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State of Minnesota

HOUSE OF REPRESENTATIVES

NINETY-SECOND SESSION

H. F. No. **4706**

03/30/2022 Authored by Liebling
The bill was read for the first time and referred to the Committee on Health Finance and Policy
04/19/2022 Adoption of Report: Amended and re-referred to the Committee on Ways and Means

1.1 A bill for an act

1.2 relating to health; changing provisions for health care and nursing facilities, hospital

1.3 construction moratorium, radioactive material, ST elevation myocardial infarction

1.4 response, health care coverage, cancer reporting system, lead hazard, safe drinking

1.5 water, nursing home and health profession licensure, certain advisory councils,

1.6 assisted living and home care providers, body art, medical cannabis, health care

1.7 financing, certain health care and provider fees, certain health profession loan

1.8 forgiveness programs, hospital core staffing plans, certain grant programs;

1.9 modifying certain definitions; adding provisions for hemp and edible cannabinoid

1.10 product requirements; prohibiting discrimination in access to transplants; changing

1.11 provisions for medical assistance eligibility and coverage, co-payments, report

1.12 requirements, treatment of trusts, telehealth requirements, health-related licensing

1.13 board requirements, practice of pharmacy, temporary ambulance service,

1.14 prescription drug price reporting and public posting, drug administration,

1.15 medication repository program, health insurance coverage; establishing certain

1.16 advisory councils and boards, managed care opt-out, public MinnesotaCare option,

1.17 climate resiliency program, long COVID program, national suicide prevention

1.18 lifeline number, drug overdose and substance abuse prevention, ombudsperson

1.19 for managed care, certain grants, school health initiative, Emmett Louis Till Victims

1.20 Recovery, Keeping Nurses at the Bedside Act, registry for life-sustaining treatment

1.21 orders; allowing change of sex designation; addressing health disparities; requiring

1.22 balance billing and analysis of Universal Health Reform proposal; making forecast

1.23 adjustments; providing for fees; providing civil penalties; requiring reports;

1.24 appropriating money; amending Minnesota Statutes 2020, sections 34A.01,

1.25 subdivision 4; 62A.02, subdivision 1; 62A.25, subdivision 2; 62A.28, subdivision

1.26 2; 62A.30, by adding a subdivision; 62J.2930, subdivision 3; 62J.84, as amended;

1.27 62Q.021, by adding a subdivision; 62Q.55, subdivision 5; 62Q.556; 62Q.56,

1.28 subdivision 2; 62Q.73, subdivision 7; 62U.04, subdivision 11, by adding a

1.29 subdivision; 62U.10, subdivision 7; 137.68; 144.1201, subdivisions 2, 4; 144.122;

1.30 144.1501, subdivision 4; 144.1503; 144.1505; 144.1911, subdivision 4; 144.292,

1.31 subdivision 6; 144.383; 144.497; 144.554; 144.565, subdivision 4; 144.586, by

1.32 adding a subdivision; 144.6502, subdivision 1; 144.651, by adding a subdivision;

1.33 144.69; 144.7055; 144.9501, subdivisions 9, 26a, 26b; 144.9505, subdivisions 1,

1.34 1h; 144A.01; 144A.03, subdivision 1; 144A.04, subdivisions 4, 6; 144A.06;

1.35 144A.4799, subdivisions 1, 3; 144A.75, subdivision 12; 144G.08, by adding a

1.36 subdivision; 144G.15; 144G.17; 144G.19, by adding a subdivision; 144G.20,

1.37 subdivisions 1, 4, 5, 8, 9, 12, 15; 144G.30, subdivision 5; 144G.31, subdivisions

1.38 4, 8; 144G.41, subdivisions 7, 8; 144G.42, subdivision 10; 144G.50, subdivision

2.1 2; 144G.52, subdivisions 2, 8, 9; 144G.53; 144G.55, subdivisions 1, 3; 144G.56,
 2.2 subdivisions 3, 5; 144G.57, subdivisions 1, 3, 5; 144G.70, subdivisions 2, 4;
 2.3 144G.80, subdivision 2; 144G.90, subdivision 1, by adding a subdivision; 144G.91,
 2.4 subdivisions 13, 21; 144G.92, subdivision 1; 144G.93; 144G.95; 145.56, by adding
 2.5 subdivisions; 145.924; 145A.131, subdivisions 1, 5; 145A.14, by adding a
 2.6 subdivision; 146B.04, subdivision 1; 148B.33, by adding a subdivision; 148E.100,
 2.7 subdivision 3; 148E.105, subdivision 3; 148E.106, subdivision 3; 148E.110,
 2.8 subdivision 7; 149A.01, subdivisions 2, 3; 149A.02, subdivision 13a, by adding
 2.9 subdivisions; 149A.03; 149A.09; 149A.11; 149A.60; 149A.61, subdivisions 4, 5;
 2.10 149A.62; 149A.63; 149A.65, subdivision 2; 149A.70, subdivisions 3, 4, 5, 7;
 2.11 149A.90, subdivisions 2, 4, 5; 149A.94, subdivision 1; 150A.06, subdivisions 1c,
 2.12 2c, 6, by adding a subdivision; 150A.09; 150A.091, subdivisions 2, 5, 8, 9, by
 2.13 adding subdivisions; 151.01, subdivisions 23, 27, by adding subdivisions; 151.071,
 2.14 subdivisions 1, 2; 151.37, by adding a subdivision; 151.555, as amended; 151.72,
 2.15 subdivisions 1, 2, 3, 4, 6, by adding a subdivision; 152.01, subdivision 23; 152.02,
 2.16 subdivisions 2, 3; 152.11, by adding a subdivision; 152.12, by adding a subdivision;
 2.17 152.125; 152.22, subdivision 8, by adding subdivisions; 152.25, subdivision 1, by
 2.18 adding a subdivision; 152.29, subdivisions 3a, 4, by adding a subdivision; 152.30;
 2.19 152.32; 152.33, subdivision 1; 152.35; 152.36; 153.16, subdivision 1; 256.01, by
 2.20 adding a subdivision; 256.969, by adding a subdivision; 256B.021, subdivision 4;
 2.21 256B.055, subdivisions 2, 17; 256B.056, subdivisions 3, 3b, 3c, 4, 7, 11;
 2.22 256B.0595, subdivision 1; 256B.0625, subdivisions 13f, 17a, 18h, 22, 28b, 64, by
 2.23 adding subdivisions; 256B.0631, as amended; 256B.69, subdivisions 4, 5c, 28,
 2.24 36; 256B.692, subdivision 1; 256B.6925, subdivisions 1, 2; 256B.6928, subdivision
 2.25 3; 256B.76, subdivision 1; 256B.77, subdivision 13; 256L.03, subdivisions 1a, 5;
 2.26 256L.04, subdivisions 1c, 7a, 10, by adding a subdivision; Minnesota Statutes
 2.27 2021 Supplement, sections 62J.497, subdivisions 1, 3; 62J.84, subdivisions 6, 9;
 2.28 144.0724, subdivision 4; 144.1481, subdivision 1; 144.1501, subdivisions 1, 2, 3;
 2.29 144.551, subdivision 1; 144.9501, subdivision 17; 148B.5301, subdivision 2;
 2.30 151.335; 151.72, subdivision 5; 152.27, subdivision 2; 152.29, subdivisions 1, 3;
 2.31 256B.0371, subdivision 4; 256B.04, subdivision 14; 256B.0625, subdivisions 3b,
 2.32 9, as amended, 13, 17, 30, 31; 256B.0631, subdivision 1, as amended; 256L.07,
 2.33 subdivision 1; 256L.15, subdivision 2; 363A.50; Laws 2015, chapter 71, article
 2.34 14, section 2, subdivision 5, as amended; Laws 2020, First Special Session chapter
 2.35 7, section 1, subdivisions 1, as amended, 5, as amended; Laws 2021, First Special
 2.36 Session chapter 2, article 1, section 4, subdivision 2; Laws 2021, First Special
 2.37 Session chapter 7, article 1, section 36; article 3, section 44; article 16, section 2,
 2.38 subdivisions 29, 31, 33; article 17, sections 3; 6; 10; 11; 12; 17, subdivision 3;
 2.39 proposing coding for new law in Minnesota Statutes, chapters 62A; 62J; 62Q;
 2.40 62W; 115; 144; 144A; 145; 149A; 152; 256B; 256L; repealing Minnesota Statutes
 2.41 2020, sections 150A.091, subdivisions 3, 15, 17; 256B.057, subdivision 7;
 2.42 256B.063; 256B.69, subdivision 20; 501C.0408, subdivision 4; 501C.1206;
 2.43 Minnesota Statutes 2021 Supplement, section 144G.07, subdivision 6.

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

2.45 ARTICLE 1

2.46 DEPARTMENT OF HEALTH FINANCE

2.47 Section 1. **[62J.811] PROVIDER BALANCE BILLING REQUIREMENTS.**

2.48 **Subdivision 1. Requirements.** (a) Each health provider and health facility shall comply
 2.49 with Division BB, Title I of the Consolidated Appropriations Act, 2021, also known as the
 2.50 "No Surprises Act," including any federal regulations adopted under that act, to the extent

3.1 that it imposes requirements that apply in this state but are not required under the laws of
3.2 this state. This section does not require compliance with any provision of the No Surprises
3.3 Act before January 1, 2022.

3.4 (b) For the purposes of this section, "provider" or "facility" means any health care
3.5 provider or facility pursuant to section 62A.63, subdivision 2, or 62J.03, subdivision 8, that
3.6 is subject to relevant provisions of the No Surprises Act.

3.7 Subd. 2. **Compliance and investigations.** (a) The commissioner of health shall, to the
3.8 extent practicable, seek the cooperation of health care providers and facilities in obtaining
3.9 compliance with this section.

3.10 (b) A person who believes a health care provider or facility has not complied with the
3.11 requirements of the No Surprises Act or this section may file a complaint with the
3.12 commissioner of health. Complaints filed under this section must be filed in writing, either
3.13 on paper or electronically. The commissioner may prescribe additional procedures for the
3.14 filing of complaints.

3.15 (c) The commissioner may also conduct compliance reviews to determine whether health
3.16 care providers and facilities are complying with this section.

3.17 (d) The commissioner will investigate complaints filed under this section. The
3.18 commissioner may prioritize complaint investigations, compliance reviews, and the collection
3.19 of any possible civil monetary penalties under paragraph (g), clause (2), based on factors
3.20 such as repeat complaints or violations, the seriousness of the complaint or violation, and
3.21 other factors as determined by the commissioner.

3.22 (e) The commissioner shall inform the health care provider or facility of the complaint
3.23 or findings of a compliance review and shall provide an opportunity for the health care
3.24 provider or facility to submit information the health care provider or facility considers
3.25 relevant to further review and investigation of the complaint or the findings of the compliance
3.26 review. The health care provider or facility must submit any such information to the
3.27 commissioner within 30 days of receipt of notification of a complaint or compliance review
3.28 under this section.

3.29 (f) If, after reviewing any information described in paragraph (e) and the results of any
3.30 investigation, the commissioner determines that the provider or facility has not violated this
3.31 section, the commissioner shall notify the provider or facility as well as any relevant
3.32 complainant.

4.1 (g) If, after reviewing any information described in paragraph (e) and the results of any
4.2 investigation, the commissioner determines that the provider or facility is in violation of
4.3 this section, the commissioner shall notify the provider or facility and take the following
4.4 steps:

4.5 (1) in cases of noncompliance with this section, the commissioner shall first attempt to
4.6 achieve compliance through successful remediation on the part of the noncompliant provider
4.7 or facility including completion of a corrective action plan or other agreement; and

4.8 (2) if, after taking the action in clause (1) compliance has not been achieved, the
4.9 commissioner of health shall notify the provider or facility that the provider or facility is in
4.10 violation of this section and that the commissioner is imposing a civil monetary penalty. If
4.11 the commissioner determines that more than one health care provider or facility was
4.12 responsible for a violation, the commissioner may impose a civil money penalty against
4.13 each health care provider or facility. The amount of a civil money penalty shall be up to
4.14 \$100 for each violation, but shall not exceed \$25,000 for identical violations during a
4.15 calendar year; and

4.16 (3) no civil money penalty shall be imposed under this section for violations that occur
4.17 prior to January 1, 2023. Warnings must be issued and any compliance issues must be
4.18 referred to the federal government for enforcement pursuant to the federal No Surprises Act
4.19 or other applicable federal laws and regulations.

4.20 (h) A health care provider or facility may contest whether the finding of facts constitute
4.21 a violation of this section according to the contested case proceeding in sections 14.57 to
4.22 14.62, subject to appeal according to sections 14.63 to 14.68.

4.23 (i) When steps in paragraphs (b) to (h) have been completed as needed, the commissioner
4.24 shall notify the health care provider or facility and, if the matter arose from a complaint,
4.25 the complainant regarding the disposition of complaint or compliance review.

4.26 (j) Any data collected by the commissioner of health as part of an active investigation
4.27 or active compliance review under this section are classified as protected nonpublic data
4.28 pursuant to section 13.02, subdivision 13, in the case of data not on individuals and
4.29 confidential pursuant to section 13.02, subdivision 3, in the case of data on individuals.
4.30 Data describing the final disposition of an investigation or compliance review are classified
4.31 as public.

4.32 (k) Civil money penalties imposed and collected under this subdivision shall be deposited
4.33 into the general fund and are appropriated to the commissioner of health for the purposes
4.34 of this section, including the provision of compliance reviews and technical assistance.

5.1 (l) Any compliance and investigative action taken by the department under this section
5.2 shall only include potential violations that occur on or after the effective date of this section.

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

5.4 Sec. 2. Minnesota Statutes 2020, section 62Q.021, is amended by adding a subdivision to
5.5 read:

5.6 Subd. 3. **Compliance with 2021 federal law.** Each health plan company, health provider,
5.7 and health facility shall comply with Division BB, Title I of the Consolidated Appropriations
5.8 Act, 2021, also known as the "No Surprises Act," including any federal regulations adopted
5.9 under that act, to the extent that it imposes requirements that apply in this state but are not
5.10 required under the laws of this state. This section does not require compliance with any
5.11 provision of the No Surprises Act before the effective date provided for that provision in
5.12 the Consolidated Appropriations Act. The commissioner shall enforce this subdivision.

5.13 Sec. 3. Minnesota Statutes 2020, section 62Q.55, subdivision 5, is amended to read:

5.14 Subd. 5. **Coverage restrictions or limitations.** If emergency services are provided by
5.15 a nonparticipating provider, with or without prior authorization, the health plan company
5.16 shall not impose coverage restrictions or limitations that are more restrictive than apply to
5.17 emergency services received from a participating provider. Cost-sharing requirements that
5.18 apply to emergency services received out-of-network must be the same as the cost-sharing
5.19 requirements that apply to services received in-network and shall count toward the in-network
5.20 deductible. All coverage and charges for emergency services must comply with all
5.21 requirements of Division BB, Title I of the Consolidated Appropriations Act, 2021, including
5.22 any federal regulations adopted under that act.

5.23 Sec. 4. Minnesota Statutes 2020, section 62Q.556, is amended to read:

5.24 **62Q.556 UNAUTHORIZED PROVIDER SERVICES CONSUMER**
5.25 **PROTECTIONS AGAINST BALANCE BILLING.**

5.26 Subdivision 1. ~~Unauthorized provider services~~ **Nonparticipating provider balance**
5.27 **billing prohibition.** (a) Except as provided in paragraph ~~(e)~~ (b), ~~unauthorized provider~~
5.28 ~~services occur~~ balance billing is prohibited when an enrollee receives services:

5.29 (1) from a nonparticipating provider at a participating hospital or ambulatory surgical
5.30 center, ~~when the services are rendered:~~ as described by Division BB, Title I of the
5.31 Consolidated Appropriations Act, 2021, including any federal regulations adopted under
5.32 that act;

6.1 ~~(i) due to the unavailability of a participating provider;~~

6.2 ~~(ii) by a nonparticipating provider without the enrollee's knowledge; or~~

6.3 ~~(iii) due to the need for unforeseen services arising at the time the services are being~~
6.4 ~~rendered; or~~

6.5 (2) from a participating provider that sends a specimen taken from the enrollee in the
6.6 participating provider's practice setting to a nonparticipating laboratory, pathologist, or other
6.7 medical testing facility; or

6.8 ~~(b) Unauthorized provider services do not include emergency services as defined in~~
6.9 ~~section 62Q.55, subdivision 3.~~

6.10 (3) from a nonparticipating provider or facility providing emergency services as defined
6.11 in section 62Q.55, subdivision 3, and other services as described in the requirements of
6.12 Division BB, Title I of the Consolidated Appropriations Act, 2021, including any federal
6.13 regulations adopted under that act.

6.14 ~~(e)~~ (b) The services described in paragraph (a), ~~clause~~ clauses (1) and (2), as defined in
6.15 Division BB, Title I of the Consolidated Appropriations Act, 2021, and any federal
6.16 regulations adopted under that act, are not unauthorized provider services subject to balance
6.17 billing if the enrollee gives advance written informed consent to the prior to receiving
6.18 services from the nonparticipating provider acknowledging that the use of a provider, or
6.19 the services to be rendered, may result in costs not covered by the health plan. The informed
6.20 consent must comply with all requirements of Division BB, Title I of the Consolidated
6.21 Appropriations Act, 2021, including any federal regulations adopted under that act.

6.22 Subd. 2. **Prohibition Cost-sharing requirements and independent dispute**
6.23 **resolution.** (a) An enrollee's financial responsibility for the ~~unauthorized~~ nonparticipating
6.24 provider services described in subdivision 1, paragraph (a), shall be the same cost-sharing
6.25 requirements, including co-payments, deductibles, coinsurance, coverage restrictions, and
6.26 coverage limitations, as those applicable to services received by the enrollee from a
6.27 participating provider. A health plan company must apply any enrollee cost sharing
6.28 requirements, including co-payments, deductibles, and coinsurance, for unauthorized provider
6.29 services to the enrollee's annual out-of-pocket limit to the same extent payments to a
6.30 participating provider would be applied.

6.31 (b) A health plan company ~~must attempt to negotiate the reimbursement, less any~~
6.32 ~~applicable enrollee cost sharing under paragraph (a), for the unauthorized provider services~~
6.33 ~~with the nonparticipating provider. If a health plan company's and nonparticipating provider's~~

7.1 ~~attempts to negotiate reimbursement for the health care services do not result in a resolution,~~
7.2 ~~the health plan company or provider may elect to refer the matter for binding arbitration,~~
7.3 ~~chosen in accordance with paragraph (e). A nondisclosure agreement must be executed by~~
7.4 ~~both parties prior to engaging an arbitrator in accordance with this section. The cost of~~
7.5 ~~arbitration must be shared equally between the parties~~ and nonparticipating provider shall
7.6 initiate open negotiations of disputed amounts. If there is no agreement, either party may
7.7 initiate the federal independent dispute resolution process pursuant to Division BB, Title I
7.8 of the Consolidated Appropriations Act, 2021, including any federal regulations adopted
7.9 under that act.

7.10 ~~(e) The commissioner of health, in consultation with the commissioner of the Bureau~~
7.11 ~~of Mediation Services, must develop a list of professionals qualified in arbitration, for the~~
7.12 ~~purpose of resolving disputes between a health plan company and nonparticipating provider~~
7.13 ~~arising from the payment for unauthorized provider services. The commissioner of health~~
7.14 ~~shall publish the list on the Department of Health website, and update the list as appropriate.~~

7.15 ~~(d) The arbitrator must consider relevant information, including the health plan company's~~
7.16 ~~payments to other nonparticipating providers for the same services, the circumstances and~~
7.17 ~~complexity of the particular case, and the usual and customary rate for the service based on~~
7.18 ~~information available in a database in a national, independent, not-for-profit corporation,~~
7.19 ~~and similar fees received by the provider for the same services from other health plans in~~
7.20 ~~which the provider is nonparticipating, in reaching a decision.~~

7.21 Subd. 3. **Annual data reporting.** (a) Beginning April 1, 2023, a health plan company
7.22 must report annually to the commissioner:

7.23 (1) the total number of claims and total billed and paid amount for nonparticipating
7.24 provider services, by service and provider type, submitted to the health plan in the prior
7.25 calendar year; and

7.26 (2) the total number of enrollee complaints received regarding the rights and protections
7.27 established by Division BB, Title I of the Consolidated Appropriations Act, 2021, including
7.28 any federal regulations adopted under that act, in the prior calendar year.

7.29 (b) The commissioners of commerce and health may develop the form and manner for
7.30 health plan companies to comply with paragraph (a).

7.31 Subd. 4. **Enforcement.** (a) Any provider or facility, including a health care provider or
7.32 facility pursuant to section 62A.63, subdivision 2, or 62J.03, subdivision 8, that is subject
7.33 to relevant provisions of the No Surprises Act is subject to the requirements of this section.

8.1 (b) The commissioner of commerce or health may enforce this section.

8.2 (c) If the commissioner of health has cause to believe that any hospital or facility licensed
8.3 under chapter 144 has violated this section, the commissioner may investigate, examine,
8.4 and otherwise enforce this section pursuant to chapter 144 or may refer the potential violation
8.5 to the relevant licensing board with regulatory authority over the provider.

8.6 (d) If a health-related licensing board has cause to believe that a provider has violated
8.7 this section, it may further investigate and enforce the provisions of this section pursuant
8.8 to chapter 214.

8.9 Sec. 5. Minnesota Statutes 2020, section 62Q.56, subdivision 2, is amended to read:

8.10 Subd. 2. **Change in health plans.** (a) If an enrollee is subject to a change in health plans,
8.11 the enrollee's new health plan company must provide, upon request, authorization to receive
8.12 services that are otherwise covered under the terms of the new health plan through the
8.13 enrollee's current provider:

8.14 (1) for up to 120 days if the enrollee is engaged in a current course of treatment for one
8.15 or more of the following conditions:

8.16 (i) an acute condition;

8.17 (ii) a life-threatening mental or physical illness;

8.18 (iii) pregnancy ~~beyond the first trimester of pregnancy;~~

8.19 (iv) a physical or mental disability defined as an inability to engage in one or more major
8.20 life activities, provided that the disability has lasted or can be expected to last for at least
8.21 one year, or can be expected to result in death; or

8.22 (v) a disabling or chronic condition that is in an acute phase; or

8.23 (2) for the rest of the enrollee's life if a physician certifies that the enrollee has an expected
8.24 lifetime of 180 days or less.

8.25 For all requests for authorization under this paragraph, the health plan company must grant
8.26 the request for authorization unless the enrollee does not meet the criteria provided in this
8.27 paragraph.

8.28 (b) The health plan company shall prepare a written plan that provides a process for
8.29 coverage determinations regarding continuity of care of up to 120 days for new enrollees
8.30 who request continuity of care with their former provider, if the new enrollee:

9.1 (1) is receiving culturally appropriate services and the health plan company does not
9.2 have a provider in its preferred provider network with special expertise in the delivery of
9.3 those culturally appropriate services within the time and distance requirements of section
9.4 62D.124, subdivision 1; or

9.5 (2) does not speak English and the health plan company does not have a provider in its
9.6 preferred provider network who can communicate with the enrollee, either directly or through
9.7 an interpreter, within the time and distance requirements of section 62D.124, subdivision
9.8 1.

9.9 The written plan must explain the criteria that will be used to determine whether a need for
9.10 continuity of care exists and how it will be provided.

9.11 (c) This subdivision applies only to group coverage and continuation and conversion
9.12 coverage, and applies only to changes in health plans made by the employer.

9.13 Sec. 6. Minnesota Statutes 2020, section 62Q.73, subdivision 7, is amended to read:

9.14 Subd. 7. **Standards of review.** (a) For an external review of any issue in an adverse
9.15 determination that does not require a medical necessity determination, the external review
9.16 must be based on whether the adverse determination was in compliance with the enrollee's
9.17 health benefit plan and any applicable state and federal law.

9.18 (b) For an external review of any issue in an adverse determination by a health plan
9.19 company licensed under chapter 62D that requires a medical necessity determination, the
9.20 external review must determine whether the adverse determination was consistent with the
9.21 definition of medically necessary care in Minnesota Rules, part 4685.0100, subpart 9b.

9.22 (c) For an external review of any issue in an adverse determination by a health plan
9.23 company, other than a health plan company licensed under chapter 62D, that requires a
9.24 medical necessity determination, the external review must determine whether the adverse
9.25 determination was consistent with the definition of medically necessary care in section
9.26 62Q.53, subdivision 2.

9.27 (d) For an external review of an adverse determination involving experimental or
9.28 investigational treatment, the external review entity must base its decision on all documents
9.29 submitted by the health plan company and enrollee, including medical records, the attending
9.30 physician, advanced practice registered nurse, or health care professional's recommendation,
9.31 consulting reports from health care professionals, the terms of coverage, federal Food and
9.32 Drug Administration approval, and medical or scientific evidence or evidence-based
9.33 standards.

10.1 Sec. 7. Minnesota Statutes 2020, section 62U.04, is amended by adding a subdivision to
10.2 read:

10.3 Subd. 5b. **Non-claims-based payments.** (a) Beginning in 2024, all health plan companies
10.4 and third-party administrators shall submit to a private entity designated by the commissioner
10.5 of health all non-claims-based payments made to health care providers. The data shall be
10.6 submitted in a form, manner, and frequency specified by the commissioner. Non-claims-based
10.7 payments are payments to health care providers designed to pay for value of health care
10.8 services over volume of health care services and include alternative payment models or
10.9 incentives, payments for infrastructure expenditures or investments, and payments for
10.10 workforce expenditures or investments. Non-claims-based payments submitted under this
10.11 subdivision must, to the extent possible, be attributed to a health care provider in the same
10.12 manner in which claims-based data are attributed to a health care provider and, where
10.13 appropriate, must be combined with data collected under subdivisions 4 and 5 in analyses
10.14 of health care spending.

10.15 (b) Data collected under this subdivision are nonpublic data as defined in section 13.02.
10.16 Notwithstanding the definition of summary data in section 13.02, subdivision 19, summary
10.17 data prepared under this subdivision may be derived from nonpublic data. The commissioner
10.18 shall establish procedures and safeguards to protect the integrity and confidentiality of any
10.19 data maintained by the commissioner.

10.20 (c) The commissioner shall consult with health plan companies, hospitals, and health
10.21 care providers in developing the data reported under this subdivision and standardized
10.22 reporting forms.

10.23 Sec. 8. Minnesota Statutes 2020, section 62U.04, subdivision 11, is amended to read:

10.24 **Subd. 11. Restricted uses of the all-payer claims data.** (a) Notwithstanding subdivision
10.25 4, paragraph (b), and subdivision 5, paragraph (b), the commissioner or the commissioner's
10.26 designee shall only use the data submitted under subdivisions 4 ~~and~~ 5, and 5b for the
10.27 following purposes:

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

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

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

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

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

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

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

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

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

11.13 (v) not lead to the collection of additional data elements beyond what is authorized under
11.14 this section as of June 30, 2015.

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

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

11.21 ~~(d) The commissioner or the commissioner's designee may use the data submitted under~~
11.22 ~~subdivisions 4 and 5 for the purpose described in paragraph (a), clause (3), until July 1,~~
11.23 ~~2023.~~

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

11.27 Sec. 9. Minnesota Statutes 2020, section 62U.10, subdivision 7, is amended to read:

11.28 Subd. 7. **Outcomes reporting; savings determination.** (a) ~~Beginning November 1,~~
11.29 ~~2016, and~~ Each November 1 thereafter, the commissioner of health shall determine the
11.30 actual total private and public health care and long-term care spending for Minnesota
11.31 residents related to each health indicator projected in subdivision 6 for the most recent
11.32 calendar year available. The commissioner shall determine the difference between the

12.1 projected and actual spending for each health indicator and for each year, and determine
12.2 the savings attributable to changes in these health indicators. The assumptions and research
12.3 methods used to calculate actual spending must be determined to be appropriate by an
12.4 independent actuarial consultant. If the actual spending is less than the projected spending,
12.5 the commissioner, in consultation with the commissioners of human services and management
12.6 and budget, shall use the proportion of spending for state-administered health care programs
12.7 to total private and public health care spending for each health indicator for the calendar
12.8 year two years before the current calendar year to determine the percentage of the calculated
12.9 aggregate savings amount accruing to state-administered health care programs.

12.10 (b) The commissioner may use the data submitted under section 62U.04, subdivisions
12.11 ~~4 and~~ 5, and 5b, to complete the activities required under this section, but may only report
12.12 publicly on regional data aggregated to granularity of 25,000 lives or greater for this purpose.

12.13 **Sec. 10. [115.7411] ADVISORY COUNCIL ON WATER SUPPLY SYSTEMS AND**
12.14 **WASTEWATER TREATMENT FACILITIES.**

12.15 Subdivision 1. Purpose; membership. The advisory council on water supply systems
12.16 and wastewater treatment facilities shall advise the commissioners of health and the Pollution
12.17 Control Agency regarding classification of water supply systems and wastewater treatment
12.18 facilities, qualifications and competency evaluation of water supply system operators and
12.19 wastewater treatment facility operators, and additional laws, rules, and procedures that may
12.20 be desirable for regulating the operation of water supply systems and of wastewater treatment
12.21 facilities. The advisory council is composed of 11 voting members, of whom:

12.22 (1) one member must be from the Department of Health, Division of Environmental
12.23 Health, appointed by the commissioner of health;

12.24 (2) one member must be from the Pollution Control Agency, appointed by the
12.25 commissioner of the Pollution Control Agency;

12.26 (3) three members must be certified water supply system operators, appointed by the
12.27 commissioner of health, one of whom must represent a nonmunicipal community or
12.28 nontransient noncommunity water supply system;

12.29 (4) three members must be certified wastewater treatment facility operators, appointed
12.30 by the commissioner of the Pollution Control Agency;

12.31 (5) one member must be a representative from an organization representing municipalities,
12.32 appointed by the commissioner of health with the concurrence of the commissioner of the
12.33 Pollution Control Agency; and

13.1 (6) two members must be members of the public who are not associated with water
13.2 supply systems or wastewater treatment facilities. One must be appointed by the
13.3 commissioner of health and the other by the commissioner of the Pollution Control Agency.
13.4 Consideration should be given to one of these members being a representative of academia
13.5 knowledgeable in water or wastewater matters.

13.6 Subd. 2. **Geographic representation.** At least one of the water supply system operators
13.7 and at least one of the wastewater treatment facility operators must be from outside the
13.8 seven-county metropolitan area, and one wastewater treatment facility operator must be
13.9 from the Metropolitan Council.

13.10 Subd. 3. **Terms; compensation.** The terms of the appointed members and the
13.11 compensation and removal of all members are governed by section 15.059.

13.12 Subd. 4. **Officers.** When new members are appointed to the council, a chair must be
13.13 elected at the next council meeting. The Department of Health representative shall serve as
13.14 secretary of the council.

13.15 Sec. 11. Minnesota Statutes 2020, section 144.122, is amended to read:

13.16 **144.122 LICENSE, PERMIT, AND SURVEY FEES.**

13.17 (a) The state commissioner of health, by rule, may prescribe procedures and fees for
13.18 filing with the commissioner as prescribed by statute and for the issuance of original and
13.19 renewal permits, licenses, registrations, and certifications issued under authority of the
13.20 commissioner. The expiration dates of the various licenses, permits, registrations, and
13.21 certifications as prescribed by the rules shall be plainly marked thereon. Fees may include
13.22 application and examination fees and a penalty fee for renewal applications submitted after
13.23 the expiration date of the previously issued permit, license, registration, and certification.
13.24 The commissioner may also prescribe, by rule, reduced fees for permits, licenses,
13.25 registrations, and certifications when the application therefor is submitted during the last
13.26 three months of the permit, license, registration, or certification period. Fees proposed to
13.27 be prescribed in the rules shall be first approved by the Department of Management and
13.28 Budget. All fees proposed to be prescribed in rules shall be reasonable. The fees shall be
13.29 in an amount so that the total fees collected by the commissioner will, where practical,
13.30 approximate the cost to the commissioner in administering the program. All fees collected
13.31 shall be deposited in the state treasury and credited to the state government special revenue
13.32 fund unless otherwise specifically appropriated by law for specific purposes.

14.1 (b) The commissioner may charge a fee for voluntary certification of medical laboratories
 14.2 and environmental laboratories, and for environmental and medical laboratory services
 14.3 provided by the department, without complying with paragraph (a) or chapter 14. Fees
 14.4 charged for environment and medical laboratory services provided by the department must
 14.5 be approximately equal to the costs of providing the services.

14.6 (c) The commissioner may develop a schedule of fees for diagnostic evaluations
 14.7 conducted at clinics held by the services for children with disabilities program. All receipts
 14.8 generated by the program are annually appropriated to the commissioner for use in the
 14.9 maternal and child health program.

14.10 (d) The commissioner shall set license fees for hospitals and nursing homes that are not
 14.11 boarding care homes at the following levels:

14.12	Joint Commission on Accreditation of	\$7,655 plus \$16 per bed
14.13	Healthcare Organizations (JCAHO) and	
14.14	American Osteopathic Association (AOA)	
14.15	hospitals	
14.16	Non-JCAHO and non-AOA hospitals	\$5,280 plus \$250 per bed
14.17	Nursing home	\$183 plus \$91 per bed until June 30, 2018.
14.18		\$183 plus \$100 per bed between July 1, 2018,
14.19		and June 30, 2020. \$183 plus \$105 per bed
14.20		beginning July 1, 2020.

14.21 The commissioner shall set license fees for outpatient surgical centers, boarding care
 14.22 homes, supervised living facilities, assisted living facilities, and assisted living facilities
 14.23 with dementia care at the following levels:

14.24	Outpatient surgical centers	\$3,712
14.25	Boarding care homes	\$183 plus \$91 per bed
14.26	Supervised living facilities	\$183 plus \$91 per bed.
14.27	Assisted living facilities with dementia care	\$3,000 plus \$100 per resident.
14.28	Assisted living facilities	\$2,000 plus \$75 per resident.

14.29 Fees collected under this paragraph are nonrefundable. The fees are nonrefundable even if
 14.30 received before July 1, 2017, for licenses or registrations being issued effective July 1, 2017,
 14.31 or later.

14.32 (e) Unless prohibited by federal law, the commissioner of health shall charge applicants
 14.33 the following fees to cover the cost of any initial certification surveys required to determine
 14.34 a provider's eligibility to participate in the Medicare or Medicaid program:

14.35	Prospective payment surveys for hospitals	\$	900
14.36	Swing bed surveys for nursing homes	\$	1,200

15.1	Psychiatric hospitals		\$	1,400
15.2	Rural health facilities		\$	1,100
15.3	Portable x-ray providers		\$	500
15.4	Home health agencies		\$	1,800
15.5	Outpatient therapy agencies		\$	800
15.6	End stage renal dialysis providers		\$	2,100
15.7	Independent therapists		\$	800
15.8	Comprehensive rehabilitation outpatient facilities		\$	1,200
15.9	Hospice providers		\$	1,700
15.10	Ambulatory surgical providers		\$	1,800
15.11	Hospitals		\$	4,200
15.12	Other provider categories or additional	Actual surveyor costs: average		
15.13	resurveys required to complete initial			
15.14	certification			surveyor cost x number of hours for the survey process.

15.15 These fees shall be submitted at the time of the application for federal certification and
 15.16 shall not be refunded. All fees collected after the date that the imposition of fees is not
 15.17 prohibited by federal law shall be deposited in the state treasury and credited to the state
 15.18 government special revenue fund.

15.19 (f) Notwithstanding section 16A.1283, the commissioner may adjust the fees assessed
 15.20 on assisted living facilities and assisted living facilities with dementia care under paragraph
 15.21 (d), in a revenue-neutral manner in accordance with the requirements of this paragraph:

15.22 (1) a facility seeking to renew a license shall pay a renewal fee in an amount that is up
 15.23 to ten percent lower than the applicable fee in paragraph (d) if residents who receive home
 15.24 and community-based waiver services under chapter 256S and section 256B.49 comprise
 15.25 more than 50 percent of the facility's capacity in the calendar year prior to the year in which
 15.26 the renewal application is submitted; and

15.27 (2) a facility seeking to renew a license shall pay a renewal fee in an amount that is up
 15.28 to ten percent higher than the applicable fee in paragraph (d) if residents who receive home
 15.29 and community-based waiver services under chapter 256S and section 256B.49 comprise
 15.30 less than 50 percent of the facility's capacity during the calendar year prior to the year in
 15.31 which the renewal application is submitted.

15.32 The commissioner may annually adjust the percentages in clauses (1) and (2), to ensure this
 15.33 paragraph is implemented in a revenue-neutral manner. The commissioner shall develop a
 15.34 method for determining capacity thresholds in this paragraph in consultation with the
 15.35 commissioner of human services and must coordinate the administration of this paragraph
 15.36 with the commissioner of human services for purposes of verification.

16.1 (g) The commissioner shall charge hospitals an annual licensing base fee of \$1,150 per
16.2 hospital, plus an additional \$15 per licensed bed/bassinet fee. Revenue shall be deposited
16.3 to the state government special revenue fund and credited toward trauma hospital designations
16.4 under sections 144.605 and 144.6071.

16.5 Sec. 12. Minnesota Statutes 2021 Supplement, section 144.1501, subdivision 1, is amended
16.6 to read:

16.7 Subdivision 1. **Definitions.** (a) For purposes of this section, the following definitions
16.8 apply.

16.9 (b) "Acupuncture practitioner" means an individual licensed to practice acupuncture
16.10 under chapter 147B.

16.11 ~~(b)~~ (c) "Advanced dental therapist" means an individual who is licensed as a dental
16.12 therapist under section 150A.06, and who is certified as an advanced dental therapist under
16.13 section 150A.106.

16.14 (d) "Advanced practice provider" means a nurse practitioner, nurse-midwife, nurse
16.15 anesthetist, clinical nurse specialist, or physician assistant.

16.16 ~~(e)~~ (e) "Alcohol and drug counselor" means an individual who is licensed as an alcohol
16.17 and drug counselor under chapter 148F.

16.18 ~~(d)~~ (f) "Dental therapist" means an individual who is licensed as a dental therapist under
16.19 section 150A.06.

16.20 ~~(e)~~ (g) "Dentist" means an individual who is licensed to practice dentistry.

16.21 ~~(f)~~ (h) "Designated rural area" means a statutory and home rule charter city or township
16.22 that is outside the seven-county metropolitan area as defined in section 473.121, subdivision
16.23 2, excluding the cities of Duluth, Mankato, Moorhead, Rochester, and St. Cloud.

16.24 ~~(g)~~ (i) "Emergency circumstances" means those conditions that make it impossible for
16.25 the participant to fulfill the service commitment, including death, total and permanent
16.26 disability, or temporary disability lasting more than two years.

16.27 ~~(h)~~ (j) "Mental health professional" means an individual providing clinical services in
16.28 the treatment of mental illness who is qualified in at least one of the ways specified in section
16.29 245.462, subdivision 18.

16.30 ~~(i)~~ (k) "Medical resident" means an individual participating in a medical residency in
16.31 family practice, internal medicine, obstetrics and gynecology, pediatrics, or psychiatry.

17.1 ~~(j)~~ "Midlevel practitioner" means a nurse practitioner, nurse-midwife, nurse anesthetist,
17.2 advanced clinical nurse specialist, or physician assistant.

17.3 ~~(k)~~ (l) "Nurse" means an individual who has completed training and received all licensing
17.4 or certification necessary to perform duties as a licensed practical nurse or registered nurse.

17.5 ~~(l)~~ (m) "Nurse-midwife" means a registered nurse who has graduated from a program
17.6 of study designed to prepare registered nurses for advanced practice as nurse-midwives.

17.7 ~~(m)~~ (n) "Nurse practitioner" means a registered nurse who has graduated from a program
17.8 of study designed to prepare registered nurses for advanced practice as nurse practitioners.

17.9 ~~(n)~~ (o) "Pharmacist" means an individual with a valid license issued under chapter 151.

17.10 ~~(o)~~ (p) "Physician" means an individual who is licensed to practice medicine in the areas
17.11 of family practice, internal medicine, obstetrics and gynecology, pediatrics, or psychiatry.

17.12 ~~(p)~~ (q) "Physician assistant" means a person licensed under chapter 147A.

17.13 (r) "Public health employee" means an individual working in a local, Tribal, or state
17.14 public health department.

17.15 ~~(q)~~ (s) "Public health nurse" means a registered nurse licensed in Minnesota who has
17.16 obtained a registration certificate as a public health nurse from the Board of Nursing in
17.17 accordance with Minnesota Rules, chapter 6316.

17.18 ~~(r)~~ (t) "Qualified educational loan" means a government, commercial, or foundation loan
17.19 for actual costs paid for tuition, reasonable education expenses, and reasonable living
17.20 expenses related to the graduate or undergraduate education of a health care professional.

17.21 (u) "Underserved patient population" means patients who are state public program
17.22 enrollees or patients receiving sliding fee schedule discounts through a formal sliding fee
17.23 schedule meeting the standards established by the United States Department of Health and
17.24 Human Services under Code of Federal Regulations, title 42, section 51c.303.

17.25 ~~(s)~~ (v) "Underserved urban community" means a Minnesota urban area or population
17.26 included in the list of designated primary medical care health professional shortage areas
17.27 (HPSAs), medically underserved areas (MUAs), or medically underserved populations
17.28 (MUPs) maintained and updated by the United States Department of Health and Human
17.29 Services.

18.1 Sec. 13. Minnesota Statutes 2021 Supplement, section 144.1501, subdivision 2, is amended
18.2 to read:

18.3 Subd. 2. **Creation of account.** (a) A health professional education loan forgiveness
18.4 program account is established. The commissioner of health shall use money from the
18.5 account to establish a loan forgiveness program:

18.6 (1) for medical residents, mental health professionals, and alcohol and drug counselors
18.7 agreeing to practice in designated rural areas or in underserved urban communities, or
18.8 agreeing to provide at least 25 percent of the provider's yearly patient encounters to patients
18.9 in an underserved patient population, or specializing in the area of pediatric psychiatry;

18.10 (2) for ~~midlevel practitioners~~ advanced practice providers agreeing to practice in
18.11 designated rural areas or to teach at least 12 credit hours, or 720 hours per year in the nursing
18.12 field in a postsecondary program at the undergraduate level or the equivalent at the graduate
18.13 level;

18.14 (3) for nurses who agree to practice in a Minnesota nursing home; an intermediate care
18.15 facility for persons with developmental disability; a hospital if the hospital owns and operates
18.16 a Minnesota nursing home and a minimum of 50 percent of the hours worked by the nurse
18.17 is in the nursing home; a housing with services establishment as defined in section 144D.01,
18.18 subdivision 4; a school district or charter school; or for a home care provider as defined in
18.19 section 144A.43, subdivision 4; or agree to teach at least 12 credit hours, or 720 hours per
18.20 year in the nursing field in a postsecondary program at the undergraduate level or the
18.21 equivalent at the graduate level;

18.22 (4) for other health care technicians agreeing to teach at least 12 credit hours, or 720
18.23 hours per year in their designated field in a postsecondary program at the undergraduate
18.24 level or the equivalent at the graduate level. The commissioner, in consultation with the
18.25 Healthcare Education-Industry Partnership, shall determine the health care fields where the
18.26 need is the greatest, including, but not limited to, respiratory therapy, clinical laboratory
18.27 technology, radiologic technology, and surgical technology;

18.28 (5) for pharmacists, advanced dental therapists, dental therapists, acupuncture
18.29 practitioners, and public health nurses who agree to practice in designated rural areas; ~~and~~

18.30 (6) for dentists agreeing to deliver at least 25 percent of the dentist's yearly patient
18.31 encounters to ~~state public program enrollees or patients receiving sliding fee schedule~~
18.32 ~~discounts through a formal sliding fee schedule meeting the standards established by the~~
18.33 ~~United States Department of Health and Human Services under Code of Federal Regulations,~~
18.34 ~~title 42, section 51, chapter 303.~~ patients in an underserved patient population;

19.1 (7) for mental health professionals agreeing to provide up to 768 hours per year of clinical
19.2 supervision in their designated field; and

19.3 (8) for public health employees serving in a local, Tribal, or state public health department
19.4 in an area of high need as determined by the commissioner.

19.5 (b) Appropriations made to the account do not cancel and are available until expended,
19.6 except that at the end of each biennium, any remaining balance in the account that is not
19.7 committed by contract and not needed to fulfill existing commitments shall cancel to the
19.8 fund.

19.9 Sec. 14. Minnesota Statutes 2021 Supplement, section 144.1501, subdivision 3, is amended
19.10 to read:

19.11 Subd. 3. **Eligibility.** (a) To be eligible to participate in the loan forgiveness program, an
19.12 individual must:

19.13 (1) be a medical or dental resident; a licensed pharmacist; or be enrolled in a training or
19.14 education program to become a dentist, dental therapist, advanced dental therapist, mental
19.15 health professional, alcohol and drug counselor, pharmacist, public health employee, public
19.16 health nurse, ~~midlevel practitioner~~ advanced practice provider, acupuncture practitioner,
19.17 registered nurse, or a licensed practical nurse. The commissioner may also consider
19.18 applications submitted by graduates in eligible professions who are licensed and in practice;
19.19 and

19.20 (2) submit an application to the commissioner of health.

19.21 (b) Except as provided in paragraph (c), an applicant selected to participate must sign a
19.22 contract to agree to serve a minimum three-year full-time service obligation according to
19.23 subdivision 2, which shall begin no later than March 31 following completion of required
19.24 training, with the exception of a nurse, who must agree to serve a minimum two-year
19.25 full-time service obligation according to subdivision 2, which shall begin no later than
19.26 March 31 following completion of required training.

19.27 (c) An applicant selected to participate who is a public health employee is eligible for
19.28 loan forgiveness within three years after completion of required training. An applicant
19.29 selected to participate who is a nurse and who agrees to teach according to subdivision 2,
19.30 paragraph (a), clause (3), must sign a contract to agree to teach for a minimum of two years.

20.1 Sec. 15. Minnesota Statutes 2020, section 144.1501, subdivision 4, is amended to read:

20.2 Subd. 4. **Loan forgiveness.** (a) The commissioner of health may select applicants each
20.3 year for participation in the loan forgiveness program, within the limits of available funding.
20.4 For public health employees, available funds are limited to the appropriations funded in
20.5 fiscal year 2022. In considering applications from applicants who are mental health
20.6 professionals, the commissioner shall give preference to applicants who work in rural or
20.7 culturally specific organizations. In considering applications from all other applicants, the
20.8 commissioner shall give preference to applicants who document diverse cultural
20.9 competencies. Except as provided in paragraph (b), the commissioner shall distribute
20.10 available funds for loan forgiveness proportionally among the eligible professions according
20.11 to the vacancy rate for each profession in the required geographic area, facility type, teaching
20.12 area, patient group, or specialty type specified in subdivision 2. The commissioner shall
20.13 allocate funds for physician loan forgiveness so that 75 percent of the funds available are
20.14 used for rural physician loan forgiveness and 25 percent of the funds available are used for
20.15 underserved urban communities, physicians agreeing to provide at least 25 percent of the
20.16 physician's yearly patient encounters to patients in an underserved patient population, and
20.17 pediatric psychiatry loan forgiveness. If the commissioner does not receive enough qualified
20.18 applicants each year to use the entire allocation of funds for any eligible profession, the
20.19 remaining funds may be allocated proportionally among the other eligible professions
20.20 according to the vacancy rate for each profession in the required geographic area, patient
20.21 group, or facility type specified in subdivision 2. Applicants are responsible for securing
20.22 their own qualified educational loans. The commissioner shall select participants based on
20.23 their suitability for practice serving the required geographic area or facility type specified
20.24 in subdivision 2, as indicated by experience or training. The commissioner shall give
20.25 preference to applicants closest to completing their training. Except as specified in paragraph
20.26 (c), for each year that a participant meets the service obligation required under subdivision
20.27 3, up to a maximum of four years, the commissioner shall make annual disbursements
20.28 directly to the participant equivalent to 15 percent of the average educational debt for
20.29 indebted graduates in their profession in the year closest to the applicant's selection for
20.30 which information is available, not to exceed the balance of the participant's qualifying
20.31 educational loans. Before receiving loan repayment disbursements and as requested, the
20.32 participant must complete and return to the commissioner a confirmation of practice form
20.33 provided by the commissioner verifying that the participant is practicing as required under
20.34 subdivisions 2 and 3. The participant must provide the commissioner with verification that
20.35 the full amount of loan repayment disbursement received by the participant has been applied
20.36 toward the designated loans. After each disbursement, verification must be received by the

21.1 commissioner and approved before the next loan repayment disbursement is made.
 21.2 Participants who move their practice remain eligible for loan repayment as long as they
 21.3 practice as required under subdivision 2.

21.4 (b) The commissioner shall distribute available funds for loan forgiveness for public
 21.5 health employees according to areas of high need as determined by the commissioner.

21.6 (c) For each year that a participant who is a nurse and who has agreed to teach according
 21.7 to subdivision 2 meets the teaching obligation required in subdivision 3, the commissioner
 21.8 shall make annual disbursements directly to the participant equivalent to 15 percent of the
 21.9 average annual educational debt for indebted graduates in the nursing profession in the year
 21.10 closest to the participant's selection for which information is available, not to exceed the
 21.11 balance of the participant's qualifying educational loans.

21.12 Sec. 16. Minnesota Statutes 2020, section 144.1503, is amended to read:

21.13 **144.1503 HOME AND COMMUNITY-BASED SERVICES EMPLOYEE**
 21.14 **SCHOLARSHIP AND LOAN FORGIVENESS PROGRAM.**

21.15 Subdivision 1. **Creation.** The home and community-based services employee scholarship
 21.16 and loan forgiveness grant program is established for the purpose of assisting to assist
 21.17 qualified provider applicants to fund in funding employee scholarships and qualified
 21.18 educational loan repayments for education, training, field experience, and examinations in
 21.19 nursing and, other health care fields, and licensure as an assisted living director under section
 21.20 144A.20, subdivision 4.

21.21 Subd. 1a. **Definition.** For purposes of this section, "qualified educational loan" means
 21.22 a government, commercial, or foundation loan secured by an employee of a qualifying
 21.23 provider for actual costs paid for tuition, training, and examinations; reasonable education,
 21.24 training, and field experience expenses; and reasonable living expenses related to the
 21.25 employee's graduate or undergraduate education.

21.26 Subd. 2. **Provision of grants.** The commissioner shall make grants available to qualified
 21.27 providers of older adult services. Grants must be used by home and community-based service
 21.28 providers to recruit and train staff through the establishment of an employee scholarship
 21.29 and loan forgiveness fund.

