any, under which an obligation to provide private health care coverage for the joint child will shift from one parent to the other; and

~~(3) if appropriate health care coverage is not available for the joint child,~~ (iv) whether a contribution for ~~medical support~~ public health care coverage is required; and

~~(4)~~ (3) how unreimbursed or uninsured ~~medical~~ health-related expenses will be allocated between the parents.

Subd. 3. **Determining appropriate health care coverage.** Public health care coverage is presumed appropriate. In determining whether a parent has appropriate private health care coverage for the joint child, the court must consider the following factors:

(1) comprehensiveness of private health care coverage providing medical benefits. Dependent private health care coverage providing medical benefits is presumed comprehensive if it includes medical and hospital coverage and provides for preventive, emergency, acute, and chronic care; or if it meets the minimum essential coverage definition in United States Code, title 26, section 5000A(f). If both parents have private health care

coverage providing medical benefits that is presumed comprehensive under this paragraph, the court must determine which parent's private health care coverage is more comprehensive by considering what other benefits are included in the private health care coverage;

(2) accessibility. Dependent private health care coverage is accessible if the covered joint child can obtain services from a health plan provider with reasonable effort by the parent with whom the joint child resides. Private health care coverage is presumed accessible if:

(i) primary care is available within 30 minutes or 30 miles of the joint child's residence and specialty care is available within 60 minutes or 60 miles of the joint child's residence;

(ii) the private health care coverage is available through an employer and the employee can be expected to remain employed for a reasonable amount of time; and

(iii) no preexisting conditions exist to unduly delay enrollment in private health care coverage;

(3) the joint child's special medical needs, if any; and

(4) affordability. Dependent private health care coverage is presumed affordable if ~~it is reasonable in cost. If both parents have health care coverage available for a joint child that is comparable with regard to comprehensiveness of medical benefits, accessibility, and the joint child's special needs, the least costly health care coverage is presumed to be the most appropriate health care coverage for the joint child~~ the premium to cover the marginal cost of the joint child does not exceed five percent of the parents' combined monthly PICS. A court may additionally consider high deductibles and the cost to enroll the parent if the parent must enroll themselves in private health care coverage to access private health care coverage for the child.

Subd. 4. **Ordering health care coverage.** ~~(a) If a joint child is presently enrolled in health care coverage, the court must order that the parent who currently has the joint child enrolled continue that enrollment unless the parties agree otherwise or a party requests a change in coverage and the court determines that other health care coverage is more appropriate.~~

~~(b) If a joint child is not presently enrolled in health care coverage providing medical benefits, upon motion of a parent or the public authority, the court must determine whether one or both parents have appropriate health care coverage providing medical benefits for the joint child.~~

(a) If a joint child is presently enrolled in health care coverage, the court shall order that the parent who currently has the joint child enrolled in health care coverage continue that enrollment if the health care coverage is appropriate as defined under subdivision 3.

~~(c)~~ (b) If only one parent has appropriate health care coverage providing medical benefits available, the court must order that parent to carry the coverage for the joint child.

~~(d)~~ (c) If both parents have appropriate health care coverage providing medical benefits available, the court must order the parent with whom the joint child resides to carry the health care coverage for the joint child, unless:

(1) a party expresses a preference for private health care coverage providing medical benefits available through the parent with whom the joint child does not reside;

(2) the parent with whom the joint child does not reside is already carrying dependent private health care coverage providing medical benefits for other children and the cost of contributing to the premiums of the other parent's health care coverage would cause the parent with whom the joint child does not reside extreme hardship; or

(3) the parties agree as to which parent will carry health care coverage providing medical benefits and agree on the allocation of costs.

~~(e)~~ (d) If the exception in paragraph ~~(d)~~ (c), clause (1) or (2), applies, the court must determine which parent has the most appropriate health care coverage providing medical benefits available and order that parent to carry health care coverage for the joint child.

~~(f)~~ (e) If neither parent has appropriate health care coverage available, the court must order the parents to~~:~~

~~(1)~~ contribute toward the actual health care costs of the joint children based on a pro rata share~~; or~~.

~~(2) if the joint child is receiving any form of public coverage, the parent with whom the joint child does not reside shall contribute a monthly amount toward the actual cost of public coverage. The amount of the noncustodial parent's contribution is determined by applying the noncustodial parent's PICS to the premium scale for MinnesotaCare under section 256L.15, subdivision 2, paragraph (d). If the noncustodial parent's PICS meets the eligibility requirements for MinnesotaCare, the contribution is the amount the noncustodial parent would pay for the child's premium. If the noncustodial parent's PICS exceeds the eligibility requirements, the contribution is the amount of the premium for the highest eligible income on the premium scale for MinnesotaCare under section 256L.15, subdivision 2, paragraph (d). For purposes of determining the premium amount, the noncustodial parent's household~~

~~size is equal to one parent plus the child or children who are the subject of the child support order. The custodial parent's obligation is determined under the requirements for public coverage as set forth in chapter 256B; or~~

~~(3) if the noncustodial parent's PICS meet the eligibility requirement for public coverage under chapter 256B or the noncustodial parent receives public assistance, the noncustodial parent must not be ordered to contribute toward the cost of public coverage.~~

~~(g)~~ (f) If neither parent has appropriate health care coverage available, the court may order the parent with whom the child resides to apply for public health care coverage for the child.

~~(h) The commissioner of human services must publish a table with the premium schedule for public coverage and update the chart for changes to the schedule by July 1 of each year.~~

~~(i)~~ (g) If a joint child is not presently enrolled in private health care coverage providing dental benefits, upon motion of a parent or the public authority, the court must determine whether one or both parents have appropriate ~~dental~~ private health care coverage providing dental benefits for the joint child, and the court may order a parent with appropriate ~~dental~~ private health care coverage providing dental benefits available to carry the health care coverage for the joint child.

~~(j)~~ (h) If a joint child is not presently enrolled in available private health care coverage providing benefits other than medical benefits or dental benefits, upon motion of a parent or the public authority, the court may determine whether ~~that other~~ private health care coverage providing other health benefits for the joint child is appropriate, and the court may order a parent with that appropriate private health care coverage available to carry the coverage for the joint child.

Subd. 5. **Medical support costs; unreimbursed and uninsured ~~medical~~ health-related expenses.** (a) Unless otherwise agreed to by the parties and approved by the court, the court must order that the cost of private health care coverage and all unreimbursed and uninsured ~~medical~~ health-related expenses ~~under the health plan~~ be divided between the obligor and obligee based on their proportionate share of the parties' combined monthly PICS. The amount allocated for medical support is considered child support but is not subject to a cost-of-living adjustment under section 518A.75.

(b) If a party owes a ~~joint child~~ basic support obligation for a joint child and is ordered to carry private health care coverage for the joint child, and the other party is ordered to contribute to the carrying party's cost for coverage, the carrying party's ~~child~~ basic support payment must be reduced by the amount of the contributing party's contribution.

(c) If a party owes a ~~joint child~~ basic support obligation for a joint child and is ordered to contribute to the other party's cost for carrying private health care coverage for the joint child, the contributing party's child support payment must be increased by the amount of the contribution. The contribution toward private health care coverage must not be charged in any month in which the party ordered to carry private health care coverage fails to maintain private coverage.

(d) If the party ordered to carry private health care coverage for the joint child already carries dependent private health care coverage for other dependents and would incur no additional premium costs to add the joint child to the existing health care coverage, the court must not order the other party to contribute to the premium costs for health care coverage of the joint child.

(e) If a party ordered to carry private health care coverage for the joint child does not already carry dependent private health care coverage but has other dependents who may be added to the ordered health care coverage, the full premium costs of the dependent private health care coverage must be allocated between the parties in proportion to the party's share of the parties' combined monthly PICS, unless the parties agree otherwise.

(f) If a party ordered to carry private health care coverage for the joint child is required to enroll in a health plan so that the joint child can be enrolled in dependent private health care coverage under the plan, the court must allocate the costs of the dependent private health care coverage between the parties. The costs of the private health care coverage for the party ordered to carry the health care coverage for the joint child must not be allocated between the parties.

(g) If the joint child is receiving any form of public health care coverage:

(1) the parent with whom the joint child does not reside shall contribute a monthly amount toward the actual cost of public health care coverage. The amount of the noncustodial parent's contribution is determined by applying the noncustodial parent's PICS to the premium scale for MinnesotaCare under section 256L.15, subdivision 2, paragraph (d). If the noncustodial parent's PICS meets the eligibility requirements for MinnesotaCare, the contribution is the amount that the noncustodial parent would pay for the child's premium;

(2) if the noncustodial parent's PICS exceeds the eligibility requirements, the contribution is the amount of the premium for the highest eligible income on the premium scale for MinnesotaCare under section 256L.15, subdivision 2, paragraph (d). For purposes of determining the premium amount, the noncustodial parent's household size is equal to one parent plus the child or children who are the subject of the order;

(3) the custodial parent's obligation is determined under the requirements for public health care coverage in chapter 256B; or

(4) if the noncustodial parent's PICS is less than 200 percent of the federal poverty guidelines for one person or the noncustodial parent receives public assistance, the noncustodial parent must not be ordered to contribute toward the cost of public health care coverage.

(h) The commissioner of human services must publish a table for section 256L.15, subdivision 2, paragraph (d), and update the table with changes to the schedule by July 1 of each year.

Subd. 6. **Notice or court order sent to party's employer, union, or health carrier.** (a) The public authority must forward a copy of the national medical support notice or court order for private health care coverage to the party's employer within two business days after the date the party is entered into the work reporting system under section 256.998.

(b) The public authority or a party seeking to enforce an order for private health care coverage must forward a copy of the national medical support notice or court order to the obligor's employer or union, or to the health carrier under the following circumstances:

(1) the party ordered to carry private health care coverage for the joint child fails to provide written proof to the other party or the public authority, within 30 days of the effective date of the court order, that the party has applied for private health care coverage for the joint child;

(2) the party seeking to enforce the order or the public authority gives written notice to the party ordered to carry private health care coverage for the joint child of its intent to enforce medical support. The party seeking to enforce the order or public authority must mail the written notice to the last known address of the party ordered to carry private health care coverage for the joint child; and

(3) the party ordered to carry private health care coverage for the joint child fails, within 15 days after the date on which the written notice under clause (2) was mailed, to provide written proof to the other party or the public authority that the party has applied for private health care coverage for the joint child.

(c) The public authority is not required to forward a copy of the national medical support notice or court order to the obligor's employer or union, or to the health carrier, if the court orders private health care coverage for the joint child that is not employer-based or union-based coverage.

Subd. 7. **Employer or union requirements.** (a) An employer or union must forward the national medical support notice or court order to its health plan within 20 business days after the date on the national medical support notice or after receipt of the court order.

(b) Upon determination by an employer's or union's health plan administrator that a joint child is eligible to be covered under the health plan, the employer or union and health plan must enroll the joint child as a beneficiary in the health plan, and the employer must withhold any required premiums from the income or wages of the party ordered to carry health care coverage for the joint child.

(c) If enrollment of the party ordered to carry private health care coverage for a joint child is necessary to obtain dependent private health care coverage under the plan, and the party is not enrolled in the health plan, the employer or union must enroll the party in the plan.

(d) Enrollment of dependents and, if necessary, the party ordered to carry private health care coverage for the joint child must be immediate and not dependent upon open enrollment periods. Enrollment is not subject to the underwriting policies under section 62A.048.

(e) Failure of the party ordered to carry private health care coverage for the joint child to execute any documents necessary to enroll the dependent in the health plan does not affect the obligation of the employer or union and health plan to enroll the dependent in a plan. Information and authorization provided by the public authority, or by a party or guardian, is valid for the purposes of meeting enrollment requirements of the health plan.

(f) An employer or union that is included under the federal Employee Retirement Income Security Act of 1974 (ERISA), United States Code, title 29, section 1169(a), may not deny enrollment to the joint child or to the parent if necessary to enroll the joint child based on exclusionary clauses described in section 62A.048.

(g) A new employer or union of a party who is ordered to provide private health care coverage for a joint child must enroll the joint child in the party's health plan as required by a national medical support notice or court order.

Subd. 8. **Health plan requirements.** (a) If a health plan administrator receives a completed national medical support notice or court order, the plan administrator must notify the parties, and the public authority if the public authority provides support enforcement services, within 40 business days after the date of the notice or after receipt of the court order, of the following:

(1) whether health care coverage is available to the joint child under the terms of the health plan and, if not, the reason why health care coverage is not available;

(2) whether the joint child is covered under the health plan;

(3) the effective date of the joint child's coverage under the health plan; and

(4) what steps, if any, are required to effectuate the joint child's coverage under the health plan.

(b) If the employer or union offers more than one plan and the national medical support notice or court order does not specify the plan to be carried, the plan administrator must notify the parents and the public authority if the public authority provides support enforcement services. When there is more than one option available under the plan, the public authority, in consultation with the parent with whom the joint child resides, must promptly select from available plan options.

(c) The plan administrator must provide the parents and public authority, if the public authority provides support enforcement services, with a notice of the joint child's enrollment, description of the health care coverage, and any documents necessary to effectuate coverage.

(d) The health plan must send copies of all correspondence regarding the private health care coverage to the parents.

(e) An insured joint child's parent's signature is a valid authorization to a health plan for purposes of processing an insurance reimbursement payment to the medical services provider or to the parent, if medical services have been prepaid by that parent.

Subd. 9. **Employer or union liability.** (a) An employer or union that willfully fails to comply with the order or notice is liable for any uninsured ~~medical~~ health-related expenses incurred by the dependents while the dependents were eligible to be enrolled in the health plan and for any other premium costs incurred because the employer or union willfully failed to comply with the order or notice.

(b) An employer or union that fails to comply with the order or notice is subject to a contempt finding, a $250 civil penalty under section 518A.73, and is subject to a civil penalty of $500 to be paid to the party entitled to reimbursement or the public authority. Penalties paid to the public authority are designated for child support enforcement services.

Subd. 10. **Contesting enrollment.** (a) A party may contest a joint child's enrollment in a health plan on the limited grounds that the enrollment is improper due to mistake of fact or that the enrollment meets the requirements of section 518.145.

(b) If the party chooses to contest the enrollment, the party must do so no later than 15 days after the employer notifies the party of the enrollment by doing the following:

(1) filing a motion in district court or according to section 484.702 and the expedited child support process rules if the public authority provides support enforcement services;

(2) serving the motion on the other party and public authority if the public authority provides support enforcement services; and

(3) securing a date for the matter to be heard no later than 45 days after the notice of enrollment.

(c) The enrollment must remain in place while the party contests the enrollment.

Subd. 11. **Disenrollment; continuation of coverage; coverage options.** (a) Unless a court order provides otherwise, a child for whom a party is required to provide private health care coverage under this section must be covered as a dependent of the party until the child is emancipated, until further order of the court, or as consistent with the terms of the health care coverage.

(b) The health carrier, employer, or union may not disenroll or eliminate health care coverage for the child unless:

(1) the health carrier, employer, or union is provided satisfactory written evidence that the court order is no longer in effect;

(2) the joint child is or will be enrolled in comparable private health care coverage through another health plan that will take effect no later than the effective date of the disenrollment;

(3) the employee is no longer eligible for dependent health care coverage; or

(4) the required premium has not been paid by or on behalf of the joint child.

(c) The health plan must provide 30 days' written notice to the joint child's parents, and the public authority if the public authority provides support enforcement services, before the health plan disenrolls or eliminates the joint child's health care coverage.

(d) A joint child enrolled in private health care coverage under a qualified medical child support order, including a national medical support notice, under this section is a dependent and a qualified beneficiary under the Consolidated Omnibus Budget and Reconciliation Act of 1985 (COBRA), Public Law 99-272. Upon expiration of the order, the joint child is entitled to the opportunity to elect continued health care coverage that is available under

the health plan. The employer or union must provide notice to the parties and the public authority, if it provides support services, within ten days of the termination date.

(e) If the public authority provides support enforcement services and a plan administrator reports to the public authority that there is more than one coverage option available under the health plan, the public authority, in consultation with the parent with whom the joint child resides, must promptly select health care coverage from the available options.

Subd. 12. **Spousal or former spousal coverage.** The court must require the parent with whom the joint child does not reside to provide dependent private health care coverage for the benefit of the parent with whom the joint child resides if the parent with whom the child does not reside is ordered to provide dependent private health care coverage for the parties' joint child and adding the other parent to the health care coverage results in no additional premium cost.

Subd. 13. **Disclosure of information.** (a) If the public authority provides support enforcement services, the parties must provide the public authority with the following information:

(1) information relating to dependent health care coverage ~~or public coverage~~ available for the benefit of the joint child for whom support is sought, including all information required to be included in a medical support order under this section;

(2) verification that application for court-ordered health care coverage was made within 30 days of the court's order; and

(3) the reason that a joint child is not enrolled in court-ordered health care coverage, if a joint child is not enrolled in health care coverage or subsequently loses health care coverage.

(b) Upon request from the public authority under section 256.978, an employer, union, or plan administrator, including an employer subject to the federal Employee Retirement Income Security Act of 1974 (ERISA), United States Code, title 29, section 1169(a), must provide the public authority the following information:

(1) information relating to dependent private health care coverage available to a party for the benefit of the joint child for whom support is sought, including all information required to be included in a medical support order under this section; and

(2) information that will enable the public authority to determine whether a health plan is appropriate for a joint child, including, but not limited to, all available plan options, any geographic service restrictions, and the location of service providers.

(c) The employer, union, or plan administrator must not release information regarding one party to the other party. The employer, union, or plan administrator must provide both parties with insurance identification cards and all necessary written information to enable the parties to utilize the insurance benefits for the covered dependent.

(d) The public authority is authorized to release to a party's employer, union, or health plan information necessary to verify availability of dependent private health care coverage, or to establish, modify, or enforce medical support.

(e) An employee must disclose to an employer if medical support is required to be withheld under this section and the employer must begin withholding according to the terms of the order and under section 518A.53. If an employee discloses an obligation to obtain private health care coverage and health care coverage is available through the employer, the employer must make all application processes known to the individual and enroll the employee and dependent in the plan.

Subd. 14. **Child support enforcement services.** The public authority must take necessary steps to establish, enforce, and modify an order for medical support if the joint child receives public assistance or a party completes an application for services from the public authority under section 518A.51.

Subd. 15. **Enforcement.** (a) Remedies available for collecting and enforcing child support apply to medical support.

(b) For the purpose of enforcement, the following are additional support:

(1) the costs of individual or group health or hospitalization coverage;

(2) dental coverage;

(3) medical costs ordered by the court to be paid by either party, including health care coverage premiums paid by the obligee because of the obligor's failure to obtain health care coverage as ordered; and

(4) liabilities established under this subdivision.

(c) A party who fails to carry court-ordered dependent private health care coverage is liable for the joint child's uninsured ~~medical~~ health-related expenses unless a court order provides otherwise. A party's failure to carry court-ordered health care coverage, or to provide other medical support as ordered, is a basis for modification of medical support under section 518A.39, subdivision 8, unless it meets the presumption in section 518A.39, subdivision 2.

(d) Payments by the health carrier or employer for services rendered to the dependents that are directed to a party not owed reimbursement must be endorsed over to and forwarded to the vendor or appropriate party or the public authority. A party retaining insurance reimbursement not owed to the party is liable for the amount of the reimbursement.