21.30 Subd. 3. **Eligibility.** (a) Eligible providers must primarily provide services to individuals
 21.31 who are 65 years of age and older in home and community-based settings, including housing
 21.32 with services establishments as defined in section 144D.01, subdivision 4; assisted living
 21.33 facilities as defined in section 144G.08, subdivision 7; adult day care as defined in section

22.1 245A.02, subdivision 2a; and home care services as defined in section 144A.43, subdivision
22.2 3.

22.3 (b) Qualifying providers must establish a home and community-based services employee
22.4 scholarship and loan forgiveness program, as specified in subdivision 4. Providers that
22.5 receive funding under this section must use the funds to award scholarships to, and to repay
22.6 qualified educational loans of, employees who work an average of at least 16 hours per
22.7 week for the provider.

22.8 Subd. 4. **Home and community-based services employee scholarship and loan**
22.9 **forgiveness program.** Each qualifying provider under this section must propose a home
22.10 and community-based services employee scholarship and loan forgiveness program. Providers
22.11 must establish criteria by which funds are to be distributed among employees. At a minimum,
22.12 the scholarship and loan forgiveness program must cover employee costs and repay qualified
22.13 educational loans of employees related to a course of study that is expected to lead to career
22.14 advancement with the provider or in the field of long-term care, including home care, care
22.15 of persons with disabilities, ~~or~~ nursing, or management as a licensed assisted living director.

22.16 Subd. 5. **Participating providers.** The commissioner shall publish a request for proposals
22.17 in the State Register, specifying provider eligibility requirements, criteria for a qualifying
22.18 employee scholarship and loan forgiveness program, provider selection criteria,
22.19 documentation required for program participation, maximum award amount, and methods
22.20 of evaluation. The commissioner must publish additional requests for proposals each year
22.21 in which funding is available for this purpose.

22.22 Subd. 6. **Application requirements.** Eligible providers seeking a grant shall submit an
22.23 application to the commissioner. Applications must contain a complete description of the
22.24 employee scholarship and loan forgiveness program being proposed by the applicant,
22.25 including the need for the organization to enhance the education of its workforce, the process
22.26 for determining which employees will be eligible for scholarships or loan repayment, any
22.27 other sources of funding for scholarships or loan repayment, the expected degrees or
22.28 credentials eligible for scholarships or loan repayment, the amount of funding sought for
22.29 the scholarship and loan forgiveness program, a proposed budget detailing how funds will
22.30 be spent, and plans for retaining eligible employees after completion of their scholarship
22.31 or repayment of their loan.

22.32 Subd. 7. **Selection process.** The commissioner shall determine a maximum award for
22.33 grants and make grant selections based on the information provided in the grant application,
22.34 including the demonstrated need for an applicant provider to enhance the education of its

23.1 workforce, the proposed employee scholarship and loan forgiveness selection process, the
23.2 applicant's proposed budget, and other criteria as determined by the commissioner.
23.3 Notwithstanding any law or rule to the contrary, funds awarded to grantees in a grant
23.4 agreement do not lapse until the grant agreement expires.

23.5 Subd. 8. **Reporting requirements.** Participating providers shall submit an invoice for
23.6 reimbursement and a report to the commissioner on a schedule determined by the
23.7 commissioner and on a form supplied by the commissioner. The report shall include the
23.8 amount spent on scholarships and loan repayment; the number of employees who received
23.9 scholarships and the number of employees for whom loans were repaid; and, for each
23.10 scholarship or loan forgiveness recipient, the name of the recipient, the current position of
23.11 the recipient, the amount awarded or loan amount repaid, the educational institution attended,
23.12 the nature of the educational program, and the expected or actual program completion date.
23.13 During the grant period, the commissioner may require and collect from grant recipients
23.14 other information necessary to evaluate the program.

23.15 Sec. 17. **[144.1504] HOSPITAL NURSING LOAN FORGIVENESS PROGRAM.**

23.16 Subdivision 1. Definition. (a) For purposes of this section, the following definitions
23.17 apply.

23.18 (b) "Nurse" means an individual who is licensed as a registered nurse and who is
23.19 providing direct patient care in a nonprofit hospital.

23.20 (c) "PSLF program" means the federal Public Student Loan Forgiveness program
23.21 established under Code of Federal Regulations, title 34, section 685.21.

23.22 Subd. 2. Eligibility. (a) To be eligible to participate in the hospital nursing loan
23.23 forgiveness program, a nurse must be:

23.24 (1) enrolled in the PSLF program;

23.25 (2) employed full time as a registered nurse by a nonprofit hospital that is an eligible
23.26 employer under the PSLF program; and

23.27 (3) providing direct care to patients at the nonprofit hospital.

23.28 (b) An applicant for loan forgiveness must submit to the commissioner of health:

23.29 (1) a completed application on forms provided by the commissioner;

23.30 (2) proof that the applicant is enrolled in the PSLF program; and

24.1 (3) confirmation that the applicant is employed full time as a registered nurse by a
24.2 nonprofit hospital and is providing direct patient care.

24.3 (c) The applicant selected to participate must sign a contract to agree to continue to
24.4 provide direct patient care as a registered nurse at a nonprofit hospital for the repayment
24.5 period of the participant's eligible loan under the PSLF program.

24.6 Subd. 3. **Loan forgiveness.** (a) The commissioner of health shall select applicants each
24.7 year for participation in the hospital nursing loan forgiveness program, within limits of
24.8 available funding. Applicants are responsible for applying for and maintaining eligibility
24.9 for the PSLF program.

24.10 (b) For each year that a participant meets the eligibility requirements described in
24.11 subdivision 2, the commissioner shall make an annual disbursement directly to the participant
24.12 in an amount equal to the minimum loan payments required to be paid by the participant
24.13 under the participant's repayment plan under the PSLF program for the previous loan year.
24.14 Before receiving the annual loan repayment disbursement, the participant must complete
24.15 and return to the commissioner a confirmation of practice form provided by the
24.16 commissioner, verifying that the participant continues to meet the eligibility requirements
24.17 under subdivision 2.

24.18 (c) The participant must provide the commissioner with verification that the full amount
24.19 of loan repayment disbursement received by the participant has been applied toward the
24.20 loan for which forgiveness is sought under the PSLF program.

24.21 Subd. 4. **Penalty for nonfulfillment.** If a participant does not fulfill the required
24.22 minimum commitment of service as required under subdivision 2, or the secretary of
24.23 education determines that the participant does not meet eligibility requirements for the PSLF
24.24 program, the commissioner shall collect from the participant the total amount paid to the
24.25 participant under the hospital nursing loan forgiveness program plus interest at a rate
24.26 established according to section 270C.40. The commissioner shall deposit the money
24.27 collected in the health care access fund to be credited to the health professional education
24.28 loan forgiveness program account established in section 144.1501, subdivision 2. The
24.29 commissioner shall allow waivers of all or part of the money owed to the commissioner as
24.30 a result of a nonfulfillment penalty if emergency circumstances prevent fulfillment of the
24.31 service commitment or if the PSLF program is discontinued before the participant's service
24.32 commitment is fulfilled.

25.1 Sec. 18. Minnesota Statutes 2020, section 144.1505, is amended to read:

25.2 **144.1505 HEALTH PROFESSIONALS CLINICAL TRAINING EXPANSION**
25.3 **AND RURAL AND UNDERSERVED CLINICAL ROTATIONS GRANT PROGRAM**
25.4 **PROGRAMS.**

25.5 Subdivision 1. **Definitions.** For purposes of this section, the following definitions apply:

25.6 (1) "eligible advanced practice registered nurse program" means a program that is located
25.7 in Minnesota and is currently accredited as a master's, doctoral, or postgraduate level
25.8 advanced practice registered nurse program by the Commission on Collegiate Nursing
25.9 Education or by the Accreditation Commission for Education in Nursing, or is a candidate
25.10 for accreditation;

25.11 (2) "eligible dental program" means a dental residency training program that is located
25.12 in Minnesota and is currently accredited by the accrediting body or is a candidate for
25.13 accreditation;

25.14 ~~(2)~~ (3) "eligible dental therapy program" means a dental therapy education program or
25.15 advanced dental therapy education program that is located in Minnesota and is either:

25.16 (i) approved by the Board of Dentistry; or

25.17 (ii) currently accredited by the Commission on Dental Accreditation;

25.18 ~~(3)~~ (4) "eligible mental health professional program" means a program that is located
25.19 in Minnesota and is listed as a mental health professional program by the appropriate
25.20 accrediting body for clinical social work, psychology, marriage and family therapy, or
25.21 licensed professional clinical counseling, or is a candidate for accreditation;

25.22 ~~(4)~~ (5) "eligible pharmacy program" means a program that is located in Minnesota and
25.23 is currently accredited as a doctor of pharmacy program by the Accreditation Council on
25.24 Pharmacy Education;

25.25 ~~(5)~~ (6) "eligible physician assistant program" means a program that is located in
25.26 Minnesota and is currently accredited as a physician assistant program by the Accreditation
25.27 Review Commission on Education for the Physician Assistant, or is a candidate for
25.28 accreditation;

25.29 (7) "eligible physician program" means a physician residency training program that is
25.30 located in Minnesota and is currently accredited by the accrediting body or is a candidate
25.31 for accreditation;

26.1 ~~(6)~~ (8) "mental health professional" means an individual providing clinical services in
26.2 the treatment of mental illness who meets one of the qualifications under section 245.462,
26.3 subdivision 18; and

26.4 ~~(7)~~ (9) "project" means a project to establish or expand clinical training for physician
26.5 assistants, advanced practice registered nurses, pharmacists, physicians, dentists, dental
26.6 therapists, advanced dental therapists, or mental health professionals in Minnesota.

26.7 Subd. 2. **Health professionals clinical training expansion grant program.** (a) The
26.8 commissioner of health shall award health professional training site grants to eligible
26.9 physician assistant, advanced practice registered nurse, pharmacy, dental therapy, and mental
26.10 health professional programs to plan and implement expanded clinical training. A planning
26.11 grant shall not exceed \$75,000, and a training grant shall not exceed \$150,000 for the first
26.12 year, \$100,000 for the second year, and \$50,000 for the third year per program.

26.13 (b) Funds may be used for:

26.14 (1) establishing or expanding clinical training for physician assistants, advanced practice
26.15 registered nurses, pharmacists, dental therapists, advanced dental therapists, and mental
26.16 health professionals in Minnesota;

26.17 (2) recruitment, training, and retention of students and faculty;

26.18 (3) connecting students with appropriate clinical training sites, internships, practicums,
26.19 or externship activities;

26.20 (4) travel and lodging for students;

26.21 (5) faculty, student, and preceptor salaries, incentives, or other financial support;

26.22 (6) development and implementation of cultural competency training;

26.23 (7) evaluations;

26.24 (8) training site improvements, fees, equipment, and supplies required to establish,
26.25 maintain, or expand a physician assistant, advanced practice registered nurse, pharmacy,
26.26 dental therapy, or mental health professional training program; and

26.27 (9) supporting clinical education in which trainees are part of a primary care team model.

26.28 Subd. 2a. **Health professional rural and underserved clinical rotations grant**
26.29 **program.** (a) The commissioner of health shall award health professional training site grants
26.30 to eligible physician, physician assistant, advanced practice registered nurse, pharmacy,
26.31 dentistry, dental therapy, and mental health professional programs to augment existing
26.32 clinical training programs by adding rural and underserved rotations or clinical training

27.1 experiences, such as credential or certificate rural tracks or other specialized training. For
27.2 physician and dentist training, the expanded training must include rotations in primary care
27.3 settings such as community clinics, hospitals, health maintenance organizations, or practices
27.4 in rural communities.

27.5 (b) Funds may be used for:

27.6 (1) establishing or expanding rotations and clinical trainings;

27.7 (2) recruitment, training, and retention of students and faculty;

27.8 (3) connecting students with appropriate clinical training sites, internships, practicums,
27.9 or externship activities;

27.10 (4) travel and lodging for students;

27.11 (5) faculty, student, and preceptor salaries, incentives, or other financial support;

27.12 (6) development and implementation of cultural competency training;

27.13 (7) evaluations;

27.14 (8) training site improvements, fees, equipment, and supplies required to establish,
27.15 maintain, or expand training programs; and

27.16 (9) supporting clinical education in which trainees are part of a primary care team model.

27.17 Subd. 3. **Applications.** Eligible physician assistant, advanced practice registered nurse,
27.18 pharmacy, dental therapy, ~~and~~ mental health professional, physician, and dental programs
27.19 seeking a grant shall apply to the commissioner. Applications must include a description
27.20 of the number of additional students who will be trained using grant funds; attestation that
27.21 funding will be used to support an increase in the number of clinical training slots; a
27.22 description of the problem that the proposed project will address; a description of the project,
27.23 including all costs associated with the project, sources of funds for the project, detailed uses
27.24 of all funds for the project, and the results expected; and a plan to maintain or operate any
27.25 component included in the project after the grant period. The applicant must describe
27.26 achievable objectives, a timetable, and roles and capabilities of responsible individuals in
27.27 the organization. Applicants applying under subdivision 2a must also include information
27.28 about the length of training and training site settings, the geographic locations of rural sites,
27.29 and rural populations expected to be served.

27.30 Subd. 4. **Consideration of applications.** The commissioner shall review each application
27.31 to determine whether or not the application is complete and whether the program and the
27.32 project are eligible for a grant. In evaluating applications, the commissioner shall score each

28.1 application based on factors including, but not limited to, the applicant's clarity and
28.2 thoroughness in describing the project and the problems to be addressed, the extent to which
28.3 the applicant has demonstrated that the applicant has made adequate provisions to ensure
28.4 proper and efficient operation of the training program once the grant project is completed,
28.5 the extent to which the proposed project is consistent with the goal of increasing access to
28.6 primary care and mental health services for rural and underserved urban communities, the
28.7 extent to which the proposed project incorporates team-based primary care, and project
28.8 costs and use of funds.

28.9 Subd. 5. **Program oversight.** The commissioner shall determine the amount of a grant
28.10 to be given to an eligible program based on the relative score of each eligible program's
28.11 application and rural locations if applicable under subdivision 2b, other relevant factors
28.12 discussed during the review, and the funds available to the commissioner. Appropriations
28.13 made to the program do not cancel and are available until expended. During the grant period,
28.14 the commissioner may require and collect from programs receiving grants any information
28.15 necessary to evaluate the program.

28.16 Sec. 19. [144.1507] PRIMARY CARE RURAL RESIDENCY TRAINING GRANT
28.17 PROGRAM.

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

28.20 (b) "Eligible program" means a program that meets the following criteria:

28.21 (1) is located in Minnesota;

28.22 (2) trains medical residents in the specialties of family medicine, general internal
28.23 medicine, general pediatrics, psychiatry, geriatrics, or general surgery; and

28.24 (3) is accredited by the Accreditation Council for Graduate Medical Education or presents
28.25 a credible plan to obtain accreditation.

28.26 (c) "Rural residency training program" means a residency program that utilizes local
28.27 clinics and community hospitals and that provides an initial year of training in an existing
28.28 accredited residency program in Minnesota. The subsequent years of the residency program
28.29 are based in rural communities with specialty rotations in nearby regional medical centers.

28.30 (d) "Eligible project" means a project to establish and maintain a rural residency training
28.31 program.

29.1 Subd. 2. Rural residency training program. (a) The commissioner of health shall
29.2 award rural residency training program grants to eligible programs to plan and implement
29.3 rural residency training programs. A rural residency training program grant shall not exceed
29.4 \$250,000 per resident per year for the first year of planning and development, and \$225,000
29.5 for each of the following years.

29.6 (b) Funds may be spent to cover the costs of:

29.7 (1) planning related to establishing an accredited rural residency training program;

29.8 (2) obtaining accreditation by the Accreditation Council for Graduate Medical Education
29.9 or another national body that accredits rural residency training programs;

29.10 (3) establishing new rural residency training programs;

29.11 (4) recruitment, training, and retention of new residents and faculty;

29.12 (5) travel and lodging for new residents;

29.13 (6) faculty, new resident, and preceptor salaries related to new rural residency training
29.14 program;

29.15 (7) training site improvements, fees, equipment, and supplies required for new rural
29.16 residency training program; and

29.17 (8) supporting clinical education in which trainees are part of a primary care team model.

29.18 Subd. 3. Applications for rural residency training program grants. (a) Eligible
29.19 programs seeking a grant shall apply to the commissioner. Applications must include: (1)
29.20 the number of new primary care rural residency training program slots planned, under
29.21 development, or under contract; (2) a description of the training program, including the
29.22 location of the established residency program and rural training sites; (3) a description of
29.23 the project, including all costs associated with the project; (4) all sources of funds for the
29.24 project; (5) detailed uses of all funds for the project; (6) the results expected; and (7) a plan
29.25 to seek federal funding for graduate medical education for the site if eligible.

29.26 (b) The applicant must describe achievable objectives, a timetable, and the roles and
29.27 capabilities of responsible individuals in the organization.

29.28 Subd. 4. Consideration of grant applications. The commissioner shall review each
29.29 application to determine if the residency program application is complete, if the proposed
29.30 rural residency program and residency slots are eligible for a grant, and if the program is
29.31 eligible for federal graduate medical education funding, and when funding becomes available.

30.1 The commissioner shall award grants to support training programs in family medicine,
30.2 general internal medicine, general pediatrics, psychiatry, geriatrics, and general surgery.

30.3 Subd. 5. **Program oversight.** During the grant period, the commissioner may require
30.4 and collect from grantees any information necessary to evaluate the program. Appropriations
30.5 made to the program do not cancel and are available until expended.

30.6 Sec. 20. [144.1508] MENTAL HEALTH PROVIDER SUPERVISION GRANT
30.7 PROGRAM.

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

30.10 (b) "Mental health professional" means an individual with a qualification specified in
30.11 section 245I.04, subdivision 2.

30.12 (c) "Underrepresented community" has the meaning given in section 148E.010,
30.13 subdivision 20.

30.14 Subd. 2. **Grant program established.** The commissioner of health shall award grants
30.15 to licensed or certified mental health providers who meet the criteria in subdivision 3 to
30.16 fund supervision of interns and clinical trainees who are working toward becoming a licensed
30.17 mental health professional and to subsidize the costs of mental health professional licensing
30.18 applications and examination fees for clinical trainees.

30.19 Subd. 3. **Eligible providers.** In order to be eligible for a grant under this section, a mental
30.20 health provider must:

30.21 (1) provide at least 25 percent of the provider's yearly patient encounters to state public
30.22 program enrollees or patients receiving sliding fee schedule discounts through a formal
30.23 sliding fee schedule meeting the standards established by the United States Department of
30.24 Health and Human Services under Code of Federal Regulations, title 42, section 51c.303;
30.25 or

30.26 (2) primarily serve persons from communities of color or underrepresented communities.

30.27 Subd. 4. **Application; grant award.** A mental health provider seeking a grant under
30.28 this section must apply to the commissioner at a time and in a manner specified by the
30.29 commissioner. The commissioner shall review each application to determine if the application
30.30 is complete, the mental health provider is eligible for a grant, and the proposed project is
30.31 an allowable use of grant funds. The commissioner shall give preference to grant applicants
30.32 who work in rural or culturally specific organizations. The commissioner must determine

31.1 the grant amount awarded to applicants that the commissioner determines will receive a
31.2 grant.

31.3 Subd. 5. **Allowable uses of grant funds.** A mental health provider must use grant funds
31.4 received under this section for one or more of the following:

31.5 (1) to pay for direct supervision hours for interns and clinical trainees, in an amount up
31.6 to \$7,500 per intern or clinical trainee;

31.7 (2) to establish a program to provide supervision to multiple interns or clinical trainees;
31.8 or

31.9 (3) to pay mental health professional licensing application and examination fees for
31.10 clinical trainees.

31.11 Subd. 6. **Program oversight.** During the grant period, the commissioner may require
31.12 grant recipients to provide the commissioner with information necessary to evaluate the
31.13 program.

31.14 Sec. 21. **[144.1509] MENTAL HEALTH PROFESSIONAL SCHOLARSHIP GRANT**
31.15 **PROGRAM.**

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

31.18 (b) "Mental health professional" means an individual with a qualification specified in
31.19 section 245I.04, subdivision 2.

31.20 (c) "Underrepresented community" has the meaning given in section 148E.010,
31.21 subdivision 20.

31.22 Subd. 2. **Grant program established.** A mental health professional scholarship program
31.23 is established to assist mental health providers in funding employee scholarships for master's
31.24 level education programs in order to create a pathway to becoming a mental health
31.25 professional.

31.26 Subd. 3. **Provision of grants.** The commissioner of health shall award grants to licensed
31.27 or certified mental health providers who meet the criteria in subdivision 4 to provide tuition
31.28 reimbursement for master's level programs and certain related costs for individuals who
31.29 have worked for the mental health provider for at least the past two years in one or more of
31.30 the following roles:

31.31 (1) a mental health behavioral aide who meets a qualification in section 245I.04,
31.32 subdivision 16;

32.1 (2) a mental health certified family peer specialist who meets the qualifications in section
32.2 245I.04, subdivision 12;

32.3 (3) a mental health certified peer specialist who meets the qualifications in section
32.4 245I.04, subdivision 10;

32.5 (4) a mental health practitioner who meets a qualification in section 245I.04, subdivision
32.6 4;

32.7 (5) a mental health rehabilitation worker who meets the qualifications in section 245I.04,
32.8 subdivision 14;

32.9 (6) an individual employed in a role in which the individual provides face-to-face client
32.10 services at a mental health center or certified community behavioral health center; or

32.11 (7) a staff person who provides care or services to residents of a residential treatment
32.12 facility.

32.13 Subd. 4. **Eligibility.** In order to be eligible for a grant under this section, a mental health
32.14 provider must:

32.15 (1) primarily provide at least 25 percent of the provider's yearly patient encounters to
32.16 state public program enrollees or patients receiving sliding fee schedule discounts through
32.17 a formal sliding fee schedule meeting the standards established by the United States
32.18 Department of Health and Human Services under Code of Federal Regulations, title 42,
32.19 section 51c.303; or

32.20 (2) primarily serve people from communities of color or underrepresented communities.

32.21 Subd. 5. **Request for proposals.** The commissioner must publish a request for proposals
32.22 in the State Register specifying provider eligibility requirements, criteria for a qualifying
32.23 employee scholarship program, provider selection criteria, documentation required for
32.24 program participation, the maximum award amount, and methods of evaluation. The
32.25 commissioner must publish additional requests for proposals each year in which funding is
32.26 available for this purpose.

32.27 Subd. 6. **Application requirements.** An eligible provider seeking a grant under this
32.28 section must submit an application to the commissioner. An application must contain a
32.29 complete description of the employee scholarship program being proposed by the applicant,
32.30 including the need for the mental health provider to enhance the education of its workforce,
32.31 the process the mental health provider will use to determine which employees will be eligible
32.32 for scholarships, any other funding sources for scholarships, the amount of funding sought

33.1 for the scholarship program, a proposed budget detailing how funds will be spent, and plans
33.2 to retain eligible employees after completion of the education program.

33.3 Subd. 7. **Selection process.** The commissioner shall determine a maximum award amount
33.4 for grants and shall select grant recipients based on the information provided in the grant
33.5 application, including the demonstrated need for the applicant provider to enhance the
33.6 education of its workforce, the proposed process to select employees for scholarships, the
33.7 applicant's proposed budget, and other criteria as determined by the commissioner. The
33.8 commissioner shall give preference to grant applicants who work in rural or culturally
33.9 specific organizations.

33.10 Subd. 8. **Grant agreements.** Notwithstanding any law or rule to the contrary, funds
33.11 awarded to a grant recipient in a grant agreement do not lapse until the grant agreement
33.12 expires.

33.13 Subd. 9. **Allowable uses of grant funds.** A mental health provider receiving a grant
33.14 under this section must use the grant funds for one or more of the following:

33.15 (1) to provide employees with tuition reimbursement for a master's level program in a
33.16 discipline that will allow the employee to qualify as a mental health professional; or

33.17 (2) for resources and supports, such as child care and transportation, that allow an
33.18 employee to attend a master's level program specified in clause (1).

33.19 Subd. 10. **Reporting requirements.** A mental health provider receiving a grant under
33.20 this section shall submit to the commissioner an invoice for reimbursement and a report,
33.21 on a schedule determined by the commissioner and using a form supplied by the
33.22 commissioner. The report must include the amount spent on scholarships; the number of
33.23 employees who received scholarships; and, for each scholarship recipient, the recipient's
33.24 name, current position, amount awarded, educational institution attended, name of the
33.25 educational program, and expected or actual program completion date.

33.26 Sec. 22. **[144.1511] CLINICAL HEALTH CARE TRAINING.**

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

33.29 (b) "Accredited clinical training" means the clinical training provided by a medical
33.30 education program that is accredited through an organization recognized by the Department
33.31 of Education, the Centers for Medicare and Medicaid Services, or another national body
33.32 that reviews the accrediting organizations for multiple disciplines and whose standards for

34.1 recognizing accrediting organizations are reviewed and approved by the commissioner of
34.2 health.

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

34.4 (d) "Clinical medical education program" means the accredited clinical training of
34.5 physicians, medical students and residents, doctor of pharmacy practitioners, doctors of
34.6 chiropractic, dentists, advanced practice registered nurses, clinical nurse specialists, certified
34.7 registered nurse anesthetists, nurse practitioners, and certified nurse midwives, physician
34.8 assistants, dental therapists and advanced dental therapists, psychologists, clinical social
34.9 workers, community paramedics, community health workers, and other medical professions
34.10 as determined by the commissioner.

34.11 (e) "Eligible entity" means an organization that is located in Minnesota, provides a
34.12 clinical medical education experience, and hosts students, residents or other trainee types
34.13 as determined by the commissioner and are from an accredited Minnesota teaching program
34.14 and institution.

34.15 (f) "Teaching institution" means a hospital, medical center, clinic, or other organization
34.16 that conducts a clinical medical education program in Minnesota and which is accountable
34.17 to the accrediting body.

34.18 (g) "Trainee" means a student, resident, fellow, or other postgraduate involved in a
34.19 clinical medical education program from an accredited Minnesota teaching program and
34.20 institution.

34.21 (h) "Eligible trainee FTEs" means the number of trainees, as measured by full-time
34.22 equivalent counts, that are training in Minnesota at an entity with either currently active
34.23 medical assistance enrollment status and a National Provider Identification (NPI) number
34.24 or documentation that they provide sliding fee services. Training may occur in an inpatient
34.25 or ambulatory patient care setting or alternative setting as determined by the commissioner.
34.26 Training that occurs in nursing facility settings is not eligible for funding under this section.

34.27 Subd. 2. **Application process.** (a) An eligible entity hosting clinical trainees from a
34.28 clinical medical education program and teaching institution is eligible for funds under
34.29 subdivision 3 if the entity:

34.30 (1) is funded in part by sliding fee scale services or enrolled in the Minnesota health
34.31 care program;

34.32 (2) faces increased financial pressure as a result of competition with nonteaching patient
34.33 care entities; and

35.1 (3) emphasizes primary care or specialties that are in undersupply in rural or underserved
35.2 areas of Minnesota.

35.3 (b) An entity hosting a clinical medical education program for advanced practice nursing
35.4 is eligible for funds under subdivision 3 if the program meets the eligibility requirements
35.5 in paragraph (a) and is sponsored by the University of Minnesota Academic Health Center,
35.6 the Mayo Foundation, or an institution that is part of the Minnesota State Colleges and
35.7 Universities system or a member of the Minnesota Private College Council.

35.8 (c) An application must be submitted to the commissioner by an eligible entity or teaching
35.9 institution and contain the following information:

35.10 (1) the official name and address and the site address of the clinical medical education
35.11 program where eligible trainees are hosted;

35.12 (2) the name, title, and business address of those persons responsible for administering
35.13 the funds; and

35.14 (3) for each applicant: (i) the type and specialty orientation of trainees in the program;
35.15 (ii) the name, entity address, and medical assistance provider number and national provider
35.16 identification number of each training site used in the program, as appropriate; (iii) the
35.17 federal tax identification number of each training site, where available; (iv) the total number
35.18 of trainees at each training site; (v) the total number of eligible trainee FTEs at each site;
35.19 and (vi) other supporting information the commissioner deems necessary.

35.20 (d) An applicant that does not provide information requested by the commissioner shall
35.21 not be eligible for funds for the current funding cycle.

35.22 Subd. 3. **Distribution of funds.** (a) The commissioner may distribute funds for clinical
35.23 training in areas of Minnesota and for professions listed in subdivision 1, paragraph (d)
35.24 determined by the commissioner as a high need area and profession shortage. The
35.25 commissioner shall annually distribute medical education funds to qualifying applicants
35.26 under this section based on costs to train, service level needs, and profession or training site
35.27 shortages. Use of funds is limited to related clinical training costs for eligible programs.

35.28 (b) To ensure the quality of clinical training, eligible entities must demonstrate that they
35.29 hold contracts in good standing with eligible educational institutions that specify the terms,
35.30 expectations, and outcomes of the clinical training conducted at sites. Funds shall be
35.31 distributed in an administrative process determined by the commissioner to be efficient.

35.32 Subd. 4. **Report.** (a) Teaching institutions receiving funds under this section must sign
35.33 and submit a medical education grant verification report (GVR) to verify that the correct

36.1 grant amount was forwarded to each eligible entity. If the teaching institution fails to submit
36.2 the GVR by the stated deadline, or to request and meet the deadline for an extension, the
36.3 sponsoring institution is required to return the full amount of funds received to the
36.4 commissioner within 30 days of receiving notice from the commissioner. The commissioner
36.5 shall distribute returned funds to the appropriate training sites in accordance with the
36.6 commissioner's approval letter.

36.7 (b) Teaching institutions receiving funds under this section must provide any other
36.8 information the commissioner deems appropriate to evaluate the effectiveness of the use of
36.9 funds for medical education.

36.10 Sec. 23. Minnesota Statutes 2020, section 144.1911, subdivision 4, is amended to read:

36.11 Subd. 4. **Career guidance and support services.** (a) The commissioner shall award
36.12 grants to eligible nonprofit organizations and eligible postsecondary educational institutions,
36.13 including the University of Minnesota, to provide career guidance and support services to
36.14 immigrant international medical graduates seeking to enter the Minnesota health workforce.
36.15 Eligible grant activities include the following:

36.16 (1) educational and career navigation, including information on training and licensing
36.17 requirements for physician and nonphysician health care professions, and guidance in
36.18 determining which pathway is best suited for an individual international medical graduate
36.19 based on the graduate's skills, experience, resources, and interests;

36.20 (2) support in becoming proficient in medical English;

36.21 (3) support in becoming proficient in the use of information technology, including
36.22 computer skills and use of electronic health record technology;

36.23 (4) support for increasing knowledge of and familiarity with the United States health
36.24 care system;

36.25 (5) support for other foundational skills identified by the commissioner;

36.26 (6) support for immigrant international medical graduates in becoming certified by the
36.27 Educational Commission on Foreign Medical Graduates, including help with preparation
36.28 for required licensing examinations and financial assistance for fees; and

36.29 (7) assistance to international medical graduates in registering with the program's
36.30 Minnesota international medical graduate roster.

36.31 ~~(b) The commissioner shall award the initial grants under this subdivision by December~~
36.32 ~~31, 2015.~~

37.1 Sec. 24. [144.2182] CHANGE OF SEX.

37.2 Subdivision 1. Request to make change. A person whose birth is registered in Minnesota
37.3 may request that the commissioner change or remove the sex, if any, assigned to that person
37.4 on the person's original birth certificate. If the person is a minor, a parent or guardian may
37.5 make the request on behalf of the minor.

37.6 Subd. 2. Documentation required. A person making a request under this section must
37.7 submit any forms or fees required by the commissioner and provide acceptable documentation
37.8 to satisfy to the commissioner that granting the request will not harm the integrity and
37.9 accuracy of vital records. Acceptable documentation includes but is not limited to:

37.10 (1) a written statement from a provider of medical services that the requested change is
37.11 appropriate in their medical opinion;

37.12 (2) a certified copy of a court order from a court of competent jurisdiction in this or
37.13 another state granting the requested change; or

37.14 (3) a sworn statement provided by the person who is the subject of the birth certificate,
37.15 or by the parent or guardian of the minor who is the subject of the birth certificate, that the
37.16 request is not based upon an intent to defraud or mislead and is made in good faith and, if
37.17 the subject is a minor, that the change is in the minor's best interest.

37.18 Subd. 3. Court orders. A person may file a petition in district court to change or remove
37.19 the sex assigned on their original birth certificate. If the person is a minor, a parent or
37.20 guardian may file a petition on behalf of the minor. The court shall consider petitions filed
37.21 by persons over whom the court has jurisdiction for an order granting a change of sex on
37.22 an original birth certificate irrespective of the jurisdiction in which the original birth
37.23 certificate was issued. The court shall issue an order under this section upon a finding that
37.24 the request is not based upon an intent to defraud or mislead and is made in good faith and,
37.25 if the subject of the birth certificate is a minor, that the change is in the minor's best interest.

37.26 Subd. 4. Records sealed. When the commissioner has received the necessary information
37.27 and made the requested change on the birth certificate, the commissioner shall provide a
37.28 certified copy of the corrected birth certificate to the person requesting the change. Upon
37.29 issuance of a corrected birth certificate under this section, the original record of birth shall
37.30 be classified as confidential data pursuant to section 13.02, subdivision 3, and shall not be
37.31 disclosed except pursuant to court order or section 144.2252.

38.1 Sec. 25. Minnesota Statutes 2020, section 144.383, is amended to read:

38.2 **144.383 AUTHORITY OF COMMISSIONER; SAFE DRINKING WATER.**

38.3 In order to ~~insure~~ ensure safe drinking water in all public water supplies, the commissioner
38.4 has the ~~following powers~~ power to:

38.5 ~~(a) To~~ (1) approve the site, design, and construction and alteration of all public water
38.6 supplies and, for community and nontransient noncommunity water systems as defined in
38.7 Code of Federal Regulations, title 40, section 141.2, to approve documentation that
38.8 demonstrates the technical, managerial, and financial capacity of those systems to comply
38.9 with rules adopted under this section;

38.10 ~~(b) To~~ (2) enter the premises of a public water supply, or part thereof, to inspect the
38.11 facilities and records kept pursuant to rules promulgated by the commissioner, to conduct
38.12 sanitary surveys and investigate the standard of operation and service delivered by public
38.13 water supplies;

38.14 ~~(c) To~~ (3) contract with community health boards as defined in section 145A.02,
38.15 subdivision 5, for routine surveys, inspections, and testing of public water supply quality;

38.16 ~~(d) To~~ (4) develop an emergency plan to protect the public when a decline in water
38.17 quality or quantity creates a serious health risk, and to issue emergency orders if a health
38.18 risk is imminent;

38.19 ~~(e) To~~ (5) promulgate rules, pursuant to chapter 14 but no less stringent than federal
38.20 regulation, which may include the granting of variances and exemptions; and

38.21 (6) maintain a database of lead service lines, provide technical assistance to community
38.22 water systems, and ensure the lead service inventory data is accessible to the public with
38.23 relevant educational materials about health risks related to lead and ways to reduce exposure.

38.24 Sec. 26. Minnesota Statutes 2020, section 144.554, is amended to read:

38.25 **144.554 HEALTH FACILITIES CONSTRUCTION PLAN SUBMITTAL AND**
38.26 **FEES.**

38.27 For hospitals, nursing homes, boarding care homes, residential hospices, supervised
38.28 living facilities, freestanding outpatient surgical centers, and end-stage renal disease facilities,
38.29 the commissioner shall collect a fee for the review and approval of architectural, mechanical,
38.30 and electrical plans and specifications submitted before construction begins for each project
38.31 relative to construction of new buildings, additions to existing buildings, or remodeling or
38.32 alterations of existing buildings. All fees collected in this section shall be deposited in the

39.1 state treasury and credited to the state government special revenue fund. Fees must be paid
 39.2 at the time of submission of final plans for review and are not refundable. The fee is
 39.3 calculated as follows:

39.4 Construction project total estimated cost	Fee
39.5 \$0 - \$10,000	\$30 <u>\$45</u>
39.6 \$10,001 - \$50,000	\$150 <u>\$225</u>
39.7 \$50,001 - \$100,000	\$300 <u>\$450</u>
39.8 \$100,001 - \$150,000	\$450 <u>\$675</u>
39.9 \$150,001 - \$200,000	\$600 <u>\$900</u>
39.10 \$200,001 - \$250,000	\$750 <u>\$1,125</u>
39.11 \$250,001 - \$300,000	\$900 <u>\$1,350</u>
39.12 \$300,001 - \$350,000	\$1,050 <u>\$1,575</u>
39.13 \$350,001 - \$400,000	\$1,200 <u>\$1,800</u>
39.14 \$400,001 - \$450,000	\$1,350 <u>\$2,025</u>
39.15 \$450,001 - \$500,000	\$1,500 <u>\$2,250</u>
39.16 \$500,001 - \$550,000	\$1,650 <u>\$2,475</u>
39.17 \$550,001 - \$600,000	\$1,800 <u>\$2,700</u>
39.18 \$600,001 - \$650,000	\$1,950 <u>\$2,925</u>
39.19 \$650,001 - \$700,000	\$2,100 <u>\$3,150</u>
39.20 \$700,001 - \$750,000	\$2,250 <u>\$3,375</u>
39.21 \$750,001 - \$800,000	\$2,400 <u>\$3,600</u>
39.22 \$800,001 - \$850,000	\$2,550 <u>\$3,825</u>
39.23 \$850,001 - \$900,000	\$2,700 <u>\$4,050</u>
39.24 \$900,001 - \$950,000	\$2,850 <u>\$4,275</u>
39.25 \$950,001 - \$1,000,000	\$3,000 <u>\$4,500</u>
39.26 \$1,000,001 - \$1,050,000	\$3,150 <u>\$4,725</u>
39.27 \$1,050,001 - \$1,100,000	\$3,300 <u>\$4,950</u>
39.28 \$1,100,001 - \$1,150,000	\$3,450 <u>\$5,175</u>
39.29 \$1,150,001 - \$1,200,000	\$3,600 <u>\$5,400</u>
39.30 \$1,200,001 - \$1,250,000	\$3,750 <u>\$5,625</u>
39.31 \$1,250,001 - \$1,300,000	\$3,900 <u>\$5,850</u>
39.32 \$1,300,001 - \$1,350,000	\$4,050 <u>\$6,075</u>
39.33 \$1,350,001 - \$1,400,000	\$4,200 <u>\$6,300</u>
39.34 \$1,400,001 - \$1,450,000	\$4,350 <u>\$6,525</u>
39.35 \$1,450,001 - \$1,500,000	\$4,500 <u>\$6,750</u>
39.36 \$1,500,001 and over	\$4,800 <u>\$7,200</u>

40.1 Sec. 27. [144.7051] DEFINITIONS.

40.2 Subdivision 1. **Applicability.** For the purposes of sections 144.7051 to 144.7059, the
40.3 terms defined in this section have the meanings given.

40.4 Subd. 2. **Commissioner.** "Commissioner" means the commissioner of health.

40.5 Subd. 3. **Daily staffing schedule.** "Daily staffing schedule" means the actual number
40.6 of full-time equivalent nonmanagerial care staff assigned to an inpatient care unit and
40.7 providing care in that unit during a 24-hour period and the actual number of patients assigned
40.8 to each direct care registered nurse present and providing care in the unit.

40.9 Subd. 4. **Direct care registered nurse.** "Direct care registered nurse" means a registered
40.10 nurse, as defined in section 148.171, subdivision 20, who is nonsupervisory and
40.11 nonmanagerial and who directly provides nursing care to patients more than 60 percent of
40.12 the time.

40.13 Subd. 5. **Hospital.** "Hospital" means any setting that is licensed as a hospital under
40.14 sections 144.50 to 144.56.

40.15 **EFFECTIVE DATE.** This section is effective April 1, 2024.

40.16 Sec. 28. [144.7053] HOSPITAL NURSE STAFFING COMMITTEES.

40.17 Subdivision 1. **Hospital nurse staffing committee required.** Each hospital must establish
40.18 and maintain a functioning hospital nurse staffing committee. A hospital may assign the
40.19 functions and duties of a hospital nurse staffing committee to an existing committee, provided
40.20 the existing committee meets the membership requirements applicable to a hospital nurse
40.21 staffing committee.

40.22 Subd. 2. **Committee membership.** (a) At least 35 percent of the committee's membership
40.23 must be direct care registered nurses typically assigned to a specific unit for an entire shift,
40.24 and at least 15 percent of the committee's membership must be other direct care workers
40.25 typically assigned to a specific unit for an entire shift. Direct care registered nurses and
40.26 other direct care workers who are members of a collective bargaining unit shall be appointed
40.27 or elected to the committee according to the guidelines of the applicable collective bargaining
40.28 agreement. If there is no collective bargaining agreement, direct care registered nurses shall
40.29 be elected to the committee by direct care registered nurses employed by the hospital, and
40.30 other direct care workers shall be elected to the committee by other direct care workers
40.31 employed by the hospital.

40.32 (b) The hospital shall appoint no more than 50 percent of the committee's membership.

41.1 Subd. 3. **Compensation.** A hospital must treat participation in committee meetings by
41.2 any hospital employee as scheduled work time and compensate each committee member at
41.3 the employee's existing rate of pay. A hospital must relieve all direct care registered nurse
41.4 members of the hospital nurse staffing committee of other work duties during the times at
41.5 which the committee meets.

41.6 Subd. 4. **Meeting frequency.** Each hospital nurse staffing committee must meet at least
41.7 quarterly.

41.8 Subd. 5. **Committee duties.** (a) Each hospital nurse staffing committee shall create,
41.9 implement, continuously evaluate, and update as needed evidence-based written core staffing
41.10 plans to guide the creation of daily staffing schedules for each inpatient care unit of the
41.11 hospital.

41.12 (b) Each hospital nurse staffing committee must:

41.13 (1) establish a secure and anonymous method for any hospital employee or patient to
41.14 submit directly to the committee any concerns related to safe staffing;

41.15 (2) review each concern related to safe staffing submitted directly to the committee;

41.16 (3) review the documentation of compliance maintained by the hospital under section
41.17 144.7056, subdivision 5;

41.18 (4) conduct a trend analysis of the data related to all reported concerns regarding safe
41.19 staffing;

41.20 (5) develop a mechanism for tracking and analyzing staffing trends within the hospital;

41.21 (6) submit to the commissioner a nurse staffing report; and

41.22 (7) record in the committee minutes for each meeting a summary of the discussions and
41.23 recommendations of the committee. Each committee must maintain the minutes, records,
41.24 and distributed materials for five years.

41.25 **EFFECTIVE DATE.** This section is effective April 1, 2024.

41.26 Sec. 29. Minnesota Statutes 2020, section 144.7055, is amended to read:

41.27 **144.7055 HOSPITAL CORE STAFFING PLAN REPORTS.**

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

42.1 ~~(b)~~ (a) "Core staffing plan" means ~~the projected number of full-time equivalent~~
 42.2 ~~nonmanagerial care staff that will be assigned in a 24-hour period to an inpatient care unit~~
 42.3 ~~a plan described in subdivision 2.~~

42.4 ~~(e)~~ (b) "Nonmanagerial care staff" means registered nurses, licensed practical nurses,
 42.5 and other health care workers, which may include but is not limited to nursing assistants,
 42.6 nursing aides, patient care technicians, and patient care assistants, who perform
 42.7 nonmanagerial direct patient care functions for more than 50 percent of their scheduled
 42.8 hours on a given patient care unit.

42.9 ~~(d)~~ (c) "Inpatient care unit" or "unit" means a designated inpatient area for assigning
 42.10 patients and staff for which a ~~distinct staffing plan~~ daily staffing schedule exists and that
 42.11 operates 24 hours per day, seven days per week in a hospital setting. Inpatient care unit does
 42.12 not include any hospital-based clinic, long-term care facility, or outpatient hospital
 42.13 department.

42.14 ~~(e)~~ (d) "Staffing hours per patient day" means the number of full-time equivalent
 42.15 nonmanagerial care staff who will ordinarily be assigned to provide direct patient care
 42.16 divided by the expected average number of patients upon which such assignments are based.

42.17 ~~(f) "Patient acuity tool" means a system for measuring an individual patient's need for~~
 42.18 ~~nursing care. This includes utilizing a professional registered nursing assessment of patient~~
 42.19 ~~condition to assess staffing need.~~

42.20 Subd. 2. **Hospital core staffing report plans.** (a) ~~The chief nursing executive or nursing~~
 42.21 ~~designee~~ hospital nurse staffing committee of every ~~reporting~~ hospital ~~in Minnesota under~~
 42.22 ~~section 144.50 will~~ must develop a core staffing plan for each ~~patient~~ inpatient care unit.

42.23 (b) Core staffing plans ~~shall~~ must specify all of the following:

42.24 (1) the projected number of full-time equivalent ~~for~~ nonmanagerial care staff that will
 42.25 be assigned in a 24-hour period to each patient inpatient care unit ~~for each 24-hour period;~~

42.26 (2) the maximum number of patients on each inpatient care unit for whom a direct care
 42.27 registered nurse can be assigned and for whom a licensed practical nurse or certified nursing
 42.28 assistant can typically safely care;

42.29 (3) criteria for determining when circumstances exist on each inpatient care unit such
 42.30 that a direct care nurse cannot safely care for the typical number of patients and when
 42.31 assigning a lower number of patients to each nurse on the inpatient unit would be appropriate;

43.1 (4) a procedure for each inpatient care unit to make shift-to-shift adjustments in staffing
43.2 levels when such adjustments are required by patient acuity and nursing intensity in the
43.3 unit;

43.4 (5) a contingency plan for each inpatient unit to safely address circumstances in which
43.5 patient care needs unexpectedly exceed the staffing resources provided for in a daily staffing
43.6 schedule. A contingency plan must include a method to quickly identify for each daily
43.7 staffing schedule additional direct care registered nurses who are available to provide direct
43.8 care on the inpatient care unit; and

43.9 (6) strategies to enable direct care registered nurses to take breaks to which they are
43.10 entitled under law or under an applicable collective bargaining agreement.

43.11 (c) Core staffing plans must ensure that:

43.12 (1) the person creating a daily staffing schedule has sufficiently detailed information to
43.13 create a daily staffing schedule that meets the requirements of the plan;

43.14 (2) daily staffing nurse schedules do not rely on assigning individual nonmanagerial
43.15 care staff to work overtime hours in excess of 16 hours in a 24-hour period or to work
43.16 consecutive 24-hour periods requiring 16 or more hours;

43.17 (3) a direct care registered nurse is not required or expected to perform functions outside
43.18 the nurse's professional license;

43.19 (4) light duty direct care registered nurses are given appropriate assignments; and

43.20 (5) daily staffing schedules do not interfere with applicable collective bargaining
43.21 agreements.

43.22 **Subd. 2a. Development of hospital core staffing plans.** (a) Prior to submitting
43.23 completing or updating the core staffing plan, as required in subdivision 3, hospitals shall
43.24 a hospital nurse staffing committee must consult with representatives of the hospital medical
43.25 staff, managerial and nonmanagerial care staff, and other relevant hospital personnel about
43.26 the core staffing plan and the expected average number of patients upon which the core
43.27 staffing plan is based.

43.28 (b) When developing a core staffing plan, a hospital nurse staffing committee must
43.29 consider all of the following:

43.30 (1) the individual needs and expected census of each inpatient care unit;

43.31 (2) unit-specific patient acuity, including fall risk and behaviors requiring intervention,
43.32 such as physical aggression toward self or others, or destruction of property;

44.1 (3) unit-specific demands on direct care registered nurses' time, including: frequency of
 44.2 admissions, discharges, and transfers; frequency and complexity of patient evaluations and
 44.3 assessments; frequency and complexity of nursing care planning; planning for patient
 44.4 discharge; assessing for patient referral; patient education; and implementing infectious
 44.5 disease protocols;

44.6 (4) the architecture and geography of the inpatient care unit, including the placement of
 44.7 patient rooms, treatment areas, nursing stations, medication preparation areas, and equipment;

44.8 (5) mechanisms and procedures to provide for one-to-one patient observation for patients
 44.9 on psychiatric or other units;

44.10 (6) the stress under which direct care nurses are placed when required to work extreme
 44.11 amounts of overtime, such as shifts in excess of 12 hours or multiple consecutive double
 44.12 shifts;

44.13 (7) the need for specialized equipment and technology on the unit;

44.14 (8) other special characteristics of the unit or community patient population, including
 44.15 age, cultural and linguistic diversity and needs, functional ability, communication skills,
 44.16 and other relevant social and socioeconomic factors;

44.17 (9) the skill mix of personnel other than direct care registered nurses providing or
 44.18 supporting direct patient care on the unit;

44.19 (10) mechanisms and procedures for identifying additional registered nurses who are
 44.20 available for direct patient care when patients' unexpected needs exceed the planned workload
 44.21 for direct care staff; and

44.22 (11) demands on direct care registered nurses' time not directly related to providing
 44.23 direct care on a unit, such as involvement in quality improvement activities, professional
 44.24 development, service to the hospital, including serving on the hospital nurse staffing
 44.25 committee, and service to the profession.

44.26 Subd. 3. **Standard electronic reporting developed of core staffing plans.** (a) Hospitals
 44.27 Each hospital must submit the core staffing plans approved by the hospital's nurse staffing
 44.28 committee to the Minnesota Hospital Association by January 1, 2014. The Minnesota
 44.29 Hospital Association shall include each ~~reporting~~ hospital's core staffing ~~plan~~ plans on the
 44.30 Minnesota Hospital Association's Minnesota Hospital Quality Report website ~~by April 1,~~
 44.31 2014 by June 1, 2024. Hospitals shall submit to the Minnesota Hospital Association any
 44.32 substantial changes updates to the a core staffing plan shall be updated within 30 days of
 44.33 the approval of the updates by the hospital's nurse staffing committee or of amendment

45.1 through arbitration. The Minnesota Hospital Association shall update the Minnesota Hospital
45.2 Quality Report website with the updated core staffing plans within 30 days of receipt of the
45.3 updated plan.

45.4 Subd. 4. **Standard electronic reporting of direct patient care report.** ~~(b)~~ The Minnesota
45.5 Hospital Association shall include on its website for each reporting hospital on a quarterly
45.6 basis the actual direct patient care hours per patient and per unit. Hospitals must submit the
45.7 direct patient care report to the Minnesota Hospital Association by July 1, 2014, and quarterly
45.8 thereafter.