Subd. 16. **Offset.** (a) If a party is the parent with primary physical custody as defined in section 518A.26, subdivision 17, and is an obligor ordered to contribute to the other party's cost for carrying health care coverage for the joint child, the other party's child support and spousal maintenance obligations are subject to an offset under subdivision 5.

(b) The public authority, if the public authority provides child support enforcement services, may remove the offset to a party's child support obligation when:

(1) the party's court-ordered private health care coverage for the joint child terminates;

(2) the party does not enroll the joint child in other private health care coverage; and

(3) a modification motion is not pending.

The public authority must provide notice to the parties of the action. If neither party requests a hearing, the public authority must remove the offset effective the first day of the month following termination of the joint child's private health care coverage.

(c) The public authority, if the public authority provides child support enforcement services, may resume the offset when the party ordered to provide private health care coverage for the joint child has resumed the court-ordered private health care coverage or enrolled the joint child in other private health care coverage. The public authority must provide notice to the parties of the action. If neither party requests a hearing, the public authority must resume the offset effective the first day of the month following certification that private health care coverage is in place for the joint child.

(d) A party may contest the public authority's action to remove or resume the offset to the child support obligation if the party makes a written request for a hearing within 30 days after receiving written notice. If a party makes a timely request for a hearing, the public authority must schedule a hearing and send written notice of the hearing to the parties by mail to the parties' last known addresses at least 14 days before the hearing. The hearing must be conducted in district court or in the expedited child support process if section 484.702 applies. The district court or child support magistrate must determine whether removing or resuming the offset is appropriate and, if appropriate, the effective date for the removal or resumption.

Subd. 16a. **Suspension or reinstatement of medical support contribution.** (a) If a party is the parent with primary physical custody, as defined in section 518A.26, subdivision 17, and is ordered to carry private health care coverage for the joint child but fails to carry the court-ordered private health care coverage, the public authority may suspend the medical support obligation of the other party if that party has been court-ordered to contribute to the cost of the private health care coverage carried by the parent with primary physical custody of the joint child.

(b) If the public authority provides child support enforcement services, the public authority may suspend the other party's medical support contribution toward private health care coverage when:

(1) the party's court-ordered private health care coverage for the joint child terminates;

(2) the party does not enroll the joint child in other private health care coverage; and

(3) a modification motion is not pending.

The public authority must provide notice to the parties of the action. If neither party requests a hearing, the public authority must remove the medical support contribution effective the first day of the month following the termination of the joint child's private health care coverage.

(c) If the public authority provides child support enforcement services, the public authority may reinstate the medical support contribution when the party ordered to provide private health care coverage for the joint child has resumed the joint child's court-ordered private health care coverage or has enrolled the joint child in other private health care coverage. The public authority must provide notice to the parties of the action. If neither party requests a hearing, the public authority must resume the medical support contribution effective the first day of the month following certification that the joint child is enrolled in private health care coverage.

(d) A party may contest the public authority's action to suspend or reinstate the medical support contribution if the party makes a written request for a hearing within 30 days after receiving written notice. If a party makes a timely request for a hearing, the public authority must schedule a hearing and send written notice of the hearing to the parties by mail to the parties' last known addresses at least 14 days before the hearing. The hearing must be conducted in district court or in the expedited child support process if section 484.702 applies. The district court or child support magistrate must determine whether suspending or reinstating the medical support contribution is appropriate and, if appropriate, the effective date of the removal or reinstatement of the medical support contribution.

Subd. 17. **Collecting unreimbursed or uninsured ~~medical~~ health-related expenses.** (a) This subdivision and subdivision 18 apply when a court order has determined and ordered the parties' proportionate share and responsibility to contribute to unreimbursed or uninsured ~~medical~~ health-related expenses.

(b) A party requesting reimbursement of unreimbursed or uninsured ~~medical~~ health-related expenses must initiate a request to the other party within two years of the date that the requesting party incurred the unreimbursed or uninsured ~~medical~~ health-related expenses. If a court order has been signed ordering the contribution ~~towards~~ toward unreimbursed or uninsured expenses, a two-year limitations provision must be applied to any requests made on or after January 1, 2007. The provisions of this section apply retroactively to court orders signed before January 1, 2007. Requests for unreimbursed or uninsured expenses made on or after January 1, 2007, may include expenses incurred before January 1, 2007, and on or after January 1, 2005.

(c) A requesting party must mail a written notice of intent to collect the unreimbursed or uninsured ~~medical~~ health-related expenses and a copy of an affidavit of health care expenses to the other party at the other party's last known address.

(d) The written notice must include a statement that the other party has 30 days from the date the notice was mailed to (1) pay in full; (2) agree to a payment schedule; or (3) file a motion requesting a hearing to contest the amount due or to set a court-ordered monthly payment amount. If the public authority provides services, the written notice also must include a statement that, if the other party does not respond within the 30 days, the requesting party may submit the amount due to the public authority for collection.

(e) The affidavit of health care expenses must itemize and document the joint child's unreimbursed or uninsured ~~medical~~ health-related expenses and include copies of all bills, receipts, and insurance company explanations of benefits.

(f) If the other party does not respond to the request for reimbursement within 30 days, the requesting party may commence enforcement against the other party under subdivision 18; file a motion for a court-ordered monthly payment amount under paragraph (i); or notify the public authority, if the public authority provides services, that the other party has not responded.

(g) The notice to the public authority must include: a copy of the written notice, a copy of the affidavit of health care expenses, and copies of all bills, receipts, and insurance company explanations of benefits.

(h) If noticed under paragraph (f), the public authority must serve the other party with a notice of intent to enforce unreimbursed and uninsured ~~medical~~ health-related expenses and file an affidavit of service by mail with the district court administrator. The notice must state that the other party has 14 days to (1) pay in full; or (2) file a motion to contest the amount due or to set a court-ordered monthly payment amount. The notice must also state that if there is no response within 14 days, the public authority will commence enforcement of the expenses as arrears under subdivision 18.

(i) To contest the amount due or set a court-ordered monthly payment amount, a party must file a timely motion and schedule a hearing in district court or in the expedited child support process if section 484.702 applies. The moving party must provide the other party and the public authority, if the public authority provides services, with written notice at least 14 days before the hearing by mailing notice of the hearing to the public authority and to the requesting party at the requesting party's last known address. The moving party must file the affidavit of health care expenses with the court at least five days before the hearing. The district court or child support magistrate must determine liability for the expenses and order that the liable party is subject to enforcement of the expenses as arrears under subdivision 18 or set a court-ordered monthly payment amount.

Subd. 18. **Enforcing unreimbursed or uninsured ~~medical~~ health-related expenses as arrears.** (a) Unreimbursed or uninsured ~~medical~~ health-related expenses enforced under this subdivision are collected as arrears.

(b) If the liable party is the parent with primary physical custody as defined in section 518A.26, subdivision 17, the unreimbursed or uninsured ~~medical~~ health-related expenses must be deducted from any arrears the requesting party owes the liable party. If unreimbursed or uninsured expenses remain after the deduction, the expenses must be collected as follows:

(1) If the requesting party owes a current child support obligation to the liable party, 20 percent of each payment received from the requesting party must be returned to the requesting party. The total amount returned to the requesting party each month must not exceed 20 percent of the current monthly support obligation.

(2) If the requesting party does not owe current child support or arrears, a payment agreement under section 518A.69 is required. If the liable party fails to enter into or comply with a payment agreement, the requesting party or the public authority, if the public authority provides services, may schedule a hearing to set a court-ordered payment. The requesting party or the public authority must provide the liable party with written notice of the hearing at least 14 days before the hearing.

(c) If the liable party is not the parent with primary physical custody as defined in section 518A.26, subdivision 17, the unreimbursed or uninsured ~~medical~~ health-related expenses must be deducted from any arrears the requesting party owes the liable party. If unreimbursed or uninsured expenses remain after the deduction, the expenses must be added and collected as arrears owed by the liable party.

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

Sec. 29. Minnesota Statutes 2022, section 518A.42, subdivision 1, is amended to read:

Subdivision 1. **Ability to pay.** (a) It is a rebuttable presumption that a child support order should not exceed the obligor's ability to pay. To determine the amount of child support the obligor has the ability to pay, the court shall follow the procedure set out in this section.

(b) The court shall calculate the obligor's income available for support by subtracting a monthly self-support reserve equal to 120 percent of the federal poverty guidelines for one person from the obligor's parental income for determining child support (PICS). If benefits under section 518A.31 are received by the obligee as a representative payee for a joint child or are received by the child attending school, based on the other parent's eligibility, the court shall subtract the amount of benefits from the obligor's PICS before subtracting the self-support reserve. If the obligor's income available for support calculated under this paragraph is equal to or greater than the obligor's support obligation calculated under section 518A.34, the court shall order child support under section 518A.34.

(c) If the obligor's income available for support calculated under paragraph (b) is more than the minimum support amount under subdivision 2, but less than the guideline amount under section 518A.34, then the court shall apply a reduction to the child support obligation in the following order, until the support order is equal to the obligor's income available for support:

(1) medical support obligation;

(2) child care support obligation; and

(3) basic support obligation.

(d) If the obligor's income available for support calculated under paragraph (b) is equal to or less than the minimum support amount under subdivision 2 or if the obligor's gross income is less than 120 percent of the federal poverty guidelines for one person, the minimum support amount under subdivision 2 applies.

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

Sec. 30. Minnesota Statutes 2022, section 518A.42, subdivision 3, is amended to read:

Subd. 3. **Exception.** (a) This section does not apply to an obligor who is incarcerated or is a recipient of a general assistance grant, Supplemental Security Income, temporary assistance for needy families (TANF) grant, or comparable state-funded Minnesota family investment program (MFIP) benefits.

(b) If the court finds the obligor receives no income and completely lacks the ability to earn income, the minimum basic support amount under this subdivision does not apply.

(c) If the obligor's basic support amount is reduced below the minimum basic support amount due to the application of the parenting expense adjustment, the minimum basic support amount under this subdivision does not apply and the lesser amount is the guideline basic support.

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

Sec. 31. Minnesota Statutes 2022, section 518A.65, is amended to read:

518A.65 DRIVER'S LICENSE SUSPENSION.

(a) This paragraph is effective July 1, 2023. Upon motion of an obligee, which has been properly served on the obligor and upon which there has been an opportunity for hearing, if a court finds that the obligor has been or may be issued a driver's license by the commissioner of public safety and the obligor is in arrears in court-ordered child support or maintenance payments, or both, in an amount equal to or greater than three times the obligor's total monthly support and maintenance payments and is not in compliance with a written payment agreement pursuant to section 518A.69 that is approved by the court, a child support magistrate, or the public authority, the court ~~shall~~ may order the commissioner of public safety to suspend the obligor's driver's license. The court may consider the circumstances in paragraph (i) to determine whether driver's license suspension is an appropriate remedy that is likely to induce the payment of child support. The court may consider whether driver's license suspension would have a direct harmful effect on the obligor or joint children that would make driver's license suspension an inappropriate remedy. The public authority may not administratively reinstate a driver's license suspended by the court unless specifically authorized in the court order. This paragraph expires December 31, 2025.

(b) This paragraph is effective January 1, 2026. Upon motion of an obligee, which has been properly served on the obligor and upon which there has been an opportunity for hearing, if a court finds that the obligor has a valid driver's license issued by the commissioner

of public safety and the obligor is in arrears in court-ordered child support or maintenance payments, or both, in an amount equal to or greater than three times the obligor's total monthly support and maintenance payments and is not in compliance with a written payment agreement pursuant to section 518A.69 that is approved by the court, a child support magistrate, or the public authority, the court may order the commissioner of public safety to suspend the obligor's driver's license. The court may consider the circumstances in paragraph (i) to determine whether driver's license suspension is an appropriate remedy that is likely to induce the payment of child support. The court may consider whether driver's license suspension would have a direct harmful effect on the obligor or joint children that would make driver's license suspension an inappropriate remedy. The public authority may not administratively reinstate a driver's license suspended by the court unless specifically authorized in the court order.

(c) The court's order must be stayed for 90 days in order to allow the obligor to execute a written payment agreement pursuant to section 518A.69. The payment agreement must be approved by either the court or the public authority responsible for child support enforcement. If the obligor has not executed or is not in compliance with a written payment agreement pursuant to section 518A.69 after the 90 days expires, the court's order becomes effective and the commissioner of public safety shall suspend the obligor's driver's license. The remedy under this section is in addition to any other enforcement remedy available to the court. An obligee may not bring a motion under this paragraph within 12 months of a denial of a previous motion under this paragraph.

~~(b)~~ (d) This paragraph is effective July 1, 2023. If a public authority responsible for child support enforcement determines that the obligor has been or may be issued a driver's license by the commissioner of public safety ~~and~~; the obligor is in arrears in court-ordered child support or maintenance payments or both in an amount equal to or greater than three times the obligor's total monthly support and maintenance payments and not in compliance with a written payment agreement pursuant to section 518A.69 that is approved by the court, a child support magistrate, or the public authority, the public authority shall direct the commissioner of public safety to suspend the obligor's driver's license unless exercising administrative discretion under paragraph (i). The remedy under this section is in addition to any other enforcement remedy available to the public authority. This paragraph expires December 31, 2025.

(e) This paragraph is effective January 1, 2026. If a public authority responsible for child support enforcement determines that:

(1) the obligor has a valid driver's license issued by the commissioner of public safety;

(2) the obligor is in arrears in court-ordered child support or maintenance payments or both in an amount equal to or greater than three times the obligor's total monthly support and maintenance payments;

(3) the obligor is not in compliance with a written payment agreement pursuant to section 518A.69 that is approved by the court, a child support magistrate, or the public authority; and

(4) the obligor's mailing address is known to the public authority;

then the public authority shall direct the commissioner of public safety to suspend the obligor's driver's license unless exercising administrative discretion under paragraph (i). The remedy under this section is in addition to any other enforcement remedy available to the public authority.

~~(c)~~ (f) At least 90 days prior to notifying the commissioner of public safety according to paragraph ~~(b)~~ (d), the public authority must mail a written notice to the obligor at the obligor's last known address, that it intends to seek suspension of the obligor's driver's license and that the obligor must request a hearing within 30 days in order to contest the suspension. If the obligor makes a written request for a hearing within 30 days of the date of the notice, a court hearing must be held. Notwithstanding any law to the contrary, the obligor must be served with 14 days' notice in writing specifying the time and place of the hearing and the allegations against the obligor. The notice must include information that apprises the obligor of the requirement to develop a written payment agreement that is approved by a court, a child support magistrate, or the public authority responsible for child support enforcement regarding child support, maintenance, and any arrearages in order to avoid license suspension. The notice may be served personally or by mail. If the public authority does not receive a request for a hearing within 30 days of the date of the notice, and the obligor does not execute a written payment agreement pursuant to section 518A.69 that is approved by the public authority within 90 days of the date of the notice, the public authority shall direct the commissioner of public safety to suspend the obligor's driver's license under paragraph ~~(b)~~ (d).

~~(d)~~ (g) At a hearing requested by the obligor under paragraph ~~(c)~~ (f), and on finding that the obligor is in arrears in court-ordered child support or maintenance payments or both in an amount equal to or greater than three times the obligor's total monthly support and maintenance payments, the district court or child support magistrate shall order the commissioner of public safety to suspend the obligor's driver's license or operating privileges unless:

(1) the court or child support magistrate determines that the obligor has executed and is in compliance with a written payment agreement pursuant to section 518A.69 that is approved by the court, a child support magistrate, or the public authority~~.~~; or

(2) the court, in its discretion, determines that driver's license suspension is unlikely to induce payment of child support or would have direct harmful effects on the obligor or joint child that makes driver's license suspension an inappropriate remedy. The court may consider the circumstances in paragraph (i) in exercising the court's discretion.

~~(e)~~ (h) An obligor whose driver's license or operating privileges are suspended may:

(1) provide proof to the public authority responsible for child support enforcement that the obligor is in compliance with all written payment agreements pursuant to section 518A.69;

(2) bring a motion for reinstatement of the driver's license. At the hearing, if the court or child support magistrate orders reinstatement of the driver's license, the court or child support magistrate must establish a written payment agreement pursuant to section 518A.69; or

(3) seek a limited license under section 171.30. A limited license issued to an obligor under section 171.30 expires 90 days after the date it is issued.

Within 15 days of the receipt of that proof or a court order, the public authority shall inform the commissioner of public safety that the obligor's driver's license or operating privileges should no longer be suspended.

(i) Prior to notifying the commissioner of public safety that an obligor's driver's license should be suspended or after an obligor's driving privileges have been suspended, the public authority responsible for child support enforcement may use administrative authority to end the suspension process or inform the commissioner of public safety that the obligor's driving privileges should no longer be suspended under any of the following circumstances:

(1) the full amount of court-ordered payments have been received for at least one month;

(2) an income withholding notice has been sent to an employer or payor of money;

(3) payments less than the full court-ordered amount have been received and the circumstances of the obligor demonstrate the obligor's substantial intent to comply with the order;

(4) the obligor receives public assistance;

(5) the case is being reviewed by the public authority for downward modification due to changes in the obligor's financial circumstances or a party has filed a motion to modify the child support order;

(6) the obligor no longer lives in the state and the child support case is in the process of interstate enforcement;

(7) the obligor is currently incarcerated for one week or more or is receiving in-patient treatment for physical health, mental health, chemical dependency, or other treatment. This clause applies for six months after the obligor is no longer incarcerated or receiving in-patient treatment;

(8) the obligor is temporarily or permanently disabled and unable to pay child support;

(9) the obligor has presented evidence to the public authority that the obligor needs driving privileges to maintain or obtain the obligor's employment;

(10) the obligor has not had a meaningful opportunity to pay toward arrears; and

(11) other circumstances of the obligor indicate that a temporary condition exists for which suspension of a driver's license for the nonpayment of child support is not appropriate. When considering whether driver's license suspension is appropriate, the public authority must assess: (i) whether suspension of the driver's license is likely to induce payment of child support; and (ii) whether suspension of the driver's license would have direct harmful effects on the obligor or joint children that make driver's license suspension an inappropriate remedy.

The presence of circumstances in this paragraph does not prevent the public authority from proceeding with a suspension of a driver's license.

~~(f)~~ (j) In addition to the criteria established under this section for the suspension of an obligor's driver's license, a court, a child support magistrate, or the public authority may direct the commissioner of public safety to suspend the license of a party who has failed, after receiving notice, to comply with a subpoena relating to a paternity or child support proceeding. Notice to an obligor of intent to suspend must be served by first class mail at the obligor's last known address. The notice must inform the obligor of the right to request a hearing. If the obligor makes a written request within ten days of the date of the hearing, a hearing must be held. At the hearing, the only issues to be considered are mistake of fact and whether the obligor received the subpoena.

~~(g)~~ (k) The license of an obligor who fails to remain in compliance with an approved written payment agreement may be suspended. Prior to suspending a license for

noncompliance with an approved written payment agreement, the public authority must mail to the obligor's last known address a written notice that (1) the public authority intends to seek suspension of the obligor's driver's license under this paragraph, and (2) the obligor must request a hearing, within 30 days of the date of the notice, to contest the suspension. If, within 30 days of the date of the notice, the public authority does not receive a written request for a hearing and the obligor does not comply with an approved written payment agreement, the public authority must direct the Department of Public Safety to suspend the obligor's license under paragraph ~~(b)~~ (d). If the obligor makes a written request for a hearing within 30 days of the date of the notice, a court hearing must be held. Notwithstanding any law to the contrary, the obligor must be served with 14 days' notice in writing specifying the time and place of the hearing and the allegations against the obligor. The notice may be served personally or by mail at the obligor's last known address. If the obligor appears at the hearing and the court determines that the obligor has failed to comply with an approved written payment agreement, the court or public authority shall notify the Department of Public Safety to suspend the obligor's license under paragraph ~~(b)~~ (d). If the obligor fails to appear at the hearing, the court or public authority must notify the Department of Public Safety to suspend the obligor's license under paragraph ~~(b)~~ (d).