45.9 Subd. 5. **Mandatory submission of core staffing plan to commissioner.** Each hospital
45.10 must submit the core staffing plans and any updates to the commissioner on the same
45.11 schedule described in subdivision 3. Core staffing plans held by the commissioner are public.

45.12 **EFFECTIVE DATE.** This section is effective April 1, 2024.

45.13 Sec. 30. **[144.7056] IMPLEMENTATION OF HOSPITAL CORE STAFFING PLANS.**

45.14 Subdivision 1. **Plan implementation required.** A hospital must implement the core
45.15 staffing plans approved by a majority vote of the hospital nurse staffing committee.

45.16 Subd. 2. **Public posting of core staffing plans.** A hospital must post the core staffing
45.17 plan for the inpatient care unit in a public area on the unit.

45.18 Subd. 3. **Public posting of compliance with plan.** For each publicly posted core staffing
45.19 plan, a hospital must post a notice stating whether the current staffing on the unit complies
45.20 with the hospital's core staffing plan for that unit. The public notice of compliance must
45.21 include a list of the number of nonmanagerial care staff working on the unit during the
45.22 current shift and the number of patients assigned to each direct care registered nurse working
45.23 on the unit during the current shift. The list must enumerate the nonmanagerial care staff
45.24 by health care worker type. The public notice of compliance must be posted immediately
45.25 adjacent to the publicly posted core staffing plan.

45.26 Subd. 4. **Public distribution of core staffing plan and notice of compliance.** (a) A
45.27 hospital must include with the posted materials described in subdivisions 2 and 3, a statement
45.28 that individual copies of the posted materials are available upon request to any patient on
45.29 the unit or to any visitor of a patient on the unit. The statement must include specific
45.30 instructions for obtaining copies of the posted materials.

45.31 (b) A hospital must, within four hours after the request, provide individual copies of all
45.32 the posted materials described in subdivisions 2 and 3 to any patient on the unit or to any
45.33 visitor of a patient on the unit who requests the materials.

46.1 Subd. 5. **Documentation of compliance.** Each hospital must document compliance with
46.2 its core nursing plans and maintain records demonstrating compliance for each inpatient
46.3 care unit for five years. Each hospital must provide its nurse staffing committee with access
46.4 to all documentation required under this subdivision.

46.5 Subd. 6. **Dispute resolution.** (a) If hospital management objects to a core staffing plan
46.6 approved by a majority vote of the hospital nurse staffing committee, the hospital may elect
46.7 to attempt to amend the core staffing plan through arbitration.

46.8 (b) During an ongoing dispute resolution process, a hospital must continue to implement
46.9 the core staffing plan as written and approved by the hospital nurse staffing committee.

46.10 (c) If the dispute resolution process results in an amendment to the core staffing plan,
46.11 the hospital must implement the amended core staffing plan.

46.12 **EFFECTIVE DATE.** This section is effective June 1, 2024.

46.13 Sec. 31. **[144.7059] RETALIATION PROHIBITED.**

46.14 Neither a hospital or nor a health-related licensing board may retaliate against or discipline
46.15 a hospital employee regulated by the health-related licensing board, either formally or
46.16 informally, for:

46.17 (1) challenging the process by which a hospital nurse staffing committee is formed or
46.18 conducts its business;

46.19 (2) challenging a core staffing plan approved by a hospital nurse staffing committee;

46.20 (3) objecting to or submitting a grievance related to a patient assignment that leads to a
46.21 direct care registered nurse violating medical restrictions recommended by the nurse's
46.22 medical provider; or

46.23 (4) submitting a report of unsafe staffing conditions.

46.24 **EFFECTIVE DATE.** This section is effective April 1, 2024.

46.25 Sec. 32. **[144.8611] DRUG OVERDOSE AND SUBSTANCE ABUSE PREVENTION.**

46.26 Subdivision 1. **Strategies.** The commissioner of health shall support collaboration and
46.27 coordination between state and community partners to develop, refine, and expand
46.28 comprehensive funding to address the drug overdose epidemic by implementing three
46.29 strategies: (1) regional multidisciplinary overdose prevention teams to implement overdose
46.30 prevention in local communities and local public health organizations; (2) enhance supportive
46.31 services for the homeless who are at risk of overdose by providing emergency and short-term

47.1 housing subsidies through the Homeless Overdose Prevention Hub; and (3) enhance employer
47.2 resources to promote health and well-being of employees through the recovery friendly
47.3 workplace initiative. These strategies address the underlying social conditions that impact
47.4 health status.

47.5 Subd. 2. **Regional teams.** The commissioner of health shall establish community-based
47.6 prevention grants and contracts for the eight regional multidisciplinary overdose prevention
47.7 teams. These teams are geographically aligned with the eight emergency medical services
47.8 regions described in section 144E.52. The regional teams shall implement prevention
47.9 programs, policies, and practices that are specific to the challenges and responsive to the
47.10 data of the region.

47.11 Subd. 3. **Homeless Overdose Prevention Hub.** The commissioner of health shall
47.12 establish a community-based grant to enhance supportive services for the homeless who
47.13 are at risk of overdose by providing emergency and short-term housing subsidies through
47.14 the Homeless Overdose Prevention Hub. The Homeless Overdose Prevention Hub serves
47.15 primarily urban American Indians in Minneapolis and Saint Paul and is managed by the
47.16 Native American Community Clinic.

47.17 Subd. 4. **Workplace health.** The commissioner of health shall establish a grants and
47.18 contracts program to strengthen the recovery friendly workplace initiative. This initiative
47.19 helps create work environments that promote employee health, safety, and well-being by:
47.20 (1) preventing abuse and misuse of drugs in the first place; (2) providing training to
47.21 employers; and (3) reducing stigma and supporting recovery for people seeking services
47.22 and who are in recovery.

47.23 Subd. 5. **Eligible grantees.** (a) Organizations eligible to receive grant funding under
47.24 subdivision 4 include not-for-profit agencies or organizations with existing organizational
47.25 structure, capacity, trainers, facilities, and infrastructure designed to deliver model workplace
47.26 policies and practices; that have training and education for employees, supervisors, and
47.27 executive leadership of companies, businesses, and industry; and that have the ability to
47.28 evaluate the three goals of the workplace initiative specified in subdivision 4.

47.29 (b) At least one organization may be selected for a grant under subdivision 4 with
47.30 statewide reach and influence. Up to five smaller organizations may be selected to reach
47.31 specific geographic or population groups.

47.32 Subd. 6. **Evaluation.** The commissioner of health shall design, conduct, and evaluate
47.33 each of the components of the drug overdose and substance abuse prevention program using

48.1 measures such as mortality, morbidity, homelessness, workforce wellness, employee
48.2 retention, and program reach.

48.3 Subd. 7. **Report.** Grantees must report grant program outcomes to the commissioner on
48.4 the forms and according to the timelines established by the commissioner.

48.5 Sec. 33. Minnesota Statutes 2020, section 144.9501, subdivision 9, is amended to read:

48.6 Subd. 9. **Elevated blood lead level.** "Elevated blood lead level" means a diagnostic
48.7 blood lead test with a result that is equal to or greater than ~~ten~~ 3.5 micrograms of lead per
48.8 deciliter of whole blood in any person, unless the commissioner finds that a lower
48.9 concentration is necessary to protect public health.

48.10 Sec. 34. [144.9981] CLIMATE RESILIENCY.

48.11 Subdivision 1. **Climate resiliency program.** The commissioner of health shall implement
48.12 a climate resiliency program to:

48.13 (1) increase awareness of climate change;

48.14 (2) track the public health impacts of climate change and extreme weather events;

48.15 (3) provide technical assistance and tools that support climate resiliency to local public
48.16 health, Tribal health, soil and water conservation districts, and other local governmental
48.17 and nongovernmental organizations; and

48.18 (4) coordinate with the commissioners of the pollution control agency, natural resources,
48.19 agriculture and other state agencies in climate resiliency related planning and implementation.

48.20 Subd. 2. **Grants authorized; allocation.** (a) The commissioner of health shall manage
48.21 a grant program for the purpose of climate resiliency planning. The commissioner shall
48.22 award grants through a request for proposals process to local public health organizations,
48.23 Tribal health organizations, soil and water conservation districts, or other local organizations
48.24 for planning for the health impacts of extreme weather events and developing adaptation
48.25 actions. Priority shall be given to small rural water systems and organizations incorporating
48.26 the needs of private water supplies into their planning. Priority shall also be given to
48.27 organizations that serve communities that are disproportionately impacted by climate change.

48.28 (b) Grantees must use the funds to develop a plan or implement strategies that will reduce
48.29 the risk of health impacts from extreme weather events. The grant application must include:

48.30 (1) a description of the plan or project for which the grant funds will be used;

48.31 (2) a description of the pathway between the plan or project and its impacts on health;

- 49.1 (3) a description of the objectives, a work plan, and a timeline for implementation; and
49.2 (4) the community or group the grant proposes to focus on.

49.3 **Sec. 35. [145.361] LONG COVID; SUPPORTING SURVIVORS AND MONITORING**
49.4 **IMPACT.**

49.5 Subdivision 1. **Definition.** For the purpose of this section, "long COVID" means health
49.6 problems that people experience four or more weeks after being infected with SARS-CoV-2,
49.7 the virus that causes COVID-19. Long COVID is also called post COVID, long-haul COVID,
49.8 chronic COVID, post-acute COVID, or post-acute sequelae of COVID-19 (PASC).

49.9 Subd. 2. **Statewide monitoring.** The commissioner of health shall establish a program
49.10 to conduct community needs assessments, perform epidemiologic studies, and establish a
49.11 population-based surveillance system to address long COVID. The purpose of these
49.12 assessments, studies, and surveillance system is to:

49.13 (1) monitor trends in incidence, prevalence, mortality, care management, health outcomes,
49.14 quality of life, and needs of individuals with long COVID and to detect potential public
49.15 health problems, predict risks, and assist in investigating long COVID health disparities;

49.16 (2) more accurately target intervention resources for communities and patients and their
49.17 families;

49.18 (3) inform health professionals and citizens about risks, early detection, and treatment
49.19 of long COVID known to be elevated in their communities; and

49.20 (4) promote high quality studies to provide better information for long COVID prevention
49.21 and control and to address public concerns and questions about long COVID.

49.22 Subd. 3. **Partnerships.** The commissioner of health shall, in consultation with health
49.23 care professionals, the Department of Human Services, local public health organizations,
49.24 health insurers, employers, schools, long COVID survivors, and community organizations
49.25 serving people at high risk of long COVID, routinely identify priority actions and activities
49.26 to address the need for communication, services, resources, tools, strategies, and policies
49.27 to support long COVID survivors and their families.

49.28 Subd. 4. **Grants and contracts.** The commissioner of health shall coordinate and
49.29 collaborate with community and organizational partners to implement evidence-informed
49.30 priority actions, including through community-based grants and contracts.

49.31 Subd. 5. **Grant recipient and contractor eligibility.** The commissioner of health shall
49.32 award contracts and competitive grants to organizations that serve communities

50.1 disproportionately impacted by COVID-19 and long COVID including but not limited to
50.2 rural and low-income areas, Black and African Americans, African immigrants, American
50.3 Indians, Asian American-Pacific Islanders, Latino, LGBTQ+, and persons with disabilities.
50.4 Organizations may also address intersectionality within such groups.

50.5 Subd. 6. **Grants and contracts authorized.** The commissioner of health shall award
50.6 grants and contracts to eligible organizations to plan, construct, and disseminate resources
50.7 and information to support survivors of long COVID, their caregivers, health care providers,
50.8 ancillary health care workers, workplaces, schools, communities, local and Tribal public
50.9 health, and other entities deemed necessary.

50.10 Sec. 36. Minnesota Statutes 2020, section 145.56, is amended by adding a subdivision to
50.11 read:

50.12 Subd. 6. **988; National Suicide Prevention Lifeline number.** The National Suicide
50.13 Prevention Lifeline is expanded to improve the quality of care and access to behavioral
50.14 health crisis services and to further health equity and save lives.

50.15 Sec. 37. Minnesota Statutes 2020, section 145.56, is amended by adding a subdivision to
50.16 read:

50.17 Subd. 7. **Definitions.** (a) For the purposes of this section, the following terms have the
50.18 meanings given.

50.19 (b) "National Suicide Prevention Lifeline" means a national network of certified local
50.20 crisis centers maintained by the Federal Substance Abuse and Mental Health Services
50.21 Administration that provides free and confidential emotional support to people in suicidal
50.22 crisis or emotional distress 24 hours a day, seven days a week.

50.23 (c) "988 Hotline" or "Lifeline Center" means a state identified center that is a member
50.24 of the National Suicide Prevention Lifeline network that responds to statewide or regional
50.25 988 contacts.

50.26 (d) "988 administrator" means the administrator of the 988 National Suicide Prevention
50.27 Lifeline.

50.28 (e) "Veterans Crisis Line" means the Veterans Crisis Line maintained by the Secretary
50.29 of Veterans Affairs under United States Code, title 38, section 170F(h).

50.30 (f) "Department" means the Department of Health.

50.31 (g) "Commissioner" means the commissioner of health.

51.1 Sec. 38. Minnesota Statutes 2020, section 145.56, is amended by adding a subdivision to
51.2 read:

51.3 Subd. 8. **988 National Suicide Prevention Lifeline.** (a) The commissioner of health
51.4 shall administer the designated lifeline and oversee a Lifeline Center or a network of Lifeline
51.5 Centers to answer contacts from individuals accessing the National Suicide Prevention
51.6 Lifeline 24 hours per day, seven days per week.

51.7 (b) The designated Lifeline Center(s) shall:

51.8 (1) have an active agreement with the administrator of the 988 National Suicide
51.9 Prevention Lifeline for participation within the network;

51.10 (2) meet the 988 administrator requirements and best practice guidelines for operational
51.11 and clinical standards;

51.12 (3) provide data, report, and participate in evaluations and related quality improvement
51.13 activities as required by the 988 administrator and the department;

51.14 (4) use technology that is interoperable across crisis and emergency response systems
51.15 used in the state, such as 911 systems, emergency medical services, and the National Suicide
51.16 Prevention Lifeline;

51.17 (5) deploy crisis and outgoing services, including mobile crisis teams in accordance with
51.18 guidelines established by the 988 administrator and the department;

51.19 (6) actively collaborate with local mobile crisis teams to coordinate linkages for persons
51.20 contacting the 988 Hotline for ongoing care needs;

51.21 (7) offer follow-up services to individuals accessing the Lifeline Center that are consistent
51.22 with guidance established by the 988 administrator and the department; and

51.23 (8) meet the requirements set by the 988 administrator and the department for serving
51.24 high risk and specialized populations.

51.25 (c) The department shall collaborate with the National Suicide Prevention Lifeline and
51.26 Veterans Crisis Line networks for the purpose of ensuring consistency of public messaging
51.27 about 988 services.

51.28 Sec. 39. **[145.871] UNIVERSAL, VOLUNTARY HOME VISITING PROGRAM.**

51.29 Subdivision 1. **Grant program.** (a) The commissioner of health shall award grants to
51.30 eligible individuals and entities to establish voluntary home visiting services to families
51.31 expecting or caring for an infant, including families adopting an infant. The following

52.1 individuals and entities are eligible for a grant under this section: community health boards;
52.2 nonprofit organizations; Tribal Nations; and health care providers, including doulas,
52.3 community health workers, perinatal health educators, early childhood family education
52.4 home visiting providers, nurses, community health technicians, and local public health
52.5 nurses.

52.6 (b) The grant money awarded under this section must be used to establish home visiting
52.7 services that:

52.8 (1) provide a range of one to six visits that occur prenatally or within the first four months
52.9 of the expected birth or adoption of an infant; and

52.10 (2) improve outcomes in two or more of the following areas:

52.11 (i) maternal and newborn health;

52.12 (ii) school readiness and achievement;

52.13 (iii) family economic self-sufficiency;

52.14 (iv) coordination and referral for other community resources and supports;

52.15 (v) reduction in child injuries, abuse, or neglect; or

52.16 (vi) reduction in crime or domestic violence.

52.17 (c) The commissioner shall ensure that the voluntary home visiting services established
52.18 under this section are available to all families residing in the state by June 30, 2025. In
52.19 awarding grants prior to the home visiting services being available statewide, the
52.20 commissioner shall prioritize applicants serving high-risk or high-need populations of
52.21 pregnant women and families with infants, including populations with insufficient access
52.22 to prenatal care, high incidence of mental illness or substance use disorder, low
52.23 socioeconomic status, and other factors as determined by the commissioner.

52.24 Subd. 2. **Home visiting services.** (a) The home visiting services provided under this
52.25 section must, at a minimum:

52.26 (1) offer information on infant care, child growth and development, positive parenting,
52.27 preventing diseases, preventing exposure to environmental hazards, and support services
52.28 in the community;

52.29 (2) provide information on and referrals to health care services, including information
52.30 on and assistance in applying for health care coverage for which the child or family may
52.31 be eligible, and provide information on the availability of group prenatal care, preventative
52.32 services, developmental assessments, and public assistance programs as appropriate;

53.1 (3) include an assessment of the physical, social, and emotional factors affecting the
53.2 family and provide information and referrals to address each family's identified needs;

53.3 (4) connect families to additional resources available in the community, including early
53.4 care and education programs, health or mental health services, family literacy programs,
53.5 employment agencies, and social services, as needed;

53.6 (5) utilize appropriate racial, ethnic, and cultural approaches to providing home visiting
53.7 services; and

53.8 (6) be voluntary and free of charge to families.

53.9 (b) Home visiting services under this section may be provided through telephone or
53.10 video communication when the commissioner determines the methods are necessary to
53.11 protect the health and safety of individuals receiving the visits and the home visiting
53.12 workforce.

53.13 Subd. 3. **Administrative costs.** The commissioner may use up to seven percent of the
53.14 annual appropriation under this section to provide training and technical assistance, to
53.15 administer the program, and to conduct ongoing evaluations of the program. The
53.16 commissioner may contract for training, capacity-building support for grantees or potential
53.17 grantees, technical assistance, and evaluation support.

53.18 Sec. 40. Minnesota Statutes 2020, section 145.924, is amended to read:

53.19 **145.924 AIDS PREVENTION GRANTS.**

53.20 (a) The commissioner may award grants to community health boards as defined in section
53.21 145A.02, subdivision 5, state agencies, state councils, or nonprofit corporations to provide
53.22 evaluation and counseling services to populations at risk for acquiring human
53.23 immunodeficiency virus infection, including, but not limited to, minorities, adolescents,
53.24 intravenous drug users, and homosexual men.

53.25 (b) The commissioner may award grants to agencies experienced in providing services
53.26 to communities of color, for the design of innovative outreach and education programs for
53.27 targeted groups within the community who may be at risk of acquiring the human
53.28 immunodeficiency virus infection, including intravenous drug users and their partners,
53.29 adolescents, gay and bisexual individuals and women. Grants shall be awarded on a request
53.30 for proposal basis and shall include funds for administrative costs. Priority for grants shall
53.31 be given to agencies or organizations that have experience in providing service to the
53.32 particular community which the grantee proposes to serve; that have policy makers
53.33 representative of the targeted population; that have experience in dealing with issues relating

54.1 to HIV/AIDS; and that have the capacity to deal effectively with persons of differing sexual
54.2 orientations. For purposes of this paragraph, the "communities of color" are: the
54.3 American-Indian community; the Hispanic community; the African-American community;
54.4 and the Asian-Pacific community.

54.5 (c) All state grants awarded under this section for programs targeted to adolescents shall
54.6 include the promotion of abstinence from sexual activity and drug use.

54.7 (d) The commissioner may manage a program and award grants to agencies experienced
54.8 in syringe services programs for expanding access to harm reduction services and improving
54.9 linkages to care to prevent HIV/AIDS, hepatitis, and other infectious diseases for those
54.10 experiencing homelessness or housing instability.

54.11 **Sec. 41. [145.9271] COMMUNITY SOLUTIONS FOR HEALTHY CHILD**
54.12 **DEVELOPMENT GRANT PROGRAM.**

54.13 Subdivision 1. Establishment. The commissioner of health shall establish the community
54.14 solutions for a healthy child development grant program. The purposes of the program are
54.15 to:

54.16 (1) improve child development outcomes related to the well-being of children of color
54.17 and American Indian children from prenatal to grade 3 and their families, including but not
54.18 limited to the goals outlined by the Department of Human Service's early childhood systems
54.19 reform effort that include: early learning; health and well-being; economic security; and
54.20 safe, stable, nurturing relationships and environments, by funding community-based solutions
54.21 for challenges that are identified by the affected communities;

54.22 (2) reduce racial disparities in children's health and development from prenatal to grade
54.23 3; and

54.24 (3) promote racial and geographic equity.

54.25 Subd. 2. Commissioner's duties. The commissioner of health shall:

54.26 (1) develop a request for proposals for the healthy child development grant program in
54.27 consultation with the community solutions advisory council established in subdivision 3;

54.28 (2) provide outreach, technical assistance, and program development support to increase
54.29 capacity for new and existing service providers in order to better meet statewide needs,
54.30 particularly in greater Minnesota and areas where services to reduce health disparities have
54.31 not been established;

55.1 (3) review responses to requests for proposals, in consultation with the community
55.2 solutions advisory council, and award grants under this section;

55.3 (4) ensure communication with the ethnic councils, Minnesota Indian Affairs Council,
55.4 and the Children's Cabinet on the request for proposal process;

55.5 (5) establish a transparent and objective accountability process, in consultation with the
55.6 community solutions advisory council, focused on outcomes that grantees agree to achieve;

55.7 (6) provide grantees with access to data to assist grantees in establishing and
55.8 implementing effective community-led solutions;

55.9 (7) maintain data on outcomes reported by grantees; and

55.10 (8) contract with an independent third-party entity to evaluate the success of the grant
55.11 program and to build the evidence base for effective community solutions in reducing health
55.12 disparities of children of color and American Indian children from prenatal to grade 3.

55.13 Subd. 3. **Community solutions advisory council; establishment; duties;**

55.14 **compensation.** (a) The commissioner of health shall establish a community solutions
55.15 advisory council. By October 1, 2022, the commissioner shall convene a 12-member
55.16 community solutions advisory council. Members of the advisory council are:

55.17 (1) two members representing the African Heritage community;

55.18 (2) two members representing the Latino community;

55.19 (3) two members representing the Asian-Pacific Islander community;

55.20 (4) two members representing the American Indian community;

55.21 (5) two parents who are Black, indigenous, or nonwhite people of color with children
55.22 under nine years of age;

55.23 (6) one member with research or academic expertise in racial equity and healthy child
55.24 development; and

55.25 (7) one member representing an organization that advocates on behalf of communities
55.26 of color or American Indians.

55.27 (b) At least three of the 12 members of the advisory council must come from outside
55.28 the seven-county metropolitan area.

55.29 (c) The community solutions advisory council shall:

55.30 (1) advise the commissioner on the development of the request for proposals for
55.31 community solutions healthy child development grants. In advising the commissioner, the

56.1 council must consider how to build on the capacity of communities to promote child and
56.2 family well-being and address social determinants of healthy child development;

56.3 (2) review responses to requests for proposals and advise the commissioner on the
56.4 selection of grantees and grant awards;

56.5 (3) advise the commissioner on the establishment of a transparent and objective
56.6 accountability process focused on outcomes the grantees agree to achieve;

56.7 (4) advise the commissioner on ongoing oversight and necessary support in the
56.8 implementation of the program; and

56.9 (5) support the commissioner on other racial equity and early childhood grant efforts.

56.10 (d) Each advisory council member shall be compensated as provided in section 15.059,
56.11 subdivision 3.

56.12 Subd. 4. **Eligible grantees.** Organizations eligible to receive grant funding under this
56.13 section include:

56.14 (1) organizations or entities that work with Black, indigenous, and non-Black people of
56.15 color communities;

56.16 (2) Tribal nations and Tribal organizations as defined in section 658P of the Child Care
56.17 and Development Block Grant Act of 1990; and

56.18 (3) organizations or entities focused on supporting healthy child development.

56.19 Subd. 5. **Strategic consideration and priority of proposals; eligible populations;**
56.20 **grant awards.** (a) The commissioner, in consultation with the community solutions advisory
56.21 council, shall develop a request for proposals for healthy child development grants. In
56.22 developing the proposals and awarding the grants, the commissioner shall consider building
56.23 on the capacity of communities to promote child and family well-being and address social
56.24 determinants of healthy child development. Proposals must focus on increasing racial equity
56.25 and healthy child development and reducing health disparities experienced by children of
56.26 Black, nonwhite people of color, and American Indian communities from prenatal to grade
56.27 3 and their families.

56.28 (b) In awarding the grants, the commissioner shall provide strategic consideration and
56.29 give priority to proposals from:

56.30 (1) organizations or entities led by Black and other nonwhite people of color and serving
56.31 Black and nonwhite communities of color;

57.1 (2) organizations or entities led by American Indians and serving American Indians,
57.2 including Tribal nations and Tribal organizations;

57.3 (3) organizations or entities with proposals focused on healthy development from prenatal
57.4 to age three;

57.5 (4) organizations or entities with proposals focusing on multigenerational solutions;

57.6 (5) organizations or entities located in or with proposals to serve communities located
57.7 in counties that are moderate to high risk according to the Wilder Research Risk and Reach
57.8 Report; and

57.9 (6) community-based organizations that have historically served communities of color
57.10 and American Indians and have not traditionally had access to state grant funding.

57.11 (c) The advisory council may recommend additional strategic considerations and priorities
57.12 to the commissioner.

57.13 (d) The first round of grants must be awarded no later than April 15, 2023.

57.14 Subd. 6. **Geographic distribution of grants.** To the extent possible, the commissioner
57.15 and the advisory council shall ensure that grant funds are prioritized and awarded to
57.16 organizations and entities that are within counties that have a higher proportion of Black,
57.17 nonwhite people of color, and American Indians than the state average.

57.18 Subd. 7. **Report.** Grantees must report grant program outcomes to the commissioner on
57.19 the forms and according to the timelines established by the commissioner.

57.20 Sec. 42. **[145.9272] LEAD REMEDIATION IN SCHOOLS AND CHILD CARE**
57.21 **SETTINGS GRANT PROGRAM.**

57.22 Subdivision 1. **Establishment; purpose.** The commissioner of health shall develop a
57.23 grant program for the purpose of remediating identified sources of lead in drinking water
57.24 in schools and child care settings.

57.25 Subd. 2. **Grants authorized.** The commissioner shall award grants through a request
57.26 for proposals process to schools and child care settings. Priority shall be given to schools
57.27 and child care settings with: (1) higher levels of lead detected in water samples; (2) evidence
57.28 of lead service lines or lead plumbing materials; and (3) school districts that serve
57.29 disadvantaged communities.

57.30 Subd. 3. **Grant allocation.** Grantees must use the funds to address sources of lead
57.31 contamination in their facilities including but not limited to service connections, premise
57.32 plumbing, and implementing best practices for water management within the building.

58.1 Sec. 43. **[145.9275] SKIN-LIGHTENING PRODUCTS PUBLIC AWARENESS AND**
58.2 **EDUCATION GRANT PROGRAM.**

58.3 Subdivision 1. Grant program. The commissioner of health shall award grants through
58.4 a request for proposal process to community-based organizations that serve ethnic
58.5 communities and focus on public health outreach to Black and people of color communities
58.6 on the issues of colorism, skin-lightening products, and chemical exposures from these
58.7 products. Priority in awarding grants shall be given to organizations that have historically
58.8 provided services to ethnic communities on the skin-lightening and chemical exposure issue
58.9 for the past four years.

58.10 Subd. 2. Uses of grant funds. Grant recipients must use grant funds awarded under this
58.11 section to conduct public awareness and education activities that are culturally specific and
58.12 community-based and that focus on:

58.13 (1) increasing public awareness and providing education on the health dangers associated
58.14 with using skin-lightening creams and products that contain mercury and hydroquinone and
58.15 are manufactured in other countries, brought into this country, and sold illegally online or
58.16 in stores; the dangers of exposure to mercury through dermal absorption, inhalation,
58.17 hand-to-mouth contact, and contact with individuals who have used these skin-lightening
58.18 products; the health effects of mercury poisoning, including the permanent effects on the
58.19 central nervous system and kidneys; and the dangers to mothers and infants of using these
58.20 products or being exposed to these products during pregnancy and while breastfeeding;

58.21 (2) identifying products that contain mercury and hydroquinone by testing skin-lightening
58.22 products;

58.23 (3) developing a train the trainer curriculum to increase community knowledge and
58.24 influence behavior changes by training community leaders, cultural brokers, community
58.25 health workers, and educators;

58.26 (4) continuing to build the self-esteem and overall wellness of young people who are
58.27 using skin-lightening products or are at risk of starting the practice of skin lightening; and

58.28 (5) building the capacity of community-based organizations to continue to combat
58.29 skin-lightening practices and chemical exposure.

58.30 Sec. 44. **[145.9282] COMMUNITY HEALTH WORKERS; REDUCING HEALTH**
58.31 **DISPARITIES WITH COMMUNITY-LED CARE.**

58.32 Subdivision 1. Establishment. The commissioner of health shall support collaboration
58.33 and coordination between state and community partners to develop, refine, and expand the

59.1 community health workers profession across the state equipping them to address health
59.2 needs and to improve health outcomes by addressing the social conditions that impact health
59.3 status. Community health professionals' work expands beyond health care to bring health
59.4 and racial equity into public safety, social services, youth and family services, schools,
59.5 neighborhood associations, and more.

59.6 Subd. 2. **Grants authorized; eligibility.** The commissioner of health shall establish a
59.7 community-based grant to expand and strengthen the community health workers workforce
59.8 across the state. The grantee must be a not-for-profit community organization serving,
59.9 convening, and supporting community health workers (CHW) statewide.

59.10 Subd. 3. **Evaluation.** The commissioner of health shall design, conduct, and evaluate
59.11 the CHW initiative using measures of workforce capacity, employment opportunity, reach
59.12 of services, and return on investment, as well as descriptive measures of the extant CHW
59.13 models as they compare with the national community health workers' landscape. These
59.14 more proximal measures are collected and analyzed as foundational to longer-term change
59.15 in social determinants of health and rates of death and injury by suicide, overdose, firearms,
59.16 alcohol, and chronic disease.

59.17 Subd. 4. **Report.** Grantees must report grant program outcomes to the commissioner on
59.18 the forms and according to the timelines established by the commissioner.

59.19 Sec. 45. **[145.9283] REDUCING HEALTH DISPARITIES AMONG PEOPLE WITH**
59.20 **DISABILITIES; GRANTS.**

59.21 Subdivision 1. **Goal and establishment.** The commissioner of health shall support
59.22 collaboration and coordination between state and community partners to address equity
59.23 barriers to health care and preventative services for chronic diseases among people with
59.24 disabilities. The commissioner of health, in consultation with the Olmstead Implementation
59.25 Office, Department of Human Services, Board on Aging, health care professionals, local
59.26 public health, and other community organizations that serve people with disabilities, shall
59.27 routinely identify priorities and action steps to address identified gaps in services, resources,
59.28 and tools.

59.29 Subd. 2. **Assessment and tracking.** The commissioner of health shall conduct community
59.30 needs assessments and establish a health surveillance and tracking plan in collaboration
59.31 with community and organizational partners to identify and address health disparities.

60.1 Subd. 3. **Grants authorized.** The commissioner of health shall establish
60.2 community-based grants to support establishing inclusive evidence-based chronic disease
60.3 prevention and management services to address identified gaps and disparities.

60.4 Subd. 4. **Technical assistance.** The commissioner of health shall provide and evaluate
60.5 training and capacity-building technical assistance on accessible preventive health care for
60.6 public health and health care providers of chronic disease prevention and management
60.7 programs and services.

60.8 Subd. 5. **Report.** Grantees must report grant program outcomes to the commissioner on
60.9 the forms and according to the timelines established by the commissioner.

60.10 Sec. 46. **[145.9292] PUBLIC HEALTH AMERICORPS.**

60.11 The commissioner may award a grant to a statewide, nonprofit organization to support
60.12 Public Health AmeriCorps members. The organization awarded the grant shall provide the
60.13 commissioner with any information needed by the commissioner to evaluate the program
60.14 in the form and at the timelines specified by the commissioner.

60.15 Sec. 47. **[145.987] HEALTHY BEGINNINGS, HEALTHY FAMILIES ACT.**

60.16 Subdivision 1. **Purpose.** The purpose of the Healthy Beginnings, Healthy Families Act
60.17 is to: (1) address the significant disparities in early childhood outcomes and increase the
60.18 number of children who are school ready through establishing the Minnesota collaborative
60.19 to prevent infant mortality; (2) sustain the Help Me Connect online navigator; (3) improve
60.20 universal access to developmental and social-emotional screening and follow-up; and (4)
60.21 sustain and expand the model jail practices for children of incarcerated parents in Minnesota
60.22 jails.

60.23 Subd. 2. **Minnesota collaborative to prevent infant mortality.** (a) The Minnesota
60.24 collaborative to prevent infant mortality is established. The goal of the Minnesota
60.25 collaborative to prevent infant mortality program is to:

60.26 (1) build a statewide multisectoral partnership including the state government, local
60.27 public health organizations, Tribes, the private sector, and community nonprofit organizations
60.28 with the shared goal of decreasing infant mortality rates among populations with significant
60.29 disparities, including among Black, American Indian, other nonwhite communities, and
60.30 rural populations;

61.1 (2) address the leading causes of poor infant health outcomes such as premature birth,
61.2 infant sleep-related deaths, and congenital anomalies through strategies to change social
61.3 and environmental determinants of health; and

61.4 (3) promote the development, availability, and use of data-informed, community-driven
61.5 strategies to improve infant health outcomes.

61.6 (b) The commissioner of health shall establish a statewide partnership program to engage
61.7 communities, exchange best practices, share summary data on infant health, and promote
61.8 policies to improve birth outcomes and eliminate preventable infant mortality.

61.9 Subd. 3. Grants authorized. (a) The commissioner of health shall award grants to
61.10 eligible applicants to convene, coordinate, and implement data-driven strategies and culturally
61.11 relevant activities to improve infant health by reducing preterm births, sleep-related infant
61.12 deaths, and congenital malformations and by addressing social and environmental
61.13 determinants of health. Grants shall be awarded to support community nonprofit
61.14 organizations, Tribal governments, and community health boards. Grants shall be awarded
61.15 to all federally recognized Tribal governments whose proposals demonstrate the ability to
61.16 implement programs designed to achieve the purposes in subdivision 2 and other requirements
61.17 of this section. An eligible applicant must submit an application to the commissioner of
61.18 health on a form designated by the commissioner and by the deadline established by the
61.19 commissioner. The commissioner shall award grants to eligible applicants in metropolitan
61.20 and rural areas of the state and may consider geographic representation in grant awards.

61.21 (b) Grantee activities shall:

61.22 (1) address the leading cause or causes of infant mortality;

61.23 (2) be based on community input;

61.24 (3) be focused on policy, systems, and environmental changes that support infant health;
61.25 and

61.26 (4) address the health disparities and inequities that are experienced in the grantee's
61.27 community.

61.28 (c) The commissioner shall review each application to determine whether the application
61.29 is complete and whether the applicant and the project are eligible for a grant. In evaluating
61.30 applications under this subdivision, the commissioner shall establish criteria including but
61.31 not limited to: (1) the eligibility of the project; (2) the applicant's thoroughness and clarity
61.32 in describing the infant health issues grant funds are intended to address; (3) a description
61.33 of the applicant's proposed project; (4) a description of the population demographics and

62.1 service area of the proposed project; and (5) evidence of efficiencies and effectiveness
62.2 gained through collaborative efforts.

62.3 (d) Grant recipients shall report their activities to the commissioner in a format and at
62.4 a time specified by the commissioner.

62.5 Subd. 4. **Technical assistance.** (a) The commissioner shall provide content expertise,
62.6 technical expertise, training to grant recipients, and advice on data-driven strategies.

62.7 (b) For the purposes of carrying out the grant program under this section, including for
62.8 administrative purposes, the commissioner shall award contracts to appropriate entities to
62.9 assist in training and to provide technical assistance to grantees.

62.10 (c) Contracts awarded under paragraph (b) may be used to provide technical assistance
62.11 and training in the areas of:

62.12 (1) partnership development and capacity building;

62.13 (2) Tribal support;

62.14 (3) implementation support for specific infant health strategies;

62.15 (4) communications, convening, and sharing lessons learned; and

62.16 (5) health equity.

62.17 Subd. 5. **Help Me Connect.** The Help Me Connect online navigator is established. The
62.18 goal of Help Me Connect is to connect pregnant and parenting families with young children
62.19 from birth to eight years of age with services in their local communities that support healthy
62.20 child development and family well-being. The commissioner of health shall work
62.21 collaboratively with the commissioners of human services and education to implement this
62.22 subdivision.

62.23 Subd. 6. **Duties of Help Me Connect.** (a) Help Me Connect shall facilitate collaboration
62.24 across sectors covering child health, early learning and education, child welfare, and family
62.25 supports by:

62.26 (1) providing early childhood provider outreach to support early detection, intervention,
62.27 and knowledge about local resources; and

62.28 (2) linking children and families to appropriate community-based services.

62.29 (b) Help Me Connect shall provide community outreach that includes support for and
62.30 participation in the help me connect system, including disseminating information and
62.31 compiling and maintaining a current resource directory that includes but is not limited to

63.1 primary and specialty medical care providers, early childhood education and child care
63.2 programs, developmental disabilities assessment and intervention programs, mental health
63.3 services, family and social support programs, child advocacy and legal services, public
63.4 health and human services and resources, and other appropriate early childhood information.

63.5 (c) Help Me Connect shall maintain a centralized access point for parents and
63.6 professionals to obtain information, resources, and other support services.

63.7 (d) Help Me Connect shall provide a centralized mechanism that facilitates
63.8 provider-to-provider referrals to community resources and monitors referrals to ensure that
63.9 families are connected to services.

63.10 (e) Help Me Connect shall collect program evaluation data to increase the understanding
63.11 of all aspects of the current and ongoing system under this section, including identification
63.12 of gaps in service, barriers to finding and receiving appropriate service, and lack of resources.

63.13 Subd. 7. **Universal and voluntary developmental and social-emotional screening**
63.14 **and follow-up.** (a) The commissioner shall establish a universal and voluntary developmental
63.15 and social-emotional screening to identify young children at risk for developmental and
63.16 behavioral concerns. Follow-up services shall be provided to connect families and young
63.17 children to appropriate community-based resources and programs. The commissioner of
63.18 health shall work with the commissioners of human services and education to implement
63.19 this subdivision and promote interagency coordination with other early childhood programs
63.20 including those that provide screening and assessment.

63.21 (b) The commissioner shall:

63.22 (1) increase the awareness of universal and voluntary developmental and social-emotional
63.23 screening and follow-up in coordination with community and state partners;

63.24 (2) expand existing electronic screening systems to administer developmental and
63.25 social-emotional screening of children from birth to kindergarten entrance;

63.26 (3) provide universal and voluntary periodic screening for developmental and
63.27 social-emotional delays based on current recommended best practices;

63.28 (4) review and share the results of the screening with the child's parent or guardian;

63.29 (5) support families in their role as caregivers by providing typical growth and
63.30 development information, anticipatory guidance, and linkages to early childhood resources
63.31 and programs;

64.1 (6) ensure that children and families are linked to appropriate community-based services
64.2 and resources when any developmental or social-emotional concerns are identified through
64.3 screening; and

64.4 (7) establish performance measures and collect, analyze, and share program data regarding
64.5 population-level outcomes of developmental and social-emotional screening, and make
64.6 referrals to community-based services and follow-up activities.

64.7 Subd. 8. **Grants authorized.** The commissioner shall award grants to community health
64.8 boards and Tribal nations to support follow-up services for children with developmental or
64.9 social-emotional concerns identified through screening in order to link children and their
64.10 families to appropriate community-based services and resources. The commissioner shall
64.11 provide technical assistance, content expertise, and training to grant recipients to ensure
64.12 that follow-up services are effectively provided.

64.13 Subd. 9. **Model jails practices for incarcerated parents.** (a) The commissioner of
64.14 health may make special grants to counties, groups of counties, or nonprofit organizations
64.15 to implement model jails practices to benefit the children of incarcerated parents.

64.16 (b) "Model jail practices" means a set of practices that correctional administrators can
64.17 implement to remove barriers that may prevent a child from cultivating or maintaining
64.18 relationships with the child's incarcerated parent or parents during and immediately after
64.19 incarceration without compromising the safety or security of the correctional facility.

64.20 Subd. 10. **Grants authorized.** (a) The commissioner of health shall award grants to
64.21 eligible county jails to implement model jail practices and separate grants to county
64.22 governments, Tribal governments, or nonprofit organizations in corresponding geographic
64.23 areas to build partnerships with county jails to support children of incarcerated parents and
64.24 their caregivers.

64.25 (b) Grantee activities may include but are not limited to:

64.26 (1) parenting classes or groups;

64.27 (2) family-centered intake and assessment of inmate programs;

64.28 (3) family notification, information, and communication strategies;

64.29 (4) correctional staff training;

64.30 (5) policies and practices for family visits; and

64.31 (6) family-focused reentry planning.

65.1 (c) Grant recipients shall report their activities to the commissioner in a format and at a
65.2 time specified by the commissioner.

65.3 Subd. 11. **Technical assistance and oversight.** (a) The commissioner shall provide
65.4 content expertise, training to grant recipients, and advice on evidence-based strategies,
65.5 including evidence-based training to support incarcerated parents.

65.6 (b) For the purposes of carrying out the grant program under this section, including for
65.7 administrative purposes, the commissioner shall award contracts to appropriate entities to
65.8 assist in training and provide technical assistance to grantees.

65.9 (c) Contracts awarded under paragraph (b) may be used to provide technical assistance
65.10 and training in the areas of:

65.11 (1) evidence-based training for incarcerated parents;

65.12 (2) partnership building and community engagement;

65.13 (3) evaluation of process and outcomes of model jail practices; and

65.14 (4) expert guidance on reducing the harm caused to children of incarcerated parents and
65.15 application of model jail practices.

65.16 Sec. 48. **[145.988] MINNESOTA SCHOOL HEALTH INITIATIVE.**

65.17 Subdivision 1. **Purpose.** (a) The purpose of the Minnesota School Health Initiative is
65.18 to implement evidence-based practices to strengthen and expand health promotion and
65.19 health care delivery activities in schools to improve the holistic health of students. To better
65.20 serve students, the Minnesota School Health Initiative shall unify the best practices of the
65.21 school-based health center and Whole School, Whole Community, Whole Child models.

65.22 (b) The commissioner of health and the commissioner of education shall coordinate the
65.23 projects and initiatives funded under this section with other efforts at the local, state, or
65.24 national level to avoid duplication and promote complementary efforts.

65.25 Subd. 2. **Definitions.** (a) For purposes of this section, the following terms have the
65.26 meanings given.

65.27 (b) "School-based health center" or "comprehensive school-based health center" means
65.28 a safety net health care delivery model that is located in or near a school facility and that
65.29 offers comprehensive health care, including preventive and behavioral health services, by
65.30 licensed and qualified health professionals in accordance with federal, state, and local law.
65.31 When not located on school property, the school-based health center must have an established

66.1 relationship with one or more schools in the community and operate primarily to serve those
66.2 student groups.

66.3 (c) "Sponsoring organization" means any of the following that operate a school-based
66.4 health center:

66.5 (1) health care providers;

66.6 (2) community clinics;

66.7 (3) hospitals;

66.8 (4) federally qualified health centers and look-alikes as defined in section 145.9269;

66.9 (5) health care foundations or nonprofit organizations;

66.10 (6) higher education institutions; or

66.11 (7) local health departments.

66.12 Subd. 3. **Expansion of Minnesota school-based health centers.** (a) The commissioner
66.13 of health shall administer a program to provide grants to school districts, school-based health
66.14 centers, and sponsoring organizations to support existing centers and facilitate the growth
66.15 of school-based health centers in Minnesota.

66.16 (b) Grant funds distributed under this subdivision shall be used to support new or existing
66.17 school-based health centers that:

66.18 (1) operate in partnership with a school or district and with the permission of the school
66.19 or district board;

66.20 (2) provide health services through a sponsoring organization that is specified in
66.21 subdivision 2; and

66.22 (3) provide health services to all students and youth within a school or district regardless
66.23 of ability to pay, insurance coverage, or immigration status, and in accordance with federal,
66.24 state, and local law.

66.25 (c) Grant recipients shall report their activities and annual performance measures as
66.26 defined by the commissioner in a format and time specified by the commissioner.

66.27 Subd. 4. **School-based health center services.** Services provided by a school-based
66.28 health center may include but are not limited to:

66.29 (1) preventative health care;

66.30 (2) chronic medical condition management, including diabetes and asthma care;

- 67.1 (3) mental health care and crisis management;
- 67.2 (4) acute care for illness and injury;
- 67.3 (5) oral health care;
- 67.4 (6) vision care;
- 67.5 (7) nutritional counseling;
- 67.6 (8) substance abuse counseling;
- 67.7 (9) referral to a specialist, medical home, or hospital for care;
- 67.8 (10) additional services that address social determinants of health; and
- 67.9 (11) emerging services such as mobile health and telehealth.

67.10 Subd. 5. **Sponsoring organization.** A sponsoring organization that agrees to operate a
67.11 school-based health center must enter into a memorandum of agreement with the school or
67.12 district. The memorandum of agreement must require the sponsoring organization to be
67.13 financially responsible for the operation of school-based health centers in the school or
67.14 district and must identify the costs that are the responsibility of the school or district, such
67.15 as Internet access, custodial services, utilities, and facility maintenance. To the greatest
67.16 extent possible, a sponsoring organization must bill private insurers, medical assistance,
67.17 and other public programs for services provided in the school-based health center in order
67.18 to maintain the financial sustainability of the school-based health center.

67.19 Subd. 6. **Oral health in school settings.** (a) The commissioner of health shall administer
67.20 a program to provide competitive grants to schools, oral health providers, and other
67.21 community groups to build capacity and infrastructure to establish, expand, link, or strengthen
67.22 oral health services in school settings.

67.23 (b) Grant funds distributed under this subdivision must be used to support new or existing
67.24 oral health services in schools that:

- 67.25 (1) provide oral health risk assessment, screening, education, and anticipatory guidance;
- 67.26 (2) provide oral health services, including fluoride varnish and dental sealants;
- 67.27 (3) make referrals for restorative and other follow-up dental care as needed; and
- 67.28 (4) provide free access to fluoridated drinking water to give students a healthy alternative
67.29 to sugar-sweetened beverages.

68.1 (c) Grant recipients must collect, monitor, and submit to the commissioner of health
68.2 baseline and annual data and provide information to improve the quality and impact of oral
68.3 health strategies.

68.4 Subd. 7. **Whole School, Whole Community, Whole Child Grants.** (a) The
68.5 commissioner of health shall administer a program to provide competitive grants to local
68.6 public health organizations, schools, and community organizations using the evidence-based
68.7 Whole School, Whole Community, Whole Child (WSCC) model to increase alignment,
68.8 integration, and collaboration between public health and education sectors to improve each
68.9 child's cognitive, physical, oral, social, and emotional development.

68.10 (b) Grant funds distributed under this subdivision must be used to support new or existing
68.11 programs that implement elements of the WSCC model in schools that:

68.12 (1) align health and learning strategies to improve health outcomes and academic
68.13 achievement;

68.14 (2) improve the physical, nutritional, psychological, social, and emotional environments
68.15 of schools;

68.16 (3) create collaborative approaches to engage schools, parents and guardians, and
68.17 communities; and

68.18 (4) promote and establish lifelong healthy behaviors.

68.19 (c) Grant recipients shall report grant activities and progress to the commissioner in a
68.20 time and format specified by the commissioner.

68.21 Subd. 8. **Technical assistance and oversight.** (a) The commissioner shall provide
68.22 content expertise, technical expertise, and training to grant recipients under subdivisions 6
68.23 and 7.

68.24 (b) For the purposes of carrying out the grant program under this section, including for
68.25 administrative purposes, the commissioner shall award contracts to appropriate entities to
68.26 assist in training and provide technical assistance to grantees.

68.27 (c) Contracts awarded under paragraph (b) may be used to provide technical assistance
68.28 and training in the areas of:

68.29 (1) needs assessment;

68.30 (2) community engagement and capacity building;

68.31 (3) community asset building and risk behavior reduction;

- 69.1 (4) dental provider training in calibration;
- 69.2 (5) dental services related equipment, instruments, supplies;
- 69.3 (6) communications;
- 69.4 (7) community, school, health care, work site, and other site-specific strategies;
- 69.5 (8) health equity;
- 69.6 (9) data collection and analysis; and
- 69.7 (10) evaluation.

69.8 Sec. 49. Minnesota Statutes 2020, section 145A.131, subdivision 1, is amended to read:

69.9 Subdivision 1. **Funding formula for community health boards.** (a) Base funding for
69.10 each community health board eligible for a local public health grant under section 145A.03,
69.11 subdivision 7, shall be determined by each community health board's fiscal year 2003
69.12 allocations, prior to unallotment, for the following grant programs: community health
69.13 services subsidy; state and federal maternal and child health special projects grants; family
69.14 home visiting grants; TANF MN ENABL grants; TANF youth risk behavior grants; and
69.15 available women, infants, and children grant funds in fiscal year 2003, prior to unallotment,
69.16 distributed based on the proportion of WIC participants served in fiscal year 2003 within
69.17 the CHS service area.

69.18 (b) Base funding for a community health board eligible for a local public health grant
69.19 under section 145A.03, subdivision 7, as determined in paragraph (a), shall be adjusted by
69.20 the percentage difference between the base, as calculated in paragraph (a), and the funding
69.21 available for the local public health grant.

69.22 (c) Multicounty or multicity community health boards shall receive a local partnership
69.23 base of up to \$5,000 per year for each county or city in the case of a multicity community
69.24 health board included in the community health board.

69.25 (d) The State Community Health Services Advisory Committee may recommend a
69.26 formula to the commissioner to use in distributing funds to community health boards.

69.27 (e) Notwithstanding any adjustment in paragraph (b), community health boards, all or
69.28 a portion of which are located outside of the counties of Anoka, Chisago, Carver, Dakota,
69.29 Hennepin, Isanti, Ramsey, Scott, Sherburne, Washington, and Wright, are eligible to receive
69.30 an increase equal to ten percent of the grant award to the community health board under
69.31 paragraph (a) starting July 1, 2015. The increase in calendar year 2015 shall be prorated for
69.32 the last six months of the year. For calendar years beginning on or after January 1, 2016,

70.1 the amount distributed under this paragraph shall be adjusted each year based on available
70.2 funding and the number of eligible community health boards.