EFFECTIVE DATE. This section is effective July 1, 2023, unless otherwise specified.

Sec. 32. Minnesota Statutes 2022, section 518A.77, is amended to read:

518A.77 GUIDELINES REVIEW.

~~(a)~~ No later than 2006 and every four years after that, the Department of Human Services must conduct a review of the child support guidelines as required under Code of Federal Regulations, title 45, section 302.56(h).

~~(b) This section expires January 1, 2032.~~

ARTICLE 16
MISCELLANEOUS

Section 1. Minnesota Statutes 2022, section 256.01, is amended by adding a subdivision to read:

Subd. 43. **Grant program reporting.** The commissioner must submit a report to the chairs and ranking minority members of the legislative committees with jurisdiction over human services by December 31, 2023, and by each December 31 thereafter on the following information:

(1) the number of grant programs administered by the commissioner that required a full-time equivalent staff appropriation or administrative appropriation in order to implement;

(2) the total amount of funds appropriated to the commissioner for full-time equivalent staff or administration for all the grant programs; and

(3) for each grant program administered by the commissioner:

(i) the amount of funds appropriated to the commissioner for full-time equivalent staff or administration to administer that particular grant program;

(ii) the actual amount of funds that were spent on full-time equivalent staff or administration to administer that particular grant program; and

(iii) if there were funds appropriated that were not spent on full-time equivalent staff or administration to administer that particular grant program, what the funds were actually spent on.

Sec. 2. **DIRECTION TO COMMISSIONER; IMPROVING THE MINNESOTA ELIGIBILITY TECHNOLOGY SYSTEM (METS).**

(a) The commissioner of human services must allocate funding in this section to complete the 24 priorities for METS core functionality that were initially compiled in 2018, and to complete any project that was put on hold during the federal public health emergency for COVID-19.

(b) The commissioner must implement changes to METS that permit an eligibility worker to record receipt of an eligibility renewal form for medical assistance or MinnesotaCare and to pause the automatic case closure functionality of METS until the eligibility renewal form is completed.

(c) The commissioner must implement changes to METS that allow a closed medical assistance or MinnesotaCare case to be reopened administratively.

(d) The commissioner must implement changes to METS that support processing medical assistance renewals during the federally required four-month reconsideration period.

(e) The commissioner must provide additional staffing and execute a contract to respond to the recommendations in the 2021 Department of Human Services Gartner Go Forward strategy report.

(f) The commissioner must identify and implement additional changes to METS that mitigate the most severe sources of manual processes needed to address the core functionality limitations of METS.

Sec. 3. **DIRECTION TO COMMISSIONER; MODERNIZING THE MEDICAID MANAGEMENT INFORMATION SYSTEM (MMIS).**

(a) The commissioner of human services must refine the web-based Medicaid provider enrollment application and automate the provider screening process and reporting functionality. The commissioner must develop a provider directory that meets some of the requirements of the Centers for Medicare and Medicaid Services interoperability rule.

(b) The commissioner must execute a contract to process outpatient pharmacy claims and manage the outpatient fee-for-service medical assistance benefit.

(c) The commissioner must execute a contract for consultation services to analyze the MMIS infrastructure and functionality and provide advice on the technical and planning gaps that must be addressed in a modernized MMIS. The commissioner must use the analysis to establish a strategic plan for the configuration, requirements, and trajectory of the modernized MMIS and for mapping a modernized claims system functionality and integration with other MMIS subsystems.

(d) The commissioner must develop a MMIS third-party liability subsystem that includes a case management system with enhanced claims search functions, financial adjustment and tracking functionality, and a connection to the electronic document management system.

(e) The commissioner must contract for services to leverage, sequence, and integrate the products that will constitute the modernized MMIS so that all components of the modernized MMIS interface with one another, exchange and make available needed data, and ensure smooth implementation.

Sec. 4. **OUTCOMES AND EVALUATION CONSULTATION REQUIREMENTS.**

For any section in this act that includes program outcomes, evaluation metrics or requirements, progress indicators, or other related measurements, any commissioner must consult with the commissioner of management and budget to develop outcomes, metrics or requirements, indicators, or other related measurements for each section in this act affected by this section. The commissioner must only implement program outcomes, evaluation metrics or requirements, progress indicators, or other related measurements that are determined through and agreed upon during the consultation with the commissioner of management and budget. The commissioner shall not implement any sections affected by this section until the consultation with the commissioner of management and budget is completed. The commissioner must incorporate agreed-upon program outcomes, evaluation

metrics, and progress indicators into grant applications, requests for proposals, and any reports to the legislature.

ARTICLE 17
HEALTH CARE AFFORDABILITY AND DELIVERY

Section 1. **[62J.86] DEFINITIONS.**

Subdivision 1. **Definitions.** For the purposes of sections 62J.86 to 62J.92, the following terms have the meanings given.

Subd. 2. **Advisory council.** "Advisory council" means the Health Care Affordability Advisory Council established under section 62J.88.

Subd. 3. **Board.** "Board" means the Health Care Affordability Board established under section 62J.87.

Sec. 2. **[62J.87] HEALTH CARE AFFORDABILITY BOARD.**

Subdivision 1. **Establishment.** The Legislative Coordinating Commission shall establish the Health Care Affordability Board, which shall be governed as a board under section 15.012, paragraph (a), to protect consumers, state and local governments, health plan companies, providers, and other health care system stakeholders from unaffordable health care costs. The board must be operational by January 1, 2024.

Subd. 2. **Membership.** (a) The Health Care Affordability Board consists of 13 members, appointed as follows:

(1) five members appointed by the governor;

(2) two members appointed by the majority leader of the senate;

(3) two members appointed by the minority leader of the senate;

(4) two members appointed by the speaker of the house; and

(5) two members appointed by the minority leader of the house of representatives.

(b) All appointed members must have knowledge and demonstrated expertise in one or more of the following areas: health care finance, health economics, health care management or administration at a senior level, health care consumer advocacy, representing the health care workforce as a leader in a labor organization, purchasing health care insurance as a health benefits administrator, delivery of primary care, health plan company administration, public or population health, and addressing health disparities and structural inequities.

(c) A member may not participate in board proceedings involving an organization, activity, or transaction in which the member has either a direct or indirect financial interest, other than as an individual consumer of health services.

(d) The Legislative Coordinating Commission shall coordinate appointments under this subdivision to ensure that board members are appointed by August 1, 2023, and that board members as a whole meet all of the criteria related to the knowledge and expertise specified in paragraph (b).

Subd. 3. **Terms.** (a) Board appointees shall serve four-year terms. A board member shall not serve more than three consecutive terms.

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

Subd. 4. **Chair; other officers.** (a) The governor shall designate an acting chair from the members appointed by the governor.

(b) The board shall elect a chair to replace the acting chair at the first meeting of the board by a majority of the members. The chair shall serve for two years.

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

Subd. 5. **Staff; technical assistance; contracting.** (a) The board shall hire a full-time executive director and other staff, who shall serve in the unclassified service. The executive director must have significant knowledge and expertise in health economics and demonstrated experience in health policy.

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

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

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

Subd. 6. **Access to information.** (a) The board may request that a state agency provide the board with any publicly available information in a usable format as requested by the board, at no cost to the board.

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

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

(d) Any data submitted to the board shall retain its original classification under the Minnesota Data Practices Act in chapter 13.

Subd. 7. **Compensation.** Board members shall not receive compensation but may receive reimbursement for expenses as authorized under section 15.059, subdivision 3.

Subd. 8. **Meetings.** (a) Meetings of the board are subject to chapter 13D. The board shall meet publicly at least quarterly. The board may meet in closed session when reviewing proprietary information as specified in section 62J.71, subdivision 4.

(b) The board shall announce each public meeting at least two weeks prior to the scheduled date of the meeting. Any materials for the meeting shall be made public at least one week prior to the scheduled date of the meeting.

(c) At each public meeting, the board shall provide the opportunity for comments from the public, including the opportunity for written comments to be submitted to the board prior to a decision by the board.

Sec. 3. **[62J.88] HEALTH CARE AFFORDABILITY ADVISORY COUNCIL.**

Subdivision 1. **Establishment.** The governor shall appoint a Health Care Affordability Advisory Council to provide advice to the board on health care costs and access issues and to represent the views of patients and other stakeholders. Members of the advisory council shall be appointed based on their knowledge and demonstrated expertise in one or more of the following areas: health care delivery, ensuring health care access for diverse populations, public and population health, patient perspectives, health care cost trends and drivers, clinical and health services research, innovation in health care delivery, and health care benefits management.

Subd. 2. **Duties; reports.** (a) The council shall provide technical recommendations to the board on:

(1) the identification of economic indicators and other metrics related to the development and setting of health care spending growth targets;

(2) data sources for measuring health care spending; and

(3) measurement of the impact of health care spending growth targets on diverse communities and populations, including but not limited to those communities and populations adversely affected by health disparities.

(b) The council shall report technical recommendations and a summary of its activities to the board at least annually, and shall submit additional reports on its activities and recommendations to the board, as requested by the board or at the discretion of the council.

Subd. 3. **Terms.** (a) The initial appointed advisory council members shall serve staggered terms of two, three, or four years determined by lot by the secretary of state. Following the initial appointments, advisory council members shall serve four-year terms.

(b) Removal and vacancies of advisory council members shall be governed by section 15.059.

Subd. 4. **Compensation.** Advisory council members may be compensated according to section 15.059.

Subd. 5. **Meetings.** The advisory council shall meet at least quarterly. Meetings of the advisory council are subject to chapter 13D.

Subd. 6. **Exemption.** Notwithstanding section 15.059, the advisory council shall not expire.

Sec. 4. **[62J.89] DUTIES OF THE BOARD.**

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

(1) set health care spending growth targets for the state, as specified under section 62J.90;

(2) enhance the transparency of provider organizations;

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

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

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

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

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

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

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

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

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

Subd. 3. **Recommendations for reform.** The board shall make recommendations for legislative policy, market, or any other reforms to:

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

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

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

Subd. 4. **Office of Patient Protection.** The board shall establish an Office of Patient Protection, to be operational by January 1, 2025. The office shall assist consumers with issues related to access and quality of health care, and advise the legislature on ways to reduce consumer health care spending and improve consumer experiences by reducing complexity for consumers.

Sec. 5. **[62J.90] HEALTH CARE SPENDING GROWTH TARGETS.**

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

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

(b) The health care spending growth target must:

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

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

(3) define the health care markets and the entities to which the targets apply;

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

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

(6) incorporate specific benchmarks related to health equity.

(c) In developing, implementing, and evaluating the growth target program, the board shall:

(1) consider the incorporation of quality of care and primary care spending goals;

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

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

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

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

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

(5) ensure that growth targets:

(i) do not constrain the Minnesota health care workforce, including the need to provide competitive wages and benefits;

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

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

(6) consult with the advisory council and other stakeholders.

Subd. 3. **Data.** The board shall identify data to be used for tracking performance in meeting the growth target and identify methods of data collection necessary for efficient implementation by the board. In identifying data and methods, the board shall:

(1) consider the availability, timeliness, quality, and usefulness of existing data, including the data collected under section 62U.04;

(2) assess the need for additional investments in data collection, data validation, or data analysis capacity to support the board in performing its duties; and

(3) minimize the reporting burden to the extent possible.

Subd. 4. **Setting growth targets; related duties.** (a) The board, by June 15, 2024, and by June 15 of each succeeding calendar year through June 15, 2028, shall establish annual health care spending growth targets for the next calendar year consistent with the requirements of this section. The board shall set annual health care spending growth targets for the five-year period from January 1, 2025, through December 31, 2029.

(b) The board shall periodically review all components of the health care spending growth target program methodology, economic indicators, and other factors. The board may revise the annual spending growth targets after a public hearing, as appropriate. If the board revises a spending growth target, the board must provide public notice at least 60 days before the start of the calendar year to which the revised growth target will apply.

(c) The board, based on an analysis of drivers of health care spending and evidence from public testimony, shall evaluate strategies and new policies, including the establishment of accountability mechanisms, that are able to contribute to meeting growth targets and limiting health care spending growth without increasing disparities in access to health care.

Subd. 5. **Hearings.** At least annually, the board shall hold public hearings to present findings from spending growth target monitoring. The board shall also regularly hold public hearings to take testimony from stakeholders on health care spending growth, setting and revising health care spending growth targets, the impact of spending growth and growth targets on health care access and quality, and as needed to perform the duties assigned under section 62J.89, subdivisions 1, 2, and 3.

Sec. 6. **[62J.91] NOTICE TO HEALTH CARE ENTITIES.**

Subdivision 1. **Notice.** (a) The board shall provide notice to all health care entities that have been identified by the board as exceeding the spending growth target for any given year.

(b) For purposes of this section, "health care entity" shall be defined by the board during the development of the health care spending growth methodology. When developing this methodology, the board shall consider a definition of health care entity that includes clinics, hospitals, ambulatory surgical centers, physician organizations, accountable care organizations, integrated provider and plan systems, and other entities defined by the board, provided that physician organizations with a patient panel of 15,000 or fewer, or which represent providers who collectively receive less than $25,000,000 in annual net patient service revenue from health plan companies and other payers, shall be exempt.

Subd. 2. **Performance improvement plans.** (a) The board shall establish and implement procedures to assist health care entities to improve efficiency and reduce cost growth by requiring some or all health care entities provided notice under subdivision 1 to file and implement a performance improvement plan. The board shall provide written notice of this requirement to health care entities.

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

(1) file a performance improvement plan with the board; or

(2) file an application with the board to waive the requirement to file a performance improvement plan or extend the timeline for filing a performance improvement plan.

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

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

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

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

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

(5) any other factors the board considers relevant. If the board declines to waive or extend the requirement for the health care entity to file a performance improvement plan, the board shall provide written notice to the health care entity that its application for a waiver or extension was denied and the health care entity shall file a performance improvement plan.

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

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

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

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

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

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

monitoring, as determined by the board. The board shall provide assistance to the health care entity in the successful implementation of the performance improvement plan.

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

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

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

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

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

Upon the successful completion of the performance improvement plan, the board shall remove the identity of the health care entity from the board's website. The board may assist health care entities with implementing the performance improvement plans or otherwise ensure compliance with this subdivision.

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

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

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

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

(4) knowingly failed to provide information required by this subdivision to the board or knowingly provided false information, the board may assess a civil penalty to the health care entity of not more than $500,000. The board may only impose a civil penalty if the board determines that the health care entity is unlikely to voluntarily comply with all applicable provisions of this subdivision.

Sec. 7. **[62J.92] REPORTING REQUIREMENTS.**

Subdivision 1. **General requirement.** (a) The board shall present the reports required by this section to the chairs and ranking members of the legislative committees with primary jurisdiction over health care finance and policy. The board shall also make these reports available to the public on the board's website.

(b) The board may contract with a third-party vendor for technical assistance in preparing the reports.

Subd. 2. **Progress reports.** The board shall submit written progress updates about the development and implementation of the health care spending growth target program by February 15, 2025, and February 15, 2026. The updates must include reporting on board membership and activities, program design decisions, planned timelines for implementation of the program, and the progress of implementation. The reports must include the methodological details underlying program design decisions.

Subd. 3. **Health care spending trends.** By December 15, 2025, and every December 15 thereafter, the board shall submit a report on health care spending trends and the health care spending growth target program that includes:

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

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

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

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

(5) changes under consideration for revising the methodology to monitor or set growth targets;

(6) recommendations for initiatives to assist health care entities in meeting health care spending growth targets, including broader and more transparent adoption of value-based payment arrangements; and

(7) the number of health care entities whose spending growth exceeded growth targets, information on performance improvement plans and the extent to which the plans were

completed, and any civil penalties imposed on health care entities related to noncompliance with performance improvement plans and related requirements.

Sec. 8. Minnesota Statutes 2022, section 62K.15, is amended to read:

62K.15 ANNUAL OPEN ENROLLMENT PERIODS; SPECIAL ENROLLMENT PERIODS.

(a) Health carriers offering individual health plans must limit annual enrollment in the individual market to the annual open enrollment periods for MNsure. Nothing in this section limits the application of special or limited open enrollment periods as defined under the Affordable Care Act.

(b) Health carriers offering individual health plans must inform all applicants at the time of application and enrollees at least annually of the open and special enrollment periods as defined under the Affordable Care Act.

(c) Health carriers offering individual health plans must provide a special enrollment period for enrollment in the individual market by employees of a small employer that offers a qualified small employer health reimbursement arrangement in accordance with United States Code, title 26, section 9831(d). The special enrollment period shall be available only to employees newly hired by a small employer offering a qualified small employer health reimbursement arrangement, and to employees employed by the small employer at the time the small employer initially offers a qualified small employer health reimbursement arrangement. For employees newly hired by the small employer, the special enrollment period shall last for 30 days after the employee's first day of employment. For employees employed by the small employer at the time the small employer initially offers a qualified small employer health reimbursement arrangement, the special enrollment period shall last for 30 days after the date the arrangement is initially offered to employees.

(d) The commissioner of commerce shall enforce this section.

(e) Health carriers offering individual health plans through MNsure must provide a special enrollment period as required under the easy enrollment health insurance outreach program under section 62V.13.

EFFECTIVE DATE. This section is effective for taxable years beginning after December 31, 2023, and applies to health plans offered, issued, or sold on or after January 1, 2024.

Sec. 9. Minnesota Statutes 2022, section 62U.04, subdivision 11, is amended to read:

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

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

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

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

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

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

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

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

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

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

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

(6) to provide technical assistance to the Health Care Affordability Board to implement sections 62J.86 to 62J.92.

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

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

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

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

Sec. 10. **[62V.12] STATE-FUNDED COST-SHARING REDUCTIONS.**

Subdivision 1. **Establishment.** (a) The board must develop and administer a state-funded cost-sharing reduction program for eligible persons who enroll in a silver level qualified health plan through MNsure. The board must implement the cost-sharing reduction program for plan years beginning on or after January 1, 2024.

(b) For purposes of this section, an "eligible person" is an individual who meets the eligibility criteria to receive a cost-sharing reduction under Code of Federal Regulations, title 45, section 155.305(g).

Subd. 2. **Reduction in cost-sharing.** (a) The cost-sharing reduction program must use state funds to reduce enrollee cost-sharing by increasing the actuarial value of silver level health plans for eligible persons beyond the 73 percent value established in Code of Federal Regulations, title 45, section 156.420(a)(3)(ii), to an actuarial value of 87 percent.

(b) Paragraph (a) applies beginning for plan year 2024 for eligible individuals expected to have a household income above 200 percent of the federal poverty level but that does not exceed 250 percent of the federal poverty level, for the benefit year for which coverage is requested.

(c) Beginning for plan year 2026, the cost-sharing reduction program applies for eligible individuals expected to have a household income above 250 percent of the federal poverty level but that does not exceed 300 percent of the federal poverty level, for the benefit year for which coverage is requested. Under this paragraph, the cost-sharing reduction program applies by increasing the actuarial value of silver level health plans for eligible persons to the 73 percent actuarial value established in Code of Federal Regulations, title 45, section 156.420(a)(3)(ii).

Subd. 3. **Administration.** The board, when administering the program, must:

(1) allow eligible persons to enroll in a silver level health plan with a state-funded cost-sharing reduction;

(2) modify the MNsure shopping tool to display the total cost-sharing reduction benefit available to individuals eligible under this section; and

(3) reimburse health carriers on a quarterly basis for the cost to the health plan providing the state-funded cost-sharing reductions.

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

Sec. 11. **[62V.13] EASY ENROLLMENT HEALTH INSURANCE OUTREACH PROGRAM.**

Subdivision 1. **Establishment.** The board, in cooperation with the commissioner of revenue, must establish the easy enrollment health insurance outreach program to:

(1) reduce the number of uninsured Minnesotans and increase access to affordable health insurance coverage;

(2) allow the commissioner of revenue to provide return information, at the request of the taxpayer, to MNsure to provide the taxpayer with information about the potential eligibility for financial assistance and health insurance enrollment options through MNsure;

(3) allow MNsure to estimate taxpayer potential eligibility for financial assistance for health insurance coverage; and

(4) allow MNsure to conduct targeted outreach to assist interested taxpayer households in applying for and enrolling in affordable health insurance options through MNsure, including connecting interested taxpayer households with a navigator or broker for free enrollment assistance.

Subd. 2. **Screening for eligibility for insurance assistance.** Upon receipt of and based on return information received from the commissioner of revenue under section 270B.14, subdivision 22, MNsure may make a projected assessment on whether the interested taxpayer's household may qualify for a financial assistance program for health insurance coverage.

Subd. 3. **Outreach letter and special enrollment period.** (a) MNsure must provide a written letter of the projected assessment under subdivision 2 to a taxpayer who indicates to the commissioner of revenue that the taxpayer is interested in obtaining information on access to health insurance.

(b) MNsure must allow a special enrollment period for taxpayers who receive the outreach letter in paragraph (a) and are determined eligible to enroll in a qualified health plan through MNsure. The triggering event for the special enrollment period is the day the outreach letter under this subdivision is mailed to the taxpayer. An eligible individual, and their dependents, have 65 days from the triggering event to select a qualifying health plan and coverage for the qualifying health plan is effective the first day of the month after plan selection.

(c) Taxpayers who have a member of the taxpayer's household currently enrolled in a qualified health plan through MNsure are not eligible for the special enrollment under paragraph (b).

(d) MNsure must provide information about the easy enrollment health insurance outreach program and the special enrollment period described in this subdivision to the general public.

Subd. 4. **Appeals.** (a) Projected eligibility assessments for financial assistance under this section are not appealable.

(b) Qualification for the special enrollment period under this section is appealable to MNsure under this chapter and Minnesota Rules, chapter 7700.

EFFECTIVE DATE. This section is effective for taxable years beginning after December 31, 2023, and applies to health plans offered, issued, or sold on or after January 1, 2024.

Sec. 12. Minnesota Statutes 2022, section 256.962, subdivision 5, is amended to read:

Subd. 5. **Incentive program.** Beginning January 1, 2008, the commissioner shall establish an incentive program for organizations and licensed insurance producers under chapter 60K that directly identify and assist potential enrollees in filling out and submitting an application. For each applicant who is successfully enrolled in MinnesotaCare or medical assistance, the commissioner, within the available appropriation, shall pay the organization or licensed insurance producer a ~~$70~~ $100 application assistance bonus. The organization or licensed insurance producer may provide an applicant a gift certificate or other incentive upon enrollment.

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

Sec. 13. Minnesota Statutes 2022, section 256B.04, is amended by adding a subdivision to read:

Subd. 26. **Disenrollment under medical assistance and MinnesotaCare.** (a) The commissioner shall regularly update mailing addresses and other contact information for medical assistance and MinnesotaCare enrollees in cases of returned mail and nonresponse

using information available through managed care and county-based purchasing plans, state health and human services programs, and other sources.

(b) The commissioner shall not disenroll an individual from medical assistance or MinnesotaCare in cases of returned mail until the commissioner makes at least two attempts by phone, email, or other methods to contact the individual. The commissioner may disenroll the individual after providing no less than 30 days for the individual to respond to the most recent contact attempt.

Sec. 14. Minnesota Statutes 2022, section 256B.056, subdivision 7, is amended to read:

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

(b) Notwithstanding any other law to the contrary:

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

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

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

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

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

(iii) the child dies;

(iv) the child attains the maximum age; or

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

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

EFFECTIVE DATE. This section is effective January 1, 2024, or upon federal approval and the implementation of required administrative and systems changes, whichever is later.

The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

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

Subd. 1a. **Prohibition on cost-sharing and deductibles.** The medical assistance benefit plan must not include cost-sharing or deductibles for any medical assistance recipient or benefit.

EFFECTIVE DATE. This section is effective July 1, 2025, and applies to all medical assistance benefit plans offered, issued, or renewed on or after that date.

Sec. 16. Minnesota Statutes 2022, section 256L.04, subdivision 7a, is amended to read:

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

EFFECTIVE DATE. This section is effective January 1, 2027, or upon federal approval, whichever is later, subject to certification under section 30. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 17. Minnesota Statutes 2022, section 256L.04, subdivision 10, is amended to read:

Subd. 10. **Citizenship requirements.** (a) Eligibility for MinnesotaCare is limited to citizens or nationals of the United States and lawfully present noncitizens as defined in Code of Federal Regulations, title 8, section 103.12. Undocumented noncitizens, with the exception of children under 19 years of age, are ineligible for MinnesotaCare. For purposes of this subdivision, an undocumented noncitizen is an individual who resides in the United States without the approval or acquiescence of the United States Citizenship and Immigration Services. Families with children who are citizens or nationals of the United States must cooperate in obtaining satisfactory documentary evidence of citizenship or nationality according to the requirements of the federal Deficit Reduction Act of 2005, Public Law 109-171.

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

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

Sec. 18. Minnesota Statutes 2022, section 256L.04, is amended by adding a subdivision to read:

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

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

EFFECTIVE DATE. This section is effective January 1, 2027, or upon federal approval, whichever is later, subject to certification under section 30. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 19. Minnesota Statutes 2022, section 256L.07, subdivision 1, is amended to read:

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

EFFECTIVE DATE. This section is effective January 1, 2027, or upon federal approval, whichever is later, subject to certification under section 30. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 20. Minnesota Statutes 2022, section 256L.15, subdivision 2, is amended to read:

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

MinnesotaCare program. The sliding fee scale must be based on the enrollee's monthly individual or family income.

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

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

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

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

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

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

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

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

EFFECTIVE DATE. This section is effective January 1, 2024, and certification under section 30 is not required, except that paragraph (d) is effective January 1, 2027, or upon federal approval, whichever is later, subject to certification under section 30. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 21. Minnesota Statutes 2022, section 270B.14, is amended by adding a subdivision to read:

Subd. 22. **Disclosure to MNsure board.** The commissioner may disclose a return or return information to the MNsure board if a taxpayer makes the designation under section 290.433 on an income tax return filed with the commissioner. The commissioner must only disclose data necessary to provide the taxpayer with information about the potential eligibility for financial assistance and health insurance enrollment options under section 62V.13.

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

Sec. 22. **[290.433] EASY ENROLLMENT HEALTH INSURANCE OUTREACH PROGRAM CHECKOFF.**

Subdivision 1. **Taxpayer designation.** Any individual who files an income tax return may designate on their original return a request that the commissioner provide their return information to the MNsure board for purposes of providing the individual with information about potential eligibility for financial assistance and health insurance enrollment options under section 62V.13, to the extent necessary to administer the easy enrollment health insurance outreach program.

Subd. 2. **Form.** The commissioner shall notify filers of their ability to make the designation in subdivision 1 on their income tax return.

EFFECTIVE DATE. This section is effective for taxable years beginning after December 31, 2023.

Sec. 23. **DIRECTION TO MNSURE BOARD AND COMMISSIONER.**

The MNsure board and the commissioner of the Department of Revenue must develop and implement systems, policies, and procedures that encourage, facilitate, and streamline data sharing, projected eligibility assessments, and notice to taxpayers to achieve the purpose of the easy enrollment health insurance outreach program under Minnesota Statutes, section 62V.13, for operation beginning with tax year 2023.

Sec. 24. **RECOMMENDATIONS; OFFICE OF PATIENT PROTECTION.**

(a) The commissioners of human services, health, and commerce and the MNsure board shall submit to the health care affordability board and the chairs and ranking minority members of the legislative committees with primary jurisdiction over health and human services finance and policy and commerce by January 15, 2024, a report on the organization and duties of the Office of Patient Protection, to be established under Minnesota Statutes, section 62J.89, subdivision 4. The report must include recommendations on how the office shall:

(1) coordinate or consolidate within the office existing state agency patient protection activities, including but not limited to the activities of ombudsman offices and the MNsure board;

(2) enforce standards and procedures under Minnesota Statutes, chapter 62M, for utilization review organizations;

(3) work with private sector and state agency consumer assistance programs to assist consumers with questions or concerns relating to public programs and private insurance coverage;

(4) establish and implement procedures to assist consumers aggrieved by restrictions on patient choice, denials of services, and reductions in quality of care resulting from any final action by a payer or provider; and

(5) make health plan company quality of care and patient satisfaction information and other information collected by the office readily accessible to consumers on the board's website.

(b) The commissioners and the MNsure board shall consult with stakeholders as they develop the recommendations. The stakeholders consulted must include but are not limited to organizations and individuals representing: underserved communities; persons with disabilities; low-income Minnesotans; senior citizens; and public and private sector health

plan enrollees, including persons who purchase coverage through MNsure, health plan companies, and public and private sector purchasers of health coverage.

(c) The commissioners and the MNsure board may contract with a third party to develop the report and recommendations.

Sec. 25. **TRANSITION TO MINNESOTACARE PUBLIC OPTION.**

(a) The commissioner of human services must continue to administer MinnesotaCare as a basic health program in accordance with Minnesota Statutes, section 256L.02, subdivision 5, and must seek federal waivers, approvals, and law changes as required under section 26.

(b) The commissioner must present an implementation plan for the MinnesotaCare public option under Minnesota Statutes, section 256L.04, subdivision 15, to the chairs and ranking minority members of the legislative committees with jurisdiction over health care policy and finance by December 15, 2024. The plan must include:

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

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

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

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

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

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

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

(c) The commissioner shall present to the chairs and ranking minority members of the legislative committees with jurisdiction over health care policy and finance, by January 15, 2025, a report comparing service delivery and payment system models for delivering services to MinnesotaCare enrollees eligible under Minnesota Statutes, section 256L.04, subdivisions 1, 7, and 15. The report must compare the current delivery model with at least two alternative models. The alternative models must include a state-based model in which the state holds

the plan risk as the insurer and may contract with a third-party administrator for claims processing and plan administration. The alternative models may include but are not limited to:

(1) expanding the use of integrated health partnerships under Minnesota Statutes, section 256B.0755;

(2) delivering care under fee-for-service through a primary care case management system; and

(3) continuing to contract with managed care and county-based purchasing plans for some or all enrollees under modified contracts.

(d) The report must also include:

(1) a description of how each model would address:

(i) racial inequities in the delivery of health care and health care outcomes;

(ii) geographic inequities in the delivery of health care;

(iii) incentives for preventive care and other best practices; and

(iv) reimbursement of providers for high-quality, value-based care at levels sufficient to sustain or increase enrollee access to care;

(2) a comparison of the projected cost of each model; and

(3) an implementation timeline for each model that includes the earliest date by which each model could be implemented if authorized during the 2025 legislative session.

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

Sec. 26. **REQUEST FOR FEDERAL APPROVAL.**

(a) The commissioner of human services must seek all federal waivers, approvals, and law changes necessary to implement a MinnesotaCare public option and any related changes to state law, including but not limited to those waivers, approvals, and law changes necessary to allow the state to:

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

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

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

(b) In implementing this section, the commissioner of human services must contract with one or more independent entities to conduct an actuarial analysis of the implementation, administration, and effects of the provisions of a MinnesotaCare public option and any related changes to state law, including but not limited to benefits, costs, impacts on coverage, and affordability to the state and eligible enrollees, impacts on the state's individual market, and compliance with federal law, at a minimum as necessary to obtain any waivers, approvals, and law changes sought under this section.

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

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

Sec. 27. **ANALYSIS OF BENEFITS AND COSTS OF A UNIVERSAL HEALTH CARE SYSTEM.**

Subdivision 1. **Definitions.** (a) "Total public and private health care spending" means:

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

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

(b) "All necessary care" means the full range of services listed in the proposed Minnesota Health Plan legislation, including medical, dental, vision and hearing, mental health, chemical dependency treatment, reproductive and sexual health, prescription drugs, medical equipment and supplies, long-term care, home care, and coordination of care.

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

(b) The analysts shall assume that, while gross provider payments may be reduced to reflect reduced administrative costs, net provider income would remain similar to the current system. However, they shall not assume that payment rate negotiations will track current Medicaid, Medicare, or market payment rates or a combination of those rates, because provider compensation, after adjusting for reduced administrative costs, would not be universally raised or lowered but would be negotiated based on market needs, so provider compensation might be raised in an underserved area such as mental health but lowered in other areas.

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

Sec. 28. **BENEFIT AND COST ANALYSIS OF A UNIVERSAL HEALTH REFORM PROPOSAL.**

Subdivision 1. **Contract for analysis of proposal.** The commissioner of health shall contract with one or more independent entities to conduct an analysis of the benefits and costs of a legislative proposal for a universal health care financing system and a similar analysis of the current health care financing system to assist the state in comparing the proposal to the current system. The contract must strive to produce estimates for all elements in subdivision 3.

Subd. 2. **Proposal.** The commissioner of health, with input from the commissioners of human services and commerce, shall submit to the contractor for analysis the legislative proposal known as the Minnesota Health Plan, proposed in 2023 Senate File No. 2740; House File No. 2798, if enacted, that would offer a universal health care plan designed to meet a set of principles, including:

(1) ensure all Minnesotans are covered;

(2) cover all necessary care; and

(3) allow patients to choose their doctors, hospitals, and other providers.

Subd. 3. **Proposal analysis.** (a) The analysis must measure the performance of both the proposed Minnesota Health Plan and the current public and private health care financing system over a ten-year period to contrast the impact on:

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

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

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

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

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

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

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

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

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

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

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

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

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

(b) The contractor or contractors shall propose an iterative process for designing and conducting the analysis. Steps shall be reviewed with and approved by the commissioner of health and lead house and senate authors of the legislative proposal, and shall include but not be limited to:

(1) clarification of the specifics of the proposal. The analysis shall assume that the provisions in the proposal are not preempted by federal law or that the federal government gives a waiver to the preemptions;

(2) additional data elements needed to accomplish goals of the analysis;

(3) assumptions analysts are using in their analysis and the quality of the evidence behind those assumptions;

(4) timing of each stage of the project with agreed upon decision points;

(5) approaches to address any services currently provided in the existing health care system that may not be provided for within the Minnesota Health Plan as proposed; and

(6) optional scenarios provided by contractor or contractors with minor alterations in the proposed plan related to services covered or cost-sharing if those scenarios might be helpful to the legislature.

(c) The commissioner shall issue a final report by January 15, 2026, and may provide interim reports and status updates to the governor and the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services policy and finance aligned with the iterative process defined above.

(d) The contractor may offer a modeling tool as deliverable with a line-item cost provided.

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

Sec. 29. **REPEALER.**

Minnesota Statutes 2022, section 256B.0631, subdivisions 1, 2, and 3, are repealed.

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

Sec. 30. **CONTINGENT EFFECTIVE DATE.**

Sections 16, 18, and 19, and the specified portion of section 20, are effective January 1, 2027, or upon federal approval, whichever is later, but only if the commissioner of human services certifies to the legislature the following:

(1) that implementation of those sections will not result in substantial reduction in federal basic health program funding for MinnesotaCare enrollees with incomes not exceeding 200 percent of the federal poverty guidelines;

(2) premiums necessary to operationalize the program are deemed affordable in accordance with applicable federal law;

(3) the actuarial value of benefit does not fall below 94 percent and the benefit set is equal to or greater than that historically available in MinnesotaCare;

(4) the 1332 waiver was approved consistent, or without substantial deviation, from the implementation plan;

(5) the commissioner of commerce certifies that the public option would expand plan options available for individuals purchasing coverage;

(6) the state receives a substantially similar pass-through funding amount from the federal government that would have otherwise gone to enrollees' advanced premium tax credits;

(7) individuals currently served by the MinnesotaCare program are not disproportionally or substantively negatively impacted in order to make the public option affordable or implementable; and

(8) individuals currently served by the Medical Assistance program are not disproportionally or substantively negatively impacted in order to make the public option affordable or implementable.

The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

ARTICLE 18

FORECAST ADJUSTMENTS

Section 1. **HUMAN SERVICES FORECAST ADJUSTMENTS.**

The dollar amounts shown in the columns marked "Appropriations" are added to or, if shown in parentheses, are subtracted from the appropriations in Laws 2021, First Special Session chapter 7, article 15, and Laws 2021, First Special Session chapter 7, article 16, from the general fund, or any other fund named, to the commissioner of human services for the purposes specified in this article, to be available for the fiscal year indicated for each purpose. The figure "2023" used in this article means that the appropriations listed are available for the fiscal year ending June 30, 2023.

	APPROPRIATIONS Available for the Year Ending June 30 2023
Sec. 2. **COMMISSIONER OF HUMAN SERVICES**	
Subdivision 1. **Total Appropriation**	**$ (1,459,845,000)**
Appropriations by Fund	
	2023
General	(1,235,088,000)
Health Care Access	(203,530,000)
Federal TANF	(21,227,000)
Subd. 2. **Forecasted Programs**	
(a) **Minnesota Family Investment Program (MFIP)/Diversionary Work Program (DWP)**	
Appropriations by Fund	
	2023

General	(99,000)	
Federal TANF	(21,227,000)	

(b) **MFIP Child Care Assistance** (36,957,000)

(c) **General Assistance** (1,632,000)

(d) **Minnesota Supplemental Aid** 783,000

(e) **Housing Support** 180,000

(f) **Northstar Care for Children** (18,038,000)

(g) **MinnesotaCare** (203,530,000)

This appropriation is from the health care access fund.

(h) **Medical Assistance**

Appropriations by Fund	
	2023
General	(1,172,921,000)
Health Care Access	0

(i) **Behavioral Health Fund** (6,404,000)

Sec. 3. **EFFECTIVE DATE.**

Sections 1 and 2 are effective the day following final enactment.

ARTICLE 19
APPROPRIATIONS

Section 1. **HEALTH AND HUMAN SERVICES APPROPRIATIONS.**

The sums shown in the columns marked "Appropriations" are appropriated to the agencies and for the purposes specified in this article. The appropriations are from the general fund, or another named fund, and are available for the fiscal years indicated for each purpose. The figures "2024" and "2025" used in this article mean that the appropriations listed under them are available for the fiscal year ending June 30, 2024, or June 30, 2025, respectively. "The first year" is fiscal year 2024. "The second year" is fiscal year 2025. "The biennium" is fiscal years 2024 and 2025.