70.3 (f) Funding for foundational public health responsibilities shall be distributed based on
70.4 a formula determined by the commissioner in consultation with the State Community Health
70.5 Services Advisory Committee. Community health boards must use these funds as specified
70.6 in subdivision 5.

70.7 Sec. 50. Minnesota Statutes 2020, section 145A.131, subdivision 5, is amended to read:

70.8 Subd. 5. **Use of funds.** (a) Community health boards may use the base funding of their
70.9 local public health grant funds distributed according to subdivision 1, paragraphs (a) to (e),
70.10 to address the areas of public health responsibility and local priorities developed through
70.11 the community health assessment and community health improvement planning process.

70.12 (b) A community health board must use funding for foundational public health
70.13 responsibilities that is distributed according to subdivision 1, paragraph (f), to fulfill
70.14 foundational public health responsibilities as defined by the commissioner in consultation
70.15 with the State Community Health Services Advisory Committee.

70.16 (c) Notwithstanding paragraph (b), if a community health board can demonstrate that
70.17 foundational public health responsibilities are fulfilled, the community health board may
70.18 use funding for foundational public health responsibilities for local priorities developed
70.19 through the community health assessment and community health improvement planning
70.20 process.

70.21 (d) Notwithstanding paragraphs (a) to (c), by July 1, 2026, community health boards
70.22 must use all local public health funds first to fulfill foundational public health responsibilities.
70.23 Once a community health board can demonstrate foundational public health responsibilities
70.24 are fulfilled, funds may be used for local priorities developed through the community health
70.25 assessment and community health improvement planning process.

70.26 Sec. 51. Minnesota Statutes 2020, section 145A.14, is amended by adding a subdivision
70.27 to read:

70.28 Subd. 2b. **Tribal governments; foundational public health responsibilities.** The
70.29 commissioner shall distribute grants to Tribal governments for foundational public health
70.30 responsibilities as defined by each Tribal government.

71.1 Sec. 52. Minnesota Statutes 2020, section 149A.01, subdivision 2, is amended to read:

71.2 Subd. 2. **Scope.** In Minnesota no person shall, without being licensed or registered by
71.3 the commissioner of health:

71.4 (1) take charge of or remove from the place of death a dead human body;

71.5 (2) prepare a dead human body for final disposition, in any manner; or

71.6 (3) arrange, direct, or supervise a funeral, memorial service, or graveside service.

71.7 Sec. 53. Minnesota Statutes 2020, section 149A.01, subdivision 3, is amended to read:

71.8 Subd. 3. **Exceptions to licensure.** (a) Except as otherwise provided in this chapter,
71.9 nothing in this chapter shall in any way interfere with the duties of:

71.10 (1) an anatomical bequest program located within an accredited school of medicine or
71.11 an accredited college of mortuary science;

71.12 (2) a person engaged in the performance of duties prescribed by law relating to the
71.13 conditions under which unclaimed dead human bodies are held subject to anatomical study;

71.14 (3) authorized personnel from a licensed ambulance service in the performance of their
71.15 duties;

71.16 (4) licensed medical personnel in the performance of their duties; or

71.17 (5) the coroner or medical examiner in the performance of the duties of their offices.

71.18 (b) This chapter does not apply to or interfere with the recognized customs or rites of
71.19 any culture or recognized religion in the ceremonial washing, dressing, casketing, and public
71.20 transportation of their dead, to the extent that all other provisions of this chapter are complied
71.21 with.

71.22 (c) Noncompensated persons with the right to control the dead human body, under section
71.23 149A.80, subdivision 2, may remove a body from the place of death; transport the body;
71.24 prepare the body for disposition, except embalming; or arrange for final disposition of the
71.25 body, provided that all actions are in compliance with this chapter.

71.26 (d) Persons serving internships pursuant to section 149A.20, subdivision 6, ~~or~~ students
71.27 officially registered for a practicum or clinical through a program of mortuary science
71.28 accredited by the American Board of Funeral Service Education, or transfer care specialists
71.29 registered pursuant to section 149A.47 are not required to be licensed, provided that the
71.30 persons or students are registered with the commissioner and act under the direct and

72.1 exclusive supervision of a person holding a current license to practice mortuary science in
72.2 Minnesota.

72.3 (e) Notwithstanding this subdivision, nothing in this section shall be construed to prohibit
72.4 an institution or entity from establishing, implementing, or enforcing a policy that permits
72.5 only persons licensed by the commissioner to remove or cause to be removed a dead body
72.6 or body part from the institution or entity.

72.7 (f) An unlicensed person may arrange for and direct or supervise a memorial service if
72.8 that person or that person's employer does not have charge of the dead human body. An
72.9 unlicensed person may not take charge of the dead human body, unless that person has the
72.10 right to control the dead human body under section 149A.80, subdivision 2, or is that person's
72.11 noncompensated designee.

72.12 Sec. 54. Minnesota Statutes 2020, section 149A.02, is amended by adding a subdivision
72.13 to read:

72.14 Subd. 12c. **Dead human body or body.** "Dead human body" or "body" includes an
72.15 identifiable human body part that is detached from a human body.

72.16 Sec. 55. Minnesota Statutes 2020, section 149A.02, subdivision 13a, is amended to read:

72.17 Subd. 13a. **Direct supervision.** "Direct supervision" means overseeing the performance
72.18 of an individual. For the purpose of a clinical, practicum, ~~or~~ internship, or registration, direct
72.19 supervision means that the supervisor is available to observe and correct, as needed, the
72.20 performance of the trainee or registrant. The mortician supervisor is accountable for the
72.21 actions of the clinical student, practicum student, ~~or~~ intern, or registrant throughout the
72.22 course of the training. The supervising mortician is accountable for any violations of law
72.23 or rule, in the performance of their duties, by the clinical student, practicum student, ~~or~~
72.24 intern, or registrant.

72.25 Sec. 56. Minnesota Statutes 2020, section 149A.02, is amended by adding a subdivision
72.26 to read:

72.27 Subd. 37d. **Registrant.** "Registrant" means any person who is registered as a transfer
72.28 care specialist under section 149A.47.

73.1 Sec. 57. Minnesota Statutes 2020, section 149A.02, is amended by adding a subdivision
73.2 to read:

73.3 Subd. 37e. **Transfer care specialist.** "Transfer care specialist" means an individual who
73.4 is registered with the commissioner in accordance with section 149A.47 and is authorized
73.5 to perform the removal of a dead human body from the place of death under the direct
73.6 supervision of a licensed mortician.

73.7 Sec. 58. Minnesota Statutes 2020, section 149A.03, is amended to read:

73.8 **149A.03 DUTIES OF COMMISSIONER.**

73.9 The commissioner shall:

73.10 (1) enforce all laws and adopt and enforce rules relating to the:

73.11 (i) removal, preparation, transportation, arrangements for disposition, and final disposition
73.12 of dead human bodies;

73.13 (ii) licensure, registration, and professional conduct of funeral directors, morticians,
73.14 interns, transfer care specialists, practicum students, and clinical students;

73.15 (iii) licensing and operation of a funeral establishment;

73.16 (iv) licensing and operation of an alkaline hydrolysis facility; and

73.17 (v) licensing and operation of a crematory;

73.18 (2) provide copies of the requirements for licensure, registration, and permits to all
73.19 applicants;

73.20 (3) administer examinations and issue licenses, registrations, and permits to qualified
73.21 persons and other legal entities;

73.22 (4) maintain a record of the name and location of all current licensees, registrants, and
73.23 interns;

73.24 (5) perform periodic compliance reviews and premise inspections of licensees;

73.25 (6) accept and investigate complaints relating to conduct governed by this chapter;

73.26 (7) maintain a record of all current preneed arrangement trust accounts;

73.27 (8) maintain a schedule of application, examination, permit, registration, and licensure
73.28 fees, initial and renewal, sufficient to cover all necessary operating expenses;

73.29 (9) educate the public about the existence and content of the laws and rules for mortuary
73.30 science licensing and the removal, preparation, transportation, arrangements for disposition,

74.1 and final disposition of dead human bodies to enable consumers to file complaints against
74.2 licensees and others who may have violated those laws or rules;

74.3 (10) evaluate the laws, rules, and procedures regulating the practice of mortuary science
74.4 in order to refine the standards for licensing and to improve the regulatory and enforcement
74.5 methods used; and

74.6 (11) initiate proceedings to address and remedy deficiencies and inconsistencies in the
74.7 laws, rules, or procedures governing the practice of mortuary science and the removal,
74.8 preparation, transportation, arrangements for disposition, and final disposition of dead
74.9 human bodies.

74.10 Sec. 59. Minnesota Statutes 2020, section 149A.09, is amended to read:

74.11 **149A.09 DENIAL; REFUSAL TO REISSUE; REVOCATION; SUSPENSION;**
74.12 **LIMITATION OF LICENSE, REGISTRATION, OR PERMIT.**

74.13 Subdivision 1. **Denial; refusal to renew; revocation; and suspension.** The regulatory
74.14 agency may deny, refuse to renew, revoke, or suspend any license, registration, or permit
74.15 applied for or issued pursuant to this chapter when the person subject to regulation under
74.16 this chapter:

74.17 (1) does not meet or fails to maintain the minimum qualification for holding a license,
74.18 registration, or permit under this chapter;

74.19 (2) submits false or misleading material information to the regulatory agency in
74.20 connection with a license, registration, or permit issued by the regulatory agency or the
74.21 application for a license, registration, or permit;

74.22 (3) violates any law, rule, order, stipulation agreement, settlement, compliance agreement,
74.23 license, registration, or permit that regulates the removal, preparation, transportation,
74.24 arrangements for disposition, or final disposition of dead human bodies in Minnesota or
74.25 any other state in the United States;

74.26 (4) is convicted of a crime, including a finding or verdict of guilt, an admission of guilt,
74.27 or a no contest plea in any court in Minnesota or any other jurisdiction in the United States.
74.28 "Conviction," as used in this subdivision, includes a conviction for an offense which, if
74.29 committed in this state, would be deemed a felony or gross misdemeanor without regard to
74.30 its designation elsewhere, or a criminal proceeding where a finding or verdict of guilty is
74.31 made or returned, but the adjudication of guilt is either withheld or not entered;

75.1 (5) is convicted of a crime, including a finding or verdict of guilt, an admission of guilt,
75.2 or a no contest plea in any court in Minnesota or any other jurisdiction in the United States
75.3 that the regulatory agency determines is reasonably related to the removal, preparation,
75.4 transportation, arrangements for disposition or final disposition of dead human bodies, or
75.5 the practice of mortuary science;

75.6 (6) is adjudicated as mentally incompetent, mentally ill, developmentally disabled, or
75.7 mentally ill and dangerous to the public;

75.8 (7) has a conservator or guardian appointed;

75.9 (8) fails to comply with an order issued by the regulatory agency or fails to pay an
75.10 administrative penalty imposed by the regulatory agency;

75.11 (9) owes uncontested delinquent taxes in the amount of \$500 or more to the Minnesota
75.12 Department of Revenue, or any other governmental agency authorized to collect taxes
75.13 anywhere in the United States;

75.14 (10) is in arrears on any court ordered family or child support obligations; or

75.15 (11) engages in any conduct that, in the determination of the regulatory agency, is
75.16 unprofessional as prescribed in section 149A.70, subdivision 7, or renders the person unfit
75.17 to practice mortuary science or to operate a funeral establishment or crematory.

75.18 Subd. 2. **Hearings related to refusal to renew, suspension, or revocation of license,**
75.19 **registration, or permit.** If the regulatory agency proposes to deny renewal, suspend, or
75.20 revoke a license, registration, or permit issued under this chapter, the regulatory agency
75.21 must first notify, in writing, the person against whom the action is proposed to be taken and
75.22 provide an opportunity to request a hearing under the contested case provisions of sections
75.23 14.57 to 14.62. If the subject of the proposed action does not request a hearing by notifying
75.24 the regulatory agency, by mail, within 20 calendar days after the receipt of the notice of
75.25 proposed action, the regulatory agency may proceed with the action without a hearing and
75.26 the action will be the final order of the regulatory agency.

75.27 Subd. 3. **Review of final order.** A judicial review of the final order issued by the
75.28 regulatory agency may be requested in the manner prescribed in sections 14.63 to 14.69.
75.29 Failure to request a hearing pursuant to subdivision 2 shall constitute a waiver of the right
75.30 to further agency or judicial review of the final order.

75.31 Subd. 4. **Limitations or qualifications placed on license, registration, or permit.** The
75.32 regulatory agency may, where the facts support such action, place reasonable limitations

76.1 or qualifications on the right to practice mortuary science ~~or~~, to operate a funeral
76.2 establishment or crematory, or to conduct activities or actions permitted under this chapter.

76.3 Subd. 5. **Restoring license, registration, or permit.** The regulatory agency may, where
76.4 there is sufficient reason, restore a license, registration, or permit that has been revoked,
76.5 reduce a period of suspension, or remove limitations or qualifications.

76.6 Sec. 60. Minnesota Statutes 2020, section 149A.11, is amended to read:

76.7 **149A.11 PUBLICATION OF DISCIPLINARY ACTIONS.**

76.8 The regulatory agencies shall report all disciplinary measures or actions taken to the
76.9 commissioner. At least annually, the commissioner shall publish and make available to the
76.10 public a description of all disciplinary measures or actions taken by the regulatory agencies.
76.11 The publication shall include, for each disciplinary measure or action taken, the name and
76.12 business address of the licensee, registrant, or intern; the nature of the misconduct; and
76.13 the measure or action taken by the regulatory agency.

76.14 Sec. 61. **149A.47] TRANSFER CARE SPECIALIST.**

76.15 Subdivision 1. **General.** A transfer care specialist may remove a dead human body from
76.16 the place of death under the direct supervision of a licensed mortician if the transfer care
76.17 specialist is registered with the commissioner in accordance with this section. A transfer
76.18 care specialist is not licensed to engage in the practice of mortuary science and shall not
76.19 engage in the practice of mortuary science except as provided in this section.

76.20 Subd. 2. **Registration.** To be eligible for registration as a transfer care specialist, an
76.21 applicant must submit to the commissioner:

76.22 (1) a complete application on a form provided by the commissioner that includes at a
76.23 minimum:

76.24 (i) the applicant's name, home address and telephone number, business name, and business
76.25 address and telephone number; and

76.26 (ii) the name, license number, business name, and business address and telephone number
76.27 of the supervising licensed mortician;

76.28 (2) proof of completion of a training program that meets the requirements specified in
76.29 subdivision 4; and

76.30 (3) the appropriate fees specified in section 149A.65.

77.1 Subd. 3. **Duties.** A transfer care specialist registered under this section is authorized to
77.2 perform the removal of a dead human body from the place of death in accordance with this
77.3 chapter to a licensed funeral establishment. The transfer care specialist must work under
77.4 the direct supervision of a licensed mortician. The supervising mortician is responsible for
77.5 the work performed by the transfer care specialist. A licensed mortician may supervise up
77.6 to six transfer care specialists at any one time.

77.7 Subd. 4. **Training program.** (a) Each transfer care specialist must complete a training
77.8 program that has been approved by the commissioner. To be approved, a training program
77.9 must be at least seven hours long and must cover, at a minimum, the following:

77.10 (1) ethical care and transportation procedures for a deceased person;

77.11 (2) health and safety concerns to the public and the individual performing the transfer
77.12 of the deceased person; and

77.13 (3) all relevant state and federal laws and regulations related to the transfer and
77.14 transportation of deceased persons.

77.15 (b) A transfer care specialist must complete a training program every five years.

77.16 Subd. 5. **Registration renewal.** (a) A registration issued under this section expires one
77.17 year after the date of issuance and must be renewed to remain valid.

77.18 (b) To renew a registration, the transfer care specialist must submit a completed renewal
77.19 application as provided by the commissioner and the appropriate fees specified in section
77.20 149A.65. Every five years, the renewal application must include proof of completion of a
77.21 training program that meets the requirements in subdivision 4.

77.22 Sec. 62. Minnesota Statutes 2020, section 149A.60, is amended to read:

77.23 **149A.60 PROHIBITED CONDUCT.**

77.24 The regulatory agency may impose disciplinary measures or take disciplinary action
77.25 against a person whose conduct is subject to regulation under this chapter for failure to
77.26 comply with any provision of this chapter or laws, rules, orders, stipulation agreements,
77.27 settlements, compliance agreements, licenses, registrations, and permits adopted, or issued
77.28 for the regulation of the removal, preparation, transportation, arrangements for disposition
77.29 or final disposition of dead human bodies, or for the regulation of the practice of mortuary
77.30 science.

78.1 Sec. 63. Minnesota Statutes 2020, section 149A.61, subdivision 4, is amended to read:

78.2 Subd. 4. **Licensees, registrants, and interns.** A licensee, registrant, or intern regulated
78.3 under this chapter may report to the commissioner any conduct that the licensee, registrant,
78.4 or intern has personal knowledge of, and reasonably believes constitutes grounds for,
78.5 disciplinary action under this chapter.

78.6 Sec. 64. Minnesota Statutes 2020, section 149A.61, subdivision 5, is amended to read:

78.7 Subd. 5. **Courts.** The court administrator of district court or any court of competent
78.8 jurisdiction shall report to the commissioner any judgment or other determination of the
78.9 court that adjudges or includes a finding that a licensee, registrant, or intern is a person who
78.10 is mentally ill, mentally incompetent, guilty of a felony or gross misdemeanor, guilty of
78.11 violations of federal or state narcotics laws or controlled substances acts; appoints a guardian
78.12 or conservator for the licensee, registrant, or intern; or commits a licensee, registrant, or
78.13 intern.

78.14 Sec. 65. Minnesota Statutes 2020, section 149A.62, is amended to read:

78.15 **149A.62 IMMUNITY; REPORTING.**

78.16 Any person, private agency, organization, society, association, licensee, registrant, or
78.17 intern who, in good faith, submits information to a regulatory agency under section 149A.61
78.18 or otherwise reports violations or alleged violations of this chapter, is immune from civil
78.19 liability or criminal prosecution. This section does not prohibit disciplinary action taken by
78.20 the commissioner against any licensee, registrant, or intern pursuant to a self report of a
78.21 violation.

78.22 Sec. 66. Minnesota Statutes 2020, section 149A.63, is amended to read:

78.23 **149A.63 PROFESSIONAL COOPERATION.**

78.24 A licensee, clinical student, practicum student, registrant, intern, or applicant for licensure
78.25 under this chapter that is the subject of or part of an inspection or investigation by the
78.26 commissioner or the commissioner's designee shall cooperate fully with the inspection or
78.27 investigation. Failure to cooperate constitutes grounds for disciplinary action under this
78.28 chapter.

78.29 Sec. 67. Minnesota Statutes 2020, section 149A.65, subdivision 2, is amended to read:

78.30 Subd. 2. **Mortuary science fees.** Fees for mortuary science are:

- 79.1 (1) \$75 for the initial and renewal registration of a mortuary science intern;
- 79.2 (2) \$125 for the mortuary science examination;
- 79.3 (3) \$200 for issuance of initial and renewal mortuary science licenses;
- 79.4 (4) \$100 late fee charge for a license renewal; ~~and~~
- 79.5 (5) \$250 for issuing a mortuary science license by endorsement; and
- 79.6 (6) \$687 for the initial and renewal registration of a transfer care specialist.

79.7 Sec. 68. Minnesota Statutes 2020, section 149A.70, subdivision 3, is amended to read:

79.8 Subd. 3. **Advertising.** No licensee, registrant, clinical student, practicum student, or
 79.9 intern shall publish or disseminate false, misleading, or deceptive advertising. False,
 79.10 misleading, or deceptive advertising includes, but is not limited to:

- 79.11 (1) identifying, by using the names or pictures of, persons who are not licensed to practice
 79.12 mortuary science in a way that leads the public to believe that those persons will provide
 79.13 mortuary science services;
- 79.14 (2) using any name other than the names under which the funeral establishment, alkaline
 79.15 hydrolysis facility, or crematory is known to or licensed by the commissioner;
- 79.16 (3) using a surname not directly, actively, or presently associated with a licensed funeral
 79.17 establishment, alkaline hydrolysis facility, or crematory, unless the surname had been
 79.18 previously and continuously used by the licensed funeral establishment, alkaline hydrolysis
 79.19 facility, or crematory; and
- 79.20 (4) using a founding or establishing date or total years of service not directly or
 79.21 continuously related to a name under which the funeral establishment, alkaline hydrolysis
 79.22 facility, or crematory is currently or was previously licensed.

79.23 Any advertising or other printed material that contains the names or pictures of persons
 79.24 affiliated with a funeral establishment, alkaline hydrolysis facility, or crematory shall state
 79.25 the position held by the persons and shall identify each person who is licensed or unlicensed
 79.26 under this chapter.

79.27 Sec. 69. Minnesota Statutes 2020, section 149A.70, subdivision 4, is amended to read:

79.28 Subd. 4. **Solicitation of business.** No licensee shall directly or indirectly pay or cause
 79.29 to be paid any sum of money or other valuable consideration for the securing of business
 79.30 or for obtaining the authority to dispose of any dead human body.

80.1 For purposes of this subdivision, licensee includes a registered intern or transfer care
80.2 specialist or any agent, representative, employee, or person acting on behalf of the licensee.

80.3 Sec. 70. Minnesota Statutes 2020, section 149A.70, subdivision 5, is amended to read:

80.4 Subd. 5. **Reimbursement prohibited.** No licensee, clinical student, practicum student,
80.5 ~~or intern,~~ or transfer care specialist shall offer, solicit, or accept a commission, fee, bonus,
80.6 rebate, or other reimbursement in consideration for recommending or causing a dead human
80.7 body to be disposed of by a specific body donation program, funeral establishment, alkaline
80.8 hydrolysis facility, crematory, mausoleum, or cemetery.

80.9 Sec. 71. Minnesota Statutes 2020, section 149A.70, subdivision 7, is amended to read:

80.10 Subd. 7. **Unprofessional conduct.** No licensee, registrant, or intern shall engage in or
80.11 permit others under the licensee's, registrant's, or intern's supervision or employment to
80.12 engage in unprofessional conduct. Unprofessional conduct includes, but is not limited to:

80.13 (1) harassing, abusing, or intimidating a customer, employee, or any other person
80.14 encountered while within the scope of practice, employment, or business;

80.15 (2) using profane, indecent, or obscene language within the immediate hearing of the
80.16 family or relatives of the deceased;

80.17 (3) failure to treat with dignity and respect the body of the deceased, any member of the
80.18 family or relatives of the deceased, any employee, or any other person encountered while
80.19 within the scope of practice, employment, or business;

80.20 (4) the habitual overindulgence in the use of or dependence on intoxicating liquors,
80.21 prescription drugs, over-the-counter drugs, illegal drugs, or any other mood altering
80.22 substances that substantially impair a person's work-related judgment or performance;

80.23 (5) revealing personally identifiable facts, data, or information about a decedent, customer,
80.24 member of the decedent's family, or employee acquired in the practice or business without
80.25 the prior consent of the individual, except as authorized by law;

80.26 (6) intentionally misleading or deceiving any customer in the sale of any goods or services
80.27 provided by the licensee;

80.28 (7) knowingly making a false statement in the procuring, preparation, or filing of any
80.29 required permit or document; or

80.30 (8) knowingly making a false statement on a record of death.

81.1 Sec. 72. Minnesota Statutes 2020, section 149A.90, subdivision 2, is amended to read:

81.2 Subd. 2. **Removal from place of death.** No person subject to regulation under this
81.3 chapter shall remove or cause to be removed any dead human body from the place of death
81.4 without being licensed or registered by the commissioner. Every dead human body shall be
81.5 removed from the place of death by a licensed mortician or funeral director, except as
81.6 provided in section 149A.01, subdivision 3, or 149A.47.

81.7 Sec. 73. Minnesota Statutes 2020, section 149A.90, subdivision 4, is amended to read:

81.8 Subd. 4. **Certificate of removal.** No dead human body shall be removed from the place
81.9 of death by a mortician ~~or~~, funeral director, or transfer care specialist or by a noncompensated
81.10 person with the right to control the dead human body without the completion of a certificate
81.11 of removal and, where possible, presentation of a copy of that certificate to the person or a
81.12 representative of the legal entity with physical or legal custody of the body at the death site.
81.13 The certificate of removal shall be in the format provided by the commissioner that contains,
81.14 at least, the following information:

81.15 (1) the name of the deceased, if known;

81.16 (2) the date and time of removal;

81.17 (3) a brief listing of the type and condition of any personal property removed with the
81.18 body;

81.19 (4) the location to which the body is being taken;

81.20 (5) the name, business address, and license number of the individual making the removal;
81.21 and

81.22 (6) the signatures of the individual making the removal and, where possible, the individual
81.23 or representative of the legal entity with physical or legal custody of the body at the death
81.24 site.

81.25 Sec. 74. Minnesota Statutes 2020, section 149A.90, subdivision 5, is amended to read:

81.26 Subd. 5. **Retention of certificate of removal.** A copy of the certificate of removal shall
81.27 be given, where possible, to the person or representative of the legal entity having physical
81.28 or legal custody of the body at the death site. The original certificate of removal shall be
81.29 retained by the individual making the removal and shall be kept on file, at the funeral
81.30 establishment to which the body was taken, for a period of three calendar years following
81.31 the date of the removal. If the removal was performed by a transfer care specialist not

82.1 employed by the funeral establishment to which the body was taken, the transfer care
82.2 specialist shall retain a copy of the certificate on file at the transfer care specialist's business
82.3 address as registered with the commissioner for a period of three calendar years following
82.4 the date of removal. Following this period, and subject to any other laws requiring retention
82.5 of records, the funeral establishment may then place the records in storage or reduce them
82.6 to microfilm, microfiche, laser disc, or any other method that can produce an accurate
82.7 reproduction of the original record, for retention for a period of ten calendar years from the
82.8 date of the removal of the body. At the end of this period and subject to any other laws
82.9 requiring retention of records, the funeral establishment may destroy the records by shredding,
82.10 incineration, or any other manner that protects the privacy of the individuals identified in
82.11 the records.

82.12 Sec. 75. Minnesota Statutes 2020, section 149A.94, subdivision 1, is amended to read:

82.13 Subdivision 1. **Generally.** (a) Every dead human body lying within the state, except
82.14 unclaimed bodies delivered for dissection by the medical examiner, those delivered for
82.15 anatomical study pursuant to section 149A.81, subdivision 2, or lawfully carried through
82.16 the state for the purpose of disposition elsewhere; and the remains of any dead human body
82.17 after dissection or anatomical study, shall be decently buried or entombed in a public or
82.18 private cemetery, alkaline hydrolyzed, or cremated within a reasonable time after death.
82.19 Where final disposition of a body will not be accomplished within 72 hours following death
82.20 or release of the body by a competent authority with jurisdiction over the body, the body
82.21 must be properly embalmed, refrigerated, or packed with dry ice. A body may not be kept
82.22 in refrigeration for a period exceeding six calendar days, or packed in dry ice for a period
82.23 that exceeds four calendar days, from the time of death or release of the body from the
82.24 coroner or medical examiner. A body may be kept in refrigeration for up to 30 calendar
82.25 days from the time of death or release of the body from the coroner or medical examiner,
82.26 provided the dignity of the body is maintained and the funeral establishment complies with
82.27 paragraph (b) if applicable. A body may be kept in refrigeration for more than 30 calendar
82.28 days from the time of death or release of the body from the coroner or medical examiner in
82.29 accordance with paragraphs (c) and (d).

82.30 (b) For a body to be kept in refrigeration for between 15 and 30 calendar days, no later
82.31 than the 14th day of keeping the body in refrigeration the funeral establishment must notify
82.32 the person with the right to control final disposition that the body will be kept in refrigeration
82.33 for more than 14 days and that the person with the right to control final disposition has the
82.34 right to seek other arrangements.

83.1 (c) For a body to be kept in refrigeration for more than 30 calendar days, the funeral
83.2 establishment must:

83.3 (1) report at least the following to the commissioner on a form and in a manner prescribed
83.4 by the commissioner: body identification details determined by the commissioner, the funeral
83.5 establishment's plan to achieve final disposition of the body within the permitted time frame,
83.6 and other information required by the commissioner; and

83.7 (2) store each refrigerated body in a manner that maintains the dignity of the body.

83.8 (d) Each report filed with the commissioner under paragraph (c) authorizes a funeral
83.9 establishment to keep a body in refrigeration for an additional 30 calendar days.

83.10 (e) Failure to submit a report required by paragraph (c) subjects a funeral establishment
83.11 to enforcement under this chapter.

83.12 Sec. 76. Minnesota Statutes 2020, section 152.22, is amended by adding a subdivision to
83.13 read:

83.14 Subd. 1a. **Bona fide labor organization.** "Bona fide labor organization" means a labor
83.15 union that represents or is actively seeking to represent workers of a medical cannabis
83.16 manufacturer.

83.17 Sec. 77. Minnesota Statutes 2020, section 152.22, is amended by adding a subdivision to
83.18 read:

83.19 Subd. 5d. **Indian lands.** "Indian lands" means all lands within the limits of any Indian
83.20 reservation within the boundaries of Minnesota and any lands within the boundaries of
83.21 Minnesota title which are either held in trust by the United States or over which an Indian
83.22 Tribe exercises governmental power.

83.23 Sec. 78. Minnesota Statutes 2020, section 152.22, is amended by adding a subdivision to
83.24 read:

83.25 Subd. 5e. **Labor peace agreement.** "Labor peace agreement" means an agreement
83.26 between a medical cannabis manufacturer and a bona fide labor organization that protects
83.27 the state's interests by, at a minimum, prohibiting the labor organization from engaging in
83.28 picketing, work stoppages, or boycotts against the manufacturer. This type of agreement
83.29 shall not mandate a particular method of election or certification of the bona fide labor
83.30 organization.

84.1 Sec. 79. Minnesota Statutes 2020, section 152.22, is amended by adding a subdivision to
84.2 read:

84.3 Subd. 15. **Tribal medical cannabis board.** "Tribal medical cannabis board" means an
84.4 agency established by each federally recognized Tribal government and duly authorized by
84.5 each Tribe's governing body to perform regulatory oversight and monitor compliance with
84.6 a Tribal medical cannabis program and applicable regulations.

84.7 Sec. 80. Minnesota Statutes 2020, section 152.22, is amended by adding a subdivision to
84.8 read:

84.9 Subd. 16. **Tribal medical cannabis program.** "Tribal medical cannabis program" means
84.10 a program established by a federally recognized Tribal government within the boundaries
84.11 of Minnesota regarding the commercial production, processing, sale or distribution, and
84.12 possession of medical cannabis and medical cannabis products.

84.13 Sec. 81. Minnesota Statutes 2020, section 152.22, is amended by adding a subdivision to
84.14 read:

84.15 Subd. 17. **Tribal medical cannabis program patient.** "Tribal medical cannabis program
84.16 patient" means a person who possesses a valid registration verification card or equivalent
84.17 document that is issued under the laws or regulations of a Tribal Nation within the boundaries
84.18 of Minnesota and that verifies that the person is enrolled in or authorized to participate in
84.19 that Tribal Nation's Tribal medical cannabis program.

84.20 Sec. 82. Minnesota Statutes 2020, section 152.25, subdivision 1, is amended to read:

84.21 Subdivision 1. **Medical cannabis manufacturer registration and renewal.** (a) The
84.22 commissioner shall register ~~two~~ at least four and up to ten in-state manufacturers for the
84.23 production of all medical cannabis within the state. ~~A~~ The registration agreement between
84.24 ~~the commissioner and a manufacturer is valid for two years, unless revoked under subdivision~~
84.25 1a, and is nontransferable. The commissioner shall register new manufacturers or reregister
84.26 ~~the existing manufacturers by December 1 every two years, using the factors described in~~
84.27 ~~this subdivision. The commissioner shall accept applications after December 1, 2014, if one~~
84.28 ~~of the manufacturers registered before December 1, 2014, ceases to be registered as a~~
84.29 ~~manufacturer. The commissioner's determination that no manufacturer exists to fulfill the~~
84.30 ~~duties under sections 152.22 to 152.37 is subject to judicial review in Ramsey County~~
84.31 ~~District Court.~~ Once the commissioner has registered more than two manufacturers,
84.32 registration renewal for at least one manufacturer must occur each year. The commissioner

85.1 shall begin registering additional manufacturers by December 1, 2022. The commissioner
85.2 shall renew a registration if the manufacturer meets the factors described in this subdivision
85.3 and submits the registration renewal fee under section 152.35.

85.4 (b) An individual or entity seeking registration or registration renewal under this
85.5 subdivision must apply to the commissioner in a form and manner established by the
85.6 commissioner. As part of the application, the applicant must submit an attestation signed
85.7 by a bona fide labor organization stating that the applicant has entered into a labor peace
85.8 agreement. Before accepting applications for registration or registration renewal, the
85.9 commissioner must publish on the Office of Medical Cannabis website the application
85.10 scoring criteria established by the commissioner to determine whether the applicant meets
85.11 requirements for registration or registration renewal. Data submitted during the application
85.12 process are private data on individuals or nonpublic data as defined in section 13.02 until
85.13 the manufacturer is registered under this section. Data on a manufacturer that is registered
85.14 are public data, unless the data are trade secret or security information under section 13.37.

85.15 ~~(b)~~ (c) As a condition for registration, a manufacturer must agree to or registration
85.16 renewal:

85.17 ~~(1) begin supplying medical cannabis to patients by July 1, 2015; and~~

85.18 ~~(2) (1) a manufacturer must~~ comply with all requirements under sections 152.22 to
85.19 152.37.;

85.20 (2) if the manufacturer is a business entity, the manufacturer must be incorporated in
85.21 the state or otherwise formed or organized under the laws of the state; and

85.22 (3) the manufacturer must fulfill commitments made in the application for registration
85.23 or registration renewal, including but not limited to maintenance of a labor peace agreement.

85.24 ~~(e)~~ (d) The commissioner shall consider the following factors when determining which
85.25 manufacturer to register or when determining whether to renew a registration:

85.26 (1) the technical expertise of the manufacturer in cultivating medical cannabis and
85.27 converting the medical cannabis into an acceptable delivery method under section 152.22,
85.28 subdivision 6;

85.29 (2) the qualifications of the manufacturer's employees;

85.30 (3) the long-term financial stability of the manufacturer;

85.31 (4) the ability to provide appropriate security measures on the premises of the
85.32 manufacturer;

86.1 (5) whether the manufacturer has demonstrated an ability to meet the medical cannabis
86.2 production needs required by sections 152.22 to 152.37; ~~and~~

86.3 (6) the manufacturer's projection and ongoing assessment of fees on patients with a
86.4 qualifying medical condition;

86.5 (7) the manufacturer's inclusion of leadership or beneficial ownership, as defined in
86.6 section 302A.011, subdivision 41, by:

86.7 (i) minority persons as defined in section 116M.14, subdivision 6;

86.8 (ii) women;

86.9 (iii) individuals with disabilities as defined in section 363A.03, subdivision 12; or

86.10 (iv) military veterans who satisfy the requirements of section 197.447;

86.11 (8) the extent to which registering the manufacturer or renewing the registration will
86.12 expand service to a currently underserved market;

86.13 (9) the extent to which registering the manufacturer or renewing the registration will
86.14 promote development in a low-income area as defined in section 116J.982, subdivision 1,
86.15 paragraph (e);

86.16 (10) beneficial ownership as defined in section 302A.011, subdivision 41, of the
86.17 manufacturer by Minnesota residents; and

86.18 (11) other factors the commissioner determines are necessary to protect patient health
86.19 and ensure public safety.

86.20 (e) Commitments made by an applicant in the applicant's application for registration or
86.21 registration renewal, including but not limited to maintenance of a labor peace agreement,
86.22 shall be an ongoing material condition of maintaining a manufacturer registration.

86.23 ~~(d)~~ (f) If an officer, director, or controlling person of the manufacturer pleads or is found
86.24 guilty of intentionally diverting medical cannabis to a person other than allowed by law
86.25 under section 152.33, subdivision 1, the commissioner may decide not to renew the
86.26 registration of the manufacturer, provided the violation occurred while the person was an
86.27 officer, director, or controlling person of the manufacturer.

86.28 ~~(e) The commissioner shall require each medical cannabis manufacturer to contract with~~
86.29 ~~an independent laboratory to test medical cannabis produced by the manufacturer. The~~
86.30 ~~commissioner shall approve the laboratory chosen by each manufacturer and require that~~
86.31 ~~the laboratory report testing results to the manufacturer in a manner determined by the~~
86.32 ~~commissioner.~~

87.1 Sec. 83. Minnesota Statutes 2020, section 152.25, is amended by adding a subdivision to
87.2 read:

87.3 Subd. 1d. **Background study.** (a) Before the commissioner registers a manufacturer or
87.4 renews a registration, each officer, director, and controlling person of the manufacturer
87.5 must consent to a background study and must submit to the commissioner a completed
87.6 criminal history records check consent form, a full set of classifiable fingerprints, and the
87.7 required fees. The commissioner must submit these materials to the Bureau of Criminal
87.8 Apprehension. The bureau must conduct a Minnesota criminal history records check, and
87.9 the superintendent is authorized to exchange fingerprints with the Federal Bureau of
87.10 Investigation to obtain national criminal history record information. The bureau must return
87.11 the results of the Minnesota and federal criminal history records checks to the commissioner.

87.12 (b) The commissioner must not register a manufacturer or renew a registration if an
87.13 officer, director, or controlling person of the manufacturer has been convicted of, pled guilty
87.14 to, or received a stay of adjudication for:

87.15 (1) a violation of state or federal law related to theft, fraud, embezzlement, breach of
87.16 fiduciary duty, or other financial misconduct that is a felony under Minnesota law or would
87.17 be a felony if committed in Minnesota; or

87.18 (2) a violation of state or federal law relating to unlawful manufacture, distribution,
87.19 prescription, or dispensing of a controlled substance that is a felony under Minnesota law
87.20 or would be a felony if committed in Minnesota.

87.21 Sec. 84. Minnesota Statutes 2020, section 152.29, subdivision 4, is amended to read:

87.22 Subd. 4. **Report.** (a) Each manufacturer shall report to the commissioner on a monthly
87.23 basis the following information on each individual patient for the month prior to the report:

87.24 (1) the amount and dosages of medical cannabis distributed;

87.25 (2) the chemical composition of the medical cannabis; and

87.26 (3) the tracking number assigned to any medical cannabis distributed.

87.27 (b) For transactions involving Tribal medical cannabis program patients, each
87.28 manufacturer shall report to the commissioner on a weekly basis the following information
87.29 on each individual Tribal medical cannabis program patient for the week prior to the report:

87.30 (1) the name of the Tribal medical cannabis program in which the Tribal medical cannabis
87.31 program patient is enrolled;

87.32 (2) the amount and dosages of medical cannabis distributed;

88.1 (3) the chemical composition of the medical cannabis; and

88.2 (4) the tracking number assigned to the medical cannabis distributed.

88.3 Sec. 85. Minnesota Statutes 2020, section 152.29, is amended by adding a subdivision to
88.4 read:

88.5 Subd. 5. **Distribution to Tribal medical cannabis program patient.** (a) A manufacturer
88.6 may distribute medical cannabis in accordance with subdivisions 1 to 4 to a Tribal medical
88.7 cannabis program patient.

88.8 (b) Prior to distribution, the Tribal medical cannabis program patient must provide to
88.9 the manufacturer:

88.10 (1) a valid medical cannabis registration verification card or equivalent document issued
88.11 by a Tribal medical cannabis program that indicates that the Tribal medical cannabis program
88.12 patient is authorized to use medical cannabis on Indian lands over which the Tribe has
88.13 jurisdiction; and

88.14 (2) a valid photographic identification card issued by the Tribal medical cannabis
88.15 program, valid driver's license, or valid state identification card.

88.16 (c) A manufacturer shall distribute medical cannabis to a Tribal medical cannabis program
88.17 patient only in a form allowed under section 152.22, subdivision 6.

88.18 Sec. 86. **[152.291] TRIBAL MEDICAL CANNABIS PROGRAM;**
88.19 **MANUFACTURERS.**

88.20 Subdivision 1. **Manufacturer.** Notwithstanding the requirements and limitations in
88.21 section 152.29, subdivision 1, paragraph (a), a Tribal medical cannabis program operated
88.22 by a federally recognized Indian Tribe located in Minnesota shall be recognized as a medical
88.23 cannabis manufacturer.

88.24 Subd. 2. **Manufacturer transportation.** (a) A manufacturer registered with a Tribal
88.25 medical cannabis program may transport medical cannabis to testing laboratories and to
88.26 other Indian lands in the state.

88.27 (b) A manufacturer registered with a Tribal medical cannabis program must staff a motor
88.28 vehicle used to transport medical cannabis with at least two employees of the manufacturer.
88.29 Each employee in the transport vehicle must carry identification specifying that the employee
88.30 is an employee of the manufacturer, and one employee in the transport vehicle must carry

89.1 a detailed transportation manifest that includes the place and time of departure, the address
89.2 of the destination, and a description and count of the medical cannabis being transported.

89.3 Sec. 87. Minnesota Statutes 2020, section 152.30, is amended to read:

89.4 **152.30 PATIENT DUTIES.**

89.5 (a) A patient shall apply to the commissioner for enrollment in the registry program by
89.6 submitting an application as required in section 152.27 and an annual registration fee as
89.7 determined under section 152.35.

89.8 (b) As a condition of continued enrollment, patients shall agree to:

89.9 (1) continue to receive regularly scheduled treatment for their qualifying medical
89.10 condition from their health care practitioner; and

89.11 (2) report changes in their qualifying medical condition to their health care practitioner.

89.12 (c) A patient shall only receive medical cannabis from a registered manufacturer or
89.13 Tribal medical cannabis program but is not required to receive medical cannabis products
89.14 from only a registered manufacturer or Tribal medical cannabis program.

89.15 Sec. 88. Minnesota Statutes 2020, section 152.32, is amended to read:

89.16 **152.32 PROTECTIONS FOR REGISTRY PROGRAM PARTICIPATION OR**
89.17 **PARTICIPATION IN A TRIBAL MEDICAL CANNABIS PROGRAM.**

89.18 Subdivision 1. **Presumption.** (a) There is a presumption that a patient enrolled in the
89.19 registry program under sections 152.22 to 152.37 or a Tribal medical cannabis program
89.20 patient enrolled in a Tribal medical cannabis program is engaged in the authorized use of
89.21 medical cannabis.

89.22 (b) The presumption may be rebutted:

89.23 (1) by evidence that a patient's conduct related to use of medical cannabis was not for
89.24 the purpose of treating or alleviating the patient's qualifying medical condition or symptoms
89.25 associated with the patient's qualifying medical condition; or

89.26 (2) by evidence that a Tribal medical cannabis program patient's use of medical cannabis
89.27 was not for a purpose authorized by the Tribal medical cannabis program.

89.28 Subd. 2. **Criminal and civil protections.** (a) Subject to section 152.23, the following
89.29 are not violations under this chapter:

90.1 (1) use or possession of medical cannabis or medical cannabis products by a patient
90.2 enrolled in the registry program, ~~or~~; possession by a registered designated caregiver or the
90.3 parent, legal guardian, or spouse of a patient if the parent, legal guardian, or spouse is listed
90.4 on the registry verification; or use or possession of medical cannabis or medical cannabis
90.5 products by a Tribal medical cannabis program patient;

90.6 (2) possession, dosage determination, or sale of medical cannabis or medical cannabis
90.7 products by a medical cannabis manufacturer, employees of a manufacturer, a laboratory
90.8 conducting testing on medical cannabis, or employees of the laboratory; and

90.9 (3) possession of medical cannabis or medical cannabis products by any person while
90.10 carrying out the duties required under sections 152.22 to 152.37.

90.11 (b) Medical cannabis obtained and distributed pursuant to sections 152.22 to 152.37 and
90.12 associated property is not subject to forfeiture under sections 609.531 to 609.5316.

90.13 (c) The commissioner, members of a Tribal medical cannabis board, the commissioner's
90.14 or Tribal medical cannabis board's staff, the commissioner's or Tribal medical cannabis
90.15 board's agents or contractors, and any health care practitioner are not subject to any civil or
90.16 disciplinary penalties by the Board of Medical Practice, the Board of Nursing, or by any
90.17 business, occupational, or professional licensing board or entity, solely for the participation
90.18 in the registry program under sections 152.22 to 152.37 or in a Tribal medical cannabis
90.19 program. A pharmacist licensed under chapter 151 is not subject to any civil or disciplinary
90.20 penalties by the Board of Pharmacy when acting in accordance with the provisions of
90.21 sections 152.22 to 152.37. Nothing in this section affects a professional licensing board
90.22 from taking action in response to violations of any other section of law.

90.23 (d) Notwithstanding any law to the contrary, the commissioner, the governor of
90.24 Minnesota, or an employee of any state agency may not be held civilly or criminally liable
90.25 for any injury, loss of property, personal injury, or death caused by any act or omission
90.26 while acting within the scope of office or employment under sections 152.22 to 152.37.

90.27 (e) Federal, state, and local law enforcement authorities are prohibited from accessing
90.28 the patient registry under sections 152.22 to 152.37 except when acting pursuant to a valid
90.29 search warrant.

90.30 (f) Notwithstanding any law to the contrary, neither the commissioner nor a public
90.31 employee may release data or information about an individual contained in any report,
90.32 document, or registry created under sections 152.22 to 152.37 or any information obtained
90.33 about a patient participating in the program, except as provided in sections 152.22 to 152.37.

91.1 (g) No information contained in a report, document, or registry or obtained from a patient
91.2 or a Tribal medical cannabis program patient under sections 152.22 to 152.37 may be
91.3 admitted as evidence in a criminal proceeding unless independently obtained or in connection
91.4 with a proceeding involving a violation of sections 152.22 to 152.37.

91.5 (h) Notwithstanding section 13.09, any person who violates paragraph (e) or (f) is guilty
91.6 of a gross misdemeanor.

91.7 (i) An attorney may not be subject to disciplinary action by the Minnesota Supreme
91.8 Court, a Tribal court, or the professional responsibility board for providing legal assistance
91.9 to prospective or registered manufacturers or others related to activity that is no longer
91.10 subject to criminal penalties under state law pursuant to sections 152.22 to 152.37, or for
91.11 providing legal assistance to a Tribal medical cannabis program.

91.12 (j) Possession of a registry verification or application for enrollment in the program by
91.13 a person entitled to possess or apply for enrollment in the registry program, or possession
91.14 of a verification or equivalent issued by a Tribal medical cannabis program by a person
91.15 entitled to possess such verification, does not constitute probable cause or reasonable
91.16 suspicion, nor shall it be used to support a search of the person or property of the person
91.17 possessing or applying for the registry verification or equivalent, or otherwise subject the
91.18 person or property of the person to inspection by any governmental agency.

91.19 Subd. 3. **Discrimination prohibited.** (a) No school or landlord may refuse to enroll or
91.20 lease to and may not otherwise penalize a person solely for the person's status as a patient
91.21 enrolled in the registry program under sections 152.22 to 152.37 or for the person's status
91.22 as a Tribal medical cannabis program patient enrolled in a Tribal medical cannabis program,
91.23 unless failing to do so would violate federal law or regulations or cause the school or landlord
91.24 to lose a monetary or licensing-related benefit under federal law or regulations.

91.25 (b) For the purposes of medical care, including organ transplants, a registry program
91.26 enrollee's use of medical cannabis under sections 152.22 to 152.37, or a Tribal medical
91.27 cannabis program patient's use of medical cannabis as authorized by the Tribal medical
91.28 cannabis program, is considered the equivalent of the authorized use of any other medication
91.29 used at the discretion of a physician or advanced practice registered nurse and does not
91.30 constitute the use of an illicit substance or otherwise disqualify a patient from needed medical
91.31 care.

91.32 (c) Unless a failure to do so would violate federal law or regulations or cause an employer
91.33 to lose a monetary or licensing-related benefit under federal law or regulations, an employer
91.34 may not discriminate against a person in hiring, termination, or any term or condition of

92.1 employment, or otherwise penalize a person, if the discrimination is based upon ~~either~~ any
92.2 of the following:

92.3 (1) the person's status as a patient enrolled in the registry program under sections 152.22
92.4 to 152.37; ~~or~~

92.5 (2) the person's status as a Tribal medical cannabis program patient enrolled in a Tribal
92.6 medical cannabis program; or

92.7 ~~(2)~~ (3) a patient's positive drug test for cannabis components or metabolites, unless the
92.8 patient used, possessed, or was impaired by medical cannabis on the premises of the place
92.9 of employment or during the hours of employment.

92.10 (d) An employee who is required to undergo employer drug testing pursuant to section
92.11 181.953 may present verification of enrollment in the patient registry or of enrollment in a
92.12 Tribal medical cannabis program as part of the employee's explanation under section 181.953,
92.13 subdivision 6.

92.14 (e) A person shall not be denied custody of a minor child or visitation rights or parenting
92.15 time with a minor child solely based on the person's status as a patient enrolled in the registry
92.16 program under sections 152.22 to 152.37 or on the person's status as a Tribal medical
92.17 cannabis program patient enrolled in a Tribal medical cannabis program. There shall be no
92.18 presumption of neglect or child endangerment for conduct allowed under sections 152.22
92.19 to 152.37 or under a Tribal medical cannabis program, unless the person's behavior is such
92.20 that it creates an unreasonable danger to the safety of the minor as established by clear and
92.21 convincing evidence.

92.22 Sec. 89. Minnesota Statutes 2020, section 152.33, subdivision 1, is amended to read:

92.23 Subdivision 1. **Intentional diversion; criminal penalty.** In addition to any other
92.24 applicable penalty in law, a manufacturer or an agent of a manufacturer who intentionally
92.25 transfers medical cannabis to a person other than another registered manufacturer, a patient,
92.26 a registered designated caregiver, a Tribal medical cannabis program patient, or, if listed
92.27 on the registry verification, a parent, legal guardian, or spouse of a patient is guilty of a
92.28 felony punishable by imprisonment for not more than two years or by payment of a fine of
92.29 not more than \$3,000, or both. A person convicted under this subdivision may not continue
92.30 to be affiliated with the manufacturer and is disqualified from further participation under
92.31 sections 152.22 to 152.37.