APPROPRIATIONS

Available for the Year

		Ending June 30	
		2024	**2025**
Sec. 2. **COMMISSIONER OF HUMAN SERVICES**			
Subdivision 1. **Total Appropriation**	**$**	**3,936,743,000**	**$** **4,194,149,000**

Appropriations by Fund

	2024	2025
General	2,653,278,000	2,843,638,000
State Government Special Revenue	4,901,000	5,409,000
Health Care Access	999,388,000	1,063,076,000
Federal TANF	276,953,000	281,863,000
Lottery Prize	163,000	163,000
Opiate Epidemic Response	2,060,000	0

The amounts that may be spent for each purpose are specified in the following subdivisions.

Subd. 2. **TANF Maintenance of Effort**

(a) **Nonfederal expenditures.** The commissioner shall ensure that sufficient qualified nonfederal expenditures are made each year to meet the state's maintenance of effort requirements of the TANF block grant specified under Code of Federal Regulations, title 45, section 263.1. In order to meet these basic TANF maintenance of effort requirements, the commissioner may report as TANF maintenance of effort expenditures only nonfederal money expended for allowable activities listed in the following clauses:

(1) MFIP cash, diversionary work program, and food assistance benefits under Minnesota Statutes, chapter 256J;

(2) the child care assistance programs under Minnesota Statutes, sections 119B.03 and 119B.05, and county child care administrative costs under Minnesota Statutes, section 119B.15;

(3) state and county MFIP administrative costs under Minnesota Statutes, chapters 256J and 256K;

(4) state, county, and Tribal MFIP employment services under Minnesota Statutes, chapters 256J and 256K;

(5) expenditures made on behalf of legal noncitizen MFIP recipients who qualify for the MinnesotaCare program under Minnesota Statutes, chapter 256L;

(6) qualifying working family credit expenditures under Minnesota Statutes, section 290.0671;

(7) qualifying Minnesota education credit expenditures under Minnesota Statutes, section 290.0674; and

(8) qualifying Head Start expenditures under Minnesota Statutes, section 119A.50.

(b) **Nonfederal expenditures; reporting.** For the activities listed in paragraph (a), clauses (2) to (8), the commissioner must report only expenditures that are excluded from the definition of assistance under Code of Federal Regulations, title 45, section 260.31.

(c) **Limitations; exceptions.** The commissioner must not claim an amount of TANF maintenance of effort in excess of the 75 percent standard in Code of Federal

Regulations, title 45, section 263.1(a)(2), except:

(1) to the extent necessary to meet the 80 percent standard under Code of Federal Regulations, title 45, section 263.1(a)(1), if it is determined by the commissioner that the state will not meet the TANF work participation target rate for the current year;

(2) to provide any additional amounts under Code of Federal Regulations, title 45, section 264.5, that relate to replacement of TANF funds due to the operation of TANF penalties; and

(3) to provide any additional amounts that may contribute to avoiding or reducing TANF work participation penalties through the operation of the excess maintenance of effort provisions of Code of Federal Regulations, title 45, section 261.43(a)(2).

(d) **Supplemental expenditures.** For the purposes of paragraph (c), the commissioner may supplement the maintenance of effort claim with working family credit expenditures or other qualified expenditures to the extent such expenditures are otherwise available after considering the expenditures allowed in this subdivision.

(e) **Reduction of appropriations; exception.** The requirement in Minnesota Statutes, section 256.011, subdivision 3, that federal grants or aids secured or obtained under that subdivision be used to reduce any direct appropriations provided by law does not apply if the grants or aids are federal TANF funds.

(f) **IT appropriations generally.** This appropriation includes funds for information technology projects, services, and support. Notwithstanding Minnesota Statutes, section 16E.0466, funding for information technology project costs must be incorporated into the service level agreement and paid to Minnesota IT Services by the Department of Human Services under the rates and mechanism specified in that agreement.

(g) **Receipts for systems project.** Appropriations and federal receipts for information technology systems projects for MAXIS, PRISM, MMIS, ISDS, METS, and SSIS must be deposited in the state systems account authorized in Minnesota Statutes, section 256.014. Money appropriated for information technology projects approved by the chief information officer funded by the legislature, and approved by the commissioner of management and budget may be transferred from one project to another and from development to operations as the commissioner of human services considers necessary. Any unexpended balance in the appropriation for these projects does not cancel and is available for ongoing development and operations.

(h) **Federal SNAP education and training grants.** Federal funds available during fiscal years 2024 and 2025 for Supplemental Nutrition Assistance Program Education and Training and SNAP Quality Control Performance Bonus grants are appropriated to the commissioner of human services for the

purposes allowable under the terms of the federal award. This paragraph is effective the day following final enactment.

Subd. 3. **Central Office; Operations**

	Appropriations by Fund	
General	252,461,000	238,205,000
State Government Special Revenue	4,776,000	5,284,000
Health Care Access	9,347,000	11,244,000
Federal TANF	1,090,000	1,194,000

(a) **Administrative recovery; set-aside.** The commissioner may invoice local entities through the SWIFT accounting system as an alternative means to recover the actual cost of administering the following provisions:

(1) the statewide data management system authorized in Minnesota Statutes, section 125A.744, subdivision 3;

(2) repayment of the special revenue maximization account as provided under Minnesota Statutes, section 245.495, paragraph (b);

(3) repayment of the special revenue maximization account as provided under Minnesota Statutes, section 256B.0625, subdivision 20, paragraph (k);

(4) targeted case management under Minnesota Statutes, section 256B.0924, subdivision 6, paragraph (g);

(5) residential services for children with severe emotional disturbance under Minnesota Statutes, section 256B.0945, subdivision 4, paragraph (d); and

(6) repayment of the special revenue maximization account as provided under Minnesota Statutes, section 256F.10, subdivision 6, paragraph (b).

(b) **Base level adjustment.** The general fund base is $228,892,000 in fiscal year 2026 and $227,929,000 in fiscal year 2027. The state government special revenue base is $4,880,000 in fiscal year 2026 and $4,710,000 in fiscal year 2027.

Subd. 4. **Central Office; Children and Families**

	Appropriations by Fund	
General	35,632,000	36,150,000
Federal TANF	2,582,000	2,582,000

(a) **Quadrennial review of child support guidelines.** $64,000 in fiscal year 2024 and $32,000 in fiscal year 2025 are from the general fund for a quadrennial review of child support guidelines.

(b) **Transfer.** The commissioner must transfer $64,000 in fiscal year 2024 and $32,000 in fiscal year 2025 from the general fund to the special revenue fund to be used for the quadrennial review of child support guidelines.

(c) **Recognizing comparable competencies to achieve comparable compensation task force.** $141,000 in fiscal year 2024 and $165,000 in fiscal year 2025 are from the general fund for the Recognizing Comparable Competencies to Achieve Comparable Compensation Task Force. This is a onetime appropriation.

(d) **Child care and early education professional wage scale.** $637,000 in fiscal

year 2024 and $565,000 in fiscal year 2025 are from the general fund for developing a wage scale for child care and early education professionals. This is a onetime appropriation.

(e) **Cost estimation model for early care and learning programs.** $100,000 in fiscal year 2024 is from the general fund for developing a cost estimation model for providing early care and learning.

(f) **Base level adjustment.** The general fund base is $35,328,000 in fiscal year 2026 and $35,192,000 in fiscal year 2027.

Subd. 5. **Central Office; Health Care**

	Appropriations by Fund	
General	29,859,000	31,796,000
Health Care Access	28,168,000	28,168,000

(a) **Medical assistance and MinnesotaCare accessibility improvements.** $1,350,000 in fiscal year 2024 is from the general fund to improve the accessibility of applications, forms, and other consumer support resources and services for medical assistance and MinnesotaCare enrollees with limited English proficiency.

(b) **Palliative care benefit study.** $150,000 in fiscal year 2024 is from the general fund for a study of the fiscal, medical, and social impacts of implementing a palliative care benefit in medical assistance and MinnesotaCare. This is a onetime appropriation. The commissioner must report the results of the study to the chairs and ranking minority members of the legislative

committees with jurisdiction over health care by January 15, 2024.

(c) **Base level adjustment.** The general fund base is $30,931,000 in fiscal year 2026 and $34,617,000 in fiscal year 2027.

Subd. 6. **Central Office; Aging and Disabilities Services**

	Appropriations by Fund	
General	38,726,000	34,688,000
State Government Special Revenue	125,000	125,000

Catholic Charities homeless elders program. $728,000 in fiscal year 2024 and $728,000 in fiscal year 2025 are for a grant to Catholic Charities of St. Paul and Minneapolis to operate its homeless elders program. This is a onetime appropriation.

Subd. 7. **Central Office; Behavioral Health, Deaf and Hard of Hearing, and Housing Services**

	Appropriations by Fund	
General	24,963,000	24,043,000
Lottery Prize	163,000	163,000
Opiate Epidemic Response	60,000	0

(a) **Homeless management system.** $250,000 in fiscal year 2024 and $1,000,000 in fiscal year 2025 are from the general fund for a homeless management information system. The base for this appropriation is $1,140,000 in fiscal year 2026 and $1,140,000 in fiscal year 2027.

(b) **Base level adjustment.** The general fund base is $23,793,000 in fiscal year 2026 and $23,755,000 in fiscal year 2027.

Subd. 8. **Forecasted Programs; MFIP/DWP**

	Appropriations by Fund		
General	82,652,000	91,628,000	
Federal TANF	105,337,000	109,974,000	

Subd. 9. **Forecasted Programs; MFIP Child Care Assistance** 38,743,000 143,055,000

Subd. 10. **Forecasted Programs; General Assistance**

Appropriations by Fund		
General	52,026,000	74,606,000
Federal TANF	0	169,000

(a) **Emergency general assistance.** The amount appropriated for emergency general assistance is limited to no more than $6,729,812 in fiscal year 2024 and $6,729,812 in fiscal year 2025. Funds to counties shall be allocated by the commissioner using the allocation method under Minnesota Statutes, section 256D.06.

(b) **Base adjustment.** The federal TANF fund base is $1,970,000 in fiscal year 2026 and $2,447,000 in fiscal year 2027.

Subd. 11. **Forecasted Programs; Minnesota Supplemental Aid** 58,548,000 60,357,000

Subd. 12. **Forecasted Programs; Housing Support** 211,692,000 224,231,000

Subd. 13. **Forecasted Programs; Northstar Care for Children** 113,912,000 124,546,000

Subd. 14. **Forecasted Programs; MinnesotaCare** 88,884,000 56,051,000

This appropriation is from the health care access fund.

Subd. 15. **Forecasted Programs; Medical Assistance**

Appropriations by Fund		
General	1,103,945,000	1,082,102,000
Health Care Access	869,524,000	964,148,000

The health care access fund base is $881,650,000 in fiscal year 2026 and $1,197,599,000 in fiscal year 2027.

Subd. 16. **Forecasted Programs; Alternative Care** 158,000 460,000

Subd. 17. **Forecasted Programs; Behavioral Health Fund** 993,000 2,831,000

Subd. 18. **Grant Programs; Support Services Grants**

Appropriations by Fund		
General	8,715,000	8,715,000
Federal TANF	96,311,000	96,311,000

Subd. 19. **Grant Programs; Basic Sliding Fee Child Assistance Care Grants** 64,203,000 113,974,000

The general fund base is $144,650,000 in fiscal year 2026 and $142,007,000 in fiscal year 2027.

Subd. 20. **Grant Programs; Child Care Development Grants** 151,569,000 158,120,000

(a) **Child care retention program.** $102,887,000 in fiscal year 2024 and $142,989,000 in fiscal year 2025 are for the child care retention program payments under Minnesota Statutes, section 119B.27. The base for this appropriation is $145,205,000 in fiscal year 2026 and $146,098,000 in fiscal year 2027.

(b) **Transition grant program.** $41,895,000 in fiscal year 2024 is for transition grants for child care providers that intend to participate in the child care retention program. This is a onetime appropriation and is available until June 30, 2025.

(c) **REETAIN grant program.** $1,000,000 in fiscal year 2024 and $1,000,000 in fiscal

year 2025 are for the REETAIN grant program under Minnesota Statutes, section 119B.195. The general fund base for this appropriation is $1,500,000 in fiscal year 2026 and $1,500,000 in fiscal year 2027.

(d) **Child care workforce development grants administration.** $1,300,000 in fiscal year 2025 is for a grant to the statewide child care resource and referral network to administer child care workforce development grants under Minnesota Statutes, section 119B.19, subdivision 7, clause (10).

(e) **Scholarship program.** $695,000 in fiscal year 2025 is for a scholarship program for early childhood and school-age educators under Minnesota Statutes, section 119B.251.

(f) **Child care one-stop shop.** $2,920,000 in fiscal year 2025 is for a grant to the statewide child care resource and referral network to administer the child care one-stop shop regional assistance network under Minnesota Statutes, section 119B.19, subdivision 7, clause (9).

(g) **Shared services grants.** $500,000 in fiscal year 2024 and $500,000 in fiscal year 2025 are for shared services grants under Minnesota Statutes, section 119B.28.

(h) **Access to technology grants.** $300,000 in fiscal year 2024 and $300,000 in fiscal year 2025 are for child care provider access to technology grants under Minnesota Statutes, section 119B.29.

(i) **Business training and consultation.** $1,250,000 in fiscal year 2024 and $1,500,000

in fiscal year 2025 are for business training and consultation under Minnesota Statutes, section 119B.25, subdivision 3, paragraph (a), clause (6).

(j) **Early childhood registered apprenticeship grant program.** $2,000,000 in fiscal year 2024 and $2,000,000 in fiscal year 2025 are for the early childhood registered apprenticeship grant program under Minnesota Statutes, section 119B.252.

(k) **Family, friend, and neighbor grant program.** $3,179,000 in fiscal year 2024 and $3,179,000 in fiscal year 2025 are for the family, friend, and neighbor grant program under Minnesota Statutes, section 119B.196.

(l) **Base level adjustment.** The general fund base is $160,836,000 in fiscal year 2026 and $161,729,000 in fiscal year 2027.

Subd. 21. **Grant Programs; Child Support Enforcement Grants** 50,000 50,000

Subd. 22. **Grant Programs; Children's Services Grants**

	Appropriations by Fund	
General	75,524,000	85,181,000
Federal TANF	140,000	140,000

(a) **Mille Lacs Band of Ojibwe American Indian child welfare initiative.** $3,337,000 in fiscal year 2024 and $5,294,000 in fiscal year 2025 are from the general fund for the Mille Lacs Band of Ojibwe to join the American Indian child welfare initiative. The base for this appropriation is $7,893,000 in fiscal year 2026 and $7,893,000 in fiscal year 2027.

(b) **Grants for kinship navigator services.** $764,000 in fiscal year 2024 and $764,000 in fiscal year 2025 are from the general fund for grants for kinship navigator services and grants to Tribal Nations for kinship navigator services. The base for this appropriation is $750,000 in fiscal year 2026 and $750,000 in fiscal year 2027.

(c) **Family First Prevention and Early Intervention assessment response grants.** $6,100,000 in fiscal year 2024 and $9,800,000 in fiscal year 2025 are from the general fund for family assessment response grants under Minnesota Statutes, section 260.014.

(d) **Grants for evidence-based prevention and early intervention services.** $3,000,000 in fiscal year 2024 and $7,000,000 in fiscal year 2025 are from the general fund for grants to support evidence-based prevention and early intervention services under Minnesota Statutes, section 260.014. The base for this appropriation is $10,000,000 in fiscal year 2026 and $10,000,000 in fiscal year 2027.

(e) **Grant to administer pool of qualified individuals for assessments.** $450,000 in fiscal year 2024 and $450,000 in fiscal year 2025 are from the general fund for grants to establish and manage a pool of state-funded qualified individuals to conduct assessments for out-of-home placement of a child in a qualified residential treatment program.

(f) **Grants to counties to reduce foster care caseloads.** $3,000,000 in fiscal year 2024 and $3,000,000 in fiscal year 2025 are from the general fund for grants to counties and

American Indian child welfare initiative Tribes to reduce extended foster care caseload sizes.

(g) **Quality parenting initiative grant program.** $100,000 in fiscal year 2024 and $100,000 in fiscal year 2025 are from the general fund for a grant to Quality Parenting Initiative Minnesota under Minnesota Statutes, section 245.0962.

(h) **Payments to counties to reimburse revenue loss.** $2,000,000 in fiscal year 2024 and $2,000,000 in fiscal year 2025 are for payments to counties to reimburse the revenue loss attributable to prohibiting counties, as the financially responsible agency for a child placed in foster care, from receiving Supplemental Security Income on behalf of the child placed in foster care during the time the child is in foster care under Minnesota Statutes, section 256N.26, subdivision 12.

(h) **Base level adjustment.** The general fund base is $91,001,000 in fiscal year 2026 and $91,001,000 in fiscal year 2027.

Subd. 23. **Grant Programs; Children and Community Service Grants**	62,356,000	62,356,000
Subd. 24. **Grant Programs; Children and Economic Support Grants**	71,551,000	75,557,000

(a) **Fraud prevention initiative start-up grants.** $400,000 in fiscal year 2024 is for start-up grants to the Red Lake Nation, White Earth Nation, and Mille Lacs Band of Ojibwe to develop a fraud prevention program. This is a onetime appropriation and is available until June 30, 2025.

(b) **Grants to promote food security among Tribal Nations and American Indian**

communities. $1,851,000 in fiscal year 2024 and $1,851,000 in fiscal year 2025 are for grants to support food security among Tribal Nations and American Indian communities under Minnesota Statutes, section 256E.341.

(c) **Minnesota food shelf program grants.** $2,827,000 in fiscal year 2024 and $2,827,000 in fiscal year 2025 are for the Minnesota food shelf program under Minnesota Statutes, section 256E.34.

(d) **Grant to CornerHouse children's advocacy center.** $315,000 in fiscal year 2024 and $315,000 in fiscal year 2025 are for a grant to CornerHouse children's advocacy center. The grant must be used to establish a child maltreatment prevention program serving rural, urban, and suburban communities across the state and to expand response services in Hennepin and Anoka Counties for children who have experienced maltreatment. This paragraph does not expire.

(e) **Hennepin County homelessness grant program.** $5,095,000 in fiscal year 2025 is for a grant to Hennepin County under Minnesota Statutes, section 245.0966. The base for this appropriation is $10,191,000 in fiscal year 2026 and $10,191,000 in fiscal year 2027.

(f) **Diaper distribution grant program.** $500,000 in fiscal year 2024 and $500,000 in fiscal year 2025 are for the diaper distribution grant program under Minnesota Statutes, section 256E.38.

(g) **Prepared meals food relief.** $1,250,000 in fiscal year 2024 and $1,250,000 in fiscal year 2025 are for prepared meals food relief grants under Minnesota Statutes, section 256E.341.

(h) **Family supportive housing.** $4,000,000 in fiscal year 2024 and $4,000,000 in fiscal year 2025 are for the grants under Minnesota Statutes, section 256K.50.

(i) **Chosen family grants.** $1,939,000 in fiscal year 2024 is for grants to providers serving homeless youth and youth at risk of homelessness in Minnesota to establish or expand services that formalize situations where a caring adult whom a youth considers chosen family allows the youth to stay at the adult's residence to avoid being homeless. This is a onetime appropriation and is available until June 30, 2025.