93.1 Sec. 90. Minnesota Statutes 2020, section 152.35, is amended to read:

93.2 **152.35 FEES; DEPOSIT OF REVENUE.**

93.3 (a) The commissioner shall collect an enrollment fee of ~~\$200~~ \$40 from patients enrolled
93.4 under this section 152.27. ~~If the patient provides evidence of receiving Social Security~~
93.5 ~~disability insurance (SSDI), Supplemental Security Income (SSI), veterans disability, or~~
93.6 ~~railroad disability payments, or being enrolled in medical assistance or MinnesotaCare, then~~
93.7 ~~the fee shall be \$50. For purposes of this section:~~

93.8 ~~(1) a patient is considered to receive SSDI if the patient was receiving SSDI at the time~~
93.9 ~~the patient was transitioned to retirement benefits by the United States Social Security~~
93.10 ~~Administration; and~~

93.11 ~~(2) veterans disability payments include VA dependency and indemnity compensation.~~

93.12 ~~Unless a patient provides evidence of receiving payments from or participating in one of~~
93.13 ~~the programs specifically listed in this paragraph, the commissioner of health must collect~~
93.14 ~~the \$200 enrollment fee from a patient to enroll the patient in the registry program. The fees~~
93.15 ~~shall be payable annually and are due on the anniversary date of the patient's enrollment.~~
93.16 ~~The fee amount shall be deposited in the state treasury and credited to the state government~~
93.17 ~~special revenue fund.~~

93.18 (b) The commissioner shall collect ~~an~~ a nonrefundable registration application fee of
93.19 ~~\$20,000~~ \$10,000 from each entity submitting an application for registration as a medical
93.20 cannabis manufacturer. Revenue from the fee shall be deposited in the state treasury and
93.21 credited to the state government special revenue fund.

93.22 (c) The commissioner shall establish and collect an annual registration renewal fee from
93.23 a medical cannabis manufacturer equal to the cost of regulating and inspecting the
93.24 manufacturer ~~in that year~~ for the upcoming registration period. Revenue from the fee amount
93.25 shall be deposited in the state treasury and credited to the state government special revenue
93.26 fund.

93.27 (d) A medical cannabis manufacturer may charge patients enrolled in the registry program
93.28 a reasonable fee for costs associated with the operations of the manufacturer. The
93.29 manufacturer may establish a sliding scale of patient fees based upon a patient's household
93.30 income and may accept private donations to reduce patient fees.

94.1 Sec. 91. Laws 2021, First Special Session chapter 7, article 3, section 44, is amended to
94.2 read:

94.3 Sec. 44. **MENTAL HEALTH CULTURAL COMMUNITY CONTINUING**
94.4 **EDUCATION GRANT PROGRAM.**

94.5 (a) The commissioner of health shall develop a grant program, in consultation with the
94.6 relevant mental health licensing boards, to:

94.7 (1) provide for the continuing education necessary for social workers, marriage and
94.8 family therapists, psychologists, and professional clinical counselors to become supervisors
94.9 for individuals pursuing licensure in mental health professions;

94.10 (2) cover the costs when supervision is required for professionals becoming supervisors;
94.11 and

94.12 (3) cover the supervisory costs for mental health practitioners pursuing licensure at the
94.13 professional level.

94.14 (b) Social workers, marriage and family therapists, psychologists, and professional
94.15 clinical counselors obtaining continuing education and mental health practitioners needing
94.16 supervised hours to become licensed as professionals under this section must:

94.17 (1) be members of communities of color or underrepresented communities as defined
94.18 in Minnesota Statutes, section 148E.010, subdivision 20, or practice in a mental health
94.19 professional shortage area; and

94.20 (2) ~~work for community mental health providers and~~ agree to deliver at least 25 percent
94.21 of their yearly patient encounters to state public program enrollees or patients receiving
94.22 sliding fee schedule discounts through a formal sliding fee schedule meeting the standards
94.23 established by the United States Department of Health and Human Services under Code of
94.24 Federal Regulations, title 42, section 51, chapter 303.

94.25 Sec. 92. **BENEFIT AND COST ANALYSIS OF A UNIVERSAL HEALTH REFORM**
94.26 **PROPOSAL.**

94.27 Subdivision 1. **Contract for analysis of proposal.** The commissioner of health shall
94.28 contract with the University of Minnesota School of Public Health and the Carlson School
94.29 of Management to conduct an analysis of the benefits and costs of a legislative proposal for
94.30 a universal health care financing system and a similar analysis of the current health care
94.31 financing system to assist the state in comparing the proposal to the current system.

95.1 Subd. 2. **Proposal.** The commissioner of health, with input from the commissioners of
95.2 human services and commerce, shall submit to the University of Minnesota for analysis a
95.3 legislative proposal known as the Minnesota Health Plan that would offer a universal health
95.4 care plan designed to meet the following principles:

95.5 (1) ensure all Minnesotans are covered;

95.6 (2) cover all necessary care, including dental, vision and hearing, mental health, chemical
95.7 dependency treatment, prescription drugs, medical equipment and supplies, long-term care,
95.8 and home care; and

95.9 (3) allow patients to choose their doctors, hospitals, and other providers.

95.10 Subd. 3. **Proposal analysis.** (a) The analysis must measure the performance of both the
95.11 Minnesota Health Plan and the current health care financing system over a ten-year period
95.12 to contrast the impact on:

95.13 (1) the number of people covered versus the number of people who continue to lack
95.14 access to health care because of financial or other barriers, if any;

95.15 (2) the completeness of the coverage and the number of people lacking coverage for
95.16 dental, long-term care, medical equipment or supplies, vision and hearing, or other health
95.17 services that are not covered, if any;

95.18 (3) the adequacy of the coverage, the level of underinsured in the state, and whether
95.19 people with coverage can afford the care they need or whether cost prevents them from
95.20 accessing care;

95.21 (4) the timeliness and appropriateness of the care received and whether people turn to
95.22 inappropriate care such as emergency rooms because of a lack of proper care in accordance
95.23 with clinical guidelines; and

95.24 (5) total public and private health care spending in Minnesota under the current system
95.25 versus under the legislative proposal, including all spending by individuals, businesses, and
95.26 government. "Total public and private health care spending" means spending on all medical
95.27 care including but not limited to dental, vision and hearing, mental health, chemical
95.28 dependency treatment, prescription drugs, medical equipment and supplies, long-term care,
95.29 and home care, whether paid through premiums, co-pays and deductibles, other out-of-pocket
95.30 payments, or other funding from government, employers, or other sources. Total public and
95.31 private health care spending also includes the costs associated with administering, delivering,
95.32 and paying for the care. The costs of administering, delivering, and paying for the care
95.33 includes all expenses by insurers, providers, employers, individuals, and government to

96.1 select, negotiate, purchase, and administer insurance and care including but not limited to
96.2 coverage for health care, dental, long-term care, prescription drugs, medical expense portions
96.3 of workers compensation and automobile insurance, and the cost of administering and
96.4 paying for all health care products and services that are not covered by insurance. The
96.5 analysis of total health care spending shall examine whether there are savings or additional
96.6 costs under the legislative proposal compared to the existing system due to:

96.7 (i) reduced insurance, billing, underwriting, marketing, evaluation, and other
96.8 administrative functions including savings from global budgeting for hospitals and
96.9 institutional care instead of billing for individual services provided;

96.10 (ii) reduced prices on medical services and products including pharmaceuticals due to
96.11 price negotiations, if applicable under the proposal;

96.12 (iii) changes in utilization, better health outcomes, and reduced time away from work
96.13 due to prevention, early intervention, health-promoting activities, and to the extent possible
96.14 given available data and resources;

96.15 (iv) shortages or excess capacity of medical facilities and equipment under either the
96.16 current system or the proposal;

96.17 (v) the impact on state, local, and federal government non-health-care expenditures such
96.18 as reduced crime and out-of-home placement costs due to mental health or chemical
96.19 dependency coverage; and

96.20 (vi) job losses or gains in health care delivery, health billing and insurance administration,
96.21 and elsewhere in the economy under the proposal due to implementation of the reforms and
96.22 the resulting reduction of insurance and administrative burdens on businesses.

96.23 (b) The analysts may consult with authors of the legislative proposal to gain understanding
96.24 or clarification of the specifics of the proposal. The analysis shall assume that the provisions
96.25 in the proposal are not preempted by federal law or that the federal government gives a
96.26 waiver to the preemptions.

96.27 (c) The commissioner shall issue a final report by January 15, 2023, and may provide
96.28 interim reports and status updates to the governor and the chairs and ranking minority
96.29 members of the legislative committees with jurisdiction over health and human services
96.30 policy and finance.

96.31 **Sec. 93. NURSING WORKFORCE REPORT.**

96.32 The commissioner of health shall provide a public report on the following topics:

- 97.1 (1) Minnesota's supply of active licensed registered nurses;
97.2 (2) trends in Minnesota regarding retention by hospitals of licensed registered nurses;
97.3 (3) reasons licensed registered nurses are leaving direct care positions at hospitals; and
97.4 (4) reasons licensed registered nurses are choosing not to renew their licenses and leaving
97.5 the profession.

97.6 Sec. 94. **EMMETT LOUIS TILL VICTIMS RECOVERY PROGRAM.**

97.7 Subdivision 1. **Short title.** This section shall be known as the Emmett Louis Till Victims
97.8 Recovery Program.

97.9 Subd. 2. **Program established; grants.** (a) The commissioner of health shall establish
97.10 the Emmett Louis Till Victims Recovery Program to address the health and wellness needs
97.11 of victims who experienced trauma, including historical trauma, resulting from
97.12 government-sponsored activities, and to address the health and wellness needs of the families
97.13 and heirs of these victims.

97.14 (b) The commissioner, in consultation with family members of victims who experienced
97.15 trauma resulting from government-sponsored activities and with community-based
97.16 organizations that provide culturally appropriate services to victims experiencing trauma
97.17 and their families, shall award competitive grants to applicants for projects to provide the
97.18 following services to victims who experienced trauma resulting from government-sponsored
97.19 activities and their families and heirs:

97.20 (1) health and wellness services, which may include services and support to address
97.21 physical health, mental health, and cultural needs;

97.22 (2) remembrance and legacy preservation activities;

97.23 (3) cultural awareness services; and

97.24 (4) community resources and services to promote healing for victims who experienced
97.25 trauma resulting from government-sponsored activities and their families and heirs.

97.26 (c) In awarding grants under this section, the commissioner must prioritize grant awards
97.27 to community-based organizations experienced in providing support and services to victims
97.28 and families who experienced trauma resulting from government-sponsored activities.

97.29 Subd. 3. **Evaluation.** Grant recipients must provide the commissioner with information
97.30 required by the commissioner to evaluate the grant program, in a time and manner specified
97.31 by the commissioner.

98.1 Subd. 4. **Report.** By January 15, 2023, the commissioner must submit a status report
98.2 on the operation and results of the grant program, to the extent possible. The report must
98.3 be submitted to the chairs and ranking minority members of the legislative committees with
98.4 jurisdiction over health care. The report must include information on grant program activities
98.5 to date, services offered by grant recipients, and an assessment of the need to continue to
98.6 offer services to victims, families, and heirs who experienced trauma resulting from
98.7 government-sponsored activities.

98.8 Sec. 95. **IDENTIFY STRATEGIES FOR REDUCTION OF ADMINISTRATIVE**
98.9 **SPENDING AND LOW-VALUE CARE; REPORT.**

98.10 (a) The commissioner of health shall develop recommendations for strategies to reduce
98.11 the volume and growth of administrative spending by health care organizations and group
98.12 purchasers and the amount of low-value care delivered to Minnesota residents. In support
98.13 of the development of recommendations, the commissioner shall:

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

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

98.18 (3) conduct an environmental scan and key informant interviews with experts in health
98.19 care finance, health economics, health care management or administration, or the
98.20 administration of health insurance benefits to identify drivers of spending growth for spending
98.21 on administrative services or the provision of low-value care; and

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

98.26 (b) By December 15, 2024, the commissioner shall report the recommendations to the
98.27 chairs and ranking members of the legislative committees with jurisdiction over health and
98.28 human services financing and policy.

98.29 Sec. 96. **INITIAL IMPLEMENTATION OF THE KEEPING NURSES AT THE**
98.30 **BEDSIDE ACT.**

98.31 (a) By April 1, 2024, each hospital must establish and convene a hospital nurse staffing
98.32 committee as described under Minnesota Statutes, section 144.7053.

99.1 (b) By June 1, 2024, each hospital must implement core staffing plans developed by its
99.2 hospital nurse staffing committee and satisfy the plan posting requirements under Minnesota
99.3 Statutes, section 144.7056.

99.4 (c) By June 1, 2024, each hospital must submit to the commissioner of health core
99.5 staffing plans meeting the requirements of Minnesota Statutes, section 144.7055.

99.6 **Sec. 97. LEAD SERVICE LINE INVENTORY GRANT PROGRAM.**

99.7 Subdivision 1. **Establishment.** The commissioner of health must establish a grant
99.8 program to provide financial assistance to municipalities for producing an inventory of
99.9 publicly and privately owned lead service lines within their jurisdiction.

99.10 Subd. 2. **Eligible uses.** A municipality receiving a grant under this section may use the
99.11 grant funds to:

99.12 (1) survey households to determine the material of which their water service line is
99.13 made;

99.14 (2) create publicly available databases or visualizations of lead service lines; and

99.15 (3) comply with the lead service line inventory requirements in the Environmental
99.16 Protection Agency's Lead and Copper Rule.

99.17 **Sec. 98. PAYMENT MECHANISMS IN RURAL HEALTH CARE.**

99.18 The commissioner shall develop a plan to assess readiness of rural communities and
99.19 rural health care providers to adopt value-based, global budgeting, or alternative payment
99.20 systems and recommend steps needed to implement. The commissioner may use the
99.21 development of case studies and modeling of alternate payment systems to demonstrate
99.22 value-based payment systems that ensure a baseline level of essential community or regional
99.23 health services and address population health needs. The commissioner shall develop
99.24 recommendations for pilot projects by January 1, 2025, with the aim of ensuring financial
99.25 viability of rural health care systems in the context of spending growth targets. The
99.26 commissioner shall share findings with the Minnesota Health Care Spending Growth Target
99.27 Commission.

99.28 **Sec. 99. PROGRAM TO DISTRIBUTE COVID-19 TESTS, MASKS, AND**
99.29 **RESPIRATORS.**

99.30 Subdivision 1. **Definitions.** (a) The terms defined in this subdivision apply to this section.

100.1 (b) "Antigen test" means a lateral flow immunoassay intended for the qualitative detection
100.2 of nucleocapsid protein antigens from the SARS-CoV-2 virus in nasal swabs, that has
100.3 emergency use authorization from the United States Food and Drug Administration and
100.4 that is authorized for nonprescription home use with self-collected nasal swabs.

100.5 (c) "COVID-19 test" means a test authorized by the United States Food and Drug
100.6 Administration to detect the presence of genetic material of the SARS-CoV-2 virus either
100.7 through a molecular method that detects the RNA or nucleic acid component of the virus,
100.8 such as polymerase chain reaction or isothermal amplification, or through a rapid lateral
100.9 flow immunoassay that detects the nucleocapsid protein antigens from the SARS-CoV-2
100.10 virus.

100.11 (d) "KN95 respirator" means a type of filtering facepiece respirator that is commonly
100.12 made and used in China, is designed and tested to meet an international standard, and does
100.13 not include an exhalation valve.

100.14 (e) "Mask" means a face covering intended to contain droplets and particles in a person's
100.15 breath, cough, or sneeze.

100.16 (f) "Respirator" means a face covering that filters the air and fits closely on the face to
100.17 filter out particles, including the SARS-CoV-2 virus.

100.18 Subd. 2. **Program established.** In order to help reduce the number of cases of COVID-19
100.19 in the state, the commissioner of health must administer a program to distribute to individuals
100.20 in Minnesota, COVID-19 tests, including antigen tests; and masks and respirators, including
100.21 KN95 respirators and similar respirators approved by the Centers for Disease Control and
100.22 Prevention and authorized by the commissioner for distribution under this program. Masks
100.23 and respirators distributed under this program may include child-sized masks and respirators,
100.24 if such masks and respirators are available and the commissioner finds there is a need for
100.25 them. COVID-19 tests, masks, and respirators must be distributed at no cost to the individuals
100.26 receiving them and may be shipped directly to individuals; distributed through local health
100.27 departments, COVID community coordinators, and other community-based organizations;
100.28 and distributed through other means determined by the commissioner. The commissioner
100.29 may prioritize distribution under this section to communities and populations who are
100.30 disproportionately impacted by COVID-19 or who have difficulty accessing COVID-19
100.31 tests, masks, or respirators.

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

101.1 Subd. 4. **Notice.** An entity distributing KN95 respirators or similar respirators under this
101.2 section may include with the respirators a notice that individuals with a medical condition
101.3 that may make it difficult to wear a KN95 respirator or similar respirator should consult
101.4 with a health care provider before use.

101.5 Subd. 5. **Coordination.** The commissioner may coordinate this program with other state
101.6 and federal programs that distribute COVID-19 tests, masks, or respirators to the public.

101.7 **Sec. 100. REPORT ON TRANSPARENCY OF HEALTH CARE PAYMENTS.**

101.8 Subdivision 1. **Definitions.** (a) The terms defined in this subdivision apply to this section.

101.9 (b) "Commissioner" means the commissioner of health.

101.10 (c) "Non-claims-based payments" means payments to health care providers designed to
101.11 support and reward value of health care services over volume of health care services and
101.12 includes alternative payment models or incentives, payments for infrastructure expenditures
101.13 or investments, and payments for workforce expenditures or investments.

101.14 (d) "Nonpublic data" has the meaning given in Minnesota Statutes, section 13.02,
101.15 subdivision 9.

101.16 (e) "Primary care services" means integrated, accessible health care services provided
101.17 by clinicians who are accountable for addressing a large majority of personal health care
101.18 needs, developing a sustained partnership with patients, and practicing in the context of
101.19 family and community. Primary care services include but are not limited to preventive
101.20 services, office visits, administration of vaccines, annual physicals, pre-operative physicals,
101.21 assessments, care coordination, development of treatment plans, management of chronic
101.22 conditions, and diagnostic tests.

101.23 Subd. 2. **Report.** (a) To provide the legislature with information needed to meet the
101.24 evolving health care needs of Minnesotans, the commissioner shall report to the legislature
101.25 by February 15, 2023, on the volume and distribution of health care spending across payment
101.26 models used by health plan companies and third-party administrators, with a particular focus
101.27 on value-based care models and primary care spending.

101.28 (b) The report must include specific health plan and third-party administrator estimates
101.29 of health care spending for claims-based payments and non-claims-based payments for the
101.30 most recent available year, reported separately for Minnesotans enrolled in state health care
101.31 programs, Medicare Advantage, and commercial health insurance. The report must also
101.32 include recommendations on changes needed to gather better data from health plan companies
101.33 and third-party administrators on the use of value-based payments that pay for value of

102.1 health care services provided over volume of services provided, promote the health of all
102.2 Minnesotans, reduce health disparities, and support the provision of primary care services
102.3 and preventive services.

102.4 (c) In preparing the report, the commissioner shall:

102.5 (1) describe the form, manner, and timeline for submission of data by health plan
102.6 companies and third-party administrators to produce estimates as specified in paragraph
102.7 (b);

102.8 (2) collect summary data that permits the computation of:

102.9 (i) the percentage of total payments that are non-claims-based payments; and

102.10 (ii) the percentage of payments in item (i) that are for primary care services;

102.11 (3) where data was not directly derived, specify the methods used to estimate data
102.12 elements;

102.13 (4) notwithstanding Minnesota Statutes, section 62U.04, subdivision 11, conduct analyses
102.14 of the magnitude of primary care payments using data collected by the commissioner under
102.15 Minnesota Statutes, section 62U.04; and

102.16 (5) conduct interviews with health plan companies and third-party administrators to
102.17 better understand the types of non-claims-based payments and models in use, the purposes
102.18 or goals of each, the criteria for health care providers to qualify for these payments, and the
102.19 timing and structure of health plan companies or third-party administrators making these
102.20 payments to health care provider organizations.

102.21 (d) Health plan companies and third-party administrators must comply with data requests
102.22 from the commissioner under this section within 60 days after receiving the request.

102.23 (e) Data collected under this section are nonpublic data. Notwithstanding the definition
102.24 of summary data in Minnesota Statutes, section 13.02, subdivision 19, summary data prepared
102.25 under this section may be derived from nonpublic data. The commissioner shall establish
102.26 procedures and safeguards to protect the integrity and confidentiality of any data maintained
102.27 by the commissioner.

102.28 **Sec. 101. SAFETY IMPROVEMENTS FOR STATE LICENSED LONG-TERM**
102.29 **CARE FACILITIES.**

102.30 **Subdivision 1. Temporary grant program for long-term care safety**
102.31 **improvements. The commissioner of health shall develop, implement, and manage a**

103.1 temporary, competitive grant process for state-licensed long-term care facilities to improve
103.2 their ability to reduce the transmission of COVID-19 or other similar conditions.

103.3 Subd. 2. **Definitions.** (a) For the purposes of this section, the following terms have the
103.4 meanings given.

103.5 (b) "Eligible facility" means:

103.6 (1) an assisted living facility licensed under chapter 144G;

103.7 (2) a supervised living facility licensed under chapter 144;

103.8 (3) a board and care facility that is not federally certified and is licensed under chapter
103.9 144; and

103.10 (4) a nursing home that is not federally certified and is licensed under chapter 144A.

103.11 (c) "Eligible project" means a modernization project to update, remodel or replace
103.12 outdated equipment, systems, technology, or physical spaces.

103.13 Subd. 3. **Program.** (a) The commissioner of health shall award improvement grants to
103.14 an eligible facility. An improvement grant shall not exceed \$1,250,000.

103.15 (b) Funds may be used to improve the safety, quality of care, and livability of aging
103.16 infrastructure in a Department of Health licensed eligible facility with an emphasis on
103.17 reducing the transmission risk of COVID-19 and other infections. Projects include but are
103.18 not limited to:

103.19 (1) heating, ventilation, and air-conditioning systems improvements to reduce airborne
103.20 exposures;

103.21 (2) physical space changes for infection control; and

103.22 (3) technology improvements to reduce social isolation and improve resident or client
103.23 well-being.

103.24 (c) Notwithstanding any law to the contrary, funds awarded in a grant agreement do not
103.25 lapse until expended by the grantee.

103.26 Subd. 4. **Applications.** An eligible facility seeking a grant shall apply to the
103.27 commissioner. The application must include a description of the resident population
103.28 demographics, the problem the proposed project will address, a description of the project
103.29 including construction and remodeling drawings or specifications, sources of funds for the
103.30 project, including any in-kind resources, uses of funds for the project, the results expected,
103.31 and a plan to maintain or operate any facility or equipment included in the project. The

104.1 applicant must describe achievable objectives, a timetable, and roles and capabilities of
104.2 responsible individuals and organization. An applicant must submit to the commissioner
104.3 evidence that competitive bidding was used to select contractors for the project.

104.4 Subd. 5. **Consideration of applications.** The commissioner shall review each application
104.5 to determine if the application is complete and if the facility and the project are eligible for
104.6 a grant. In evaluating applications, the commissioner shall develop a standardized scoring
104.7 system that assesses: (1) the applicant's understanding of the problem, description of the
104.8 project and the likelihood of a successful outcome of the project; (2) the extent to which
104.9 the project will reduce the transmission of COVID-19; (3) the extent to which the applicant
104.10 has demonstrated that it has made adequate provisions to ensure proper and efficient operation
104.11 of the facility once the project is completed; (4) and other relevant factors as determined
104.12 by the commissioner. During application review, the commissioner may request additional
104.13 information about a proposed project, including information on project cost. Failure to
104.14 provide the information requested disqualifies an applicant.

104.15 Subd. 6. **Program oversight.** The commissioner shall determine the amount of a grant
104.16 to be given to an eligible facility based on the relative score of each eligible facility's
104.17 application, other relevant factors discussed during the review, and the funds available to
104.18 the commissioner. During the grant period and within one year after completion of the grant
104.19 period, the commissioner may collect from an eligible facility receiving a grant, any
104.20 information necessary to evaluate the program.

104.21 Subd. 7. **Expiration.** This section expires June 30, 2025.

104.22 Sec. 102. **STUDY OF THE DEVELOPMENT OF A STATEWIDE REGISTRY FOR**
104.23 **PROVIDER ORDERS FOR LIFE-SUSTAINING TREATMENT.**

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

104.26 (b) "Commissioner" means the commissioner of health.

104.27 (c) "Life-sustaining treatment" means any medical procedure, pharmaceutical drug,
104.28 medical device, or medical intervention that maintains life by sustaining, restoring, or
104.29 supplanting a vital function. Life-sustaining treatment does not include routine care necessary
104.30 to sustain patient cleanliness and comfort.

104.31 (d) "POLST" means a provider order for life-sustaining treatment, signed by a physician,
104.32 advanced practice registered nurse, or physician assistant, to ensure that the medical treatment

105.1 preferences of a patient with an advanced serious illness who is nearing the end of the their
105.2 life are honored.

105.3 (e) "POLST form" means a portable medical form used to communicate a physician's
105.4 order to help ensure that a patient's medical treatment preferences are conveyed to emergency
105.5 medical service personnel and other health care providers.

105.6 Subd. 2. **Study.** (a) The commissioner, in consultation with the advisory committee
105.7 established in paragraph (c), shall study the issues related to creating a statewide registry
105.8 of POLST forms to ensure that a patient's medical treatment preferences are followed by
105.9 all health care providers. The registry must allow for the submission of completed POLST
105.10 forms and for the forms to be accessed by health care providers and emergency medical
105.11 service personnel in a timely manner, for the provision of care or services.

105.12 (b) As a part of the study, the commissioner shall develop recommendations on the
105.13 following:

105.14 (1) electronic capture, storage, and security of information in the registry;

105.15 (2) procedures to protect the accuracy and confidentiality of information submitted to
105.16 the registry;

105.17 (3) limits as to who can access the registry;

105.18 (4) where the registry should be housed;

105.19 (5) ongoing funding models for the registry; and

105.20 (6) any other action needed to ensure that patients' rights are protected and that their
105.21 health care decisions are followed.

105.22 (c) The commissioner shall create an advisory committee with members representing
105.23 physicians, physician assistants, advanced practice registered nurses, nursing homes,
105.24 emergency medical system providers, hospice and palliative care providers, the disability
105.25 community, attorneys, medical ethicists, and the religious community.

105.26 Subd. 3. **Report.** The commissioner shall submit a report on the results of the study,
105.27 including recommendations on establishing a statewide registry of POLST forms, to the
105.28 chairs and ranking minority members of the legislative committees with jurisdiction over
105.29 health and human services policy and finance by February 1, 2023.

106.1 Sec. 103. **REVISOR INSTRUCTION.**

106.2 (a) The revisor of statutes shall codify Laws 2021, First Special Session chapter 7, article
106.3 3, section 44, as Minnesota Statutes, section 144.1512. The revisor of statutes may make
106.4 any necessary cross-reference changes.

106.5 (b) The revisor of statutes shall correct cross-references in Minnesota Statutes to conform
106.6 with the relettering of paragraphs in Minnesota Statutes, section 144.1501, subdivision 1.

106.7 (c) In Minnesota Statutes, section 144.7055, the revisor shall renumber paragraphs (b)
106.8 to (e) alphabetically as individual subdivisions under Minnesota Statutes, section 144.7051.
106.9 The revisor shall make any necessary changes to sentence structure for this renumbering
106.10 while preserving the meaning of the text. The revisor shall also make necessary
106.11 cross-reference changes in Minnesota Statutes and Minnesota Rules consistent with the
106.12 renumbering.

106.13 (d) The revisor of statutes shall renumber Minnesota Statutes, sections 145A.145 and
106.14 145A.17, as new sections following Minnesota Statutes, section 145.871. The revisor shall
106.15 also make necessary cross-reference changes consistent with the renumbering.

106.16 **ARTICLE 2**

106.17 **DEPARTMENT OF HEALTH POLICY**

106.18 Section 1. Minnesota Statutes 2021 Supplement, section 144.0724, subdivision 4, is
106.19 amended to read:

106.20 **Subd. 4. Resident assessment schedule.** (a) A facility must conduct and electronically
106.21 submit to the federal database MDS assessments that conform with the assessment schedule
106.22 defined by the Long Term Care Facility Resident Assessment Instrument User's Manual,
106.23 version 3.0, or its successor issued by the Centers for Medicare and Medicaid Services. The
106.24 commissioner of health may substitute successor manuals or question and answer documents
106.25 published by the United States Department of Health and Human Services, Centers for
106.26 Medicare and Medicaid Services, to replace or supplement the current version of the manual
106.27 or document.

106.28 (b) The assessments required under the Omnibus Budget Reconciliation Act of 1987
106.29 (OBRA) used to determine a case mix classification for reimbursement include ~~the following:~~

106.30 (1) a new admission comprehensive assessment, which must have an assessment reference
106.31 date (ARD) within 14 calendar days after admission, excluding readmissions;

107.1 (2) an annual comprehensive assessment, which must have an ARD within 92 days of
107.2 a previous quarterly review assessment or a previous comprehensive assessment, which
107.3 must occur at least once every 366 days;

107.4 (3) a significant change in status comprehensive assessment, which must have an ARD
107.5 within 14 days after the facility determines, or should have determined, that there has been
107.6 a significant change in the resident's physical or mental condition, whether an improvement
107.7 or a decline, and regardless of the amount of time since the last comprehensive assessment
107.8 or quarterly review assessment;

107.9 (4) a quarterly review assessment must have an ARD within 92 days of the ARD of the
107.10 previous quarterly review assessment or a previous comprehensive assessment;

107.11 (5) any significant correction to a prior comprehensive assessment, if the assessment
107.12 being corrected is the current one being used for RUG classification;

107.13 (6) any significant correction to a prior quarterly review assessment, if the assessment
107.14 being corrected is the current one being used for RUG classification;

107.15 (7) a required significant change in status assessment when:

107.16 (i) all speech, occupational, and physical therapies have ended. If the most recent OBRA
107.17 comprehensive or quarterly assessment completed does not result in a rehabilitation case
107.18 mix classification, then the significant change in status assessment is not required. The ARD
107.19 of this assessment must be set on day eight after all therapy services have ended; and

107.20 (ii) isolation for an infectious disease has ended. If isolation was not coded on the most
107.21 recent OBRA comprehensive or quarterly assessment completed, then the significant change
107.22 in status assessment is not required. The ARD of this assessment must be set on day 15 after
107.23 isolation has ended; and

107.24 (8) any modifications to the most recent assessments under clauses (1) to (7).

107.25 (c) In addition to the assessments listed in paragraph (b), the assessments used to
107.26 determine nursing facility level of care include the following:

107.27 (1) preadmission screening completed under section 256.975, subdivisions 7a to 7c, by
107.28 the Senior LinkAge Line or other organization under contract with the Minnesota Board on
107.29 Aging; and

107.30 (2) a nursing facility level of care determination as provided for under section 256B.0911,
107.31 subdivision 4e, as part of a face-to-face long-term care consultation assessment completed

108.1 under section 256B.0911, by a county, tribe, or managed care organization under contract
108.2 with the Department of Human Services.

108.3 Sec. 2. Minnesota Statutes 2020, section 144.1201, subdivision 2, is amended to read:

108.4 Subd. 2. ~~By-product nuclear~~ Byproduct material. "~~By-product nuclear~~ Byproduct
108.5 material" means ~~a radioactive material, other than special nuclear material, yielded in or~~
108.6 ~~made radioactive by exposure to radiation created incident to the process of producing or~~
108.7 ~~utilizing special nuclear material.:~~

108.8 (1) any radioactive material, except special nuclear material, yielded in or made
108.9 radioactive by exposure to the radiation incident to the process of producing or using special
108.10 nuclear material;

108.11 (2) the tailings or wastes produced by the extraction or concentration of uranium or
108.12 thorium from ore processed primarily for its source material content, including discrete
108.13 surface wastes resulting from uranium solution extraction processes. Underground ore
108.14 bodies depleted by these solution extraction operations do not constitute byproduct material
108.15 within this definition;

108.16 (3) any discrete source of radium-226 that is produced, extracted, or converted after
108.17 extraction for commercial, medical, or research activity, or any material that:

108.18 (i) has been made radioactive by use of a particle accelerator; and

108.19 (ii) is produced, extracted, or converted after extraction for commercial, medical, or
108.20 research activity; and

108.21 (4) any discrete source of naturally occurring radioactive material, other than source
108.22 nuclear material, that:

108.23 (i) the United States Nuclear Regulatory Commission, in consultation with the
108.24 Administrator of the Environmental Protection Agency, the Secretary of Energy, the Secretary
108.25 of Homeland Security, and the head of any other appropriate federal agency determines
108.26 would pose a threat similar to the threat posed by a discrete source of radium-226 to the
108.27 public health and safety or the common defense and security; and

108.28 (ii) is extracted or converted after extraction for use in a commercial, medical, or research
108.29 activity.

109.1 Sec. 3. Minnesota Statutes 2020, section 144.1201, subdivision 4, is amended to read:

109.2 Subd. 4. **Radioactive material.** "Radioactive material" means a matter that emits
109.3 radiation. Radioactive material includes special nuclear material, source nuclear material,
109.4 and ~~by-product nuclear~~ byproduct material.

109.5 Sec. 4. Minnesota Statutes 2021 Supplement, section 144.1481, subdivision 1, is amended
109.6 to read:

109.7 Subdivision 1. **Establishment; membership.** The commissioner of health shall establish
109.8 a ~~16-member~~ 21-member Rural Health Advisory Committee. The committee shall consist
109.9 of the following members, all of whom must reside outside the seven-county metropolitan
109.10 area, as defined in section 473.121, subdivision 2:

109.11 (1) two members from the house of representatives of the state of Minnesota, one from
109.12 the majority party and one from the minority party;

109.13 (2) two members from the senate of the state of Minnesota, one from the majority party
109.14 and one from the minority party;

109.15 (3) a volunteer member of an ambulance service based outside the seven-county
109.16 metropolitan area;

109.17 (4) a representative of a hospital located outside the seven-county metropolitan area;

109.18 (5) a representative of a nursing home located outside the seven-county metropolitan
109.19 area;

109.20 (6) a medical doctor or doctor of osteopathic medicine licensed under chapter 147;

109.21 (7) a dentist licensed under chapter 150A;

109.22 (8) ~~a midlevel practitioner~~ an advanced practice provider;

109.23 (9) a registered nurse or licensed practical nurse;

109.24 (10) a licensed health care professional from an occupation not otherwise represented
109.25 on the committee;

109.26 (11) a representative of an institution of higher education located outside the seven-county
109.27 metropolitan area that provides training for rural health care providers; ~~and~~

109.28 (12) a member of a Tribal nation;

109.29 (13) a representative of a local public health agency or community health board;

110.1 (14) a health professional or advocate with experience working with people with mental
110.2 illness;

110.3 (15) a representative of a community organization that works with individuals
110.4 experiencing health disparities;

110.5 (16) an individual with expertise in economic development, or an employer working
110.6 outside the seven-county metropolitan area; and

110.7 ~~(12)~~ (17) three consumers, at least one of whom must be an advocate for persons who
110.8 ~~are mentally ill or developmentally disabled~~ from a community experiencing health
110.9 disparities.

110.10 The commissioner will make recommendations for committee membership. Committee
110.11 members will be appointed by the governor. In making appointments, the governor shall
110.12 ensure that appointments provide geographic balance among those areas of the state outside
110.13 the seven-county metropolitan area. The chair of the committee shall be elected by the
110.14 members. The advisory committee is governed by section 15.059, except that the members
110.15 do not receive per diem compensation.

110.16 Sec. 5. Minnesota Statutes 2020, section 144.292, subdivision 6, is amended to read:

110.17 Subd. 6. **Cost.** (a) When a patient requests a copy of the patient's record for purposes of
110.18 reviewing current medical care, the provider must not charge a fee.

110.19 (b) When a provider or its representative makes copies of patient records upon a patient's
110.20 request under this section, the provider or its representative may charge the patient or the
110.21 patient's representative no more than 75 cents per page, plus \$10 for time spent retrieving
110.22 and copying the records, unless other law or a rule or contract provide for a lower maximum
110.23 charge. This limitation does not apply to x-rays. The provider may charge a patient no more
110.24 than the actual cost of reproducing x-rays, plus no more than \$10 for the time spent retrieving
110.25 and copying the x-rays.

110.26 (c) The respective maximum charges of 75 cents per page and \$10 for time provided in
110.27 this subdivision are in effect for calendar year 1992 and may be adjusted annually each
110.28 calendar year as provided in this subdivision. The permissible maximum charges shall
110.29 change each year by an amount that reflects the change, as compared to the previous year,
110.30 in the Consumer Price Index for all Urban Consumers, Minneapolis-St. Paul (CPI-U),
110.31 published by the Department of Labor.

110.32 (d) A provider or its representative may charge the \$10 retrieval fee, but must not charge
110.33 a per page fee to provide copies of records requested by a patient or the patient's authorized

111.1 representative if the request for copies of records is for purposes of appealing a denial of
111.2 Social Security disability income or Social Security disability benefits under title II or title
111.3 XVI of the Social Security Act; except that no fee shall be charged to a ~~person~~ patient who
111.4 is receiving public assistance, or to a patient who is represented by an attorney on behalf
111.5 of a civil legal services program or a volunteer attorney program based on indigency. For
111.6 the purpose of further appeals, a patient may receive no more than two medical record
111.7 updates without charge, but only for medical record information previously not provided.
111.8 For purposes of this paragraph, a patient's authorized representative does not include units
111.9 of state government engaged in the adjudication of Social Security disability claims.

111.10 Sec. 6. Minnesota Statutes 2020, section 144.497, is amended to read:

111.11 **144.497 ST ELEVATION MYOCARDIAL INFARCTION.**

111.12 The commissioner of health shall assess ~~and report on~~ the quality of care provided in
111.13 the state for ST elevation myocardial infarction response and treatment. The commissioner
111.14 shall:

111.15 (1) utilize and analyze data provided by ST elevation myocardial infarction receiving
111.16 centers to the ACTION Registry-Get with the guidelines or an equivalent data platform that
111.17 does not identify individuals or associate specific ST elevation myocardial infarction heart
111.18 attack events with an identifiable individual; and

111.19 ~~(2) quarterly post a summary report of the data in aggregate form on the Department of~~
111.20 ~~Health website;~~

111.21 ~~(3) annually inform the legislative committees with jurisdiction over public health of~~
111.22 ~~progress toward improving the quality of care and patient outcomes for ST elevation~~
111.23 ~~myocardial infarctions; and~~

111.24 ~~(4)~~ (2) coordinate to the extent possible with national voluntary health organizations
111.25 involved in ST elevation myocardial infarction heart attack quality improvement to encourage
111.26 ST elevation myocardial infarction receiving centers to report data consistent with nationally
111.27 recognized guidelines on the treatment of individuals with confirmed ST elevation myocardial
111.28 infarction heart attacks within the state and encourage sharing of information among health
111.29 care providers on ways to improve the quality of care of ST elevation myocardial infarction
111.30 patients in Minnesota.

112.1 Sec. 7. Minnesota Statutes 2021 Supplement, section 144.551, subdivision 1, is amended
112.2 to read:

112.3 Subdivision 1. **Restricted construction or modification.** (a) The following construction
112.4 or modification may not be commenced:

112.5 (1) any erection, building, alteration, reconstruction, modernization, improvement,
112.6 extension, lease, or other acquisition by or on behalf of a hospital that increases the bed
112.7 capacity of a hospital, relocates hospital beds from one physical facility, complex, or site
112.8 to another, or otherwise results in an increase or redistribution of hospital beds within the
112.9 state; and

112.10 (2) the establishment of a new hospital.

112.11 (b) This section does not apply to:

112.12 (1) construction or relocation within a county by a hospital, clinic, or other health care
112.13 facility that is a national referral center engaged in substantial programs of patient care,
112.14 medical research, and medical education meeting state and national needs that receives more
112.15 than 40 percent of its patients from outside the state of Minnesota;

112.16 (2) a project for construction or modification for which a health care facility held an
112.17 approved certificate of need on May 1, 1984, regardless of the date of expiration of the
112.18 certificate;

112.19 (3) a project for which a certificate of need was denied before July 1, 1990, if a timely
112.20 appeal results in an order reversing the denial;

112.21 (4) a project exempted from certificate of need requirements by Laws 1981, chapter 200,
112.22 section 2;

112.23 (5) a project involving consolidation of pediatric specialty hospital services within the
112.24 Minneapolis-St. Paul metropolitan area that would not result in a net increase in the number
112.25 of pediatric specialty hospital beds among the hospitals being consolidated;

112.26 (6) a project involving the temporary relocation of pediatric-orthopedic hospital beds to
112.27 an existing licensed hospital that will allow for the reconstruction of a new philanthropic,
112.28 pediatric-orthopedic hospital on an existing site and that will not result in a net increase in
112.29 the number of hospital beds. Upon completion of the reconstruction, the licenses of both
112.30 hospitals must be reinstated at the capacity that existed on each site before the relocation;

112.31 (7) the relocation or redistribution of hospital beds within a hospital building or
112.32 identifiable complex of buildings provided the relocation or redistribution does not result

113.1 in: (i) an increase in the overall bed capacity at that site; (ii) relocation of hospital beds from
113.2 one physical site or complex to another; or (iii) redistribution of hospital beds within the
113.3 state or a region of the state;

113.4 (8) relocation or redistribution of hospital beds within a hospital corporate system that
113.5 involves the transfer of beds from a closed facility site or complex to an existing site or
113.6 complex provided that: (i) no more than 50 percent of the capacity of the closed facility is
113.7 transferred; (ii) the capacity of the site or complex to which the beds are transferred does
113.8 not increase by more than 50 percent; (iii) the beds are not transferred outside of a federal
113.9 health systems agency boundary in place on July 1, 1983; (iv) the relocation or redistribution
113.10 does not involve the construction of a new hospital building; and (v) the transferred beds
113.11 are used first to replace within the hospital corporate system the total number of beds
113.12 previously used in the closed facility site or complex for mental health services and substance
113.13 use disorder services. Only after the hospital corporate system has fulfilled the requirements
113.14 of this item may the remainder of the available capacity of the closed facility site or complex
113.15 be transferred for any other purpose;

113.16 (9) a construction project involving up to 35 new beds in a psychiatric hospital in Rice
113.17 County that primarily serves adolescents and that receives more than 70 percent of its
113.18 patients from outside the state of Minnesota;

113.19 (10) a project to replace a hospital or hospitals with a combined licensed capacity of
113.20 130 beds or less if: (i) the new hospital site is located within five miles of the current site;
113.21 and (ii) the total licensed capacity of the replacement hospital, either at the time of
113.22 construction of the initial building or as the result of future expansion, will not exceed 70
113.23 licensed hospital beds, or the combined licensed capacity of the hospitals, whichever is less;

113.24 (11) the relocation of licensed hospital beds from an existing state facility operated by
113.25 the commissioner of human services to a new or existing facility, building, or complex
113.26 operated by the commissioner of human services; from one regional treatment center site
113.27 to another; or from one building or site to a new or existing building or site on the same
113.28 campus;

113.29 (12) the construction or relocation of hospital beds operated by a hospital having a
113.30 statutory obligation to provide hospital and medical services for the indigent that does not
113.31 result in a net increase in the number of hospital beds, notwithstanding section 144.552, 27
113.32 beds, of which 12 serve mental health needs, may be transferred from Hennepin County
113.33 Medical Center to Regions Hospital under this clause;

114.1 (13) a construction project involving the addition of up to 31 new beds in an existing
114.2 nonfederal hospital in Beltrami County;

114.3 (14) a construction project involving the addition of up to eight new beds in an existing
114.4 nonfederal hospital in Otter Tail County with 100 licensed acute care beds;

114.5 (15) a construction project involving the addition of 20 new hospital beds in an existing
114.6 hospital in Carver County serving the southwest suburban metropolitan area;

114.7 (16) a project for the construction or relocation of up to 20 hospital beds for the operation
114.8 of up to two psychiatric facilities or units for children provided that the operation of the
114.9 facilities or units have received the approval of the commissioner of human services;

114.10 (17) a project involving the addition of 14 new hospital beds to be used for rehabilitation
114.11 services in an existing hospital in Itasca County;

114.12 (18) a project to add 20 licensed beds in existing space at a hospital in Hennepin County
114.13 that closed 20 rehabilitation beds in 2002, provided that the beds are used only for
114.14 rehabilitation in the hospital's current rehabilitation building. If the beds are used for another
114.15 purpose or moved to another location, the hospital's licensed capacity is reduced by 20 beds;

114.16 (19) a critical access hospital established under section 144.1483, clause (9), and section
114.17 1820 of the federal Social Security Act, United States Code, title 42, section 1395i-4, that
114.18 delicensed beds since enactment of the Balanced Budget Act of 1997, Public Law 105-33,
114.19 to the extent that the critical access hospital does not seek to exceed the maximum number
114.20 of beds permitted such hospital under federal law;

114.21 (20) notwithstanding section 144.552, a project for the construction of a new hospital
114.22 in the city of Maple Grove with a licensed capacity of up to 300 beds provided that:

114.23 (i) the project, including each hospital or health system that will own or control the entity
114.24 that will hold the new hospital license, is approved by a resolution of the Maple Grove City
114.25 Council as of March 1, 2006;

114.26 (ii) the entity that will hold the new hospital license will be owned or controlled by one
114.27 or more not-for-profit hospitals or health systems that have previously submitted a plan or
114.28 plans for a project in Maple Grove as required under section 144.552, and the plan or plans
114.29 have been found to be in the public interest by the commissioner of health as of April 1,
114.30 2005;

114.31 (iii) the new hospital's initial inpatient services must include, but are not limited to,
114.32 medical and surgical services, obstetrical and gynecological services, intensive care services,

115.1 orthopedic services, pediatric services, noninvasive cardiac diagnostics, behavioral health
115.2 services, and emergency room services;

115.3 (iv) the new hospital:

115.4 (A) will have the ability to provide and staff sufficient new beds to meet the growing
115.5 needs of the Maple Grove service area and the surrounding communities currently being
115.6 served by the hospital or health system that will own or control the entity that will hold the
115.7 new hospital license;

115.8 (B) will provide uncompensated care;

115.9 (C) will provide mental health services, including inpatient beds;

115.10 (D) will be a site for workforce development for a broad spectrum of health-care-related
115.11 occupations and have a commitment to providing clinical training programs for physicians
115.12 and other health care providers;

115.13 (E) will demonstrate a commitment to quality care and patient safety;

115.14 (F) will have an electronic medical records system, including physician order entry;

115.15 (G) will provide a broad range of senior services;

115.16 (H) will provide emergency medical services that will coordinate care with regional
115.17 providers of trauma services and licensed emergency ambulance services in order to enhance
115.18 the continuity of care for emergency medical patients; and

115.19 (I) will be completed by December 31, 2009, unless delayed by circumstances beyond
115.20 the control of the entity holding the new hospital license; and

115.21 (v) as of 30 days following submission of a written plan, the commissioner of health
115.22 has not determined that the hospitals or health systems that will own or control the entity
115.23 that will hold the new hospital license are unable to meet the criteria of this clause;

115.24 (21) a project approved under section 144.553;

115.25 (22) a project for the construction of a hospital with up to 25 beds in Cass County within
115.26 a 20-mile radius of the state Ah-Gwah-Ching facility, provided the hospital's license holder
115.27 is approved by the Cass County Board;

115.28 (23) a project for an acute care hospital in Fergus Falls that will increase the bed capacity
115.29 from 108 to 110 beds by increasing the rehabilitation bed capacity from 14 to 16 and closing
115.30 a separately licensed 13-bed skilled nursing facility;

116.1 (24) notwithstanding section 144.552, a project for the construction and expansion of a
116.2 specialty psychiatric hospital in Hennepin County for up to 50 beds, exclusively for patients
116.3 who are under 21 years of age on the date of admission. The commissioner conducted a
116.4 public interest review of the mental health needs of Minnesota and the Twin Cities
116.5 metropolitan area in 2008. No further public interest review shall be conducted for the
116.6 construction or expansion project under this clause;

116.7 (25) a project for a 16-bed psychiatric hospital in the city of Thief River Falls, if the
116.8 commissioner finds the project is in the public interest after the public interest review
116.9 conducted under section 144.552 is complete;

116.10 (26)(i) a project for a 20-bed psychiatric hospital, within an existing facility in the city
116.11 of Maple Grove, exclusively for patients who are under 21 years of age on the date of
116.12 admission, if the commissioner finds the project is in the public interest after the public
116.13 interest review conducted under section 144.552 is complete;

116.14 (ii) this project shall serve patients in the continuing care benefit program under section
116.15 256.9693. The project may also serve patients not in the continuing care benefit program;
116.16 and

116.17 (iii) if the project ceases to participate in the continuing care benefit program, the
116.18 commissioner must complete a subsequent public interest review under section 144.552. If
116.19 the project is found not to be in the public interest, the license must be terminated six months
116.20 from the date of that finding. If the commissioner of human services terminates the contract
116.21 without cause or reduces per diem payment rates for patients under the continuing care
116.22 benefit program below the rates in effect for services provided on December 31, 2015, the
116.23 project may cease to participate in the continuing care benefit program and continue to
116.24 operate without a subsequent public interest review;

116.25 (27) a project involving the addition of 21 new beds in an existing psychiatric hospital
116.26 in Hennepin County that is exclusively for patients who are under 21 years of age on the
116.27 date of admission;

116.28 (28) a project to add 55 licensed beds in an existing safety net, level I trauma center
116.29 hospital in Ramsey County as designated under section 383A.91, subdivision 5, of which
116.30 15 beds are to be used for inpatient mental health and 40 are to be used for other services.
116.31 In addition, five unlicensed observation mental health beds shall be added;

116.32 (29) upon submission of a plan to the commissioner for public interest review under
116.33 section 144.552 and the addition of the 15 inpatient mental health beds specified in clause
116.34 (28), to its bed capacity, a project to add 45 licensed beds in an existing safety net, level I

117.1 trauma center hospital in Ramsey County as designated under section 383A.91, subdivision
117.2 5. Five of the 45 additional beds authorized under this clause must be designated for use
117.3 for inpatient mental health and must be added to the hospital's bed capacity before the
117.4 remaining 40 beds are added. Notwithstanding section 144.552, the hospital may add licensed
117.5 beds under this clause prior to completion of the public interest review, provided the hospital
117.6 submits its plan by the 2021 deadline and adheres to the timelines for the public interest
117.7 review described in section 144.552; ~~or~~

117.8 (30) upon submission of a plan to the commissioner for public interest review under
117.9 section 144.552, a project to add up to 30 licensed beds in an existing psychiatric hospital
117.10 in Hennepin County that exclusively provides care to patients who are under 21 years of
117.11 age on the date of admission. Notwithstanding section 144.552, the psychiatric hospital
117.12 may add licensed beds under this clause prior to completion of the public interest review,
117.13 provided the hospital submits its plan by the 2021 deadline and adheres to the timelines for
117.14 the public interest review described in section 144.552;

117.15 (31) a project to add licensed beds in a hospital in Cook County that: (i) is designated
117.16 as a critical access hospital under section 144.1483, clause (9), and United States Code, title
117.17 42, section 1395i-4; (ii) has a licensed bed capacity of fewer than 25 beds; and (iii) has an
117.18 attached nursing home, so long as the total number of licensed beds in the hospital after the
117.19 bed addition does not exceed 25 beds; or

117.20 (32) upon submission of a plan to the commissioner for public interest review under
117.21 section 144.552, a project to add 22 licensed beds at a Minnesota freestanding children's
117.22 hospital in St. Paul that is part of an independent pediatric health system with freestanding
117.23 inpatient hospitals located in Minneapolis and St. Paul. The beds shall be utilized for pediatric
117.24 inpatient behavioral health services. Notwithstanding section 144.552, the hospital may add
117.25 licensed beds under this clause prior to completion of the public interest review, provided
117.26 the hospital submits its plan by the 2022 deadline and adheres to the timelines for the public
117.27 interest review described in section 144.552.

117.28 Sec. 8. Minnesota Statutes 2020, section 144.565, subdivision 4, is amended to read:

117.29 Subd. 4. **Definitions.** (a) For purposes of this section, the following terms have the
117.30 meanings given:

117.31 (b) "Diagnostic imaging facility" means a health care facility that is not a hospital or
117.32 location licensed as a hospital which offers diagnostic imaging services in Minnesota,
117.33 regardless of whether the equipment used to provide the service is owned or leased. For the
117.34 purposes of this section, diagnostic imaging facility includes, but is not limited to, facilities

118.1 such as a physician's office, clinic, mobile transport vehicle, outpatient imaging center, or
118.2 surgical center. A dental clinic or office is not considered a diagnostic imaging facility for
118.3 the purpose of this section when the clinic or office performs diagnostic imaging through
118.4 dental cone beam computerized tomography.

118.5 (c) "Diagnostic imaging service" means the use of ionizing radiation or other imaging
118.6 technique on a human patient including, but not limited to, magnetic resonance imaging
118.7 (MRI) or computerized tomography (CT) other than dental cone beam computerized
118.8 tomography, positron emission tomography (PET), or single photon emission computerized
118.9 tomography (SPECT) scans using fixed, portable, or mobile equipment.

118.10 (d) "Financial or economic interest" means a direct or indirect:

118.11 (1) equity or debt security issued by an entity, including, but not limited to, shares of
118.12 stock in a corporation, membership in a limited liability company, beneficial interest in a
118.13 trust, units or other interests in a partnership, bonds, debentures, notes or other equity
118.14 interests or debt instruments, or any contractual arrangements;

118.15 (2) membership, proprietary interest, or co-ownership with an individual, group, or
118.16 organization to which patients, clients, or customers are referred to; or

118.17 (3) employer-employee or independent contractor relationship, including, but not limited
118.18 to, those that may occur in a limited partnership, profit-sharing arrangement, or other similar
118.19 arrangement with any facility to which patients are referred, including any compensation
118.20 between a facility and a health care provider, the group practice of which the provider is a
118.21 member or employee or a related party with respect to any of them.

118.22 (e) "Fixed equipment" means a stationary diagnostic imaging machine installed in a
118.23 permanent location.

118.24 (f) "Mobile equipment" means a diagnostic imaging machine in a self-contained transport
118.25 vehicle designed to be brought to a temporary offsite location to perform diagnostic imaging
118.26 services.

118.27 (g) "Portable equipment" means a diagnostic imaging machine designed to be temporarily
118.28 transported within a permanent location to perform diagnostic imaging services.

118.29 (h) "Provider of diagnostic imaging services" means a diagnostic imaging facility or an
118.30 entity that offers and bills for diagnostic imaging services at a facility owned or leased by
118.31 the entity.

119.1 Sec. 9. Minnesota Statutes 2020, section 144.586, is amended by adding a subdivision to
119.2 read:

119.3 Subd. 4. Screening for eligibility for health coverage or assistance. (a) A hospital
119.4 must screen a patient who is uninsured or whose insurance coverage status is not known by
119.5 the hospital, for eligibility for charity care from the hospital, eligibility for state or federal
119.6 public health care programs using presumptive eligibility or another similar process, and
119.7 eligibility for a premium tax credit. The hospital must attempt to complete this screening
119.8 process in person or by telephone within 30 days after the patient's admission to the hospital.

119.9 (b) If the patient is eligible for charity care from the hospital, the hospital must assist
119.10 the patient in applying for charity care and must refer the patient to the appropriate
119.11 department in the hospital for follow-up.

119.12 (c) If the patient is presumptively eligible for a public health care program, the hospital
119.13 must assist the patient in completing an insurance affordability program application, help
119.14 schedule an appointment for the patient with a navigator organization, or provide the patient
119.15 with contact information for navigator services. If the patient is eligible for a premium tax
119.16 credit, the hospital may schedule an appointment for the patient with a navigator organization
119.17 or provide the patient with contact information for navigator services.

119.18 (d) A patient may decline to participate in the screening process, to apply for charity
119.19 care, to complete an insurance affordability program application, to schedule an appointment
119.20 with a navigator organization, or to accept information about navigator services.

119.21 (e) For purposes of this subdivision:

119.22 (1) "hospital" means a private, nonprofit, or municipal hospital licensed under sections
119.23 144.50 to 144.56;

119.24 (2) "navigator" has the meaning given in section 62V.02, subdivision 9;

119.25 (3) "premium tax credit" means a tax credit or premium subsidy under the federal Patient
119.26 Protection and Affordable Care Act, Public Law 111-148, as amended, including the federal
119.27 Health Care and Education Reconciliation Act of 2010, Public Law 111-152, and any
119.28 amendments to and federal guidance and regulations issued under these acts; and

119.29 (4) "presumptive eligibility" has the meaning given in section 256B.057, subdivision
119.30 12.

119.31 **EFFECTIVE DATE.** This section is effective November 1, 2022.

120.1 Sec. 10. Minnesota Statutes 2020, section 144.6502, subdivision 1, is amended to read:

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

120.4 (b) "Commissioner" means the commissioner of health.

120.5 (c) "Department" means the Department of Health.

120.6 (d) "Electronic monitoring" means the placement and use of an electronic monitoring
120.7 device ~~by a resident~~ in the resident's room or private living unit in accordance with this
120.8 section.

120.9 (e) "Electronic monitoring device" means a camera or other device that captures, records,
120.10 or broadcasts audio, video, or both, that is placed in a resident's room or private living unit
120.11 and is used to monitor the resident or activities in the room or private living unit.

120.12 (f) "Facility" means a facility that is:

120.13 (1) licensed as a nursing home under chapter 144A;

120.14 (2) licensed as a boarding care home under sections 144.50 to 144.56;

120.15 (3) until August 1, 2021, a housing with services establishment registered under chapter
120.16 144D that is either subject to chapter 144G or has a disclosed special unit under section
120.17 325F.72; or

120.18 (4) on or after August 1, 2021, an assisted living facility.

120.19 (g) "Resident" means a person 18 years of age or older residing in a facility.

120.20 (h) "Resident representative" means one of the following in the order of priority listed,
120.21 to the extent the person may reasonably be identified and located:

120.22 (1) a court-appointed guardian;

120.23 (2) a health care agent as defined in section 145C.01, subdivision 2; or

120.24 (3) a person who is not an agent of a facility or of a home care provider designated in
120.25 writing by the resident and maintained in the resident's records on file with the facility.

120.26 Sec. 11. Minnesota Statutes 2020, section 144.651, is amended by adding a subdivision
120.27 to read:

120.28 Subd. 10a. **Designated support person for pregnant patient.** (a) A health care provider
120.29 and a health care facility must allow, at a minimum, one designated support person of a

121.1 pregnant patient's choosing to be physically present while the patient is receiving health
121.2 care services including during a hospital stay.

121.3 (b) For purposes of this subdivision, "designated support person" means any person
121.4 necessary to provide comfort to the patient including but not limited to the patient's spouse,
121.5 partner, family member, or another person related by affinity. Certified doulas and traditional
121.6 midwives may not be counted toward the limit of one designated support person.

121.7 Sec. 12. Minnesota Statutes 2020, section 144.69, is amended to read:

121.8 **144.69 CLASSIFICATION OF DATA ON INDIVIDUALS.**

121.9 Subdivision 1. Data collected by the cancer reporting system. Notwithstanding any
121.10 law to the contrary, including section 13.05, subdivision 9, data collected on individuals by
121.11 the cancer ~~surveillance~~ reporting system, including the names and personal identifiers of
121.12 persons required in section 144.68 to report, shall be private and may only be used for the
121.13 purposes set forth in this section and sections 144.671, 144.672, and 144.68. Any disclosure
121.14 other than is provided for in this section and sections 144.671, 144.672, and 144.68, is
121.15 declared to be a misdemeanor and punishable as such. Except as provided by rule, and as
121.16 part of an epidemiologic investigation, an officer or employee of the commissioner of health
121.17 may interview patients named in any such report, or relatives of any such patient, only after
121.18 ~~the consent of~~ notifying the attending physician, advanced practice registered nurse, or
121.19 ~~surgeon is obtained.~~

121.20 Subd. 2. Transfers of information to non-Minnesota state and federal government
121.21 agencies. (a) Information containing personal identifiers collected by the cancer reporting
121.22 system may be provided to the statewide cancer registry of other states solely for the purposes
121.23 consistent with this section and sections 144.671, 144.672, and 144.68, provided that the
121.24 other state agrees to maintain the classification of the information as provided under
121.25 subdivision 1.

121.26 (b) Information, excluding direct identifiers such as name, Social Security number,
121.27 telephone number, and street address, collected by the cancer reporting system may be
121.28 provided to the Centers for Disease Control and Prevention's National Program of Cancer
121.29 Registries and the National Cancer Institute's Surveillance, Epidemiology, and End Results
121.30 Program registry.

122.1 Sec. 13. Minnesota Statutes 2021 Supplement, section 144.9501, subdivision 17, is amended
122.2 to read:

122.3 Subd. 17. **Lead hazard reduction.** (a) "Lead hazard reduction" means abatement, swab
122.4 team services, or interim controls undertaken to make a residence, child care facility, school,
122.5 playground, or other location where lead hazards are identified lead-safe by complying with
122.6 the lead standards and methods adopted under section 144.9508.

122.7 (b) Lead hazard reduction does not include renovation activity that is primarily intended
122.8 to remodel, repair, or restore a given structure or dwelling rather than abate or control
122.9 lead-based paint hazards.

122.10 (c) Lead hazard reduction does not include activities that disturb painted surfaces that
122.11 total:

122.12 (1) less than 20 square feet (two square meters) on exterior surfaces; or

122.13 (2) less than two square feet (0.2 square meters) in an interior room.

122.14 Sec. 14. Minnesota Statutes 2020, section 144.9501, subdivision 26a, is amended to read:

122.15 Subd. 26a. **Regulated lead work.** ~~(a)~~ "Regulated lead work" means:

122.16 (1) abatement;

122.17 (2) interim controls;

122.18 (3) a clearance inspection;

122.19 (4) a lead hazard screen;

122.20 (5) a lead inspection;

122.21 (6) a lead risk assessment;

122.22 (7) lead project designer services;

122.23 (8) lead sampling technician services;

122.24 (9) swab team services;

122.25 (10) renovation activities; ~~or~~

122.26 (11) lead hazard reduction; or

122.27 ~~(11)~~ (12) activities performed to comply with lead orders issued by a community health
122.28 board or an assessing agency.

123.1 ~~(b) Regulated lead work does not include abatement, interim controls, swab team services,~~
123.2 ~~or renovation activities that disturb painted surfaces that total no more than:~~
123.3 ~~(1) 20 square feet (two square meters) on exterior surfaces; or~~
123.4 ~~(2) six square feet (0.6 square meters) in an interior room.~~

123.5 Sec. 15. Minnesota Statutes 2020, section 144.9501, subdivision 26b, is amended to read:

123.6 Subd. 26b. **Renovation.** (a) "Renovation" means the modification of any pre-1978
123.7 affected property for compensation that results in the disturbance of known or presumed
123.8 lead-containing painted surfaces defined under section 144.9508, unless that activity is
123.9 performed as lead hazard reduction. A renovation performed for the purpose of converting
123.10 a building or part of a building into an affected property is a renovation under this
123.11 subdivision.

123.12 (b) Renovation does not include activities that disturb painted surfaces that total:

123.13 (1) less than 20 square feet (two square meters) on exterior surfaces; or

123.14 (2) less than six square feet (0.6 square meters) in an interior room.

123.15 Sec. 16. Minnesota Statutes 2020, section 144.9505, subdivision 1, is amended to read:

123.16 Subdivision 1. **Licensing, certification, and permitting.** (a) Fees collected under this
123.17 section shall be deposited into the state treasury and credited to the state government special
123.18 revenue fund.

123.19 (b) Persons shall not advertise or otherwise present themselves as lead supervisors, lead
123.20 workers, lead inspectors, lead risk assessors, lead sampling technicians, lead project designers,
123.21 renovation firms, or lead firms unless they have licenses or certificates issued by the
123.22 commissioner under this section.

123.23 (c) The fees required in this section for inspectors, risk assessors, and certified lead firms
123.24 are waived for state or local government employees performing services for or as an assessing
123.25 agency.

123.26 (d) An individual who is the owner of property on which ~~regulated lead work~~ lead hazard
123.27 reduction is to be performed or an adult individual who is related to the property owner, as
123.28 defined under section 245A.02, subdivision 13, is exempt from the requirements to obtain
123.29 a license and pay a fee according to this section.

123.30 (e) A person that employs individuals to perform ~~regulated lead work~~ lead hazard
123.31 reduction, clearance inspections, lead risk assessments, lead inspections, lead hazard screens,

124.1 lead project designer services, lead sampling technician services, and swab team services
 124.2 outside of the person's property must obtain certification as a certified lead firm. An
 124.3 individual who performs lead hazard reduction, lead hazard screens, lead inspections, lead
 124.4 risk assessments, clearance inspections, lead project designer services, lead sampling
 124.5 technician services, swab team services, and activities performed to comply with lead orders
 124.6 must be employed by a certified lead firm, unless the individual is a sole proprietor and
 124.7 does not employ any other individuals; the individual is employed by a person that does
 124.8 not perform ~~regulated lead work~~ lead hazard reduction, clearance inspections, lead risk
 124.9 assessments, lead inspections, lead hazard screens, lead project designer services, lead
 124.10 sampling technician services, and swab team services outside of the person's property; or
 124.11 the individual is employed by an assessing agency.

124.12 Sec. 17. Minnesota Statutes 2020, section 144.9505, subdivision 1h, is amended to read:

124.13 Subd. 1h. **Certified renovation firm.** A person who ~~employs individuals to perform~~
 124.14 performs renovation activities ~~outside of the person's property~~ must obtain certification as
 124.15 a renovation firm. The certificate must be in writing, contain an expiration date, be signed
 124.16 by the commissioner, and give the name and address of the person to whom it is issued. A
 124.17 renovation firm certificate is valid for two years. The certification fee is \$100, is
 124.18 nonrefundable, and must be submitted with each application. The renovation firm certificate
 124.19 or a copy of the certificate must be readily available at the worksite for review by the
 124.20 contracting entity, the commissioner, and other public health officials charged with the
 124.21 health, safety, and welfare of the state's citizens.

124.22 Sec. 18. Minnesota Statutes 2020, section 144A.01, is amended to read:

124.23 **144A.01 DEFINITIONS.**

124.24 Subdivision 1. **Scope.** For the purposes of sections 144A.01 to 144A.27, the terms
 124.25 defined in this section have the meanings given them.

124.26 Subd. 2. **Commissioner of health.** "Commissioner of health" means the state
 124.27 commissioner of health established by section 144.011.

124.28 Subd. 3. **Board of Executives for Long Term Services and Supports.** "Board of
 124.29 Executives for Long Term Services and Supports" means the Board of Executives for Long
 124.30 Term Services and Supports established by section 144A.19.

124.31 Subd. 3a. **Certified.** "Certified" means certified for participation as a provider in the
 124.32 Medicare or Medicaid programs under title XVIII or XIX of the Social Security Act.

125.1 Subd. 4. **Controlling person individual.** (a) "Controlling person individual" means ~~any~~
 125.2 ~~public body, governmental agency, business entity,~~ an owner and the following individuals
 125.3 and entities, if applicable:

125.4 (1) each officer of the organization, including the chief executive officer and the chief
 125.5 financial officer;

125.6 (2) the nursing home administrator; ~~or director whose responsibilities include the~~
 125.7 ~~direction of the management or policies of a nursing home~~

125.8 (3) any managerial official.

125.9 (b) "Controlling person individual" also means any entity or natural person who, directly
 125.10 ~~or indirectly, beneficially owns any~~ has any direct or indirect ownership interest in:

125.11 (1) any corporation, partnership or other business association which is a controlling
 125.12 ~~person individual;~~

125.13 (2) any other legal or business entity;

125.14 ~~(2)~~ (3) the land on which a nursing home is located;

125.15 ~~(3)~~ (4) the structure in which a nursing home is located;

125.16 ~~(4)~~ (5) any entity with at least a five percent mortgage, contract for deed, deed of trust,
 125.17 ~~or other obligation secured in whole or part by~~ security interest in the land or structure
 125.18 comprising a nursing home; or

125.19 ~~(5)~~ (6) any lease or sublease of the land, structure, or facilities comprising a nursing
 125.20 home.

125.21 ~~(b)~~ (c) "Controlling person individual" does not include:

125.22 (1) a bank, savings bank, trust company, savings association, credit union, industrial
 125.23 loan and thrift company, investment banking firm, or insurance company unless the entity
 125.24 directly or through a subsidiary operates a nursing home;

125.25 (2) government and government-sponsored entities such as the United States Department
 125.26 of Housing and Urban Development, Ginnie Mae, Fannie Mae, Freddie Mac, and the
 125.27 Minnesota Housing Finance Agency which provide loans, financing, and insurance products
 125.28 for housing sites;

125.29 ~~(2)~~ (3) an individual who is a state or federal official or, a state or federal employee, or
 125.30 a member or employee of the governing body of a political subdivision of the state which
 125.31 or federal government that operates one or more nursing homes, unless the individual is

126.1 also an officer ~~or director of a~~ owner, or managerial official of the nursing home, receives
126.2 any remuneration from a nursing home, or ~~owns any of the beneficial interests~~ who is a
126.3 controlling individual not otherwise excluded in this subdivision;

126.4 ~~(3)~~ (4) a natural person who is a member of a tax-exempt organization under section
126.5 290.05, subdivision 2, unless the individual is also ~~an officer or director of a nursing home,~~
126.6 ~~or owns any of the beneficial interests~~ a controlling individual not otherwise excluded in
126.7 this subdivision; and

126.8 ~~(4)~~ (5) a natural person who owns less than five percent of the outstanding common
126.9 shares of a corporation:

126.10 (i) whose securities are exempt by virtue of section 80A.45, clause (6); or

126.11 (ii) whose transactions are exempt by virtue of section 80A.46, clause (7).

126.12 Subd. 4a. **Emergency.** "Emergency" means a situation or physical condition that creates
126.13 or probably will create an immediate and serious threat to a resident's health or safety.

126.14 Subd. 5. **Nursing home.** "Nursing home" means a facility or that part of a facility which
126.15 provides nursing care to five or more persons. "Nursing home" does not include a facility
126.16 or that part of a facility which is a hospital, a hospital with approved swing beds as defined
126.17 in section 144.562, clinic, doctor's office, diagnostic or treatment center, or a residential
126.18 program licensed pursuant to sections 245A.01 to 245A.16 or 252.28.

126.19 Subd. 6. **Nursing care.** "Nursing care" means health evaluation and treatment of patients
126.20 and residents who are not in need of an acute care facility but who require nursing supervision
126.21 on an inpatient basis. The commissioner of health may by rule establish levels of nursing
126.22 care.

126.23 Subd. 7. **Uncorrected violation.** "Uncorrected violation" means a violation of a statute
126.24 or rule or any other deficiency for which a notice of noncompliance has been issued and
126.25 fine assessed and allowed to be recovered pursuant to section 144A.10, subdivision 8.

126.26 Subd. 8. **Managerial employee official.** "Managerial employee official" means an
126.27 ~~employee of a~~ individual who has the decision-making authority related to the operation of
126.28 the nursing home whose duties include and the responsibility for either: (1) the ongoing
126.29 management of the nursing home; or (2) the direction of some or all of the management or
126.30 policies, services, or employees of the nursing home.

126.31 Subd. 9. **Nursing home administrator.** "Nursing home administrator" means a person
126.32 who administers, manages, supervises, or is in general administrative charge of a nursing
126.33 home, whether or not the individual has an ownership interest in the home, and whether or

127.1 not the person's functions and duties are shared with one or more individuals, and who is
127.2 licensed pursuant to section 144A.21.

127.3 Subd. 10. **Repeated violation.** "Repeated violation" means the issuance of two or more
127.4 correction orders, within a 12-month period, for a violation of the same provision of a statute
127.5 or rule.

127.6 Subd. 11. **Change of ownership.** "Change of ownership" means a change in the licensee.

127.7 Subd. 12. **Direct ownership interest.** "Direct ownership interest" means an individual
127.8 or legal entity with the possession of at least five percent equity in capital, stock, or profits
127.9 of the licensee or who is a member of a limited liability company of the licensee.

127.10 Subd. 13. **Indirect ownership interest.** "Indirect ownership interest" means an individual
127.11 or legal entity with a direct ownership interest in an entity that has a direct or indirect
127.12 ownership interest of at least five percent in an entity that is a licensee.

127.13 Subd. 14. **Licensee.** "Licensee" means a person or legal entity to whom the commissioner
127.14 issues a license for a nursing home and who is responsible for the management, control,
127.15 and operation of the nursing home.

127.16 Subd. 15. **Management agreement.** "Management agreement" means a written, executed
127.17 agreement between a licensee and manager regarding the provision of certain services on
127.18 behalf of the licensee.

127.19 Subd. 16. **Manager.** "Manager" means an individual or legal entity designated by the
127.20 licensee through a management agreement to act on behalf of the licensee in the on-site
127.21 management of the nursing home.

127.22 Subd. 17. **Managing control.** "Managing control" means any organization that exercises
127.23 operational or managerial control over the nursing home or conducts the day-to-day
127.24 operations of the nursing home.

127.25 Subd. 18. **Owner.** "Owner" means: (1) an individual or legal entity that has a direct or
127.26 indirect ownership interest of five percent or more in a licensee; and (2) for purposes of this
127.27 chapter, owner of a nonprofit corporation means the president and treasurer of the board of
127.28 directors; and (3) for an entity owned by an employee stock ownership plan, owner means
127.29 the president and treasurer of the entity. A government entity that is issued a license under
127.30 this chapter shall be designated the owner.

127.31 **EFFECTIVE DATE.** This section is effective August 1, 2022.

128.1 Sec. 19. Minnesota Statutes 2020, section 144A.03, subdivision 1, is amended to read:

128.2 Subdivision 1. **Form; requirements.** (a) The commissioner of health by rule shall
128.3 establish forms and procedures for the processing of nursing home license applications.

128.4 (b) An application for a nursing home license shall include ~~the following information:~~

128.5 (1) ~~the names~~ business name and ~~addresses of all controlling persons and managerial~~
128.6 ~~employees of the facility to be licensed~~ legal entity name of the licensee;

128.7 (2) the street address, mailing address, and legal property description of the facility;

128.8 (3) the names, e-mail addresses, telephone numbers, and mailing addresses of all owners,
128.9 controlling individuals, managerial officials, and the nursing home administrator;

128.10 (4) the name and e-mail address of the managing agent and manager, if applicable;

128.11 (5) the licensed bed capacity;

128.12 (6) the license fee in the amount specified in section 144.122;

128.13 (7) documentation of compliance with the background study requirements in section
128.14 144.057 for the owner, controlling individuals, and managerial officials. Each application
128.15 for a new license must include documentation for the applicant and for each individual with
128.16 five percent or more direct or indirect ownership in the applicant;

128.17 ~~(3)~~ (8) a copy of the architectural and engineering plans and specifications of the facility
128.18 as prepared and certified by an architect or engineer registered to practice in this state; and

128.19 (9) a copy of the executed lease agreement between the landlord and the licensee, if
128.20 applicable;

128.21 (10) a copy of the management agreement, if applicable;

128.22 (11) a copy of the operations transfer agreement or similar agreement, if applicable;

128.23 (12) an organizational chart that identifies all organizations and individuals with an
128.24 ownership interest in the licensee of five percent or greater and that specifies their relationship
128.25 with the licensee and with each other;

128.26 (13) whether the applicant, owner, controlling individual, managerial official, or nursing
128.27 home administrator of the facility has ever been convicted of:

128.28 (i) a crime or found civilly liable for a federal or state felony-level offense that was
128.29 detrimental to the best interests of the facility and its residents within the last ten years
128.30 preceding submission of the license application. Offenses include: (A) felony crimes against
128.31 persons and other similar crimes for which the individual was convicted, including guilty

129.1 pleas and adjudicated pretrial diversions; (B) financial crimes such as extortion,
129.2 embezzlement, income tax evasion, insurance fraud, and other similar crimes for which the
129.3 individual was convicted, including guilty pleas and adjudicated pretrial diversions; (C)
129.4 any felonies involving malpractice that resulted in a conviction of criminal neglect or
129.5 misconduct; and (D) any felonies that would result in a mandatory exclusion under section
129.6 1128(a) of the Social Security Act;

129.7 (ii) any misdemeanor under federal or state law related to the delivery of an item or
129.8 service under Medicaid or a state health care program or the abuse or neglect of a patient
129.9 in connection with the delivery of a health care item or service;

129.10 (iii) any misdemeanor under federal or state law related to theft, fraud, embezzlement,
129.11 breach of fiduciary duty, or other financial misconduct in connection with the delivery of
129.12 a health care item or service;

129.13 (iv) any felony or misdemeanor under federal or state law relating to the interference
129.14 with or obstruction of any investigation into any criminal offense described in Code of
129.15 Federal Regulations, title 42, section 1001.101 or 1001.201;

129.16 (v) any felony or misdemeanor under federal or state law relating to the unlawful
129.17 manufacture, distribution, prescription, or dispensing of a controlled substance; or

129.18 (vi) any felony or gross misdemeanor that relates to the operation of a nursing home or
129.19 assisted living facility or directly affects resident safety or care during that period;

129.20 (14) whether the applicant, owner, controlling individual, managerial official, or nursing
129.21 home administrator of the facility has had:

129.22 (i) any revocation or suspension of a license to provide health care by any state licensing
129.23 authority. This includes the surrender of the license while a formal disciplinary proceeding
129.24 was pending before a state licensing authority;

129.25 (ii) any revocation or suspension of accreditation; or

129.26 (iii) any suspension or exclusion from participation in, or any sanction imposed by, a
129.27 federal or state health care program or any debarment from participation in any federal
129.28 executive branch procurement or nonprocurement program;

129.29 (15) whether in the preceding three years the applicant or any owner, controlling
129.30 individual, managerial official, or nursing home administrator of the facility has a record
129.31 of defaulting in the payment of money collected for others, including the discharge of debts
129.32 through bankruptcy proceedings;

130.1 (16) the signature of the owner of the licensee or an authorized agent of the licensee;

130.2 (17) identification of all states where the applicant or individual having a five percent
 130.3 or more ownership currently or previously has been licensed as an owner or operator of a
 130.4 long-term care, community-based, or health care facility or agency where the applicant's or
 130.5 individual's license or federal certification has been denied, suspended, restricted, conditioned,
 130.6 refused, not renewed, or revoked under a private or state-controlled receivership or where
 130.7 these same actions are pending under the laws of any state or federal authority;

130.8 (18) statistical information required by the commissioner; and

130.9 ~~(4)~~ (19) any other relevant information which the commissioner of health by rule or
 130.10 otherwise may determine is necessary to properly evaluate an application for license.

130.11 (c) A controlling ~~person~~ individual which is a corporation shall submit copies of its
 130.12 articles of incorporation and bylaws and any amendments thereto as they occur, together
 130.13 with the names and addresses of its officers and directors. A controlling ~~person~~ individual
 130.14 which is a foreign corporation shall furnish the commissioner of health with a copy of its
 130.15 certificate of authority to do business in this state. ~~An application on behalf of a controlling~~
 130.16 ~~person which is a corporation, association or a governmental unit or instrumentality shall~~
 130.17 ~~be signed by at least two officers or managing agents of that entity.~~

130.18 **EFFECTIVE DATE.** This section is effective August 1, 2022.

130.19 Sec. 20. Minnesota Statutes 2020, section 144A.04, subdivision 4, is amended to read:

130.20 Subd. 4. **Controlling ~~person~~ individual restrictions.** (a) The commissioner has discretion
 130.21 to bar any controlling ~~persons~~ individual of a nursing home ~~may not include any if the~~
 130.22 ~~person who~~ was a controlling ~~person~~ individual of ~~another~~ any other nursing home ~~during~~
 130.23 ~~any period of time,~~ assisted living facility, long-term care or health care facility, or agency
 130.24 in the previous two-year period and:

130.25 (1) ~~during which that period of time of control that other nursing home~~ the facility or
 130.26 agency incurred the following number of uncorrected or repeated violations:

130.27 (i) two or more uncorrected violations or one or more repeated violations which created
 130.28 an imminent risk to direct resident or client care or safety; or

130.29 (ii) four or more uncorrected violations or two or more repeated violations ~~of any nature~~
 130.30 ~~for which the fines are in the four highest daily fine categories prescribed in rule~~ that created
 130.31 an imminent risk to direct resident or client care or safety; or

131.1 (2) ~~who~~ during that period of time, was convicted of a felony or gross misdemeanor that
 131.2 ~~relates~~ related to operation of the ~~nursing home~~ facility or agency or directly ~~affects~~ affected
 131.3 resident safety or care, ~~during that period~~.

131.4 (b) The provisions of this subdivision shall not apply to any controlling ~~person~~ individual
 131.5 who had no legal authority to affect or change decisions related to the operation of the
 131.6 nursing home which incurred the uncorrected violations.

131.7 (c) When the commissioner bars a controlling individual under this subdivision, the
 131.8 controlling individual has the right to appeal under chapter 14.

131.9 Sec. 21. Minnesota Statutes 2020, section 144A.04, subdivision 6, is amended to read:

131.10 Subd. 6. **Managerial employee official or licensed administrator; employment**
 131.11 **prohibitions.** A nursing home may not employ as a managerial employee official or as its
 131.12 licensed administrator any person who was a managerial employee official or the licensed
 131.13 administrator of another facility during any period of time in the previous two-year period:

131.14 (1) during which time of employment that other nursing home incurred the following
 131.15 number of uncorrected violations which were in the jurisdiction and control of the managerial
 131.16 employee official or the administrator:

131.17 (i) two or more uncorrected violations ~~or one or more repeated violations which created~~
 131.18 ~~an imminent risk to direct resident care or safety~~; or

131.19 (ii) four or more uncorrected violations or two or more repeated violations of any nature
 131.20 for which the fines are in the four highest daily fine categories prescribed in rule; or

131.21 (2) who was convicted of a felony or gross misdemeanor that relates to operation of the
 131.22 nursing home or directly affects resident safety or care, during that period.

131.23 **EFFECTIVE DATE.** This section is effective August 1, 2022.

131.24 Sec. 22. Minnesota Statutes 2020, section 144A.06, is amended to read:

131.25 **144A.06 TRANSFER OF ~~INTERESTS~~ LICENSE PROHIBITED.**

131.26 Subdivision 1. ~~Notice; expiration of license~~ **Transfers prohibited.** ~~Any controlling~~
 131.27 ~~person who makes any transfer of a beneficial interest in a nursing home shall notify the~~
 131.28 ~~commissioner of health of the transfer within 14 days of its occurrence. The notification~~
 131.29 ~~shall identify by name and address the transferor and transferee and shall specify the nature~~
 131.30 ~~and amount of the transferred interest. On determining that the transferred beneficial interest~~
 131.31 ~~exceeds ten percent of the total beneficial interest in the nursing home facility, the structure~~

132.1 ~~in which the facility is located, or the land upon which the structure is located, the~~
 132.2 ~~commissioner may, and on determining that the transferred beneficial interest exceeds 50~~
 132.3 ~~percent of the total beneficial interest in the facility, the structure in which the facility is~~
 132.4 ~~located, or the land upon which the structure is located, the commissioner shall require that~~
 132.5 ~~the license of the nursing home expire 90 days after the date of transfer. The commissioner~~
 132.6 ~~of health shall notify the nursing home by certified mail of the expiration of the license at~~
 132.7 ~~least 60 days prior to the date of expiration. A nursing home license may not be transferred.~~

132.8 Subd. 2. ~~Relicensure~~ **New license required; change of ownership.** (a) The
 132.9 commissioner of health by rule shall prescribe procedures for ~~relicensure~~ licensure under
 132.10 this section. ~~The commissioner of health shall relicense a nursing home if the facility satisfies~~
 132.11 ~~the requirements for license renewal established by section 144A.05. A facility shall not be~~
 132.12 ~~relicensed by the commissioner if at the time of transfer there are any uncorrected violations.~~
 132.13 ~~The commissioner of health may temporarily waive correction of one or more violations if~~
 132.14 ~~the commissioner determines that:~~

132.15 ~~(1) temporary noncorrection of the violation will not create an imminent risk of harm~~
 132.16 ~~to a nursing home resident; and~~

132.17 ~~(2) a controlling person on behalf of all other controlling persons:~~

132.18 ~~(i) has entered into a contract to obtain the materials or labor necessary to correct the~~
 132.19 ~~violation, but the supplier or other contractor has failed to perform the terms of the contract~~
 132.20 ~~and the inability of the nursing home to correct the violation is due solely to that failure; or~~

132.21 ~~(ii) is otherwise making a diligent good faith effort to correct the violation.~~

132.22 (b) A new license is required and the prospective licensee must apply for a license prior
 132.23 to operating a currently licensed nursing home. The licensee must change whenever one of
 132.24 the following events occur:

132.25 (1) the form of the licensee's legal entity structure is converted or changed to a different
 132.26 type of legal entity structure;

132.27 (2) the licensee dissolves, consolidates, or merges with another legal organization and
 132.28 the licensee's legal organization does not survive;

132.29 (3) within the previous 24 months, 50 percent or more of the licensee's ownership interest
 132.30 is transferred, whether by a single transaction or multiple transactions to:

132.31 (i) a different person; or

133.1 (ii) a person who had less than a five percent ownership interest in the facility at the
133.2 time of the first transaction; or

133.3 (4) any other event or combination of events that results in a substitution, elimination,
133.4 or withdrawal of the licensee's responsibility for the facility.

133.5 Subd. 3. **Compliance.** The commissioner must consult with the commissioner of human
133.6 services regarding the history of financial and cost reporting compliance of the prospective
133.7 licensee and prospective licensee's financial operations in any nursing home that the
133.8 prospective licensee or any controlling individual listed in the license application has had
133.9 an interest in.

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

133.12 **EFFECTIVE DATE.** This section is effective August 1, 2022.

133.13 Sec. 23. **[144A.32] CONSIDERATION OF APPLICATIONS.**

133.14 (a) Before issuing a provisional license or license or renewing an existing license, the
133.15 commissioner shall consider an applicant's compliance history in providing care in a facility
133.16 that provides care to children, the elderly, ill individuals, or individuals with disabilities.

133.17 (b) The applicant's compliance history shall include repeat violations, rule violations,
133.18 and any license or certification involuntarily suspended or terminated during an enforcement
133.19 process.

133.20 (c) The commissioner may deny, revoke, suspend, restrict, or refuse to renew the license
133.21 or impose conditions if:

133.22 (1) the applicant fails to provide complete and accurate information on the application
133.23 and the commissioner concludes that the missing or corrected information is needed to
133.24 determine if a license is granted;

133.25 (2) the applicant, knowingly or with reason to know, made a false statement of a material
133.26 fact in an application for the license or any data attached to the application or in any matter
133.27 under investigation by the department;

133.28 (3) the applicant refused to allow agents of the commissioner to inspect the applicant's
133.29 books, records, files related to the license application, or any portion of the premises;

133.30 (4) the applicant willfully prevented, interfered with, or attempted to impede in any way:

134.1 (i) the work of any authorized representative of the commissioner, the ombudsman for
 134.2 long-term care, or the ombudsman for mental health and developmental disabilities; or

134.3 (ii) the duties of the commissioner, local law enforcement, city or county attorneys, adult
 134.4 protection, county case managers, or other local government personnel;

134.5 (5) the applicant has a history of noncompliance with federal or state regulations that
 134.6 were detrimental to the health, welfare, or safety of a resident or a client; or

134.7 (6) the applicant violates any requirement in this chapter or chapter 256R.

134.8 (d) If a license is denied, the applicant has the reconsideration rights available under
 134.9 chapter 14.

134.10 **EFFECTIVE DATE.** This section is effective August 1, 2022.

134.11 Sec. 24. Minnesota Statutes 2020, section 144A.4799, subdivision 1, is amended to read:

134.12 Subdivision 1. **Membership.** The commissioner of health shall appoint ~~eight~~ 13 persons
 134.13 to a home care and assisted living program advisory council consisting of the following:

134.14 (1) ~~three~~ two public members as defined in section 214.02 who shall be persons who
 134.15 are currently receiving home care services, persons who have received home care services
 134.16 within five years of the application date, persons who have family members receiving home
 134.17 care services, or persons who have family members who have received home care services
 134.18 within five years of the application date;

134.19 (2) ~~three~~ two Minnesota home care licensees representing basic and comprehensive
 134.20 levels of licensure who may be a managerial official, an administrator, a supervising
 134.21 registered nurse, or an unlicensed personnel performing home care tasks;

134.22 (3) one member representing the Minnesota Board of Nursing;

134.23 (4) one member representing the Office of Ombudsman for Long-Term Care; ~~and~~

134.24 (5) one member representing the Office of Ombudsman for Mental Health and
 134.25 Developmental Disabilities;

134.26 ~~(5)~~ (6) beginning July 1, 2021, one member of a county health and human services or
 134.27 county adult protection office;

134.28 (7) two Minnesota assisted living facility licensees representing assisted living facilities
 134.29 and assisted living facilities with dementia care levels of licensure who may be the facility's
 134.30 assisted living director, managerial official, or clinical nurse supervisor;

135.1 (8) one organization representing long-term care providers, home care providers, and
135.2 assisted living providers in Minnesota; and

135.3 (9) two public members as defined in section 214.02. One public member shall be a
135.4 person who either is or has been a resident in an assisted living facility and one public
135.5 member shall be a person who has or had a family member living in an assisted living
135.6 facility setting.

135.7 Sec. 25. Minnesota Statutes 2020, section 144A.4799, subdivision 3, is amended to read:

135.8 Subd. 3. **Duties.** (a) At the commissioner's request, the advisory council shall provide
135.9 advice regarding regulations of Department of Health licensed assisted living and home
135.10 care providers in this chapter, including advice on the following:

135.11 (1) community standards for home care practices;

135.12 (2) enforcement of licensing standards and whether certain disciplinary actions are
135.13 appropriate;

135.14 (3) ways of distributing information to licensees and consumers of home care and assisted
135.15 living services defined under chapter 144G;

135.16 (4) training standards;

135.17 (5) identifying emerging issues and opportunities in home care and assisted living services
135.18 defined under chapter 144G;

135.19 (6) identifying the use of technology in home and telehealth capabilities;

135.20 (7) allowable home care licensing modifications and exemptions, including a method
135.21 for an integrated license with an existing license for rural licensed nursing homes to provide
135.22 limited home care services in an adjacent independent living apartment building owned by
135.23 the licensed nursing home; and

135.24 (8) recommendations for studies using the data in section 62U.04, subdivision 4, including
135.25 but not limited to studies concerning costs related to dementia and chronic disease among
135.26 an elderly population over 60 and additional long-term care costs, as described in section
135.27 62U.10, subdivision 6.

135.28 (b) The advisory council shall perform other duties as directed by the commissioner.

135.29 (c) The advisory council shall annually make recommendations to the commissioner for
135.30 the purposes in section 144A.474, subdivision 11, paragraph (i). The recommendations shall
135.31 address ways the commissioner may improve protection of the public under existing statutes

136.1 and laws and include but are not limited to projects that create and administer training of
136.2 licensees and their employees to improve residents' lives, supporting ways that licensees
136.3 can improve and enhance quality care and ways to provide technical assistance to licensees
136.4 to improve compliance; information technology and data projects that analyze and
136.5 communicate information about trends of violations or lead to ways of improving client
136.6 care; communications strategies to licensees and the public; and other projects or pilots that
136.7 benefit clients, families, and the public.

136.8 Sec. 26. Minnesota Statutes 2020, section 144A.75, subdivision 12, is amended to read:

136.9 Subd. 12. **Palliative care.** "Palliative care" means ~~the total active care of patients whose~~
136.10 ~~disease is not responsive to curative treatment. Control of pain, of other symptoms, and of~~
136.11 ~~psychological, social, and spiritual problems is paramount~~ specialized medical care for
136.12 people living with a serious illness or life-limiting condition. This type of care is focused
136.13 on reducing the pain, symptoms, and stress of a serious illness or condition. Palliative care
136.14 is a team-based approach to care, providing essential support at any age or stage of a serious
136.15 illness or condition, and is often provided together with curative treatment. The goal of
136.16 palliative care is ~~the achievement of the best quality of life for patients and their families~~
136.17 to improve quality of life for both the patient and the patient's family or care partner.

136.18 Sec. 27. Minnesota Statutes 2020, section 144G.08, is amended by adding a subdivision
136.19 to read:

136.20 Subd. 62a. **Serious injury.** "Serious injury" has the meaning given in section 245.91,
136.21 subdivision 6.

136.22 Sec. 28. Minnesota Statutes 2020, section 144G.15, is amended to read:

136.23 **144G.15 CONSIDERATION OF APPLICATIONS.**

136.24 (a) Before issuing a provisional license or license or renewing a license, the commissioner
136.25 shall consider an applicant's compliance history in providing care in this state or any other
136.26 state in a facility that provides care to children, the elderly, ill individuals, or individuals
136.27 with disabilities.

136.28 (b) The applicant's compliance history shall include repeat violation, rule violations, and
136.29 any license or certification involuntarily suspended or terminated during an enforcement
136.30 process.

136.31 (c) The commissioner may deny, revoke, suspend, restrict, or refuse to renew the license
136.32 or impose conditions if:

137.1 (1) the applicant fails to provide complete and accurate information on the application
 137.2 and the commissioner concludes that the missing or corrected information is needed to
 137.3 determine if a license shall be granted;

137.4 (2) the applicant, knowingly or with reason to know, made a false statement of a material
 137.5 fact in an application for the license or any data attached to the application or in any matter
 137.6 under investigation by the department;

137.7 (3) the applicant refused to allow agents of the commissioner to inspect its books, records,
 137.8 and files related to the license application, or any portion of the premises;

137.9 (4) the applicant willfully prevented, interfered with, or attempted to impede in any way:
 137.10 (i) the work of any authorized representative of the commissioner, the ombudsman for
 137.11 long-term care, or the ombudsman for mental health and developmental disabilities; or (ii)
 137.12 the duties of the commissioner, local law enforcement, city or county attorneys, adult
 137.13 protection, county case managers, or other local government personnel;

137.14 (5) the applicant, owner, controlling individual, managerial official, or assisted living
 137.15 director for the facility has a history of noncompliance with federal or state regulations that
 137.16 were detrimental to the health, welfare, or safety of a resident or a client; or

137.17 (6) the applicant violates any requirement in this chapter.

137.18 (d) If a license is denied, the applicant has the reconsideration rights available under
 137.19 section 144G.16, subdivision 4.

137.20 Sec. 29. Minnesota Statutes 2020, section 144G.17, is amended to read:

137.21 **144G.17 LICENSE RENEWAL.**

137.22 A license that is not a provisional license may be renewed for a period of up to one year
 137.23 if the licensee:

137.24 (1) submits an application for renewal in the format provided by the commissioner at
 137.25 least 60 calendar days before expiration of the license;

137.26 (2) submits the renewal fee under section 144G.12, subdivision 3;

137.27 (3) submits the late fee under section 144G.12, subdivision 4, if the renewal application
 137.28 is received less than 30 days before the expiration date of the license or after the expiration
 137.29 of the license;

137.30 (4) provides information sufficient to show that the applicant meets the requirements of
 137.31 licensure, including items required under section 144G.12, subdivision 1; ~~and~~

138.1 (5) provides information sufficient to show the licensee provided assisted living services
138.2 to at least one resident during the immediately preceding license year and at the assisted
138.3 living facility listed on the license; and

138.4 ~~(5)~~ (6) provides any other information deemed necessary by the commissioner.

138.5 Sec. 30. Minnesota Statutes 2020, section 144G.19, is amended by adding a subdivision
138.6 to read:

138.7 Subd. 4. **Change of licensee.** Notwithstanding any other provision of law, a change of
138.8 licensee under subdivision 2 does not require the facility to meet the design requirements
138.9 of section 144G.45, subdivisions 4 to 6, or 144G.81, subdivision 3.

138.10 Sec. 31. Minnesota Statutes 2020, section 144G.20, subdivision 1, is amended to read:

138.11 Subdivision 1. **Conditions.** (a) The commissioner may refuse to grant a provisional
138.12 license, refuse to grant a license as a result of a change in ownership, refuse to renew a
138.13 license, suspend or revoke a license, or impose a conditional license if the owner, controlling
138.14 individual, or employee of an assisted living facility:

138.15 (1) is in violation of, or during the term of the license has violated, any of the requirements
138.16 in this chapter or adopted rules;

138.17 (2) permits, aids, or abets the commission of any illegal act in the provision of assisted
138.18 living services;

138.19 (3) performs any act detrimental to the health, safety, and welfare of a resident;

138.20 (4) obtains the license by fraud or misrepresentation;

138.21 (5) knowingly makes a false statement of a material fact in the application for a license
138.22 or in any other record or report required by this chapter;

138.23 (6) denies representatives of the department access to any part of the facility's books,
138.24 records, files, or employees;

138.25 (7) interferes with or impedes a representative of the department in contacting the facility's
138.26 residents;

138.27 (8) interferes with or impedes ombudsman access according to section 256.9742,
138.28 subdivision 4, or interferes with or impedes access by the Office of Ombudsman for Mental
138.29 Health and Developmental Disabilities according to section 245.94, subdivision 1;

139.1 (9) interferes with or impedes a representative of the department in the enforcement of
139.2 this chapter or fails to fully cooperate with an inspection, survey, or investigation by the
139.3 department;

139.4 (10) destroys or makes unavailable any records or other evidence relating to the assisted
139.5 living facility's compliance with this chapter;

139.6 (11) refuses to initiate a background study under section 144.057 or 245A.04;

139.7 (12) fails to timely pay any fines assessed by the commissioner;

139.8 (13) violates any local, city, or township ordinance relating to housing or assisted living
139.9 services;

139.10 (14) has repeated incidents of personnel performing services beyond their competency
139.11 level; or

139.12 (15) has operated beyond the scope of the assisted living facility's license category.

139.13 (b) A violation by a contractor providing the assisted living services of the facility is a
139.14 violation by the facility.

139.15 Sec. 32. Minnesota Statutes 2020, section 144G.20, subdivision 4, is amended to read:

139.16 Subd. 4. **Mandatory revocation.** Notwithstanding the provisions of subdivision 13,
139.17 paragraph (a), the commissioner must revoke a license if a controlling individual of the
139.18 facility is convicted of a felony or gross misdemeanor that relates to operation of the facility
139.19 or directly affects resident safety or care. The commissioner shall notify the facility and the
139.20 Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health
139.21 and Developmental Disabilities 30 calendar days in advance of the date of revocation.

139.22 Sec. 33. Minnesota Statutes 2020, section 144G.20, subdivision 5, is amended to read:

139.23 Subd. 5. **Owners and managerial officials; refusal to grant license.** (a) The owners
139.24 and managerial officials of a facility whose Minnesota license has not been renewed or
139.25 whose ~~Minnesota~~ license in this state or any other state has been revoked because of
139.26 noncompliance with applicable laws or rules shall not be eligible to apply for nor will be
139.27 granted an assisted living facility license under this chapter or a home care provider license
139.28 under chapter 144A, or be given status as an enrolled personal care assistance provider
139.29 agency or personal care assistant by the Department of Human Services under section
139.30 256B.0659, for five years following the effective date of the nonrenewal or revocation. If

140.1 the owners or managerial officials already have enrollment status, the Department of Human
140.2 Services shall terminate that enrollment.

140.3 (b) The commissioner shall not issue a license to a facility for five years following the
140.4 effective date of license nonrenewal or revocation if the owners or managerial officials,
140.5 including any individual who was an owner or managerial official of another licensed
140.6 provider, had a ~~Minnesota~~ license in this state or any other state that was not renewed or
140.7 was revoked as described in paragraph (a).

140.8 (c) Notwithstanding subdivision 1, the commissioner shall not renew, or shall suspend
140.9 or revoke, the license of a facility that includes any individual as an owner or managerial
140.10 official who was an owner or managerial official of a facility whose ~~Minnesota~~ license in
140.11 this state or any other state was not renewed or was revoked as described in paragraph (a)
140.12 for five years following the effective date of the nonrenewal or revocation.

140.13 (d) The commissioner shall notify the facility 30 calendar days in advance of the date
140.14 of nonrenewal, suspension, or revocation of the license.