(j) **Homeless youth cash stipend pilot project.** $3,000,000 in fiscal year 2024 and $3,000,000 in fiscal year 2025 are for a grant to Youthprise for the homeless youth cash stipend pilot project. The grant must be used to provide cash stipends to homeless youth, provide cash incentives for stipend recipients to participate in periodic surveys, provide youth-designed optional services, and complete a legislative report. The general fund base for this appropriation is $3,000,000 in fiscal year 2026, $3,000,000 in fiscal year 2027, and $0 in fiscal year 2028 and thereafter.

(k) **Olmsted County homelessness grant program.** $1,164,000 in fiscal year 2024 and $1,164,000 in fiscal year 2025 are for a grant

to Olmsted County under Minnesota Statutes, section 245.0965.

(l) **Continuum of care grant program.** $6,595,000 in fiscal year 2024 and $6,595,000 in fiscal year 2025 are for a grant to Ramsey County for the Heading Home Ramsey Continuum of Care under Minnesota Statutes, section 245.0963. Of these amounts, ten percent in fiscal year 2024 and ten percent in fiscal year 2025 may be used by the grantee for administrative expenses.

(m) **Base level adjustment.** The general fund base is $79,925,000 in fiscal year 2026 and $79,925,000 in fiscal year 2027.

Subd. 25. **Grant Programs; Health Care Grants**

Appropriations by Fund		
General	7,561,000	7,561,000
Health Care Access	3,465,000	3,465,000

(a) **Grant to Indian Health Board of Minneapolis.** $2,500,000 in fiscal year 2024 and $2,500,000 in fiscal year 2025 are from the general fund for a grant to the Indian Health Board of Minneapolis to support continued access to health care coverage through medical assistance and MinnesotaCare, improve access to quality care, and increase vaccination rates among urban American Indians. The general fund base for this appropriation is $2,500,000 in fiscal year 2026 and $0 in fiscal year 2027.

(b) **Base level adjustment.** The general fund base is $7,561,000 in fiscal year 2026 and $5,061,000 in fiscal year 2027.

Subd. 26. **Grant Programs; Housing Support Grants** 18,364,000 10,364,000

Subd. 27. **Grant Programs; Adult Mental Health Grants**

	Appropriations by Fund	
General	108,545,000	144,407,000
Opiate Epidemic Response	2,000,000	0

(a) **Mobile crisis grants to Tribal Nations.** $1,000,000 in fiscal year 2024 and $1,000,000 in fiscal year 2025 are for mobile crisis grants under Minnesota Statutes section 245.4661, subdivision 9, paragraph (b), clause (15), to Tribal Nations.

(b) **Mental health provider supervision grant program.** $1,500,000 in fiscal year 2024 and $1,500,000 in fiscal year 2025 are for the mental health provider supervision grant program under Minnesota Statutes, section 245.4663.

(c) **Mental health professional scholarship grant program.** $750,000 in fiscal year 2024 and $750,000 in fiscal year 2025 are for the mental health professional scholarship grant program under Minnesota Statutes, section 245.4664.

(d) **Minnesota State University, Mankato community behavioral health center.** $750,000 in fiscal year 2024 and $750,000 in fiscal year 2025 are for a grant to the Center for Rural Behavioral Health at Minnesota State University, Mankato to establish a community behavioral health center and training clinic. The community behavioral health center must provide comprehensive, culturally specific,

trauma-informed, practice- and evidence-based, person- and family-centered mental health and substance use disorder treatment services in Blue Earth County and the surrounding region to individuals of all ages, regardless of an individual's ability to pay or place of residence. The community behavioral health center and training clinic must also provide training and workforce development opportunities to students enrolled in the university's training programs in the fields of social work, counseling and student personnel, alcohol and drug studies, psychology, and nursing. Upon request, the commissioner must make information regarding the use of this grant funding available to the chairs and ranking minority members of the legislative committees with jurisdiction over behavioral health. This is a onetime appropriation.

(e) **Base level adjustment.** The general fund base is $123,797,000 in fiscal year 2026 and $123,797,000 in fiscal year 2027.

Subd. 28. **Grant Programs; Child Mental Health Grants**	39,180,000	37,305,000

(a) **Psychiatric residential treatment facility start-up grants.** $1,000,000 in fiscal year 2024 and $1,000,000 in fiscal year 2025 are for psychiatric residential treatment facility start-up grants under Minnesota Statutes, section 256B.0941, subdivision 5.

(b) **Psychatric residential treatment facilities specialization grants.** $1,050,000 in fiscal year 2024 and $1,050,000 in fiscal year 2025 are for psychiatric residential

treatment facilities specialization grants under Minnesota Statutes, section 256B.0941, subdivision 5.

(c) **Emerging mood disorder grants.** $1,250,000 in fiscal year 2024 and $1,250,000 in fiscal year 2025 are for emerging mood disorder grants under Minnesota Statutes, section 245.4904, for evidence-informed interventions for youth and young adults who are at higher risk of developing a mood disorder or are already experiencing an emerging mood disorder.

(d) **Implementation grants for mobile response and stabilization services.** $1,000,000 in fiscal year 2024 and $1,000,000 in fiscal year 2025 are for grants to implement the mobile response and stabilization services model to promote access to crisis response services, reduce admissions to psychiatric hospitals, and reduce out-of-home placement services.

(e) **Grants for infant and early childhood mental health consultations.** $1,000,000 in fiscal year 2024 and $1,000,000 in fiscal year 2025 are for grants under Minnesota Statutes, section 245.4889, subdivision 1, paragraph (b), clause (14), for infant and early childhood mental health consultations throughout the state, including Tribal Nations for expertise in young children's development and early childhood services.

(f) **African American Child Wellness Institute.** $1,000,000 in fiscal year 2024 and $1,000,000 in fiscal year 2025 are for a grant to the African American Child Wellness

Institute to provide culturally specific mental health and substance use disorder services under Minnesota Statutes, section 245.0961.

(g) **Headway Emotional Health Services.** $300,000 in fiscal year 2024 and $300,000 in fiscal year 2025 are for a grant to Headway Emotional Health Services for day treatment transportation costs on nonschool days, student nutrition, and student learning experiences such as technology, arts, and outdoor activity. This is a onetime appropriation.

(h) **Base level adjustment.** The general fund base is $37,005,000 in fiscal year 2026 and $37,005,000 in fiscal year 2027.

Subd. 29. **Grant Programs; Chemical Dependency Treatment Support Grants** 2,350,000 1,350,000

Overdose prevention grants. $1,000,000 in fiscal year 2024 is for a grant to the Steve Rummler Hope Network for statewide outreach, education, training, and distribution of naloxone kits. Of this amount, 50 percent of the money appropriated must be provided to the Ka Joog nonprofit organization for collaborative outreach in East African and Somali communities in Minnesota. This is a onetime appropriation and is available until June 30, 2025.

Subd. 30. **Technical Activities** 71,493,000 71,493,000

This appropriation is from the federal TANF fund.

Sec. 3. **COMMISSIONER OF HEALTH**

Subdivision 1. **Total Appropriation** **$ 432,670,000 $ 421,959,000**

Appropriations by Fund

	2024	2025

General	285,869,000	268,018,000
State Government Special Revenue	83,373,000	85,902,000
Health Care Access	51,715,000	56,326,000
Federal TANF	11,713,000	11,713,000

The amounts that may be spent for each purpose are specified in the following subdivisions.

Subd. 2. **Health Improvement**

Appropriations by Fund		
General	223,550,000	205,255,000
State Government Special Revenue	12,392,000	12,682,000
Health Care Access	51,715,000	56,326,000
Federal TANF	11,713,000	11,713,000

(a) **Studies of telehealth expansion and payment parity.** $1,200,000 in fiscal year 2024 is from the general fund for studies of telehealth expansion and payment parity. This is a onetime appropriation and is available until June 30, 2025.

(b) **Advancing equity through capacity building and resource allocation grant program.** $500,000 in fiscal year 2024 and $500,000 in fiscal year 2025 are from the general fund for grants under Minnesota Statutes, section 144.9821.

(c) **Community health workers.** $971,000 in fiscal year 2024 and $971,000 in fiscal year 2025 are from the general fund for grants under Minnesota Statutes, section 144.1462.

(d) **Community solutions for healthy child development grants.** $3,678,000 in fiscal year 2024 and $3,698,000 in fiscal year 2025 are

from the general fund for grants under Minnesota Statutes, section 145.9257.

(e) **Cultural communications program.** $1,724,000 in fiscal year 2024 and $1,724,000 in fiscal year 2025 are from the general fund for the cultural communications program established in Minnesota Statutes, section 144.0752.

(f) **Emergency preparedness and response.** $16,825,000 in fiscal year 2024 and $16,662,000 in fiscal year 2025 are from the general fund for public health emergency preparedness and response, the sustainability of the strategic stockpile, and COVID-19 pandemic response transition.

(g) **Family planning grants.** $7,900,000 in fiscal year 2024 and $7,900,000 in fiscal year 2025 are from the general fund for grants under Minnesota Statutes, section 145.925.

(h) **Healthy Beginnings, Healthy Families.** $5,250,000 in fiscal year 2024 and $5,250,000 in fiscal year 2025 are from the general fund for grants under Minnesota Statutes, section 145.9571.

(i) **Help Me Connect.** $463,000 in fiscal year 2024 and $921,000 in fiscal year 2025 are from the general fund for the Help Me Connect program under Minnesota Statutes, section 145.988.

(j) **Home visiting.** $9,250,000 in fiscal year 2024 and $9,250,000 in fiscal year 2025 are from the general fund to start up or expand home visiting programs for priority

populations under Minnesota Statutes, section 145.87.

(k) **No Surprises Act enforcement.** $1,210,000 in fiscal year 2024 and $1,090,000 in fiscal year 2025 are from the general fund for implementation of the federal No Surprises Act under Minnesota Statutes, section 62Q.021, and a statewide provider directory. The general fund base for this appropriation is $855,000 in fiscal year 2026 and $855,000 in fiscal year 2027.

(l) **Office of African American Health.** $1,000,000 in fiscal year 2024 and $1,000,000 in fiscal year 2025 are from the general fund for grants under the authority of the Office of African American Health under Minnesota Statutes, section 144.0756.

(m) **Office of American Indian Health.** $1,000,000 in fiscal year 2024 and $1,000,000 in fiscal year 2025 are from the general fund for grants under the authority of the Office of American Indian Health under Minnesota Statutes, section 144.0757.

(n) **Public health system transformation grants.** (1) $9,844,000 in fiscal year 2024 and $9,844,000 in fiscal year 2025 are from the general fund for grants under Minnesota Statutes, section 145A.131, subdivision 1, paragraph (f).

(2) $535,000 in fiscal year 2024 and $535,000 in fiscal year 2025 are from the general fund for grants under Minnesota Statutes, section 145A.14, subdivision 2, paragraph (b).

(3) $321,000 in fiscal year 2024 and $321,000 in fiscal year 2025 are from the general fund for grants under Minnesota Statutes, section 144.0759.

(o) **Health care workforce.** (1) $1,154,000 in fiscal year 2024 and $3,117,000 in fiscal year 2025 are from the health care access fund for rural training tracks and rural clinicals grants under Minnesota Statutes, section 144.1508. The base for this appropriation is $4,502,000 in fiscal year 2026 and $4,502,000 in fiscal year 2027.

(2) $323,000 in fiscal year 2024 and $323,000 in fiscal year 2025 are from the health care access fund for immigrant international medical graduate training grants under Minnesota Statutes, section 144.1911.

(3) $5,771,000 in fiscal year 2024 and $5,147,000 in fiscal year 2025 are from the health care access fund for site-based clinical training grants under Minnesota Statutes, section 144.1505. The base for this appropriation is $4,426,000 in fiscal year 2026 and $4,426,000 in fiscal year 2027.

(4) $1,000,000 in fiscal year 2024 and $1,000,000 in fiscal year 2025 are from the health care access fund for mental health grants for health care professional grants. This is a onetime appropriation and is available until June 30, 2027.

(5) $2,500,000 in fiscal year 2024 and $2,500,000 in fiscal year 2025 are from the health care access fund for health professionals loan forgiveness under Minnesota Statutes,

section 144.1501, subdivision 1, paragraph (h).

(6) $708,000 in fiscal year 2024 and $708,000 in fiscal year 2025 are from the health care access fund for primary care employee recruitment education loan forgiveness under Minnesota Statutes, section 144.1504.

(7) $350,000 in fiscal year 2024 and $350,000 in fiscal year 2025 are from the health care access fund for workforce research and data analysis of shortages, maldistribution of health care providers in Minnesota, and the factors that influence decisions of health care providers to practice in rural areas of Minnesota.

(p) **School health.** $800,000 in fiscal year 2024 and $800,000 in fiscal year 2025 are from the general fund for grants under Minnesota Statutes, section 145.903.

(q) **Long COVID.** $3,146,000 in fiscal year 2024 and $3,146,000 in fiscal year 2025 are from the general fund for grants and to implement Minnesota Statutes, section 145.361.

(r) **Workplace violence prevention grants for health care entities.** $4,400,000 in fiscal year 2024 is from the general fund for grants to health care entities to improve employee safety or security. This is a onetime appropriation and is available until June 30, 2025.

(s) **Clinical dental education innovation grants.** $1,122,000 in fiscal year 2024 and $1,122,000 in fiscal year 2025 are from the

general fund for clinical dental education innovation grants under Minnesota Statutes, section 144.1913.

(t) **Skin-lightening products public awareness and education grant program.** $200,000 in fiscal year 2024 is from the general fund for a grant to the Beautywell Project under Minnesota Statutes, section 145.9275. This is a onetime appropriation.

(u) **Emmett Louis Till Victims Recovery Program.** $500,000 in fiscal year 2024 is from the general fund for a grant to the Emmett Louis Till Victims Recovery Program. The commissioner must not use any of this appropriation for administration. This is a onetime appropriation and is available until June 30, 2025.

(v) **Federally qualified health centers apprenticeship program.** $750,000 in fiscal year 2024 and $750,000 in fiscal year 2025 are from the general fund for grants under Minnesota Statutes, section 145.9272, and for the study of the feasibility of establishing additional federally qualified health centers apprenticeship programs.

(w) **Alzheimer's public information program.** $80,000 in fiscal year 2024 and $80,000 in fiscal year 2025 are from the general fund for grants to community-based organizations to co-create culturally specific messages to targeted communities and to promote public awareness materials online through diverse media channels. This is a onetime appropriation and is available until June 30, 2027.

(x) **African American Babies Coalition grant.** $260,000 in fiscal year 2024 and $260,000 in fiscal year 2025 are from the general fund for a grant to the Amherst H. Wilder Foundation for a grant under Minnesota Statutes, section 144.645, for the African American Babies Coalition initiative.

(y) (1) **Health professional loan forgiveness account.** $8,792,000 in fiscal year 2024 is from the general fund for eligible mental health professional loan forgiveness under Minnesota Statutes, section 144.1501. This is a onetime appropriation.

(2) **Transfer.** The commissioner must transfer $8,792,000 in fiscal year 2024 from the general fund to the health professional loan forgiveness account under Minnesota Statutes, section 144.1501, subdivision 2.

(z) **Primary care residency expansion grant program.** $400,000 in fiscal year 2024 and $400,000 in fiscal year 2025 are from the general fund for a psychiatry resident under Minnesota Statutes, section 144.1506.

(aa) **Pediatric primary care mental health training grant program.** $1,000,000 in fiscal year 2024 and $1,000,000 in fiscal year 2025 are from the general fund for grants under Minnesota Statutes, section 144.1507.

(bb) **Mental health cultural community continuing education grant program.** $500,000 in fiscal year 2024 and $500,000 in fiscal year 2025 are from the general fund for grants under Minnesota Statutes, section 144.1511.

(cc) **Labor trafficking services grant program.** $500,000 in fiscal year 2024 and $500,000 in fiscal year 2025 are from the general fund for grants under Minnesota Statutes, section 144.3885.

(dd) **Alzheimer's disease and dementia care training program.** $449,000 in fiscal year 2025 and $449,000 in fiscal year 2026 are to implement the Alzheimer's disease and dementia care training program under Minnesota Statutes, section 144.6504.

(ee) **Grant to Minnesota Alliance for Volunteer Advancement.** $138,000 in fiscal year 2024 is from the general fund for a grant to the Minnesota Alliance for Volunteer Advancement to administer needs-based volunteerism subgrants targeting underresourced nonprofit organizations in greater Minnesota to support selected organizations' ongoing efforts to address and minimize disparities in access to human services through increased volunteerism. Subgrant applicants must demonstrate that the populations to be served by the subgrantee are underserved or suffer from or are at risk of homelessness, hunger, poverty, lack of access to health care, or deficits in education. The Minnesota Alliance for Volunteer Advancement must give priority to organizations that are serving the needs of vulnerable populations. This is a onetime appropriation and is available until June 30, 2025.

(ff) **Palliative Care Advisory Council.** $40,000 in fiscal year 2024 and $40,000 in

fiscal year 2025 are from the general fund for grants under Minnesota Statutes, section 144.059.

(gg) **Universal health care system study.** $1,815,000 in fiscal year 2024 and $580,000 in fiscal year 2025 are from the general fund for an economic analysis of benefits and costs of a universal health care system. The base for this appropriation is $580,000 in fiscal year 2026 and $0 in fiscal year 2027.

(hh) **Study of the development of a statewide registry for provider orders for life-sustaining treatment.** $365,000 in fiscal year 2024 and $365,000 in fiscal year 2025 are from the general fund for a study of the development of a statewide registry for provider orders for life-sustaining treatment. This is a onetime appropriation.

(ii) **988 Suicide and crisis lifeline.** $4,000,000 in fiscal year 2024 is from the general fund for 988 national suicide prevention lifeline grants under Minnesota Statutes, section 145.561. This is a onetime appropriation.

(jj) **Fetal and infant mortality case review committee.** $664,000 in fiscal year 2024 and $875,000 in fiscal year 2025 are from the general fund for grants under Minnesota Statutes, section 145.9011.

(kk) **Equitable Health Care Task Force.** $779,000 in fiscal year 2024 and $749,000 in fiscal year 2025 are from the general fund for the Equitable Health Care Task Force. This is a onetime appropriation.

(ll) **Medical education and research costs.** $300,000 in fiscal year 2024 and $300,000 in fiscal year 2025 are from the general fund for the medical education and research costs program under Minnesota Statutes, section 62J.692.

(mm) **Special Guerilla Unit Veterans grant program.** $250,000 in fiscal year 2024 and $250,000 in fiscal year 2025 are from the general fund for a grant to the Special Guerrilla Units Veterans and Families of the United States of America under Minnesota Statutes, section 245.0964.