140.15 Sec. 34. Minnesota Statutes 2020, section 144G.20, subdivision 8, is amended to read:

140.16 Subd. 8. **Controlling individual restrictions.** (a) The commissioner has discretion to
140.17 bar any controlling individual of a facility if the person was a controlling individual of any
140.18 other nursing home, home care provider licensed under chapter 144A, or given status as an
140.19 enrolled personal care assistance provider agency or personal care assistant by the Department
140.20 of Human Services under section 256B.0659, or assisted living facility in the previous
140.21 two-year period and:

140.22 (1) during that period of time the nursing home, home care provider licensed under
140.23 chapter 144A, or given status as an enrolled personal care assistance provider agency or
140.24 personal care assistant by the Department of Human Services under section 256B.0659, or
140.25 assisted living facility incurred the following number of uncorrected or repeated violations:

140.26 (i) two or more repeated violations that created an imminent risk to direct resident care
140.27 or safety; or

140.28 (ii) four or more uncorrected violations that created an imminent risk to direct resident
140.29 care or safety; or

140.30 (2) during that period of time, was convicted of a felony or gross misdemeanor that
140.31 related to the operation of the nursing home, home care provider licensed under chapter
140.32 144A, or given status as an enrolled personal care assistance provider agency or personal

141.1 care assistant by the Department of Human Services under section 256B.0659, or assisted
141.2 living facility, or directly affected resident safety or care.

141.3 (b) When the commissioner bars a controlling individual under this subdivision, the
141.4 controlling individual may appeal the commissioner's decision under chapter 14.

141.5 Sec. 35. Minnesota Statutes 2020, section 144G.20, subdivision 9, is amended to read:

141.6 Subd. 9. **Exception to controlling individual restrictions.** Subdivision 8 does not apply
141.7 to any controlling individual of the facility who had no legal authority to affect or change
141.8 decisions related to the operation of the nursing home ~~or~~, assisted living facility, or home
141.9 care that incurred the uncorrected or repeated violations.

141.10 Sec. 36. Minnesota Statutes 2020, section 144G.20, subdivision 12, is amended to read:

141.11 Subd. 12. **Notice to residents.** (a) Within five business days after proceedings are initiated
141.12 by the commissioner to revoke or suspend a facility's license, or a decision by the
141.13 commissioner not to renew a living facility's license, the controlling individual of the facility
141.14 or a designee must provide to the commissioner ~~and~~, the ombudsman for long-term care,
141.15 and the Office of Ombudsman for Mental Health and Developmental Disabilities the names
141.16 of residents and the names and addresses of the residents' designated representatives and
141.17 legal representatives, and family or other contacts listed in the assisted living contract.

141.18 (b) The controlling individual or designees of the facility must provide updated
141.19 information each month until the proceeding is concluded. If the controlling individual or
141.20 designee of the facility fails to provide the information within this time, the facility is subject
141.21 to the issuance of:

141.22 (1) a correction order; and

141.23 (2) a penalty assessment by the commissioner in rule.

141.24 (c) Notwithstanding subdivisions 21 and 22, any correction order issued under this
141.25 subdivision must require that the facility immediately comply with the request for information
141.26 and that, as of the date of the issuance of the correction order, the facility shall forfeit to the
141.27 state a \$500 fine the first day of noncompliance and an increase in the \$500 fine by \$100
141.28 increments for each day the noncompliance continues.

141.29 (d) Information provided under this subdivision may be used by the commissioner ~~or~~,
141.30 the ombudsman for long-term care, or the Office of Ombudsman for Mental Health and
141.31 Developmental Disabilities only for the purpose of providing affected consumers information
141.32 about the status of the proceedings.

142.1 (e) Within ten business days after the commissioner initiates proceedings to revoke,
142.2 suspend, or not renew a facility license, the commissioner must send a written notice of the
142.3 action and the process involved to each resident of the facility, legal representatives and
142.4 designated representatives, and at the commissioner's discretion, additional resident contacts.

142.5 (f) The commissioner shall provide the ombudsman for long-term care and the Office
142.6 of Ombudsman for Mental Health and Developmental Disabilities with monthly information
142.7 on the department's actions and the status of the proceedings.

142.8 Sec. 37. Minnesota Statutes 2020, section 144G.20, subdivision 15, is amended to read:

142.9 Subd. 15. **Plan required.** (a) The process of suspending, revoking, or refusing to renew
142.10 a license must include a plan for transferring affected residents' cares to other providers by
142.11 the facility. The commissioner shall monitor the transfer plan. Within three calendar days
142.12 of being notified of the final revocation, refusal to renew, or suspension, the licensee shall
142.13 provide the commissioner, the lead agencies as defined in section 256B.0911, county adult
142.14 protection and case managers, ~~and~~ the ombudsman for long-term care, and the Office of
142.15 Ombudsman for Mental Health and Developmental Disabilities with the following
142.16 information:

142.17 (1) a list of all residents, including full names and all contact information on file;

142.18 (2) a list of the resident's legal representatives and designated representatives and family
142.19 or other contacts listed in the assisted living contract, including full names and all contact
142.20 information on file;

142.21 (3) the location or current residence of each resident;

142.22 (4) the payor sources for each resident, including payor source identification numbers;
142.23 and

142.24 (5) for each resident, a copy of the resident's service plan and a list of the types of services
142.25 being provided.

142.26 (b) The revocation, refusal to renew, or suspension notification requirement is satisfied
142.27 by mailing the notice to the address in the license record. The licensee shall cooperate with
142.28 the commissioner and the lead agencies, county adult protection and case managers, ~~and~~
142.29 the ombudsman for long-term care, and the Office of Ombudsman for Mental Health and
142.30 Developmental Disabilities during the process of transferring care of residents to qualified
142.31 providers. Within three calendar days of being notified of the final revocation, refusal to
142.32 renew, or suspension action, the facility must notify and disclose to each of the residents,
142.33 or the resident's legal and designated representatives or emergency contact persons, that the

143.1 commissioner is taking action against the facility's license by providing a copy of the
143.2 revocation, refusal to renew, or suspension notice issued by the commissioner. If the facility
143.3 does not comply with the disclosure requirements in this section, the commissioner shall
143.4 notify the residents, legal and designated representatives, or emergency contact persons
143.5 about the actions being taken. Lead agencies, county adult protection and case managers,
143.6 and the Office of Ombudsman for Long-Term Care may also provide this information. The
143.7 revocation, refusal to renew, or suspension notice is public data except for any private data
143.8 contained therein.

143.9 (c) A facility subject to this subdivision may continue operating while residents are being
143.10 transferred to other service providers.

143.11 Sec. 38. Minnesota Statutes 2020, section 144G.30, subdivision 5, is amended to read:

143.12 Subd. 5. **Correction orders.** (a) A correction order may be issued whenever the
143.13 commissioner finds upon survey or during a complaint investigation that a facility, a
143.14 managerial official, an agent of the facility, or an employee of the facility is not in compliance
143.15 with this chapter. The correction order shall cite the specific statute and document areas of
143.16 noncompliance and the time allowed for correction.

143.17 (b) The commissioner shall mail or e-mail copies of any correction order to the facility
143.18 within 30 calendar days after the survey exit date. A copy of each correction order and
143.19 copies of any documentation supplied to the commissioner shall be kept on file by the
143.20 facility and public documents shall be made available for viewing by any person upon
143.21 request. Copies may be kept electronically.

143.22 (c) By the correction order date, the facility must document in the facility's records any
143.23 action taken to comply with the correction order. The commissioner may request a copy of
143.24 this documentation and the facility's action to respond to the correction order in future
143.25 surveys, upon a complaint investigation, and as otherwise needed.

143.26 Sec. 39. Minnesota Statutes 2020, section 144G.31, subdivision 4, is amended to read:

143.27 Subd. 4. **Fine amounts.** (a) Fines and enforcement actions under this subdivision may
143.28 be assessed based on the level and scope of the violations described in subdivisions 2 and
143.29 3 as follows and may be imposed immediately with no opportunity to correct the violation
143.30 prior to imposition:

143.31 (1) Level 1, no fines or enforcement;

144.1 (2) Level 2, a fine of \$500 per violation, in addition to any enforcement mechanism
144.2 authorized in section 144G.20 for widespread violations;

144.3 (3) Level 3, a fine of \$3,000 per violation ~~per incident~~, in addition to any enforcement
144.4 mechanism authorized in section 144G.20;

144.5 (4) Level 4, a fine of \$5,000 per ~~incident~~ violation, in addition to any enforcement
144.6 mechanism authorized in section 144G.20; and

144.7 (5) for maltreatment violations for which the licensee was determined to be responsible
144.8 for the maltreatment under section 626.557, subdivision 9c, paragraph (c), a fine of \$1,000
144.9 per incident. A fine of \$5,000 per incident may be imposed if the commissioner determines
144.10 the licensee is responsible for maltreatment consisting of sexual assault, death, or abuse
144.11 resulting in serious injury.

144.12 (b) When a fine is assessed against a facility for substantiated maltreatment, the
144.13 commissioner shall not also impose an immediate fine under this chapter for the same
144.14 circumstance.

144.15 Sec. 40. Minnesota Statutes 2020, section 144G.31, subdivision 8, is amended to read:

144.16 Subd. 8. **Deposit of fines.** Fines collected under this section shall be deposited in a
144.17 dedicated special revenue account. On an annual basis, the balance in the special revenue
144.18 account shall be appropriated to the commissioner for special projects to improve ~~home~~
144.19 ~~care~~ resident quality of care and outcomes in assisted living facilities licensed under chapter
144.20 144G in Minnesota as recommended by the advisory council established in section
144.21 144A.4799.

144.22 **EFFECTIVE DATE.** This section is effective retroactively for fines collected on or
144.23 after August 1, 2021.

144.24 Sec. 41. Minnesota Statutes 2020, section 144G.41, subdivision 7, is amended to read:

144.25 Subd. 7. **Resident grievances; reporting maltreatment.** All facilities must post in a
144.26 conspicuous place information about the facilities' grievance procedure, and the name,
144.27 telephone number, and e-mail contact information for the individuals who are responsible
144.28 for handling resident grievances. The notice must also have the contact information for the
144.29 ~~state and applicable regional~~ Office of Ombudsman for Long-Term Care and the Office of
144.30 Ombudsman for Mental Health and Developmental Disabilities, and must have information
144.31 for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. The
144.32 notice must also state that if an individual has a complaint about the facility or person

145.1 providing services, the individual may contact the Office of Health Facility Complaints at
145.2 the Minnesota Department of Health.

145.3 Sec. 42. Minnesota Statutes 2020, section 144G.41, subdivision 8, is amended to read:

145.4 Subd. 8. **Protecting resident rights.** All facilities shall ensure that every resident has
145.5 access to consumer advocacy or legal services by:

145.6 (1) providing names and contact information, including telephone numbers and e-mail
145.7 addresses of at least three organizations that provide advocacy or legal services to residents,
145.8 one of which must include the designated protection and advocacy organization in Minnesota
145.9 that provides advice and representation to individuals with disabilities;

145.10 (2) providing the name and contact information for the Minnesota Office of Ombudsman
145.11 for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental
145.12 Disabilities, ~~including both the state and regional contact information;~~

145.13 (3) assisting residents in obtaining information on whether Medicare or medical assistance
145.14 under chapter 256B will pay for services;

145.15 (4) making reasonable accommodations for people who have communication disabilities
145.16 and those who speak a language other than English; and

145.17 (5) providing all information and notices in plain language and in terms the residents
145.18 can understand.

145.19 Sec. 43. Minnesota Statutes 2020, section 144G.42, subdivision 10, is amended to read:

145.20 Subd. 10. **Disaster planning and emergency preparedness plan.** (a) The facility must
145.21 meet the following requirements:

145.22 (1) have a written emergency disaster plan that contains a plan for evacuation, addresses
145.23 elements of sheltering in place, identifies temporary relocation sites, and details staff
145.24 assignments in the event of a disaster or an emergency;

145.25 (2) post an emergency disaster plan prominently;

145.26 (3) provide building emergency exit diagrams to all residents;

145.27 (4) post emergency exit diagrams on each floor; and

145.28 (5) have a written policy and procedure regarding missing ~~tenant~~ residents.

145.29 (b) The facility must provide emergency and disaster training to all staff during the initial
145.30 staff orientation and annually thereafter and must make emergency and disaster training

146.1 annually available to all residents. Staff who have not received emergency and disaster
146.2 training are allowed to work only when trained staff are also working on site.

146.3 (c) The facility must meet any additional requirements adopted in rule.

146.4 Sec. 44. Minnesota Statutes 2020, section 144G.50, subdivision 2, is amended to read:

146.5 Subd. 2. **Contract information.** (a) The contract must include in a conspicuous place
146.6 and manner on the contract the legal name and the ~~license number~~ health facility identification
146.7 of the facility.

146.8 (b) The contract must include the name, telephone number, and physical mailing address,
146.9 which may not be a public or private post office box, of:

146.10 (1) the facility and contracted service provider when applicable;

146.11 (2) the licensee of the facility;

146.12 (3) the managing agent of the facility, if applicable; and

146.13 (4) the authorized agent for the facility.

146.14 (c) The contract must include:

146.15 (1) a disclosure of the category of assisted living facility license held by the facility and,
146.16 if the facility is not an assisted living facility with dementia care, a disclosure that it does
146.17 not hold an assisted living facility with dementia care license;

146.18 (2) a description of all the terms and conditions of the contract, including a description
146.19 of and any limitations to the housing or assisted living services to be provided for the
146.20 contracted amount;

146.21 (3) a delineation of the cost and nature of any other services to be provided for an
146.22 additional fee;

146.23 (4) a delineation and description of any additional fees the resident may be required to
146.24 pay if the resident's condition changes during the term of the contract;

146.25 (5) a delineation of the grounds under which the resident may be ~~discharged, evicted,~~
146.26 ~~or~~ transferred or have housing or services terminated or be subject to an emergency
146.27 relocation;

146.28 (6) billing and payment procedures and requirements; and

146.29 (7) disclosure of the facility's ability to provide specialized diets.

147.1 (d) The contract must include a description of the facility's complaint resolution process
147.2 available to residents, including the name and contact information of the person representing
147.3 the facility who is designated to handle and resolve complaints.

147.4 (e) The contract must include a clear and conspicuous notice of:

147.5 (1) the right under section 144G.54 to appeal the termination of an assisted living contract;

147.6 (2) the facility's policy regarding transfer of residents within the facility, under what
147.7 circumstances a transfer may occur, and the circumstances under which resident consent is
147.8 required for a transfer;

147.9 (3) contact information for the Office of Ombudsman for Long-Term Care, the
147.10 Ombudsman for Mental Health and Developmental Disabilities, and the Office of Health
147.11 Facility Complaints;

147.12 (4) the resident's right to obtain services from an unaffiliated service provider;

147.13 (5) a description of the facility's policies related to medical assistance waivers under
147.14 chapter 256S and section 256B.49 and the housing support program under chapter 256I,
147.15 including:

147.16 (i) whether the facility is enrolled with the commissioner of human services to provide
147.17 customized living services under medical assistance waivers;

147.18 (ii) whether the facility has an agreement to provide housing support under section
147.19 256I.04, subdivision 2, paragraph (b);

147.20 (iii) whether there is a limit on the number of people residing at the facility who can
147.21 receive customized living services or participate in the housing support program at any
147.22 point in time. If so, the limit must be provided;

147.23 (iv) whether the facility requires a resident to pay privately for a period of time prior to
147.24 accepting payment under medical assistance waivers or the housing support program, and
147.25 if so, the length of time that private payment is required;

147.26 (v) a statement that medical assistance waivers provide payment for services, but do not
147.27 cover the cost of rent;

147.28 (vi) a statement that residents may be eligible for assistance with rent through the housing
147.29 support program; and

147.30 (vii) a description of the rent requirements for people who are eligible for medical
147.31 assistance waivers but who are not eligible for assistance through the housing support
147.32 program;

148.1 (6) the contact information to obtain long-term care consulting services under section
148.2 256B.0911; and

148.3 (7) the toll-free phone number for the Minnesota Adult Abuse Reporting Center.

148.4 **EFFECTIVE DATE.** This section is effective the day following final enactment, except
148.5 that the amendment to paragraph (a) is effective for assisted living contracts executed on
148.6 or after August 1, 2022.

148.7 Sec. 45. Minnesota Statutes 2020, section 144G.52, subdivision 2, is amended to read:

148.8 Subd. 2. **Prerequisite to termination of a contract.** (a) Before issuing a notice of
148.9 termination of an assisted living contract, a facility must schedule and participate in a meeting
148.10 with the resident and the resident's legal representative and designated representative. The
148.11 purposes of the meeting are to:

148.12 (1) explain in detail the reasons for the proposed termination; and

148.13 (2) identify and offer reasonable accommodations or modifications, interventions, or
148.14 alternatives to avoid the termination or enable the resident to remain in the facility, including
148.15 but not limited to securing services from another provider of the resident's choosing that
148.16 may allow the resident to avoid the termination. A facility is not required to offer
148.17 accommodations, modifications, interventions, or alternatives that fundamentally alter the
148.18 nature of the operation of the facility.

148.19 (b) The meeting must be scheduled to take place at least seven days before a notice of
148.20 termination is issued. The facility must make reasonable efforts to ensure that the resident,
148.21 legal representative, and designated representative are able to attend the meeting.

148.22 (c) The facility must notify the resident that the resident may invite family members,
148.23 relevant health professionals, a representative of the Office of Ombudsman for Long-Term
148.24 Care, a representative of the Office of Ombudsman for Mental Health and Developmental
148.25 Disabilities, or other persons of the resident's choosing to participate in the meeting. For
148.26 residents who receive home and community-based waiver services under chapter 256S and
148.27 section 256B.49, the facility must notify the resident's case manager of the meeting.

148.28 (d) In the event of an emergency relocation under subdivision 9, where the facility intends
148.29 to issue a notice of termination and an in-person meeting is impractical or impossible, the
148.30 facility ~~may attempt to schedule and participate in a meeting under this subdivision via~~ must
148.31 use telephone, video, or other electronic means to conduct and participate in the meeting
148.32 required under this subdivision and rules within Minnesota Rules, chapter 4659.

149.1 Sec. 46. Minnesota Statutes 2020, section 144G.52, subdivision 8, is amended to read:

149.2 Subd. 8. **Content of notice of termination.** The notice required under subdivision 7
149.3 must contain, at a minimum:

149.4 (1) the effective date of the termination of the assisted living contract;

149.5 (2) a detailed explanation of the basis for the termination, including the clinical or other
149.6 supporting rationale;

149.7 (3) a detailed explanation of the conditions under which a new or amended contract may
149.8 be executed;

149.9 (4) a statement that the resident has the right to appeal the termination by requesting a
149.10 hearing, and information concerning the time frame within which the request must be
149.11 submitted and the contact information for the agency to which the request must be submitted;

149.12 (5) a statement that the facility must participate in a coordinated move to another provider
149.13 or caregiver, as required under section 144G.55;

149.14 (6) the name and contact information of the person employed by the facility with whom
149.15 the resident may discuss the notice of termination;

149.16 (7) information on how to contact the Office of Ombudsman for Long-Term Care and
149.17 the Office of Ombudsman for Mental Health and Developmental Disabilities to request an
149.18 advocate to assist regarding the termination;

149.19 (8) information on how to contact the Senior LinkAge Line under section 256.975,
149.20 subdivision 7, and an explanation that the Senior LinkAge Line may provide information
149.21 about other available housing or service options; and

149.22 (9) if the termination is only for services, a statement that the resident may remain in
149.23 the facility and may secure any necessary services from another provider of the resident's
149.24 choosing.

149.25 Sec. 47. Minnesota Statutes 2020, section 144G.52, subdivision 9, is amended to read:

149.26 Subd. 9. **Emergency relocation.** (a) A facility may remove a resident from the facility
149.27 in an emergency if necessary due to a resident's urgent medical needs or an imminent risk
149.28 the resident poses to the health or safety of another facility resident or facility staff member.
149.29 An emergency relocation is not a termination.

149.30 (b) In the event of an emergency relocation, the facility must provide a written notice
149.31 that contains, at a minimum:

- 150.1 (1) the reason for the relocation;
- 150.2 (2) the name and contact information for the location to which the resident has been
150.3 relocated and any new service provider;
- 150.4 (3) contact information for the Office of Ombudsman for Long-Term Care and the Office
150.5 of Ombudsman for Mental Health and Developmental Disabilities;
- 150.6 (4) if known and applicable, the approximate date or range of dates within which the
150.7 resident is expected to return to the facility, or a statement that a return date is not currently
150.8 known; and
- 150.9 (5) a statement that, if the facility refuses to provide housing or services after a relocation,
150.10 the resident has the right to appeal under section 144G.54. The facility must provide contact
150.11 information for the agency to which the resident may submit an appeal.
- 150.12 (c) The notice required under paragraph (b) must be delivered as soon as practicable to:
- 150.13 (1) the resident, legal representative, and designated representative;
- 150.14 (2) for residents who receive home and community-based waiver services under chapter
150.15 256S and section 256B.49, the resident's case manager; and
- 150.16 (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated
150.17 and has not returned to the facility within four days.
- 150.18 (d) Following an emergency relocation, a facility's refusal to provide housing or services
150.19 constitutes a termination and triggers the termination process in this section.
- 150.20 Sec. 48. Minnesota Statutes 2020, section 144G.53, is amended to read:
- 150.21 **144G.53 NONRENEWAL OF HOUSING.**
- 150.22 (a) If a facility decides to not renew a resident's housing under a contract, the facility
150.23 must either (1) provide the resident with 60 calendar days' notice of the nonrenewal and
150.24 assistance with relocation planning, or (2) follow the termination procedure under section
150.25 144G.52.
- 150.26 (b) The notice must include the reason for the nonrenewal and contact information of
150.27 the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental
150.28 Health and Developmental Disabilities.
- 150.29 (c) A facility must:
- 150.30 (1) provide notice of the nonrenewal to the Office of Ombudsman for Long-Term Care;

151.1 (2) for residents who receive home and community-based waiver services under chapter
151.2 256S and section 256B.49, provide notice to the resident's case manager;

151.3 (3) ensure a coordinated move to a safe location, as defined in section 144G.55,
151.4 subdivision 2, that is appropriate for the resident;

151.5 (4) ensure a coordinated move to an appropriate service provider identified by the facility,
151.6 if services are still needed and desired by the resident;

151.7 (5) consult and cooperate with the resident, legal representative, designated representative,
151.8 case manager for a resident who receives home and community-based waiver services under
151.9 chapter 256S and section 256B.49, relevant health professionals, and any other persons of
151.10 the resident's choosing to make arrangements to move the resident, including consideration
151.11 of the resident's goals; and

151.12 (6) prepare a written plan to prepare for the move.

151.13 (d) A resident may decline to move to the location the facility identifies or to accept
151.14 services from a service provider the facility identifies, and may instead choose to move to
151.15 a location of the resident's choosing or receive services from a service provider of the
151.16 resident's choosing within the timeline prescribed in the nonrenewal notice.

151.17 Sec. 49. Minnesota Statutes 2020, section 144G.55, subdivision 1, is amended to read:

151.18 Subdivision 1. **Duties of facility.** (a) If a facility terminates an assisted living contract,
151.19 reduces services to the extent that a resident needs to move or obtain a new service provider
151.20 because of a reduction or elimination of services or the facility has its license restricted
151.21 under section 144G.20, or the facility conducts a planned closure under section 144G.57,
151.22 the facility:

151.23 (1) must ensure, subject to paragraph (c), a coordinated move to a safe location that is
151.24 appropriate for the resident and that is identified by the facility prior to any hearing under
151.25 section 144G.54;

151.26 (2) must ensure a coordinated move of the resident to an appropriate service provider
151.27 identified by the facility prior to any hearing under section 144G.54, provided services are
151.28 still needed and desired by the resident; and

151.29 (3) must consult and cooperate with the resident, legal representative, designated
151.30 representative, case manager for a resident who receives home and community-based waiver
151.31 services under chapter 256S and section 256B.49, relevant health professionals, and any

152.1 other persons of the resident's choosing to make arrangements to move the resident, including
152.2 consideration of the resident's goals.

152.3 (b) A facility may satisfy the requirements of paragraph (a), clauses (1) and (2), by
152.4 moving the resident to a different location within the same facility, if appropriate for the
152.5 resident.

152.6 (c) A resident may decline to move to the location the facility identifies or to accept
152.7 services from a service provider the facility identifies, and may choose instead to move to
152.8 a location of the resident's choosing or receive services from a service provider of the
152.9 resident's choosing within the timeline prescribed in the termination notice.

152.10 (d) Sixty days before the facility plans to reduce or eliminate one or more services for
152.11 a particular resident, the facility must provide written notice of the reduction that includes:

152.12 (1) a detailed explanation of the reasons for the reduction and the date of the reduction;

152.13 (2) the contact information for the Office of Ombudsman for Long-Term Care, the Office
152.14 of Ombudsman for Mental Health and Developmental Disabilities, and the name and contact
152.15 information of the person employed by the facility with whom the resident may discuss the
152.16 reduction of services;

152.17 (3) a statement that if the services being reduced are still needed by the resident, the
152.18 resident may remain in the facility and seek services from another provider; and

152.19 (4) a statement that if the reduction makes the resident need to move, the facility must
152.20 participate in a coordinated move of the resident to another provider or caregiver, as required
152.21 under this section.

152.22 (e) In the event of an unanticipated reduction in services caused by extraordinary
152.23 circumstances, the facility must provide the notice required under paragraph (d) as soon as
152.24 possible.

152.25 (f) If the facility, a resident, a legal representative, or a designated representative
152.26 determines that a reduction in services will make a resident need to move to a new location,
152.27 the facility must ensure a coordinated move in accordance with this section, and must provide
152.28 notice to the Office of Ombudsman for Long-Term Care.

152.29 (g) Nothing in this section affects a resident's right to remain in the facility and seek
152.30 services from another provider.

153.1 Sec. 50. Minnesota Statutes 2020, section 144G.55, subdivision 3, is amended to read:

153.2 Subd. 3. **Relocation plan required.** The facility must prepare a relocation plan to prepare
153.3 for the move to ~~the~~ a new safe location or appropriate service provider, as required by this
153.4 section.

153.5 Sec. 51. Minnesota Statutes 2020, section 144G.56, subdivision 3, is amended to read:

153.6 Subd. 3. **Notice required.** (a) A facility must provide at least 30 calendar days' advance
153.7 written notice to the resident and the resident's legal and designated representative of a
153.8 facility-initiated transfer. The notice must include:

153.9 (1) the effective date of the proposed transfer;

153.10 (2) the proposed transfer location;

153.11 (3) a statement that the resident may refuse the proposed transfer, and may discuss any
153.12 consequences of a refusal with staff of the facility;

153.13 (4) the name and contact information of a person employed by the facility with whom
153.14 the resident may discuss the notice of transfer; and

153.15 (5) contact information for the Office of Ombudsman for Long-Term Care and the Office
153.16 of Ombudsman for Mental Health and Developmental Disabilities.

153.17 (b) Notwithstanding paragraph (a), a facility may conduct a facility-initiated transfer of
153.18 a resident with less than 30 days' written notice if the transfer is necessary due to:

153.19 (1) conditions that render the resident's room or private living unit uninhabitable;

153.20 (2) the resident's urgent medical needs; or

153.21 (3) a risk to the health or safety of another resident of the facility.

153.22 Sec. 52. Minnesota Statutes 2020, section 144G.56, subdivision 5, is amended to read:

153.23 Subd. 5. **Changes in facility operations.** (a) In situations where there is a curtailment,
153.24 reduction, or capital improvement within a facility necessitating transfers, the facility must:

153.25 (1) minimize the number of transfers it initiates to complete the project or change in
153.26 operations;

153.27 (2) consider individual resident needs and preferences;

153.28 (3) provide reasonable accommodations for individual resident requests regarding the
153.29 transfers; and

154.1 (4) in advance of any notice to any residents, legal representatives, or designated
154.2 representatives, provide notice to the Office of Ombudsman for Long-Term Care and, ~~when~~
154.3 ~~appropriate,~~ the Office of Ombudsman for Mental Health and Developmental Disabilities
154.4 of the curtailment, reduction, or capital improvement and the corresponding needed transfers.

154.5 Sec. 53. Minnesota Statutes 2020, section 144G.57, subdivision 1, is amended to read:

154.6 Subdivision 1. **Closure plan required.** In the event that an assisted living facility elects
154.7 to voluntarily close the facility, the facility must notify the commissioner ~~and~~ the Office
154.8 of Ombudsman for Long-Term Care, and the Office of Ombudsman for Mental Health and
154.9 Developmental Disabilities in writing by submitting a proposed closure plan.

154.10 Sec. 54. Minnesota Statutes 2020, section 144G.57, subdivision 3, is amended to read:

154.11 Subd. 3. **Commissioner's approval required prior to implementation.** (a) The plan
154.12 shall be subject to the commissioner's approval and subdivision 6. The facility shall take
154.13 no action to close the residence prior to the commissioner's approval of the plan. The
154.14 commissioner shall approve or otherwise respond to the plan as soon as practicable.

154.15 (b) The commissioner may require the facility to work with a transitional team comprised
154.16 of department staff, staff of the Office of Ombudsman for Long-Term Care, the Office of
154.17 Ombudsman for Mental Health and Developmental Disabilities, and other professionals the
154.18 commissioner deems necessary to assist in the proper relocation of residents.

154.19 Sec. 55. Minnesota Statutes 2020, section 144G.57, subdivision 5, is amended to read:

154.20 Subd. 5. **Notice to residents.** After the commissioner has approved the relocation plan
154.21 and at least 60 calendar days before closing, except as provided under subdivision 6, the
154.22 facility must notify residents, designated representatives, and legal representatives of the
154.23 closure, the proposed date of closure, the contact information of the ombudsman for long-term
154.24 care and the ombudsman for mental health and developmental disabilities, and that the
154.25 facility will follow the termination planning requirements under section 144G.55, and final
154.26 accounting and return requirements under section 144G.42, subdivision 5. For residents
154.27 who receive home and community-based waiver services under chapter 256S and section
154.28 256B.49, the facility must also provide this information to the resident's case manager.

155.1 Sec. 56. Minnesota Statutes 2020, section 144G.70, subdivision 2, is amended to read:

155.2 Subd. 2. **Initial reviews, assessments, and monitoring.** (a) Residents who are not
155.3 receiving any assisted living services shall not be required to undergo an initial nursing
155.4 assessment.

155.5 (b) An assisted living facility shall conduct a nursing assessment by a registered nurse
155.6 of the physical and cognitive needs of the prospective resident and propose a temporary
155.7 service plan prior to the date on which a prospective resident executes a contract with a
155.8 facility or the date on which a prospective resident moves in, whichever is earlier. If
155.9 necessitated by either the geographic distance between the prospective resident and the
155.10 facility, or urgent or unexpected circumstances, the assessment may be conducted using
155.11 telecommunication methods based on practice standards that meet the resident's needs and
155.12 reflect person-centered planning and care delivery.

155.13 (c) Resident reassessment and monitoring must be conducted no more than 14 calendar
155.14 days after initiation of services. Ongoing resident reassessment and monitoring must be
155.15 conducted as needed based on changes in the needs of the resident and cannot exceed 90
155.16 calendar days from the last date of the assessment.

155.17 (d) For residents only receiving assisted living services specified in section 144G.08,
155.18 subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review
155.19 of the resident's needs and preferences. The initial review must be completed within 30
155.20 calendar days of the start of services. Resident monitoring and review must be conducted
155.21 as needed based on changes in the needs of the resident and cannot exceed 90 calendar days
155.22 from the date of the last review.

155.23 (e) A facility must inform the prospective resident of the availability of and contact
155.24 information for long-term care consultation services under section 256B.0911, prior to the
155.25 date on which a prospective resident executes a contract with a facility or the date on which
155.26 a prospective resident moves in, whichever is earlier.

155.27 Sec. 57. Minnesota Statutes 2020, section 144G.70, subdivision 4, is amended to read:

155.28 Subd. 4. **Service plan, implementation, and revisions to service plan.** (a) No later
155.29 than 14 calendar days after the date that services are first provided, an assisted living facility
155.30 shall finalize a current written service plan.

155.31 (b) The service plan and any revisions must include a signature or other authentication
155.32 by the facility and by the resident documenting agreement on the services to be provided.
155.33 The service plan must be revised, if needed, based on resident reassessment under subdivision

156.1 2. The facility must provide information to the resident about changes to the facility's fee
156.2 for services and how to contact the Office of Ombudsman for Long-Term Care and the
156.3 Office of Ombudsman for Mental Health and Developmental Disabilities.

156.4 (c) The facility must implement and provide all services required by the current service
156.5 plan.

156.6 (d) The service plan and the revised service plan must be entered into the resident record,
156.7 including notice of a change in a resident's fees when applicable.

156.8 (e) Staff providing services must be informed of the current written service plan.

156.9 (f) The service plan must include:

156.10 (1) a description of the services to be provided, the fees for services, and the frequency
156.11 of each service, according to the resident's current assessment and resident preferences;

156.12 (2) the identification of staff or categories of staff who will provide the services;

156.13 (3) the schedule and methods of monitoring assessments of the resident;

156.14 (4) the schedule and methods of monitoring staff providing services; and

156.15 (5) a contingency plan that includes:

156.16 (i) the action to be taken if the scheduled service cannot be provided;

156.17 (ii) information and a method to contact the facility;

156.18 (iii) the names and contact information of persons the resident wishes to have notified
156.19 in an emergency or if there is a significant adverse change in the resident's condition,
156.20 including identification of and information as to who has authority to sign for the resident
156.21 in an emergency; and

156.22 (iv) the circumstances in which emergency medical services are not to be summoned
156.23 consistent with chapters 145B and 145C, and declarations made by the resident under those
156.24 chapters.

156.25 Sec. 58. Minnesota Statutes 2020, section 144G.80, subdivision 2, is amended to read:

156.26 Subd. 2. **Demonstrated capacity.** (a) An applicant for licensure as an assisted living
156.27 facility with dementia care must have the ability to provide services in a manner that is
156.28 consistent with the requirements in this section. The commissioner shall consider the
156.29 following criteria, including, but not limited to:

157.1 (1) the experience of the ~~applicant in~~ applicant's assisted living director, managerial
157.2 official, and clinical nurse supervisor managing residents with dementia or previous long-term
157.3 care experience; and

157.4 (2) the compliance history of the applicant in the operation of any care facility licensed,
157.5 certified, or registered under federal or state law.

157.6 (b) If the ~~applicant does~~ applicant's assisted living director, managerial official, and
157.7 clinical nurse supervisor do not have experience in managing residents with dementia, the
157.8 applicant must employ a consultant for at least the first six months of operation. The
157.9 consultant must meet the requirements in paragraph (a), clause (1), and make
157.10 recommendations on providing dementia care services consistent with the requirements of
157.11 this chapter. The consultant must (1) have two years of work experience related to dementia,
157.12 health care, gerontology, or a related field, and (2) have completed at least the minimum
157.13 core training requirements in section 144G.64. The applicant must document an acceptable
157.14 plan to address the consultant's identified concerns and must either implement the
157.15 recommendations or document in the plan any consultant recommendations that the applicant
157.16 chooses not to implement. The commissioner must review the applicant's plan upon request.

157.17 (c) The commissioner shall conduct an on-site inspection prior to the issuance of an
157.18 assisted living facility with dementia care license to ensure compliance with the physical
157.19 environment requirements.

157.20 (d) The label "Assisted Living Facility with Dementia Care" must be identified on the
157.21 license.

157.22 Sec. 59. Minnesota Statutes 2020, section 144G.90, subdivision 1, is amended to read:

157.23 Subdivision 1. **Assisted living bill of rights; notification to resident.** (a) An assisted
157.24 living facility must provide the resident a written notice of the rights under section 144G.91
157.25 before the initiation of services to that resident. The facility shall make all reasonable efforts
157.26 to provide notice of the rights to the resident in a language the resident can understand.

157.27 (b) In addition to the text of the assisted living bill of rights in section 144G.91, the
157.28 notice shall also contain the following statement describing how to file a complaint or report
157.29 suspected abuse:

157.30 "If you want to report suspected abuse, neglect, or financial exploitation, you may contact
157.31 the Minnesota Adult Abuse Reporting Center (MAARC). If you have a complaint about
157.32 the facility or person providing your services, you may contact the Office of Health Facility
157.33 Complaints, Minnesota Department of Health. If you would like to request advocacy services,

158.1 you may ~~also~~ contact the Office of Ombudsman for Long-Term Care or the Office of
158.2 Ombudsman for Mental Health and Developmental Disabilities."

158.3 (c) The statement must include contact information for the Minnesota Adult Abuse
158.4 Reporting Center and the telephone number, website address, e-mail address, mailing
158.5 address, and street address of the Office of Health Facility Complaints at the Minnesota
158.6 Department of Health, the Office of Ombudsman for Long-Term Care, and the Office of
158.7 Ombudsman for Mental Health and Developmental Disabilities. The statement must include
158.8 the facility's name, address, e-mail, telephone number, and name or title of the person at
158.9 the facility to whom problems or complaints may be directed. It must also include a statement
158.10 that the facility will not retaliate because of a complaint.

158.11 (d) A facility must obtain written acknowledgment from the resident of the resident's
158.12 receipt of the assisted living bill of rights or shall document why an acknowledgment cannot
158.13 be obtained. Acknowledgment of receipt shall be retained in the resident's record.

158.14 Sec. 60. Minnesota Statutes 2020, section 144G.90, is amended by adding a subdivision
158.15 to read:

158.16 Subd. 6. **Notice to residents.** For any notice to a resident, legal representative, or
158.17 designated representative provided under this chapter or under Minnesota Rules, chapter
158.18 4659, that is required to include information regarding the Office of Ombudsman for
158.19 Long-Term Care and the Office of Ombudsman for Mental Health and Developmental
158.20 Disabilities, the notice must contain the following language: "You may contact the
158.21 Ombudsman for Long-Term Care for questions about your rights as an assisted living facility
158.22 resident and to request advocacy services. As an assisted living facility resident, you may
158.23 contact the Ombudsman for Mental Health and Developmental Disabilities to request
158.24 advocacy regarding your rights, concerns, or questions on issues relating to services for
158.25 mental health, developmental disabilities, or chemical dependency."

158.26 Sec. 61. Minnesota Statutes 2020, section 144G.91, subdivision 13, is amended to read:

158.27 Subd. 13. **Personal and treatment privacy.** (a) Residents have the right to consideration
158.28 of their privacy, individuality, and cultural identity as related to their social, religious, and
158.29 psychological well-being. Staff must respect the privacy of a resident's space by knocking
158.30 on the door and seeking consent before entering, except in an emergency or ~~where clearly~~
158.31 ~~inadvisable~~ or unless otherwise documented in the resident's service plan.

158.32 (b) Residents have the right to have and use a lockable door to the resident's unit. The
158.33 facility shall provide locks on the resident's unit. Only a staff member with a specific need

159.1 to enter the unit shall have keys. This right may be restricted in certain circumstances if
159.2 necessary for a resident's health and safety and documented in the resident's service plan.

159.3 (c) Residents have the right to respect and privacy regarding the resident's service plan.
159.4 Case discussion, consultation, examination, and treatment are confidential and must be
159.5 conducted discreetly. Privacy must be respected during toileting, bathing, and other activities
159.6 of personal hygiene, except as needed for resident safety or assistance.

159.7 Sec. 62. Minnesota Statutes 2020, section 144G.91, subdivision 21, is amended to read:

159.8 Subd. 21. **Access to counsel and advocacy services.** Residents have the right to the
159.9 immediate access by:

159.10 (1) the resident's legal counsel;

159.11 (2) any representative of the protection and advocacy system designated by the state
159.12 under Code of Federal Regulations, title 45, section 1326.21; or

159.13 (3) any representative of the Office of Ombudsman for Long-Term Care or the Office
159.14 of Ombudsman for Mental Health and Developmental Disabilities.

159.15 Sec. 63. Minnesota Statutes 2020, section 144G.92, subdivision 1, is amended to read:

159.16 Subdivision 1. **Retaliation prohibited.** A facility or agent of a facility may not retaliate
159.17 against a resident or employee if the resident, employee, or any person acting on behalf of
159.18 the resident:

159.19 (1) files a good faith complaint or grievance, makes a good faith inquiry, or asserts any
159.20 right;

159.21 (2) indicates a good faith intention to file a complaint or grievance, make an inquiry, or
159.22 assert any right;

159.23 (3) files, in good faith, or indicates an intention to file a maltreatment report, whether
159.24 mandatory or voluntary, under section 626.557;

159.25 (4) seeks assistance from or reports a reasonable suspicion of a crime or systemic
159.26 problems or concerns to the director or manager of the facility, the Office of Ombudsman
159.27 for Long-Term Care, the Office of Ombudsman for Mental Health and Developmental
159.28 Disabilities, a regulatory or other government agency, or a legal or advocacy organization;

159.29 (5) advocates or seeks advocacy assistance for necessary or improved care or services
159.30 or enforcement of rights under this section or other law;

160.1 (6) takes or indicates an intention to take civil action;

160.2 (7) participates or indicates an intention to participate in any investigation or
160.3 administrative or judicial proceeding;

160.4 (8) contracts or indicates an intention to contract to receive services from a service
160.5 provider of the resident's choice other than the facility; or

160.6 (9) places or indicates an intention to place a camera or electronic monitoring device in
160.7 the resident's private space as provided under section 144.6502.

160.8 Sec. 64. Minnesota Statutes 2020, section 144G.93, is amended to read:

160.9 **144G.93 CONSUMER ADVOCACY AND LEGAL SERVICES.**

160.10 Upon execution of an assisted living contract, every facility must provide the resident
160.11 with the names and contact information, including telephone numbers and e-mail addresses,
160.12 of:

160.13 (1) nonprofit organizations that provide advocacy or legal services to residents including
160.14 but not limited to the designated protection and advocacy organization in Minnesota that
160.15 provides advice and representation to individuals with disabilities; and

160.16 (2) the Office of Ombudsman for Long-Term Care, ~~including both the state and regional~~
160.17 ~~contact information~~ and the Office of Ombudsman for Mental Health and Developmental
160.18 Disabilities.

160.19 Sec. 65. Minnesota Statutes 2020, section 144G.95, is amended to read:

160.20 **144G.95 OFFICE OF OMBUDSMAN FOR LONG-TERM CARE AND OFFICE**
160.21 **OF OMBUDSMAN FOR MENTAL HEALTH AND DEVELOPMENTAL**
160.22 **DISABILITIES.**

160.23 Subdivision 1. **Immunity from liability.** (a) The Office of Ombudsman for Long-Term
160.24 Care and representatives of the office are immune from liability for conduct described in
160.25 section 256.9742, subdivision 2.

160.26 (b) The Office of Ombudsman for Mental Health and Developmental Disabilities and
160.27 representatives of the office are immune from liability for conduct described in section
160.28 245.96.

160.29 Subd. 2. **Data classification.** (a) All forms and notices received by the Office of
160.30 Ombudsman for Long-Term Care under this chapter are classified under section 256.9744.

161.1 (b) All data collected or received by the Office of Ombudsman for Mental Health and
161.2 Developmental Disabilities are classified under section 245.94.

161.3 Sec. 66. [145.9231] HEALTH EQUITY ADVISORY AND LEADERSHIP (HEAL)
161.4 COUNCIL.

161.5 Subdivision 1. Establishment; composition of advisory council. (a) The commissioner
161.6 shall establish and appoint a Health Equity Advisory and Leadership (HEAL) Council to
161.7 provide guidance to the commissioner of health regarding strengthening and improving the
161.8 health of communities most impacted by health inequities across the state. The council shall
161.9 consist of 18 members who will provide representation from the following groups:

161.10 (1) African American and African heritage communities;

161.11 (2) Asian American and Pacific Islander communities;

161.12 (3) Latina/o/x communities;

161.13 (4) American Indian communities and Tribal Government/Nations;

161.14 (5) disability communities;

161.15 (6) lesbian, gay, bisexual, transgender, and queer (LGBTQ) communities; and

161.16 (7) representatives who reside outside the seven-county metropolitan area.

161.17 (b) No members shall be employees of the Minnesota Department of Health.

161.18 Subd. 2. Organization and meetings. The advisory council shall be organized and
161.19 administered under section 15.059, except that the members do not receive per diem
161.20 compensation. Meetings shall be held at least quarterly and hosted by the department.
161.21 Subcommittees may be developed as necessary. Advisory council meetings are subject to
161.22 Open Meeting Law under chapter 13D.

161.23 Subd. 3. Duties. The advisory council shall:

161.24 (1) advise the commissioner on health equity issues and the health equity priorities and
161.25 concerns of the populations specified in subdivision 1;

161.26 (2) assist the agency in efforts to advance health equity, including consulting in specific
161.27 agency policies and programs, providing ideas and input about potential budget and policy
161.28 proposals, and recommending review of particular agency policies, standards, or procedures
161.29 that may create or perpetuate health inequities; and

161.30 (3) assist the agency in developing and monitoring meaningful performance measures
161.31 related to advancing health equity.

162.1 Subd. 4. **Expiration.** Notwithstanding section 15.059, subdivision 6, the advisory council
162.2 shall remain in existence until health inequities in the state are eliminated. Health inequities
162.3 will be considered eliminated when race, ethnicity, income, gender, gender identity,
162.4 geographic location, or other identity or social marker will no longer be predictors of health
162.5 outcomes in the state. Section 145.928 describes nine health disparities that must be
162.6 considered when determining whether health inequities have been eliminated in the state.

162.7 Sec. 67. Minnesota Statutes 2020, section 146B.04, subdivision 1, is amended to read:

162.8 Subdivision 1. **General.** Before an individual may work as a guest artist, the
162.9 commissioner shall issue a temporary license to the guest artist. The guest artist shall submit
162.10 an application to the commissioner on a form provided by the commissioner. The
162.11 commissioner must receive the application at least 14 calendar days before the guest artist
162.12 applicant conducts a body art procedure. The form must include:

162.13 (1) the name, home address, and date of birth of the guest artist;

162.14 (2) the name of the licensed technician sponsoring the guest artist;

162.15 (3) proof of having satisfactorily completed coursework within the year preceding
162.16 application and approved by the commissioner on bloodborne pathogens, the prevention of
162.17 disease transmission, infection control, and aseptic technique;

162.18 (4) the starting and anticipated completion dates the guest artist will be working; and

162.19 (5) a copy of any current body art credential or licensure issued by another local or state
162.20 jurisdiction.

162.21 Sec. 68. Minnesota Statutes 2020, section 152.22, subdivision 8, is amended to read:

162.22 Subd. 8. **Medical cannabis ~~product~~ paraphernalia.** "Medical cannabis ~~product~~
162.23 paraphernalia" means any delivery device or related supplies and educational materials used
162.24 in the administration of medical cannabis for a patient with a qualifying medical condition
162.25 enrolled in the registry program.

162.26 Sec. 69. Minnesota Statutes 2020, section 152.25, subdivision 1, is amended to read:

162.27 Subdivision 1. **Medical cannabis manufacturer registration.** (a) The commissioner
162.28 shall register two in-state manufacturers for the production of all medical cannabis within
162.29 the state. A registration agreement between the commissioner and a manufacturer is
162.30 nontransferable. The commissioner shall register new manufacturers or reregister the existing
162.31 manufacturers by December 1 every two years, using the factors described in this subdivision.

163.1 The commissioner shall accept applications after December 1, 2014, if one of the
163.2 manufacturers registered before December 1, 2014, ceases to be registered as a manufacturer.

163.3 The commissioner's determination that no manufacturer exists to fulfill the duties under
163.4 sections 152.22 to 152.37 is subject to judicial review in Ramsey County District Court.

163.5 Data submitted during the application process are private data on individuals or nonpublic
163.6 data as defined in section 13.02 until the manufacturer is registered under this section. Data
163.7 on a manufacturer that is registered are public data, unless the data are trade secret or security
163.8 information under section 13.37.

163.9 (b) As a condition for registration, a manufacturer must agree to:

163.10 (1) begin supplying medical cannabis to patients ~~by July 1, 2015~~ within eight months
163.11 of its initial registration; and

163.12 (2) comply with all requirements under sections 152.22 to 152.37.

163.13 (c) The commissioner shall consider the following factors when determining which
163.14 manufacturer to register:

163.15 (1) the technical expertise of the manufacturer in cultivating medical cannabis and
163.16 converting the medical cannabis into an acceptable delivery method under section 152.22,
163.17 subdivision 6;

163.18 (2) the qualifications of the manufacturer's employees;

163.19 (3) the long-term financial stability of the manufacturer;

163.20 (4) the ability to provide appropriate security measures on the premises of the
163.21 manufacturer;

163.22 (5) whether the manufacturer has demonstrated an ability to meet the medical cannabis
163.23 production needs required by sections 152.22 to 152.37; and

163.24 (6) the manufacturer's projection and ongoing assessment of fees on patients with a
163.25 qualifying medical condition.

163.26 (d) If an officer, director, or controlling person of the manufacturer pleads or is found
163.27 guilty of intentionally diverting medical cannabis to a person other than allowed by law
163.28 under section 152.33, subdivision 1, the commissioner may decide not to renew the
163.29 registration of the manufacturer, provided the violation occurred while the person was an
163.30 officer, director, or controlling person of the manufacturer.

163.31 (e) The commissioner shall require each medical cannabis manufacturer to contract with
163.32 an independent laboratory to test medical cannabis produced by the manufacturer. The

164.1 commissioner shall approve the laboratory chosen by each manufacturer and require that
164.2 the laboratory report testing results to the manufacturer in a manner determined by the
164.3 commissioner.

164.4 (f) The commissioner shall implement a state-centralized medical cannabis electronic
164.5 database to monitor and track the manufacturers' medical cannabis inventories from the
164.6 seed or clone source through cultivation, processing, testing, and distribution or disposal.
164.7 The inventory tracking database must allow for information regarding medical cannabis to
164.8 be updated instantaneously. Any manufacturer or third-party laboratory licensed under this
164.9 chapter must submit to the commissioner any information the commissioner deems necessary
164.10 for maintaining the inventory tracking database. The commissioner may contract with a
164.11 separate entity to establish and maintain all or any part of the inventory tracking database.
164.12 The provisions of section 13.05, subdivision 11, apply to a contract entered between the
164.13 commissioner and a third party under this paragraph.