(nn) **TANF Appropriations.** (1) TANF funds must be used as follows:

(i) $3,579,000 in fiscal year 2024 and $3,579,000 in fiscal year 2025 are from the TANF fund for home visiting and nutritional services listed under Minnesota Statutes, section 145.882, subdivision 7, clauses (6) and (7). Funds must be distributed to community health boards according to Minnesota Statutes, section 145A.131, subdivision 1;

(ii) $2,000,000 in fiscal year 2024 and $2,000,000 in fiscal year 2025 are from the TANF fund for decreasing racial and ethnic disparities in infant mortality rates under Minnesota Statutes, section 145.928, subdivision 7;

(iii) $4,978,000 in fiscal year 2024 and $4,978,000 in fiscal year 2025 are from the TANF fund for the family home visiting grant program under Minnesota Statutes, section 145A.17. $4,000,000 of the funding in fiscal

year 2024 and $4,000,000 in fiscal year 2025 must be distributed to community health boards under Minnesota Statutes, section 145A.131, subdivision 1. $978,000 of the funding in fiscal year 2024 and $978,000 in fiscal year 2025 must be distributed to Tribal governments under Minnesota Statutes, section 145A.14, subdivision 2a;

(iv) $1,156,000 in fiscal year 2024 and $1,156,000 in fiscal year 2025 are from the TANF fund for family planning grants under Minnesota Statutes, section 145.925; and

(v) the commissioner may use up to 6.23 percent of the funds appropriated from the TANF fund each fiscal year to conduct the ongoing evaluations required under Minnesota Statutes, section 145A.17, subdivision 7, and training and technical assistance as required under Minnesota Statutes, section 145A.17, subdivisions 4 and 5.

(2) **TANF Carryforward.** Any unexpended balance of the TANF appropriation in the first year does not cancel but is available in the second year.

(oo) **Base level adjustments.** The general fund base is $202,758,000 in fiscal year 2026 and $202,699,000 in fiscal year 2027. The health care access fund base is $56,361,000 in fiscal year 2026 and $55,761,000 in fiscal year 2027.

Subd. 3. **Health Protection**

	Appropriations by Fund	
General	43,827,000	44,358,000
State Government Special Revenue	70,981,000	73,220,000

(a) **Climate resiliency.** $6,000,000 in fiscal year 2024 and $6,000,000 in fiscal year 2025 are from the general fund for grants under Minnesota Statutes, section 144.9981. The base for this appropriation is $1,500,000 in fiscal year 2026 and $1,500,000 in fiscal year 2027.

(b) **Homeless mortality study.** $134,000 in fiscal year 2024 and $149,000 in fiscal year 2025 are from the general fund for a homeless mortality study. The general fund base for this appropriation is $104,000 in fiscal year 2026 and $0 in fiscal year 2027.

(c) **Lead remediation in schools and child care settings.** $146,000 in fiscal year 2024 and $239,000 in fiscal year 2025 are from the general fund for grants under Minnesota Statutes, section 145.9272.

(d) **MinnesotaOne Health Antimicrobial Stewardship Collaborative.** $312,000 in fiscal year 2024 and $312,000 in fiscal year 2025 are from the general fund for the Minnesota One Health Antibiotic Stewardship Collaborative under Minnesota Statutes, section 144.0526.

(e) **Strengthening public drinking water systems infrastructure.** $4,420,000 in fiscal year 2024 and $4,420,000 in fiscal year 2025 are from the general fund for grants under Minnesota Statutes, section 144.3832. The base for this appropriation is $1,580,000 in fiscal year 2026 and $1,580,000 in fiscal year 2027.

(f) **HIV prevention health equity.** $1,264,000 in fiscal year 2024 and $1,264,000 in fiscal year 2025 are from the general fund for equity in HIV prevention. This is a onetime appropriation.

(g) **Green burials study and report.** $79,000 in fiscal year 2024 is from the general fund for a study and report on green burials. This is a onetime appropriation.

(h) **Base level adjustments.** The general fund base is $34,020,000 in fiscal year 2026 and $33,916,000 in fiscal year 2027.

Subd. 4. **Health Operations** 18,492,000 18,405,000

Notwithstanding Minnesota Statutes, section 16E.21, subdivision 4, the amount transferred to the information and telecommunications account under Minnesota Statutes, section 16E.21, subdivision 2, for the business process automation and external website modernization projects approved by the Legislative Advisory Commission on June 24, 2019, is available until June 30, 2024.

Sec. 4. **HEALTH-RELATED BOARDS**

Subdivision 1. **Total Appropriation** **$ 32,160,000 $ 32,166,000**

Appropriations by Fund		
General	1,222,000	468,000
State Government Special Revenue	30,862,000	31,660,000
Health Care Access	76,000	38,000

The amounts that may be spent for each purpose are specified in the following subdivisions.

Subd. 2. **Board of Behavioral Health and Therapy**	1,022,000	1,044,000
Subd. 3. **Board of Chiropractic Examiners**	773,000	790,000
Subd. 4. **Board of Dentistry**	4,100,000	4,163,000

(a) **Administrative services unit; operating costs.** Of this appropriation, $1,936,000 in fiscal year 2024 and $1,960,000 in fiscal year 2025 are for operating costs of the administrative services unit. The administrative services unit may receive and expend reimbursements for services it performs for other agencies.

(b) **Administrative services unit; volunteer health care provider program.** Of this appropriation, $150,000 in fiscal year 2024 and $150,000 in fiscal year 2025 are to pay for medical professional liability coverage required under Minnesota Statutes, section 214.40.

(c) **Administrative services unit; retirement costs.** Of this appropriation, $237,000 in fiscal year 2024 and $237,000 in fiscal year 2025 are for the administrative services unit to pay for the retirement costs of health-related board employees. This funding may be transferred to the health board incurring retirement costs. Any board that has an unexpended balance for an amount transferred under this paragraph shall transfer the unexpended amount to the administrative services unit. If the amount appropriated in the first year of the biennium is not sufficient, the amount from the second year of the biennium is available.

(d) **Administrative services unit; contested cases and other legal proceedings.** Of this

appropriation, $200,000 in fiscal year 2024 and $200,000 in fiscal year 2025 are for costs of contested case hearings and other unanticipated costs of legal proceedings involving health-related boards under this section. Upon certification by a health-related board to the administrative services unit that unanticipated costs for legal proceedings will be incurred and that available appropriations are insufficient to pay for the unanticipated costs for that board, the administrative services unit is authorized to transfer money from this appropriation to the board for payment of costs for contested case hearings and other unanticipated costs of legal proceedings with the approval of the commissioner of management and budget. The commissioner of management and budget must require any board that has an unexpended balance or an amount transferred under this paragraph to transfer the unexpended amount to the administrative services unit to be deposited in the state government special revenue fund.

Subd. 5. **Board of Dietetics and Nutrition Practice**	213,000	217,000
Subd. 6. **Board of Executives for Long-term Services and Supports**	705,000	736,000
Subd. 7. **Board of Marriage and Family Therapy**	443,000	456,000
Subd. 8. **Board of Medical Practice**	5,779,000	5,971,000
Subd. 9. **Board of Nursing**	6,039,000	6,275,000
Subd. 10. **Board of Occupational Therapy Practice**	480,000	480,000
Subd. 11. **Board of Optometry**	270,000	280,000
Subd. 12. **Board of Pharmacy**		

	Appropriations by Fund	
General	1,222,000	468,000
State Government Special Revenue	5,328,000	5,309,000
Health Care Access	76,000	38,000

(a) **Prescription monitoring program.** $754,000 fiscal year 2024 is from the general fund for the Minnesota prescription monitoring program under Minnesota Statutes, section 152.126. This is a onetime appropriation and is available until June 30, 2025.

(b) **Medication repository program.** $450,000 in fiscal year 2024 and $450,000 in fiscal year 2025 are from the general fund for a contract under Minnesota Statutes, section 151.555.

(c) **Base level adjustment.** The state government special revenue fund base is $5,159,000 in fiscal year 2026 and $5,159,000 in fiscal year 2027. The health care access fund base is $0 in fiscal year 2026 and $0 in fiscal year 2027.

Subd. 13. **Board of Physical Therapy**	678,000	694,000
Subd. 14. **Board of Podiatric Medicine**	253,000	257,000
Subd. 15. **Board of Psychology**	2,618,000	2,734,000

Health professionals service program. This appropriation includes $1,234,000 in fiscal year 2024 and $1,324,000 in fiscal year 2025 for the health professional services program.

Subd. 16. **Board of Social Work**	1,779,000	1,839,000
Subd. 17. **Board of Veterinary Medicine**	382,000	415,000

Base adjustment. The state government special revenue fund base is $461,000 in fiscal year 2026 and $461,000 in fiscal year 2027.

Sec. 5. **EMERGENCY MEDICAL SERVICES REGULATORY BOARD** **$ 6,800,000 $ 6,176,000**

(a) **Cooper/Sams volunteer ambulance program.** $950,000 in fiscal year 2024 and $950,000 in fiscal year 2025 are for the Cooper/Sams volunteer ambulance program under Minnesota Statutes, section 144E.40.

(1) Of this amount, $861,000 in fiscal year 2024 and $861,000 in fiscal year 2025 are for the ambulance service personnel longevity award and incentive program under Minnesota Statutes, section 144E.40.

(2) Of this amount, $89,000 in fiscal year 2024 and $89,000 in fiscal year 2025 are for operations of the ambulance service personnel longevity award and incentive program under Minnesota Statutes, section 144E.40.

(b) **Operations.** $2,421,000 in fiscal year 2024 and $2,480,000 in fiscal year 2025 are for board operations.

(c) **Regional emergency medical services programs.** $800,000 in fiscal year 2024 and $800,000 in fiscal year 2025 are for grants to regional emergency medical services programs to be distributed among the eight emergency medical services regions according to Minnesota Statutes, section 144E.50.

(d) **Regional grants for continuing education.** $585,000 in fiscal year 2024 and $585,000 in fiscal year 2025 are for regional emergency medical services programs to be

distributed equally to the eight emergency medical service regions under Minnesota Statutes, section 144E.52.

(e) **Ambulance training grants.** $361,000 in fiscal year 2024 and $361,000 in fiscal year 2025 are for training grants under Minnesota Statutes, section 144E.35.

(f) **Medical resource communication center grants.** $1,633,000 in fiscal year 2024 and $970,000 in fiscal year 2025 are for medical resource communication center grants under Minnesota Statutes, section 144E.53.

Sec. 6. **OMBUDSPERSON FOR FAMILIES** **$ 759,000 $ 776,000**

Sec. 7. **OMBUDSPERSON FOR AMERICAN INDIAN FAMILIES** **$ 336,000 $ 340,000**

Sec. 8. **OFFICE OF THE FOSTER YOUTH OMBUDSPERSON** **$ 742,000 $ 759,000**

Sec. 9. **MNSURE**

Appropriations by Fund		
General	29,447,000	45,526,000
Health Care Access	2,270,000	1,470,000

(a) **Technology Modernization.** $11,025,000 in fiscal year 2024 and $10,726,000 in fiscal year 2025 are from the general fund to establish a single end-to-end information technology system with seamless, real-time interoperability between qualified health plan eligibility and enrollment services. The base for this appropriation is $3,521,000 in fiscal year 2026 and $0 in fiscal year 2027.

(b) **Easy Enrollment.** $70,000 in fiscal year 2024 and $70,000 in fiscal year 2025 are from the general fund to implement easy enrollment.

(c) **Transfer.** The Board of Directors of MNsure must transfer $11,095,000 in fiscal year 2024 and $14,996,000 in fiscal year 2025 from the general fund to the enterprise account under Minnesota Statutes, section 62V.07. The base for this transfer is $3,591,000 in fiscal year 2026 and $70,000 in fiscal year 2027.

(d) **Minnesota insulin safety net public awareness campaign.** $800,000 in fiscal year 2024 is from the health care access fund for a public awareness campaign for the insulin safety net program under Minnesota Statutes, section 151.74. This is a onetime appropriation and is available until June 30, 2025.

(e) **Cost-sharing reduction program.** $15,000,000 in fiscal year 2024 and $30,000,000 in fiscal year 2025 are from the general fund to implement the cost-sharing reduction program under Minnesota Statutes, section 62V.12.

(f) **Base level adjustment.** The general fund base is $36,621,000 in fiscal year 2026 and $35,600,000 in fiscal year 2027.

Sec. 10. **RARE DISEASE ADVISORY COUNCIL** **$ 654,000 $ 602,000**

Sec. 11. **COMMISSIONER OF REVENUE** **$ 40,000 $ 4,000**

Easy enrollment. $40,000 in fiscal year 2024 and $4,000 in fiscal year 2025 are for the administrative costs associated with the easy enrollment program.

Sec. 12. **COMMISSIONER OF MANAGEMENT AND BUDGET** **$ 12,231,000 $ 2,366,000**

(a) $300,000 in fiscal year 2024 and $300,000 in fiscal year 2025 are for outcomes and evaluation consultation requirements.

(b) $11,931,000 in fiscal year 2024 and $2,066,000 in fiscal year 2025 are to establish the Department of Children, Youth, and Families. This is a onetime appropriation.

(c) **Base adjustment.** The general fund base is $300,000 in fiscal year 2026 and $300,000 in fiscal year 2027.

Sec. 13. **COMMISSIONER OF CHILDREN, YOUTH, AND FAMILIES** **$ 823,000 $ 3,521,000**

Sec. 14. **COMMISSIONER OF COMMERCE** **$ 42,000 $ 51,000**

(a) **Heath Care Affordability Board Requirements.** $42,000 in fiscal year 2024 and $17,000 in fiscal year 2025 are for responsibilities related to the Health Care Affordability Board.

(b) **Defrayal of costs for mandated coverage of biomarker testing.** $17,000 in fiscal year 2025 is for administrative costs to implement mandated coverage of biomarker testing to diagnose, treat, manage, and monitor illness or disease. The base for this appropriation is $2,611,000 in fiscal year 2026 and $2,611,000 in fiscal year 2027. The base includes $2,594,000 in fiscal year 2026 and $2,594,000 in fiscal year 2027 for defrayal of costs for mandated coverage of biomarker testing to diagnose, treat, manage, and monitor illness or disease.

(c) **Consultation for coverage of services provided by pharmacists.** $17,000 in fiscal year 2025 is for consultation with health plan

companies, pharmacies, and pharmacy benefit managers to develop guidance and implement equal coverage for services provided by pharmacists. This is a onetime appropriation.

(d) **Base adjustment.** The general fund base is $2,628,000 in fiscal year 2026 and $2,628,000 in fiscal year 2027.

Sec. 15. **HEALTH CARE AFFORDABILITY BOARD** **$ 1,336,000 $ 1,727,000**

Base adjustment. The general fund base is $1,793,000 in fiscal year 2026 and $1,790,000 in fiscal year 2027.

Sec. 16. **TRANSFERS.**

Subdivision 1. **Grants.** The commissioner of human services, with the approval of the commissioner of management and budget, may transfer unencumbered appropriation balances for the biennium ending June 30, 2025, within fiscal years among the MFIP; general assistance; medical assistance; MinnesotaCare; MFIP child care assistance under Minnesota Statutes, section 119B.05; Minnesota supplemental aid program; group residential housing program; the entitlement portion of Northstar Care for Children under Minnesota Statutes, chapter 256N; and the entitlement portion of the behavioral health fund between fiscal years of the biennium. The commissioner shall inform the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services quarterly about transfers made under this subdivision.

Subd. 2. **Administration.** Positions, salary money, and nonsalary administrative money may be transferred within the Department of Human Services and the Department of Health as the commissioners consider necessary, with the advance approval of the commissioner of management and budget. The commissioners shall inform the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services finance quarterly about transfers made under this section.

Sec. 17. **INDIRECT COSTS NOT TO FUND PROGRAMS.**

The commissioner of health shall not use indirect cost allocations to pay for the operational costs of any program for which they are responsible.

Sec. 18. **EXPIRATION OF UNCODIFIED LANGUAGE.**

All uncodified language contained in this article expires on June 30, 2025, unless a 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. 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. 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.

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.

119B.03 BASIC SLIDING FEE PROGRAM.

Subd. 4. **Funding priority.** (a) First priority for child care assistance under the basic sliding fee program must be given to eligible non-MFIP families who do not have a high school diploma or commissioner of education-selected high school equivalency certification or who need remedial and basic skill courses in order to pursue employment or to pursue education leading to employment and who need child care assistance to participate in the education program. This includes student parents as defined under section 119B.011, subdivision 19b. Within this priority, the following subpriorities must be used:

(1) child care needs of minor parents;

(2) child care needs of parents under 21 years of age; and

(3) child care needs of other parents within the priority group described in this paragraph.

(b) Second priority must be given to parents who have completed their MFIP or DWP transition year, or parents who are no longer receiving or eligible for diversionary work program supports.

(c) Third priority must be given to families who are eligible for portable basic sliding fee assistance through the portability pool under subdivision 9.

(d) Fourth priority must be given to families in which at least one parent is a veteran as defined under section 197.447.

(e) Families under paragraph (b) must be added to the basic sliding fee waiting list on the date they begin the transition year under section 119B.011, subdivision 20, and must be moved into the basic sliding fee program as soon as possible after they complete their transition year.

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.

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.

144.212 DEFINITIONS.

Subd. 11. **Consent to disclosure.** "Consent to disclosure" means an affidavit filed with the state registrar which sets forth the following information:

(1) the current name and address of the affiant;

(2) any previous name by which the affiant was known;

(3) the original and adopted names, if known, of the adopted child whose original birth record is to be disclosed;

(4) the place and date of birth of the adopted child;

(5) the biological relationship of the affiant to the adopted child; and

(6) the affiant's consent to disclosure of information from the original birth record of the adopted child.

245C.02 DEFINITIONS.

Subd. 14b. **Public law background study.** "Public law background study" means a background study conducted by the commissioner pursuant to section 245C.032.

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;

(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.11 BACKGROUND STUDY; COUNTY AGENCIES.

Subd. 3. **Criminal history data.** County agencies shall have access to the criminal history data in the same manner as county licensing agencies under this chapter for purposes of background studies completed before the implementation of NETStudy 2.0 by county agencies on legal nonlicensed child care providers to determine eligibility for child care funds under chapter 119B.

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.

256.8799 SUPPLEMENTAL NUTRITION ASSISTANCE OUTREACH PROGRAM.

Subdivision 1. **Establishment.** The commissioner of human services shall establish, in consultation with the representatives from community action agencies, a statewide outreach program to better inform potential recipients of the existence and availability of Supplemental Nutrition Assistance Program (SNAP) benefits under SNAP. As part of the outreach program, the commissioner and community action agencies shall encourage recipients in the use of SNAP benefits at food cooperatives. The commissioner shall explore and pursue federal funding sources, and specifically, apply for funding from the United States Department of Agriculture for the SNAP outreach program.

Subd. 2. **Administration of the program.** A community association representing community action agencies under section 256E.31, in consultation with the commissioner shall administer the outreach program, issue the request for proposals, and review and approve the potential grantee's plan. Grantees shall comply with the monitoring and reporting requirements as developed by the commissioner in accordance with subdivision 4, and must also participate in the evaluation process

as directed by the commissioner. Grantees must successfully complete one year of outreach and demonstrate compliance with all monitoring and reporting requirements in order to be eligible for additional funding.

Subd. 3. **Plan content.** In approving the plan, the association shall evaluate the plan and give highest priority to a plan that:

(1) targets communities in which 50 percent or fewer of the residents with incomes below 125 percent of the poverty level receive SNAP benefits;

(2) demonstrates that the grantee has the experience necessary to administer the program;

(3) demonstrates a cooperative relationship with the local county social service agencies;

(4) provides ways to improve the dissemination of information on SNAP as well as other assistance programs through a statewide hotline or other community agencies;

(5) provides direct advocacy consisting of face-to-face assistance with the potential applicants;

(6) improves access to SNAP by documenting barriers to participation and advocating for changes in the administrative structure of the program; and

(7) develops strategies for combatting community stereotypes about SNAP benefit recipients and SNAP, misinformation about the program, and the stigma associated with using SNAP benefits.

Subd. 4. **Coordinated development.** The commissioner shall consult with representatives from the United States Department of Agriculture, Minnesota Community Action Association, Food First Coalition, Minnesota Department of Human Services, Urban Coalition/University of Minnesota extension services, county social service agencies, local social service agencies, and organizations that have previously administered the state-funded SNAP outreach programs to:

(1) develop the reporting requirements for the program;

(2) develop and implement the monitoring of the program;

(3) develop, coordinate, and assist in the evaluation process; and

(4) provide an interim report to the legislature by January 1997, and a final report to the legislature by January 1998, which includes the results of the evaluation and recommendations.

256.9864 REPORTS BY RECIPIENT.

(a) An assistance unit with a recent work history or with earned income shall report monthly to the county agency on income received and other circumstances affecting eligibility or assistance amounts. All other assistance units shall report on income and other circumstances affecting eligibility and assistance amounts, as specified by the state agency.

(b) An assistance unit required to submit a report on the form designated by the commissioner and within ten days of the due date or the date of the significant change, whichever is later, or otherwise report significant changes which would affect eligibility or assistance amounts, is considered to have continued its application for assistance effective the date the required report is received by the county agency, if a complete report is received within a calendar month in which assistance was received.

256B.0631 MEDICAL ASSISTANCE CO-PAYMENTS.

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

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

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

(3) $3 per brand-name drug prescription, $1 per generic drug prescription, and $1 per prescription for a brand-name multisource drug listed in preferred status on the preferred drug list, subject to a

$12 per month maximum for prescription drug co-payments. No co-payments shall apply to antipsychotic drugs when used for the treatment of mental illness;

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

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

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

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

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

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

Subd. 2. **Exceptions.** Co-payments and deductibles shall be subject to the following exceptions:

(1) children under the age of 21;

(2) pregnant women for services that relate to the pregnancy or any other medical condition that may complicate the pregnancy;

(3) recipients expected to reside for at least 30 days in a hospital, nursing home, or intermediate care facility for the developmentally disabled;

(4) recipients receiving hospice care;

(5) 100 percent federally funded services provided by an Indian health service;

(6) emergency services;

(7) family planning services;

(8) services that are paid by Medicare, resulting in the medical assistance program paying for the coinsurance and deductible;

(9) co-payments that exceed one per day per provider for nonpreventive visits, eyeglasses, and nonemergency visits to a hospital-based emergency room;

(10) services, fee-for-service payments subject to volume purchase through competitive bidding;

(11) American Indians who meet the requirements in Code of Federal Regulations, title 42, sections 447.51 and 447.56;

(12) persons needing treatment for breast or cervical cancer as described under section 256B.057, subdivision 10; and

(13) services that currently have a rating of A or B from the United States Preventive Services Task Force (USPSTF), immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention, and preventive services and screenings provided to women as described in Code of Federal Regulations, title 45, section 147.130.

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

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

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

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

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

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.

(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.

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.

(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.

256J.08 DEFINITIONS.

Subd. 10. **Budget month.** "Budget month" means the calendar month which the county agency uses to determine the income or circumstances of an assistance unit to calculate the amount of the assistance payment in the payment month.

Subd. 53. **Lump sum.** "Lump sum" means nonrecurring income as described in section 256P.06, subdivision 3, clause (2), item (ix).

Subd. 61. **Monthly income test.** "Monthly income test" means the test used to determine ongoing eligibility and the assistance payment amount according to section 256J.21.

Subd. 62. **Nonrecurring income.** "Nonrecurring income" means a form of income which is received:

(1) only one time or is not of a continuous nature; or

(2) in a prospective payment month but is no longer received in the corresponding retrospective payment month.

Subd. 81. **Retrospective budgeting.** "Retrospective budgeting" means a method of determining the amount of the assistance payment in which the payment month is the second month after the budget month.

Subd. 83. **Significant change.** "Significant change" means a decline in gross income of the amount of the disregard as defined in section 256P.03 or more from the income used to determine the grant for the current month.

256J.30 APPLICANT AND PARTICIPANT REQUIREMENTS AND RESPONSIBILITIES.

Subd. 5. **Monthly MFIP household reports.** Each assistance unit with a member who has earned income or a recent work history, and each assistance unit that has income deemed to it from a financially responsible person must complete a monthly MFIP household report form. "Recent work history" means the individual received earned income in the report month or any of the previous three calendar months even if the earnings are excluded. To be complete, the MFIP household report form must be signed and dated by the caregivers no earlier than the last day of the reporting period. All questions required to determine assistance payment eligibility must be answered, and documentation of earned income must be included.

Subd. 7. **Due date of MFIP household report form.** An MFIP household report form must be received by the county agency by the eighth calendar day of the month following the reporting period covered by the form. When the eighth calendar day of the month falls on a weekend or holiday, the MFIP household report form must be received by the county agency the first working day that follows the eighth calendar day.

Subd. 8. **Late MFIP household report forms.** (a) Paragraphs (b) to (e) apply to the reporting requirements in subdivision 7.

(b) When the county agency receives an incomplete MFIP household report form, the county agency must immediately contact the caregiver by phone or in writing to acquire the necessary information to complete the form.

(c) The automated eligibility system must send a notice of proposed termination of assistance to the assistance unit if a complete MFIP household report form is not received by a county agency. The automated notice must be mailed to the caregiver by approximately the 16th of the month. When a caregiver submits an incomplete form on or after the date a notice of proposed termination has been sent, the termination is valid unless the caregiver submits a complete form before the end of the month.

(d) An assistance unit required to submit an MFIP household report form is considered to have continued its application for assistance if a complete MFIP household report form is received within a calendar month after the month in which the form was due and assistance shall be paid for the period beginning with the first day of that calendar month.

(e) A county agency must allow good cause exemptions from the reporting requirements under subdivision 5 when any of the following factors cause a caregiver to fail to provide the county agency with a completed MFIP household report form before the end of the month in which the form is due:

(1) an employer delays completion of employment verification;

(2) a county agency does not help a caregiver complete the MFIP household report form when the caregiver asks for help;

(3) a caregiver does not receive an MFIP household report form due to mistake on the part of the department or the county agency or due to a reported change in address;

(4) a caregiver is ill, or physically or mentally incapacitated; or

(5) some other circumstance occurs that a caregiver could not avoid with reasonable care which prevents the caregiver from providing a completed MFIP household report form before the end of the month in which the form is due.

256J.33 PROSPECTIVE AND RETROSPECTIVE MFIP ELIGIBILITY.

Subd. 3. **Retrospective eligibility.** After the first two months of MFIP eligibility, a county agency must continue to determine whether an assistance unit is prospectively eligible for the payment month by looking at all factors other than income and then determine whether the assistance unit is retrospectively income eligible by applying the monthly income test to the income from the budget month. When the monthly income test is not satisfied, the assistance payment must be suspended when ineligibility exists for one month or ended when ineligibility exists for more than one month.

Subd. 4. **Monthly income test.** A county agency must apply the monthly income test retrospectively for each month of MFIP eligibility. An assistance unit is not eligible when the countable income equals or exceeds the MFIP standard of need or the family wage level for the assistance unit. The income applied against the monthly income test must include:

(1) gross earned income from employment as described in chapter 256P, prior to mandatory payroll deductions, voluntary payroll deductions, wage authorizations, and after the disregards in section 256J.21, subdivision 4, and the allocations in section 256J.36;

(2) gross earned income from self-employment less deductions for self-employment expenses in section 256J.37, subdivision 5, but prior to any reductions for personal or business state and federal income taxes, personal FICA, personal health and life insurance, and after the disregards in section 256J.21, subdivision 4, and the allocations in section 256J.36;

(3) unearned income as described in section 256P.06, subdivision 3, after deductions for allowable expenses in section 256J.37, subdivision 9, and allocations in section 256J.36;

(4) gross earned income from employment as determined under clause (1) which is received by a member of an assistance unit who is a minor child or minor caregiver and less than a half-time student;

(5) child support received by an assistance unit, excluded under section 256P.06, subdivision 3, clause (2), item (xvi);

(6) spousal support received by an assistance unit;

(7) the income of a parent when that parent is not included in the assistance unit;

(8) the income of an eligible relative and spouse who seek to be included in the assistance unit; and

(9) the unearned income of a minor child included in the assistance unit.

Subd. 5. **When to terminate assistance.** When an assistance unit is ineligible for MFIP assistance for two consecutive months, the county agency must terminate MFIP assistance.

256J.34 CALCULATING ASSISTANCE PAYMENTS.

Subdivision 1. **Prospective budgeting.** A county agency must use prospective budgeting to calculate the assistance payment amount for the first two months for an applicant who has not received assistance in this state for at least one payment month preceding the first month of payment under a current application. Notwithstanding subdivision 3, paragraph (a), clause (2), a county agency must use prospective budgeting for the first two months for a person who applies to be added to an assistance unit. Prospective budgeting is not subject to overpayments or underpayments unless fraud is determined under section 256.98.

(a) The county agency must apply the income received or anticipated in the first month of MFIP eligibility against the need of the first month. The county agency must apply the income received or anticipated in the second month against the need of the second month.

(b) When the assistance payment for any part of the first two months is based on anticipated income, the county agency must base the initial assistance payment amount on the information available at the time the initial assistance payment is made.

(c) The county agency must determine the assistance payment amount for the first two months of MFIP eligibility by budgeting both recurring and nonrecurring income for those two months.

Subd. 2. **Retrospective budgeting.** The county agency must use retrospective budgeting to calculate the monthly assistance payment amount after the payment for the first two months has been made under subdivision 1.

Subd. 3. **Additional uses of retrospective budgeting.** Notwithstanding subdivision 1, the county agency must use retrospective budgeting to calculate the monthly assistance payment amount for the first two months under paragraphs (a) and (b).

(a) The county agency must use retrospective budgeting to determine the amount of the assistance payment in the first two months of MFIP eligibility:

(1) when an assistance unit applies for assistance for the same month for which assistance has been interrupted, the interruption in eligibility is less than one payment month, the assistance payment for the preceding month was issued in this state, and the assistance payment for the immediately preceding month was determined retrospectively; or

(2) when a person applies in order to be added to an assistance unit, that assistance unit has received assistance in this state for at least the two preceding months, and that person has been living with and has been financially responsible for one or more members of that assistance unit for at least the two preceding months.

(b) Except as provided in clauses (1) to (4), the county agency must use retrospective budgeting and apply income received in the budget month by an assistance unit and by a financially responsible household member who is not included in the assistance unit against the MFIP standard of need or family wage level to determine the assistance payment to be issued for the payment month.

(1) When a source of income ends prior to the third payment month, that income is not considered in calculating the assistance payment for that month. When a source of income ends prior to the fourth payment month, that income is not considered when determining the assistance payment for that month.

(2) When a member of an assistance unit or a financially responsible household member leaves the household of the assistance unit, the income of that departed household member is not budgeted retrospectively for any full payment month in which that household member does not live with that household and is not included in the assistance unit.

(3) When an individual is removed from an assistance unit because the individual is no longer a minor child, the income of that individual is not budgeted retrospectively for payment months in which that individual is not a member of the assistance unit, except that income of an ineligible child in the household must continue to be budgeted retrospectively against the child's needs when the parent or parents of that child request allocation of their income against any unmet needs of that ineligible child.

(4) When a person ceases to have financial responsibility for one or more members of an assistance unit, the income of that person is not budgeted retrospectively for the payment months which follow the month in which financial responsibility ends.

Subd. 4. **Significant change in gross income.** The county agency must recalculate the assistance payment when an assistance unit experiences a significant change, as defined in section 256J.08, resulting in a reduction in the gross income received in the payment month from the gross income received in the budget month. The county agency must issue a supplemental assistance payment based on the county agency's best estimate of the assistance unit's income and circumstances for the payment month. Supplemental assistance payments that result from significant changes are limited to two in a 12-month period regardless of the reason for the change. Notwithstanding any other statute or rule of law, supplementary assistance payments shall not be made when the significant change in income is the result of receipt of a lump sum, receipt of an extra paycheck, business fluctuation in self-employment income, or an assistance unit member's participation in a strike or other labor action.

256J.37 TREATMENT OF INCOME AND LUMP SUMS.

Subd. 10. **Treatment of lump sums.** (a) The agency must treat lump-sum payments as earned or unearned income. If the lump-sum payment is included in the category of income identified in subdivision 9, it must be treated as unearned income. A lump sum is counted as income in the month received and budgeted either prospectively or retrospectively depending on the budget cycle at the time of receipt. When an individual receives a lump-sum payment, that lump sum must be combined with all other earned and unearned income received in the same budget month, and it must be applied according to paragraphs (a) to (c). A lump sum may not be carried over into subsequent months. Any funds that remain in the third month after the month of receipt are counted in the asset limit.

(b) For a lump sum received by an applicant during the first two months, prospective budgeting is used to determine the payment and the lump sum must be combined with other earned or unearned income received and budgeted in that prospective month.

(c) For a lump sum received by a participant after the first two months of MFIP eligibility, the lump sum must be combined with other income received in that budget month, and the combined amount must be applied retrospectively against the applicable payment month.

(d) When a lump sum, combined with other income under paragraphs (b) and (c), is less than the MFIP transitional standard for the appropriate payment month, the assistance payment must be reduced according to the amount of the countable income. When the countable income is greater than the MFIP standard or family wage level, the assistance payment must be suspended for the payment month.

259.83 POSTADOPTION SERVICES.

Subd. 3. **Identifying information.** In adoptive placements made on and after August 1, 1982, the agency responsible for or supervising the placement shall obtain from the birth parents named on the original birth record an affidavit attesting to the following:

(a) that the birth parent has been informed of the right of the adopted person at the age specified in section 259.89 to request from the agency the name, last known address, birthdate and birthplace of the birth parents named on the adopted person's original birth record;

(b) that each birth parent may file in the agency record an affidavit objecting to the release of any or all of the information listed in clause (a) about that birth parent, and that parent only, to the adopted person;

(c) that if the birth parent does not file an affidavit objecting to release of information before the adopted person reaches the age specified in section 259.89, the agency will provide the adopted person with the information upon request;

(d) that notwithstanding the filing of an affidavit, the adopted person may petition the court according to section 259.61 for release of identifying information about a birth parent;

(e) that the birth parent shall then have the opportunity to present evidence to the court that nondisclosure of identifying information is of greater benefit to the birth parent than disclosure to the adopted person; and

(f) that any objection filed by the birth parent shall become invalid when withdrawn by the birth parent or when the birth parent dies. Upon receipt of a death record for the birth parent, the agency shall release the identifying information to the adopted person if requested.

259.89 ACCESS TO ORIGINAL BIRTH RECORD INFORMATION.

Subdivision 1. **Request.** An adopted person who is 19 years of age or over may request the commissioner of health to disclose the information on the adopted person's original birth record. The commissioner of health shall, within five days of receipt of the request, notify the commissioner of human services' agent or licensed child-placing agency when known, or the commissioner of human services when the agency is not known in writing of the request by the adopted person.

Subd. 2. **Search.** Within six months after receiving notice of the request of the adopted person, the commissioner of human services' agent or a licensed child-placing agency shall make complete and reasonable efforts to notify each parent identified on the original birth record of the adopted person. The commissioner, the commissioner's agents, and licensed child-placing agencies may charge a reasonable fee to the adopted person for the cost of making a search pursuant to this subdivision. Every licensed child-placing agency in the state shall cooperate with the commissioner of human services in efforts to notify an identified parent. All communications under this subdivision are confidential pursuant to section 13.02, subdivision 3.

For purposes of this subdivision, "notify" means a personal and confidential contact with the birth parents named on the original birth record of the adopted person. The contact shall be by an employee or agent of the licensed child-placing agency which processed the pertinent adoption or some other licensed child-placing agency designated by the commissioner of human services when it is determined to be reasonable by the commissioner; otherwise contact shall be by mail or telephone. The contact shall be evidenced by filing with the commissioner of health an affidavit of notification executed by the person who notified each parent certifying that each parent was given the following information:

(1) the nature of the information requested by the adopted person;

(2) the date of the request of the adopted person;

(3) the right of the parent to file, within 30 days of receipt of the notice, an affidavit with the commissioner of health stating that the information on the original birth record should not be disclosed;

(4) the right of the parent to file a consent to disclosure with the commissioner of health at any time; and

(5) the effect of a failure of the parent to file either a consent to disclosure or an affidavit stating that the information on the original birth record should not be disclosed.

Subd. 3. **Failure to notify parent.** If the commissioner of human services certifies to the commissioner of health an inability to notify a parent identified on the original birth record within six months, and if neither identified parent has at any time filed an unrevoked consent to disclosure with the commissioner of health, the information may be disclosed as follows:

(a) If the person was adopted prior to August 1, 1977, the person may petition the appropriate court for disclosure of the original birth record pursuant to section 259.61, and the court shall grant the petition if, after consideration of the interests of all known persons involved, the court determines that disclosure of the information would be of greater benefit than nondisclosure.

(b) If the person was adopted on or after August 1, 1977, the commissioner of health shall release the requested information to the adopted person.

If either parent identified on the birth record has at any time filed with the commissioner of health an unrevoked affidavit stating that the information on the original birth record should not be disclosed, the commissioner of health shall not disclose the information to the adopted person until the affidavit is revoked by the filing of a consent to disclosure by that parent.

Subd. 4. **Release of information after notice.** If, within six months, the commissioner of human services' agent or licensed child-placing agency documents to the commissioner of health notification of each parent identified on the original birth record pursuant to subdivision 2, the commissioner of health shall disclose the information requested by the adopted person 31 days after the date of the latest notice to either parent. This disclosure will occur if, at any time during the 31 days both of the parents identified on the original birth record have filed a consent to disclosure with the commissioner of health and neither consent to disclosure has been revoked by the subsequent filing by a parent of an affidavit stating that the information should not be disclosed. If only one parent has filed a consent to disclosure and the consent has not been revoked, the commissioner of health shall disclose, to the adopted person, original birth record information on the consenting parent only.

Subd. 5. **Death of parent.** Notwithstanding the provisions of subdivisions 3 and 4, if a parent named on the original birth record of an adopted person has died, and at any time prior to the death the parent has filed an unrevoked affidavit with the commissioner of health stating that the information on the original birth record should not be disclosed, the adopted person may petition the court of original jurisdiction of the adoption proceeding for disclosure of the original birth record pursuant to section 259.61. The court shall grant the petition if, after consideration of the interests of all known persons involved, the court determines that disclosure of the information would be of greater benefit than nondisclosure.

Subd. 6. **Determination of eligibility for enrollment or membership in a federally recognized American Indian tribe.** The state registrar shall provide a copy of an adopted person's original birth record to an authorized representative of a federally recognized American Indian tribe for the sole purpose of determining the adopted person's eligibility for enrollment or membership in the tribe.

Subd. 7. **Adult adoptions.** Notwithstanding section 144.218, a person adopted as an adult shall be permitted to access the person's birth records that existed prior to the adult adoption. Access to the existing birth records shall be the same access that was permitted prior to the adult adoption.

260C.637 ACCESS TO ORIGINAL BIRTH RECORD INFORMATION.

An adopted person may ask the commissioner of health to disclose the information on the adopted person's original birth record according to section 259.89.