164.14 Sec. 70. Minnesota Statutes 2021 Supplement, section 152.27, subdivision 2, is amended
164.15 to read:

164.16 Subd. 2. **Commissioner duties.** (a) The commissioner shall:

164.17 (1) give notice of the program to health care practitioners in the state who are eligible
164.18 to serve as health care practitioners and explain the purposes and requirements of the
164.19 program;

164.20 (2) allow each health care practitioner who meets or agrees to meet the program's
164.21 requirements and who requests to participate, to be included in the registry program to
164.22 collect data for the patient registry;

164.23 (3) provide explanatory information and assistance to each health care practitioner in
164.24 understanding the nature of therapeutic use of medical cannabis within program requirements;

164.25 (4) create and provide a certification to be used by a health care practitioner for the
164.26 practitioner to certify whether a patient has been diagnosed with a qualifying medical
164.27 condition ~~and include in the certification an option for the practitioner to certify whether~~
164.28 ~~the patient, in the health care practitioner's medical opinion, is developmentally or physically~~
164.29 ~~disabled and, as a result of that disability, the patient requires assistance in administering~~
164.30 ~~medical cannabis or obtaining medical cannabis from a distribution facility;~~

164.31 (5) supervise the participation of the health care practitioner in conducting patient
164.32 treatment and health records reporting in a manner that ensures stringent security and

165.1 record-keeping requirements and that prevents the unauthorized release of private data on
165.2 individuals as defined by section 13.02;

165.3 (6) develop safety criteria for patients with a qualifying medical condition as a
165.4 requirement of the patient's participation in the program, to prevent the patient from
165.5 undertaking any task under the influence of medical cannabis that would constitute negligence
165.6 or professional malpractice on the part of the patient; and

165.7 (7) conduct research and studies based on data from health records submitted to the
165.8 registry program and submit reports on intermediate or final research results to the legislature
165.9 and major scientific journals. The commissioner may contract with a third party to complete
165.10 the requirements of this clause. Any reports submitted must comply with section 152.28,
165.11 subdivision 2.

165.12 (b) The commissioner may add a delivery method under section 152.22, subdivision 6,
165.13 or add, remove, or modify a qualifying medical condition under section 152.22, subdivision
165.14 14, upon a petition from a member of the public or the task force on medical cannabis
165.15 therapeutic research or as directed by law. The commissioner shall evaluate all petitions to
165.16 add a qualifying medical condition or to remove or modify an existing qualifying medical
165.17 condition submitted by the task force on medical cannabis therapeutic research or as directed
165.18 by law and may make the addition, removal, or modification if the commissioner determines
165.19 the addition, removal, or modification is warranted based on the best available evidence
165.20 and research. If the commissioner wishes to add a delivery method under section 152.22,
165.21 subdivision 6, or add or remove a qualifying medical condition under section 152.22,
165.22 subdivision 14, the commissioner must notify the chairs and ranking minority members of
165.23 the legislative policy committees having jurisdiction over health and public safety of the
165.24 addition or removal and the reasons for its addition or removal, including any written
165.25 comments received by the commissioner from the public and any guidance received from
165.26 the task force on medical cannabis research, by January 15 of the year in which the
165.27 commissioner wishes to make the change. The change shall be effective on August 1 of that
165.28 year, unless the legislature by law provides otherwise.

165.29 Sec. 71. Minnesota Statutes 2021 Supplement, section 152.29, subdivision 1, is amended
165.30 to read:

165.31 Subdivision 1. **Manufacturer; requirements.** (a) A manufacturer may operate eight
165.32 distribution facilities, which may include the manufacturer's single location for cultivation,
165.33 harvesting, manufacturing, packaging, and processing but is not required to include that
165.34 location. The commissioner shall designate the geographical service areas to be served by

166.1 each manufacturer based on geographical need throughout the state to improve patient
166.2 access. A manufacturer shall not have more than two distribution facilities in each
166.3 geographical service area assigned to the manufacturer by the commissioner. A manufacturer
166.4 shall operate only one location where all cultivation, harvesting, manufacturing, packaging,
166.5 and processing of medical cannabis shall be conducted. This location may be one of the
166.6 manufacturer's distribution facility sites. The additional distribution facilities may dispense
166.7 medical cannabis and medical cannabis ~~products~~ paraphernalia but may not contain any
166.8 medical cannabis in a form other than those forms allowed under section 152.22, subdivision
166.9 6, and the manufacturer shall not conduct any cultivation, harvesting, manufacturing,
166.10 packaging, or processing at the other distribution facility sites. Any distribution facility
166.11 operated by the manufacturer is subject to all of the requirements applying to the
166.12 manufacturer under sections 152.22 to 152.37, including, but not limited to, security and
166.13 distribution requirements.

166.14 (b) A manufacturer may acquire hemp grown in this state from a hemp grower, and may
166.15 acquire hemp products produced by a hemp processor. A manufacturer may manufacture
166.16 or process hemp and hemp products into an allowable form of medical cannabis under
166.17 section 152.22, subdivision 6. Hemp and hemp products acquired by a manufacturer under
166.18 this paragraph are subject to the same quality control program, security and testing
166.19 requirements, and other requirements that apply to medical cannabis under sections 152.22
166.20 to 152.37 and Minnesota Rules, chapter 4770.

166.21 (c) A medical cannabis manufacturer shall contract with a laboratory approved by the
166.22 commissioner, subject to any additional requirements set by the commissioner, for purposes
166.23 of testing medical cannabis manufactured or hemp or hemp products acquired by the medical
166.24 cannabis manufacturer as to content, contamination, and consistency to verify the medical
166.25 cannabis meets the requirements of section 152.22, subdivision 6. The laboratory must
166.26 collect, or contract with a third party that is not a manufacturer to collect, from the
166.27 manufacturer's production facility the medical cannabis samples it will test. The cost of
166.28 collecting samples and laboratory testing shall be paid by the manufacturer.

166.29 (d) The operating documents of a manufacturer must include:

166.30 (1) procedures for the oversight of the manufacturer and procedures to ensure accurate
166.31 record keeping;

166.32 (2) procedures for the implementation of appropriate security measures to deter and
166.33 prevent the theft of medical cannabis and unauthorized entrance into areas containing medical
166.34 cannabis; and

167.1 (3) procedures for the delivery and transportation of hemp between hemp growers and
167.2 manufacturers and for the delivery and transportation of hemp products between hemp
167.3 processors and manufacturers.

167.4 (e) A manufacturer shall implement security requirements, including requirements for
167.5 the delivery and transportation of hemp and hemp products, protection of each location by
167.6 a fully operational security alarm system, facility access controls, perimeter intrusion
167.7 detection systems, and a personnel identification system.

167.8 (f) A manufacturer shall not share office space with, refer patients to a health care
167.9 practitioner, or have any financial relationship with a health care practitioner.

167.10 (g) A manufacturer shall not permit any person to consume medical cannabis on the
167.11 property of the manufacturer.

167.12 (h) A manufacturer is subject to reasonable inspection by the commissioner.

167.13 (i) For purposes of sections 152.22 to 152.37, a medical cannabis manufacturer is not
167.14 subject to the Board of Pharmacy licensure or regulatory requirements under chapter 151.

167.15 (j) A medical cannabis manufacturer may not employ any person who is under 21 years
167.16 of age or who has been convicted of a disqualifying felony offense. An employee of a
167.17 medical cannabis manufacturer must submit a completed criminal history records check
167.18 consent form, a full set of classifiable fingerprints, and the required fees for submission to
167.19 the Bureau of Criminal Apprehension before an employee may begin working with the
167.20 manufacturer. The bureau must conduct a Minnesota criminal history records check and
167.21 the superintendent is authorized to exchange the fingerprints with the Federal Bureau of
167.22 Investigation to obtain the applicant's national criminal history record information. The
167.23 bureau shall return the results of the Minnesota and federal criminal history records checks
167.24 to the commissioner.

167.25 (k) A manufacturer may not operate in any location, whether for distribution or
167.26 cultivation, harvesting, manufacturing, packaging, or processing, within 1,000 feet of a
167.27 public or private school existing before the date of the manufacturer's registration with the
167.28 commissioner.

167.29 (l) A manufacturer shall comply with reasonable restrictions set by the commissioner
167.30 relating to signage, marketing, display, and advertising of medical cannabis.

167.31 (m) Before a manufacturer acquires hemp from a hemp grower or hemp products from
167.32 a hemp processor, the manufacturer must verify that the hemp grower or hemp processor
167.33 has a valid license issued by the commissioner of agriculture under chapter 18K.

168.1 (n) Until a state-centralized, seed-to-sale system is implemented that can track a specific
168.2 medical cannabis plant from cultivation through testing and point of sale, the commissioner
168.3 shall conduct at least one unannounced inspection per year of each manufacturer that includes
168.4 inspection of:

168.5 (1) business operations;

168.6 (2) physical locations of the manufacturer's manufacturing facility and distribution
168.7 facilities;

168.8 (3) financial information and inventory documentation, including laboratory testing
168.9 results; and

168.10 (4) physical and electronic security alarm systems.

168.11 Sec. 72. Minnesota Statutes 2021 Supplement, section 152.29, subdivision 3, is amended
168.12 to read:

168.13 Subd. 3. **Manufacturer; distribution.** (a) A manufacturer shall require that employees
168.14 licensed as pharmacists pursuant to chapter 151 be the only employees to give final approval
168.15 for the distribution of medical cannabis to a patient. A manufacturer may transport medical
168.16 cannabis or medical cannabis ~~products~~ paraphernalia that have been cultivated, harvested,
168.17 manufactured, packaged, and processed by that manufacturer to another registered
168.18 manufacturer for the other manufacturer to distribute.

168.19 (b) A manufacturer may distribute medical cannabis ~~products~~ paraphernalia, whether
168.20 or not the ~~products~~ medical cannabis paraphernalia have been manufactured by that
168.21 manufacturer.

168.22 (c) Prior to distribution of any medical cannabis, the manufacturer shall:

168.23 (1) verify that the manufacturer has received the registry verification from the
168.24 commissioner for that individual patient;

168.25 (2) verify that the person requesting the distribution of medical cannabis is the patient,
168.26 the patient's registered designated caregiver, or the patient's parent, legal guardian, or spouse
168.27 listed in the registry verification using the procedures described in section 152.11, subdivision
168.28 2d;

168.29 (3) assign a tracking number to any medical cannabis distributed from the manufacturer;

168.30 (4) ensure that any employee of the manufacturer licensed as a pharmacist pursuant to
168.31 chapter 151 has consulted with the patient to determine the proper dosage for the individual
168.32 patient after reviewing the ranges of chemical compositions of the medical cannabis and

169.1 the ranges of proper dosages reported by the commissioner. For purposes of this clause, a
169.2 consultation may be conducted remotely by secure videoconference, telephone, or other
169.3 remote means, so long as the employee providing the consultation is able to confirm the
169.4 identity of the patient and the consultation adheres to patient privacy requirements that apply
169.5 to health care services delivered through telehealth. A pharmacist consultation under this
169.6 clause is not required when a manufacturer is distributing medical cannabis to a patient
169.7 according to a patient-specific dosage plan established with that manufacturer and is not
169.8 modifying the dosage or product being distributed under that plan and the medical cannabis
169.9 is distributed by a pharmacy technician;

169.10 (5) properly package medical cannabis in compliance with the United States Poison
169.11 Prevention Packing Act regarding child-resistant packaging and exemptions for packaging
169.12 for elderly patients, and label distributed medical cannabis with a list of all active ingredients
169.13 and individually identifying information, including:

169.14 (i) the patient's name and date of birth;

169.15 (ii) the name and date of birth of the patient's registered designated caregiver or, if listed
169.16 on the registry verification, the name of the patient's parent or legal guardian, if applicable;

169.17 (iii) the patient's registry identification number;

169.18 (iv) the chemical composition of the medical cannabis; and

169.19 (v) the dosage; and

169.20 (6) ensure that the medical cannabis distributed contains a maximum of a 90-day supply
169.21 of the dosage determined for that patient.

169.22 (d) A manufacturer shall require any employee of the manufacturer who is transporting
169.23 medical cannabis or medical cannabis ~~products~~ paraphernalia to a distribution facility or to
169.24 another registered manufacturer to carry identification showing that the person is an employee
169.25 of the manufacturer.

169.26 (e) A manufacturer shall distribute medical cannabis in dried raw cannabis form only
169.27 to a patient age 21 or older, or to the registered designated caregiver, parent, legal guardian,
169.28 or spouse of a patient age 21 or older.

169.29 Sec. 73. Minnesota Statutes 2020, section 152.29, subdivision 3a, is amended to read:

169.30 Subd. 3a. **Transportation of medical cannabis; transport staffing.** (a) A medical
169.31 cannabis manufacturer may staff a transport motor vehicle with only one employee if the
169.32 medical cannabis manufacturer is transporting medical cannabis to ~~either a certified~~

170.1 ~~laboratory for the purpose of testing or~~ a facility for the purpose of disposal. If the medical
170.2 cannabis manufacturer is transporting medical cannabis for any other purpose or destination,
170.3 the transport motor vehicle must be staffed with a minimum of two employees as required
170.4 by rules adopted by the commissioner.

170.5 (b) Notwithstanding paragraph (a), a medical cannabis manufacturer that is only
170.6 transporting hemp for any purpose may staff the transport motor vehicle with only one
170.7 employee.

170.8 (c) A medical cannabis manufacturer may contract with a third party for armored car
170.9 services for deliveries of medical cannabis from its production facility to distribution
170.10 facilities. A medical cannabis manufacturer that contracts for armored car services remains
170.11 responsible for compliance with transportation manifest and inventory tracking requirements
170.12 in rules adopted by the commissioner.

170.13 (d) A third-party testing laboratory may staff a transport motor vehicle with one or more
170.14 employees when transporting medical cannabis from a manufacturer's production facility
170.15 to the testing laboratory for the purpose of testing samples.

170.16 (e) Department of Health staff may transport medical cannabis for the purposes of
170.17 delivering medical cannabis and other samples to a laboratory for testing under rules adopted
170.18 by the commissioner and in cases of special investigations when the commissioner has
170.19 determined there is a potential threat to public health. The transport motor vehicle must be
170.20 staffed by a minimum of two Department of Health employees. The employees must carry
170.21 their Department of Health identification cards and a transport manifest that meets the
170.22 requirements in Minnesota Rules, part 4770.1100, subpart 2.

170.23 (f) A Tribal medical cannabis program operated by a federally recognized Indian Tribe
170.24 located within the state of Minnesota may transport samples of medical cannabis to testing
170.25 laboratories and to other Indian lands in the state. Transport vehicles must be staffed by at
170.26 least two employees of the Tribal medical cannabis program. Transporters must carry
170.27 identification identifying them as employees of the Tribal medical cannabis program and
170.28 a detailed transportation manifest that includes the place and time of departure, the address
170.29 of the destination, and a description and count of the medical cannabis being transported.

171.1 Sec. 74. Minnesota Statutes 2020, section 152.30, is amended to read:

171.2 **152.30 PATIENT DUTIES.**

171.3 (a) A patient shall apply to the commissioner for enrollment in the registry program by
171.4 submitting an application as required in section 152.27 and an annual registration fee as
171.5 determined under section 152.35.

171.6 (b) As a condition of continued enrollment, patients shall agree to:

171.7 (1) continue to receive regularly scheduled treatment for their qualifying medical
171.8 condition from their health care practitioner; and

171.9 (2) report changes in their qualifying medical condition to their health care practitioner.

171.10 (c) A patient shall only receive medical cannabis from a registered manufacturer but is
171.11 not required to receive medical cannabis ~~products~~ paraphernalia from only a registered
171.12 manufacturer.

171.13 Sec. 75. Minnesota Statutes 2020, section 152.32, subdivision 2, is amended to read:

171.14 Subd. 2. **Criminal and civil protections.** (a) Subject to section 152.23, the following
171.15 are not violations under this chapter:

171.16 (1) use or possession of medical cannabis or medical cannabis products by a patient
171.17 enrolled in the registry program, or possession by a registered designated caregiver or the
171.18 parent, legal guardian, or spouse of a patient if the parent, legal guardian, or spouse is listed
171.19 on the registry verification;

171.20 (2) possession, dosage determination, or sale of medical cannabis or medical cannabis
171.21 products by a medical cannabis manufacturer, employees of a manufacturer, a laboratory
171.22 conducting testing on medical cannabis, or employees of the laboratory; and

171.23 (3) possession of medical cannabis or medical cannabis ~~products~~ paraphernalia by any
171.24 person while carrying out the duties required under sections 152.22 to 152.37.

171.25 (b) Medical cannabis obtained and distributed pursuant to sections 152.22 to 152.37 and
171.26 associated property is not subject to forfeiture under sections 609.531 to 609.5316.

171.27 (c) The commissioner, the commissioner's staff, the commissioner's agents or contractors,
171.28 and any health care practitioner are not subject to any civil or disciplinary penalties by the
171.29 Board of Medical Practice, the Board of Nursing, or by any business, occupational, or
171.30 professional licensing board or entity, solely for the participation in the registry program
171.31 under sections 152.22 to 152.37. A pharmacist licensed under chapter 151 is not subject to

172.1 any civil or disciplinary penalties by the Board of Pharmacy when acting in accordance
172.2 with the provisions of sections 152.22 to 152.37. Nothing in this section affects a professional
172.3 licensing board from taking action in response to violations of any other section of law.

172.4 (d) Notwithstanding any law to the contrary, the commissioner, the governor of
172.5 Minnesota, or an employee of any state agency may not be held civilly or criminally liable
172.6 for any injury, loss of property, personal injury, or death caused by any act or omission
172.7 while acting within the scope of office or employment under sections 152.22 to 152.37.

172.8 (e) Federal, state, and local law enforcement authorities are prohibited from accessing
172.9 the patient registry under sections 152.22 to 152.37 except when acting pursuant to a valid
172.10 search warrant.

172.11 (f) Notwithstanding any law to the contrary, neither the commissioner nor a public
172.12 employee may release data or information about an individual contained in any report,
172.13 document, or registry created under sections 152.22 to 152.37 or any information obtained
172.14 about a patient participating in the program, except as provided in sections 152.22 to 152.37.

172.15 (g) No information contained in a report, document, or registry or obtained from a patient
172.16 under sections 152.22 to 152.37 may be admitted as evidence in a criminal proceeding
172.17 unless independently obtained or in connection with a proceeding involving a violation of
172.18 sections 152.22 to 152.37.

172.19 (h) Notwithstanding section 13.09, any person who violates paragraph (e) or (f) is guilty
172.20 of a gross misdemeanor.

172.21 (i) An attorney may not be subject to disciplinary action by the Minnesota Supreme
172.22 Court or professional responsibility board for providing legal assistance to prospective or
172.23 registered manufacturers or others related to activity that is no longer subject to criminal
172.24 penalties under state law pursuant to sections 152.22 to 152.37.

172.25 (j) Possession of a registry verification or application for enrollment in the program by
172.26 a person entitled to possess or apply for enrollment in the registry program does not constitute
172.27 probable cause or reasonable suspicion, nor shall it be used to support a search of the person
172.28 or property of the person possessing or applying for the registry verification, or otherwise
172.29 subject the person or property of the person to inspection by any governmental agency.

173.1 Sec. 76. Minnesota Statutes 2020, section 152.36, is amended to read:

173.2 **152.36 IMPACT ASSESSMENT OF MEDICAL CANNABIS THERAPEUTIC**
173.3 **RESEARCH.**

173.4 Subdivision 1. **Task force on medical cannabis therapeutic research.** (a) A 23-member
173.5 task force on medical cannabis therapeutic research is created to conduct an impact
173.6 assessment of medical cannabis therapeutic research. The task force shall consist of the
173.7 following members:

173.8 (1) two members of the house of representatives, one selected by the speaker of the
173.9 house, the other selected by the minority leader;

173.10 (2) two members of the senate, one selected by the majority leader, the other selected
173.11 by the minority leader;

173.12 (3) four members representing consumers or patients enrolled in the registry program,
173.13 including at least two parents of patients under age 18;

173.14 (4) four members representing health care providers, including one licensed pharmacist;

173.15 (5) four members representing law enforcement, one from the Minnesota Chiefs of
173.16 Police Association, one from the Minnesota Sheriff's Association, one from the Minnesota
173.17 Police and Peace Officers Association, and one from the Minnesota County Attorneys
173.18 Association;

173.19 (6) four members representing substance use disorder treatment providers; and

173.20 (7) the commissioners of health, human services, and public safety.

173.21 (b) Task force members listed under paragraph (a), clauses (3), (4), (5), and (6), shall
173.22 be appointed by the governor under the appointment process in section 15.0597. Members
173.23 shall serve on the task force at the pleasure of the appointing authority. ~~All members must~~
173.24 ~~be appointed by July 15, 2014, and the commissioner of health shall convene the first meeting~~
173.25 ~~of the task force by August 1, 2014.~~

173.26 (c) There shall be two cochair of the task force chosen from the members listed under
173.27 paragraph (a). One cochair shall be selected by the speaker of the house and the other cochair
173.28 shall be selected by the majority leader of the senate. The authority to convene meetings
173.29 shall alternate between the cochair.

173.30 (d) Members of the task force other than those in paragraph (a), clauses (1), (2), and (7),
173.31 shall receive expenses as provided in section 15.059, subdivision 6.

174.1 Subd. 1a. **Administration.** The commissioner of health shall provide administrative and
174.2 technical support to the task force.

174.3 Subd. 2. **Impact assessment.** The task force shall hold hearings to evaluate the impact
174.4 of the use of medical cannabis and hemp and Minnesota's activities involving medical
174.5 cannabis and hemp, including, but not limited to:

174.6 (1) program design and implementation;

174.7 (2) the impact on the health care provider community;

174.8 (3) patient experiences;

174.9 (4) the impact on the incidence of substance abuse;

174.10 (5) access to and quality of medical cannabis, hemp, and medical cannabis products
174.11 paraphernalia;

174.12 (6) the impact on law enforcement and prosecutions;

174.13 (7) public awareness and perception; and

174.14 (8) any unintended consequences.

174.15 ~~Subd. 3. **Cost assessment.** By January 15 of each year, beginning January 15, 2015,~~
174.16 ~~and ending January 15, 2019, the commissioners of state departments impacted by the~~
174.17 ~~medical cannabis therapeutic research study shall report to the cochairs of the task force on~~
174.18 ~~the costs incurred by each department on implementing sections 152.22 to 152.37. The~~
174.19 ~~reports must compare actual costs to the estimated costs of implementing these sections and~~
174.20 ~~must be submitted to the task force on medical cannabis therapeutic research.~~

174.21 Subd. 4. **Reports to the legislature.** (a) The cochairs of the task force shall submit ~~the~~
174.22 ~~following reports~~ an impact assessment report to the chairs and ranking minority members
174.23 of the legislative committees and divisions with jurisdiction over health and human services,
174.24 public safety, judiciary, and civil law:

174.25 ~~(1) by February 1, 2015, a report on the design and implementation of the registry~~
174.26 ~~program; and every two years thereafter, a complete impact assessment report; and.~~

174.27 ~~(2) upon receipt of a cost assessment from a commissioner of a state agency, the~~
174.28 ~~completed cost assessment.~~

174.29 (b) The task force may make recommendations to the legislature on whether to add or
174.30 remove conditions from the list of qualifying medical conditions.

175.1 Subd. 5. **No expiration.** The task force on medical cannabis therapeutic research does
175.2 not expire.

175.3 Sec. 77. **COMMISSIONER OF HEALTH; RECOMMENDATION REGARDING**
175.4 **EXCEPTION TO HOSPITAL CONSTRUCTION MORATORIUM.**

175.5 By February 1, 2023, the commissioner of health, in consultation with the commissioner
175.6 of human services, shall make a recommendation to the chairs and ranking minority members
175.7 of the legislative committees with jurisdiction over health and human services finance as
175.8 to whether Minnesota Statutes, section 144.551, subdivision 1, should be amended to
175.9 authorize exceptions, for hospitals in other counties and without a public interest review,
175.10 that are substantially similar to the exception in Minnesota Statutes, section 144.551,
175.11 subdivision 1, paragraph (b), clause (31).

175.12 Sec. 78. **REVISOR INSTRUCTION.**

175.13 (a) The revisor of statutes shall change the term "cancer surveillance system" to "cancer
175.14 reporting system" wherever it appears in Minnesota Statutes and Minnesota Rules.

175.15 (b) The revisor of statutes shall make any necessary cross-reference changes required
175.16 as a result of the amendments in sections 17 to 22.

175.17 Sec. 79. **REPEALER.**

175.18 Minnesota Statutes 2021 Supplement, section 144G.07, subdivision 6, is repealed.

175.19 **ARTICLE 3**
175.20 **HEALTH CARE FINANCE**

175.21 Section 1. **[62J.86] DEFINITIONS.**

175.22 Subdivision 1. **Definitions.** For the purposes of sections 62J.86 to 62J.92, the following
175.23 terms have the meanings given.

175.24 Subd. 2. **Advisory council.** "Advisory council" means the Health Care Affordability
175.25 Advisory Council established under section 62J.88.

175.26 Subd. 3. **Board.** "Board" means the Health Care Affordability Board established under
175.27 section 62J.87.

176.1 **Sec. 2. [62J.87] HEALTH CARE AFFORDABILITY BOARD.**

176.2 **Subdivision 1. Establishment.** The Health Care Affordability Board is established and
176.3 shall be governed as a board under section 15.012, paragraph (a), to protect consumers,
176.4 state and local governments, health plan companies, providers, and other health care system
176.5 stakeholders from unaffordable health care costs. The board must be operational by January
176.6 1, 2023.

176.7 **Subd. 2. Membership.** (a) The Health Care Affordability Board consists of 13 members,
176.8 appointed as follows:

176.9 (1) five members appointed by the governor;

176.10 (2) two members appointed by the majority leader of the senate;

176.11 (3) two members appointed by the minority leader of the senate;

176.12 (4) two members appointed by the speaker of the house; and

176.13 (5) two members appointed by the minority leader of the house of representatives.

176.14 (b) All appointed members must have knowledge and demonstrated expertise in one or
176.15 more of the following areas: health care finance, health economics, health care management
176.16 or administration at a senior level, health care consumer advocacy, representing the health
176.17 care workforce as a leader in a labor organization, purchasing health care insurance as a
176.18 health benefits administrator, delivery of primary care, health plan company administration,
176.19 public or population health, and addressing health disparities and structural inequities.

176.20 (c) A member may not participate in board proceedings involving an organization,
176.21 activity, or transaction in which the member has either a direct or indirect financial interest,
176.22 other than as an individual consumer of health services.

176.23 (d) The Legislative Coordinating Commission shall coordinate appointments under this
176.24 subdivision to ensure that board members are appointed by August 1, 2022, and that board
176.25 members as a whole meet all of the criteria related to the knowledge and expertise specified
176.26 in paragraph (b).

176.27 **Subd. 3. Terms.** (a) Board appointees shall serve four-year terms. A board member shall
176.28 not serve more than three consecutive terms.

176.29 (b) A board member may resign at any time by giving written notice to the board.

176.30 **Subd. 4. Chair; other officers.** (a) The governor shall designate an acting chair from
176.31 the members appointed by the governor.

177.1 (b) The board shall elect a chair to replace the acting chair at the first meeting of the
177.2 board by a majority of the members. The chair shall serve for two years.

177.3 (c) The board shall elect a vice-chair and other officers from its membership as it deems
177.4 necessary.

177.5 Subd. 5. **Staff; technical assistance; contracting.** (a) The board shall hire a full-time
177.6 executive director and other staff, who shall serve in the unclassified service. The executive
177.7 director must have significant knowledge and expertise in health economics and demonstrated
177.8 experience in health policy.

177.9 (b) The attorney general shall provide legal services to the board.

177.10 (c) The Health Economics Program within the Department of Health shall provide
177.11 technical assistance to the board in analyzing health care trends and costs and in setting
177.12 health care spending growth targets.

177.13 (d) The board may employ or contract for professional and technical assistance, including
177.14 actuarial assistance, as the board deems necessary to perform the board's duties.

177.15 Subd. 6. **Access to information.** (a) The board may request that a state agency provide
177.16 the board with any publicly available information in a usable format as requested by the
177.17 board, at no cost to the board.

177.18 (b) The board may request from a state agency unique or custom data sets, and the agency
177.19 may charge the board for providing the data at the same rate the agency would charge any
177.20 other public or private entity.

177.21 (c) Any information provided to the board by a state agency must be de-identified. For
177.22 purposes of this subdivision, "de-identification" means the process used to prevent the
177.23 identity of a person or business from being connected with the information and ensuring
177.24 all identifiable information has been removed.

177.25 (d) Any data submitted to the board retains its original classification under the Minnesota
177.26 Data Practices Act in chapter 13.

177.27 Subd. 7. **Compensation.** Board members shall not receive compensation but may receive
177.28 reimbursement for expenses as authorized under section 15.059, subdivision 3.

177.29 Subd. 8. **Meetings.** (a) Meetings of the board are subject to chapter 13D. The board shall
177.30 meet publicly at least quarterly. The board may meet in closed session when reviewing
177.31 proprietary information as specified in section 62J.71, subdivision 4.

178.1 (b) The board shall announce each public meeting at least two weeks prior to the
178.2 scheduled date of the meeting. Any materials for the meeting must be made public at least
178.3 one week prior to the scheduled date of the meeting.

178.4 (c) At each public meeting, the board shall provide the opportunity for comments from
178.5 the public, including the opportunity for written comments to be submitted to the board
178.6 prior to a decision by the board.

178.7 **Sec. 3. [62J.88] HEALTH CARE AFFORDABILITY ADVISORY COUNCIL.**

178.8 Subdivision 1. **Establishment.** The governor shall appoint a Health Care Affordability
178.9 Advisory Council of up to 15 members to provide advice to the board on health care costs
178.10 and access issues and to represent the views of patients and other stakeholders. Members
178.11 of the advisory council must be appointed based on their knowledge and demonstrated
178.12 expertise in one or more of the following areas: health care delivery, ensuring health care
178.13 access for diverse populations, public and population health, patient perspectives, health
178.14 care cost trends and drivers, clinical and health services research, innovation in health care
178.15 delivery, and health care benefits management.

178.16 Subd. 2. **Duties; reports.** (a) The council shall provide technical recommendations to
178.17 the board on:

178.18 (1) the identification of economic indicators and other metrics related to the development
178.19 and setting of health care spending growth targets;

178.20 (2) data sources for measuring health care spending; and

178.21 (3) measurement of the impact of health care spending growth targets on diverse
178.22 communities and populations, including but not limited to those communities and populations
178.23 adversely affected by health disparities.

178.24 (b) The council shall report technical recommendations and a summary of its activities
178.25 to the board at least annually, and shall submit additional reports on its activities and
178.26 recommendations to the board, as requested by the board or at the discretion of the council.

178.27 Subd. 3. **Terms.** (a) The initial appointed advisory council members shall serve staggered
178.28 terms of two, three, or four years determined by lot by the secretary of state. Following the
178.29 initial appointments, advisory council members shall serve four-year terms.

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

178.31 Subd. 4. **Compensation.** Advisory council members may be compensated according to
178.32 section 15.059.

179.1 Subd. 5. **Meetings.** The advisory council shall meet at least quarterly. Meetings of the
179.2 advisory council are subject to chapter 13D.

179.3 Subd. 6. **Exemption.** Notwithstanding section 15.059, the advisory council shall not
179.4 expire.

179.5 **Sec. 4. [62J.89] DUTIES OF THE BOARD.**

179.6 Subdivision 1. **General.** (a) The board shall monitor the administration and reform of
179.7 the health care delivery and payment systems in the state. The board shall:

179.8 (1) set health care spending growth targets for the state, as specified under section 62J.90;

179.9 (2) enhance the transparency of provider organizations;

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

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

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

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

179.15 (b) The board shall establish goals to reduce health care disparities in racial and ethnic
179.16 communities and to ensure access to quality care for persons with disabilities or with chronic
179.17 or complex health conditions.

179.18 Subd. 2. **Market trends.** The board shall monitor efforts to reform the health care
179.19 delivery and payment system in Minnesota to understand emerging trends in the commercial
179.20 health insurance market, including large self-insured employers and the state's public health
179.21 care programs, in order to identify opportunities for state action to achieve:

179.22 (1) improved patient experience of care, including quality and satisfaction;

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

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

179.25 Subd. 3. **Recommendations for reform.** The board shall recommend legislative policy,
179.26 market, or any other reforms to:

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

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

180.1 (3) improve the quality and value of care for all Minnesotans, and for specific populations
180.2 adversely affected by health inequities.

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

180.8 Sec. 5. **[62J.90] HEALTH CARE SPENDING GROWTH TARGETS.**

180.9 Subdivision 1. **Establishment and administration.** The board shall establish and
180.10 administer the health care spending growth target program to limit health care spending
180.11 growth in the state, and shall report regularly to the legislature and the public on progress
180.12 toward these targets.

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

180.16 (b) The health care spending growth target must:

180.17 (1) use a clear and operational definition of total state health care spending;

180.18 (2) promote a predictable and sustainable rate of growth for total health care spending
180.19 as measured by an established economic indicator, such as the rate of increase of the state's
180.20 economy or of the personal income of residents of this state, or a combination;

180.21 (3) define the health care markets and the entities to which the targets apply;

180.22 (4) take into consideration the potential for variability in targets across public and private
180.23 payers;

180.24 (5) account for the health status of patients; and

180.25 (6) incorporate specific benchmarks related to health equity.

180.26 (c) In developing, implementing, and evaluating the growth target program, the board
180.27 shall:

180.28 (1) consider the incorporation of quality of care and primary care spending goals;

180.29 (2) ensure that the program does not place a disproportionate burden on communities
180.30 most impacted by health disparities, the providers who primarily serve communities most

181.1 impacted by health disparities, or individuals who reside in rural areas or have high health
181.2 care needs;

181.3 (3) explicitly consider payment models that help ensure financial sustainability of rural
181.4 health care delivery systems and the ability to provide population health;

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

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

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

181.10 (5) ensure that growth targets:

181.11 (i) do not constrain the Minnesota health care workforce, including the need to provide
181.12 competitive wages and benefits;

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

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

181.16 (6) consult with the advisory council and other stakeholders.

181.17 Subd. 3. **Data.** The board shall identify data to be used for tracking performance in
181.18 meeting the growth target and identify methods of data collection necessary for efficient
181.19 implementation by the board. In identifying data and methods, the board shall:

181.20 (1) consider the availability, timeliness, quality, and usefulness of existing data, including
181.21 the data collected under section 62U.04;

181.22 (2) assess the need for additional investments in data collection, data validation, or data
181.23 analysis capacity to support the board in performing its duties; and

181.24 (3) minimize the reporting burden to the extent possible.

181.25 Subd. 4. **Setting growth targets; related duties.** (a) The board, by June 15, 2023, and
181.26 by June 15 of each succeeding calendar year through June 15, 2027, shall establish annual
181.27 health care spending growth targets for the next calendar year consistent with the
181.28 requirements of this section. The board shall set annual health care spending growth targets
181.29 for the five-year period from January 1, 2024, through December 31, 2028.

181.30 (b) The board shall periodically review all components of the health care spending
181.31 growth target program methodology, economic indicators, and other factors. The board may

182.1 revise the annual spending growth targets after a public hearing, as appropriate. If the board
182.2 revises a spending growth target, the board must provide public notice at least 60 days
182.3 before the start of the calendar year to which the revised growth target will apply.

182.4 (c) The board, based on an analysis of drivers of health care spending and evidence from
182.5 public testimony, shall evaluate strategies and new policies, including the establishment of
182.6 accountability mechanisms, that are able to contribute to meeting growth targets and limiting
182.7 health care spending growth without increasing disparities in access to health care.

182.8 Subd. 5. **Hearings.** At least annually, the board shall hold public hearings to present
182.9 findings from spending growth target monitoring. The board shall also regularly hold public
182.10 hearings to take testimony from stakeholders on health care spending growth, setting and
182.11 revising health care spending growth targets, the impact of spending growth and growth
182.12 targets on health care access and quality, and as needed to perform the duties assigned under
182.13 section 62J.89, subdivisions 1, 2, and 3.

182.14 Sec. 6. **[62J.91] NOTICE TO HEALTH CARE ENTITIES.**

182.15 Subdivision 1. **Notice.** (a) The board shall provide notice to all health care entities that
182.16 have been identified by the board as exceeding the spending growth target for any given
182.17 year.

182.18 (b) For purposes of this section, "health care entity" must be defined by the board during
182.19 the development of the health care spending growth methodology. When developing this
182.20 methodology, the board shall consider a definition of health care entity that includes clinics,
182.21 hospitals, ambulatory surgical centers, physician organizations, accountable care
182.22 organizations, integrated provider and plan systems, and other entities defined by the board,
182.23 provided that physician organizations with a patient panel of 15,000 or fewer, or which
182.24 represent providers who collectively receive less than \$25,000,000 in annual net patient
182.25 service revenue from health plan companies and other payers, are exempt.

182.26 Subd. 2. **Performance improvement plans.** (a) The board shall establish and implement
182.27 procedures to assist health care entities to improve efficiency and reduce cost growth by
182.28 requiring some or all health care entities provided notice under subdivision 1 to file and
182.29 implement a performance improvement plan. The board shall provide written notice of this
182.30 requirement to health care entities.

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

182.33 (1) file a performance improvement plan with the board; or

183.1 (2) file an application with the board to waive the requirement to file a performance
183.2 improvement plan or extend the timeline for filing a performance improvement plan.

183.3 (c) The health care entity may file any documentation or supporting evidence with the
183.4 board to support the health care entity's application to waive or extend the timeline to file
183.5 a performance improvement plan. The board shall require the health care entity to submit
183.6 any other relevant information it deems necessary in considering the waiver or extension
183.7 application, provided that this information must be made public at the discretion of the
183.8 board. The board may waive or delay the requirement for a health care entity to file a
183.9 performance improvement plan in response to a waiver or extension request in light of all
183.10 information received from the health care entity, based on a consideration of the following
183.11 factors:

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

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

183.17 (3) whether the factors that led to increased costs for the health care entity can reasonably
183.18 be considered to be unanticipated and outside of the control of the entity. These factors may
183.19 include but are not limited to age and other health status adjusted factors and other cost
183.20 inputs such as pharmaceutical expenses and medical device expenses;

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

183.22 (5) any other factors the board considers relevant. If the board declines to waive or
183.23 extend the requirement for the health care entity to file a performance improvement plan,
183.24 the board shall provide written notice to the health care entity that its application for a waiver
183.25 or extension was denied and the health care entity shall file a performance improvement
183.26 plan.

183.27 (d) A health care entity shall file a performance improvement plan with the board:

183.28 (1) within 45 days of receipt of an initial notice;

183.29 (2) if the health care entity has requested a waiver or extension, within 45 days of receipt
183.30 of a notice that such waiver or extension has been denied; or

183.31 (3) if the health care entity is granted an extension, on the date given on the extension.

184.1 (e) The performance improvement plan must identify the causes of the entity's cost
184.2 growth and include but not be limited to specific strategies, adjustments, and action steps
184.3 the entity proposes to implement to improve cost performance. The proposed performance
184.4 improvement plan must include specific identifiable and measurable expected outcomes
184.5 and a timetable for implementation. The timetable for a performance improvement plan
184.6 must not exceed 18 months.

184.7 (f) The board shall approve any performance improvement plan it determines is
184.8 reasonably likely to address the underlying cause of the entity's cost growth and has a
184.9 reasonable expectation for successful implementation. If the board determines that the
184.10 performance improvement plan is unacceptable or incomplete, the board may provide
184.11 consultation on the criteria that have not been met and may allow an additional time period
184.12 of up to 30 calendar days for resubmission. Upon approval of the proposed performance
184.13 improvement plan, the board shall notify the health care entity to begin immediate
184.14 implementation of the performance improvement plan. The board shall provide public notice
184.15 on its website identifying that the health care entity is implementing a performance
184.16 improvement plan. All health care entities implementing an approved performance
184.17 improvement plan shall be subject to additional reporting requirements and compliance
184.18 monitoring, as determined by the board. The board shall provide assistance to the health
184.19 care entity in the successful implementation of the performance improvement plan.

184.20 (g) All health care entities shall in good faith work to implement the performance
184.21 improvement plan. At any point during the implementation of the performance improvement
184.22 plan, the health care entity may file amendments to the performance improvement plan,
184.23 subject to approval of the board. At the conclusion of the timetable established in the
184.24 performance improvement plan, the health care entity shall report to the board regarding
184.25 the outcome of the performance improvement plan. If the board determines the performance
184.26 improvement plan was not implemented successfully, the board shall:

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

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

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

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

184.33 (h) Upon the successful completion of the performance improvement plan, the board
184.34 shall remove the identity of the health care entity from the board's website. The board may

185.1 assist health care entities with implementing the performance improvement plans or otherwise
185.2 ensure compliance with this subdivision.

185.3 (i) If the board determines that a health care entity has:

185.4 (1) willfully neglected to file a performance improvement plan with the board within
185.5 45 days as required;

185.6 (2) failed to file an acceptable performance improvement plan in good faith with the
185.7 board;

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

185.9 (4) knowingly failed to provide information required by this subdivision to the board or
185.10 knowingly provided false information, the board may assess a civil penalty to the health
185.11 care entity of not more than \$500,000. The board must only impose a civil penalty as a last
185.12 resort.

185.13 **Sec. 7. [62J.92] REPORTING REQUIREMENTS.**

185.14 Subdivision 1. **General requirement.** (a) The board shall present the reports required
185.15 by this section to the chairs and ranking members of the legislative committees with primary
185.16 jurisdiction over health care finance and policy. The board shall also make these reports
185.17 available to the public on the board's website.

185.18 (b) The board may contract with a third-party vendor for technical assistance in preparing
185.19 the reports.

185.20 Subd. 2. **Progress reports.** The board shall submit written progress updates about the
185.21 development and implementation of the health care spending growth target program by
185.22 February 15, 2024, and February 15, 2025. The updates must include reporting on board
185.23 membership and activities, program design decisions, planned timelines for implementation
185.24 of the program, and the progress of implementation. The reports must include the
185.25 methodological details underlying program design decisions.

185.26 Subd. 3. **Health care spending trends.** By December 15, 2024, and every December
185.27 15 thereafter, the board shall submit a report on health care spending trends and the health
185.28 care spending growth target program that includes:

185.29 (1) spending growth in aggregate and for entities subject to health care spending growth
185.30 targets relative to established target levels;

185.31 (2) findings from analyses of drivers of health care spending growth;

186.1 (3) estimates of the impact of health care spending growth on Minnesota residents,
186.2 including for communities most impacted by health disparities, related to their access to
186.3 insurance and care, value of health care, and the ability to pursue other spending priorities;

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

186.6 (5) changes under consideration for revising the methodology to monitor or set growth
186.7 targets;

186.8 (6) recommendations for initiatives to assist health care entities in meeting health care
186.9 spending growth targets, including broader and more transparent adoption of value-based
186.10 payment arrangements; and

186.11 (7) the number of health care entities whose spending growth exceeded growth targets,
186.12 information on performance improvement plans and the extent to which the plans were
186.13 completed, and any civil penalties imposed on health care entities related to noncompliance
186.14 with performance improvement plans and related requirements.

186.15 Sec. 8. Minnesota Statutes 2020, section 62U.04, subdivision 11, is amended to read:

186.16 Subd. 11. **Restricted uses of the all-payer claims data.** (a) Notwithstanding subdivision
186.17 4, paragraph (b), and subdivision 5, paragraph (b), the commissioner or the commissioner's
186.18 designee shall only use the data submitted under subdivisions 4 and 5 for the following
186.19 purposes:

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

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

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

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

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

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

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

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

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

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

187.9 (6) to provide technical assistance to the Health Care Affordability Board to implement
187.10 sections 62J.86 to 62J.92.

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

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

187.17 (d) The commissioner or the commissioner's designee may use the data submitted under
187.18 subdivisions 4 and 5 for the purpose described in paragraph (a), clause (3), until July 1,
187.19 2023.

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

187.23 Sec. 9. Minnesota Statutes 2020, section 256.01, is amended by adding a subdivision to
187.24 read:

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

188.1 and the information and resources to be provided. Hospitals and providers must make this
188.2 protocol available to the commissioner upon request.

188.3 Sec. 10. Minnesota Statutes 2020, section 256.969, is amended by adding a subdivision
188.4 to read:

188.5 Subd. 31. **Long-acting reversible contraceptives.** (a) The commissioner must provide
188.6 separate reimbursement to hospitals for long-acting reversible contraceptives provided
188.7 immediately postpartum in the inpatient hospital setting. This payment must be in addition
188.8 to the diagnostic related group (DRG) reimbursement for labor and delivery.

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

188.11 **EFFECTIVE DATE.** This section is effective January 1, 2023.

188.12 Sec. 11. Minnesota Statutes 2020, section 256B.021, subdivision 4, is amended to read:

188.13 Subd. 4. **Projects.** The commissioner shall request permission and funding to further
188.14 the following initiatives.

188.15 (a) Health care delivery demonstration projects. This project involves testing alternative
188.16 payment and service delivery models in accordance with sections 256B.0755 and 256B.0756.
188.17 These demonstrations will allow the Minnesota Department of Human Services to engage
188.18 in alternative payment arrangements with provider organizations that provide services to a
188.19 specified patient population for an agreed upon total cost of care or risk/gain sharing payment
188.20 arrangement, but are not limited to these models of care delivery or payment. Quality of
188.21 care and patient experience will be measured and incorporated into payment models alongside
188.22 the cost of care. Demonstration sites should include Minnesota health care programs
188.23 fee-for-services recipients and managed care enrollees and support a robust primary care
188.24 model and improved care coordination for recipients.

188.25 (b) Promote personal responsibility and encourage and reward healthy outcomes. This
188.26 project provides Medicaid funding to provide individual and group incentives to encourage
188.27 healthy behavior, prevent the onset of chronic disease, and reward healthy outcomes. Focus
188.28 areas may include diabetes prevention and management, tobacco cessation, reducing weight,
188.29 lowering cholesterol, and lowering blood pressure.

188.30 (c) Encourage utilization of high quality, cost-effective care. This project creates
188.31 incentives ~~through Medicaid and MinnesotaCare enrollee cost-sharing and other means to~~

189.1 encourage the utilization of high-quality, low-cost, high-value providers, as determined by
189.2 the state's provider peer grouping initiative under section 62U.04.

189.3 (d) Adults without children. This proposal includes requesting federal authority to impose
189.4 a limit on assets for adults without children in medical assistance, as defined in section
189.5 256B.055, subdivision 15, who have a household income equal to or less than 75 percent
189.6 of the federal poverty limit, and to impose a 180-day durational residency requirement in
189.7 MinnesotaCare, consistent with section 256L.09, subdivision 4, for adults without children,
189.8 regardless of income.

189.9 (e) Empower and encourage work, housing, and independence. This project provides
189.10 services and supports for individuals who have an identified health or disabling condition
189.11 but are not yet certified as disabled, in order to delay or prevent permanent disability, reduce
189.12 the need for intensive health care and long-term care services and supports, and to help
189.13 maintain or obtain employment or assist in return to work. Benefits may include:

189.14 (1) coordination with health care homes or health care coordinators;

189.15 (2) assessment for wellness, housing needs, employment, planning, and goal setting;

189.16 (3) training services;

189.17 (4) job placement services;

189.18 (5) career counseling;

189.19 (6) benefit counseling;

189.20 (7) worker supports and coaching;

189.21 (8) assessment of workplace accommodations;

189.22 (9) transitional housing services; and

189.23 (10) assistance in maintaining housing.

189.24 (f) Redesign home and community-based services. This project realigns existing funding,
189.25 services, and supports for people with disabilities and older Minnesotans to ensure community
189.26 integration and a more sustainable service system. This may involve changes that promote
189.27 a range of services to flexibly respond to the following needs:

189.28 (1) provide people less expensive alternatives to medical assistance services;

189.29 (2) offer more flexible and updated community support services under the Medicaid
189.30 state plan;

189.31 (3) provide an individual budget and increased opportunity for self-direction;

- 190.1 (4) strengthen family and caregiver support services;
- 190.2 (5) allow persons to pool resources or save funds beyond a fiscal year to cover unexpected
190.3 needs or foster development of needed services;
- 190.4 (6) use of home and community-based waiver programs for people whose needs cannot
190.5 be met with the expanded Medicaid state plan community support service options;
- 190.6 (7) target access to residential care for those with higher needs;
- 190.7 (8) develop capacity within the community for crisis intervention and prevention;
- 190.8 (9) redesign case management;
- 190.9 (10) offer life planning services for families to plan for the future of their child with a
190.10 disability;
- 190.11 (11) enhance self-advocacy and life planning for people with disabilities;
- 190.12 (12) improve information and assistance to inform long-term care decisions; and
- 190.13 (13) increase quality assurance, performance measurement, and outcome-based
190.14 reimbursement.
- 190.15 This project may include different levels of long-term supports that allow seniors to remain
190.16 in their homes and communities, and expand care transitions from acute care to community
190.17 care to prevent hospitalizations and nursing home placement. The levels of support for
190.18 seniors may range from basic community services for those with lower needs, access to
190.19 residential services if a person has higher needs, and targets access to nursing home care to
190.20 those with rehabilitation or high medical needs. This may involve the establishment of
190.21 medical need thresholds to accommodate the level of support needed; provision of a
190.22 long-term care consultation to persons seeking residential services, regardless of payer
190.23 source; adjustment of incentives to providers and care coordination organizations to achieve
190.24 desired outcomes; and a required coordination with medical assistance basic care benefit
190.25 and Medicare/Medigap benefit. This proposal will improve access to housing and improve
190.26 capacity to maintain individuals in their existing home; adjust screening and assessment
190.27 tools, as needed; improve transition and relocation efforts; seek federal financial participation
190.28 for alternative care and essential community supports; and provide Medigap coverage for
190.29 people having lower needs.
- 190.30 (g) Coordinate and streamline services for people with complex needs, including those
190.31 with multiple diagnoses of physical, mental, and developmental conditions. This project

191.1 will coordinate and streamline medical assistance benefits for people with complex needs
191.2 and multiple diagnoses. It would include changes that:

191.3 (1) develop community-based service provider capacity to serve the needs of this group;

191.4 (2) build assessment and care coordination expertise specific to people with multiple
191.5 diagnoses;

191.6 (3) adopt service delivery models that allow coordinated access to a range of services
191.7 for people with complex needs;

191.8 (4) reduce administrative complexity;

191.9 (5) measure the improvements in the state's ability to respond to the needs of this
191.10 population; and

191.11 (6) increase the cost-effectiveness for the state budget.

191.12 (h) Implement nursing home level of care criteria. This project involves obtaining any
191.13 necessary federal approval in order to implement the changes to the level of care criteria in
191.14 section 144.0724, subdivision 11, and implement further changes necessary to achieve
191.15 reform of the home and community-based service system.

191.16 (i) Improve integration of Medicare and Medicaid. This project involves reducing
191.17 fragmentation in the health care delivery system to improve care for people eligible for both
191.18 Medicare and Medicaid, and to align fiscal incentives between primary, acute, and long-term
191.19 care. The proposal may include:

191.20 (1) requesting an exception to the new Medicare methodology for payment adjustment
191.21 for fully integrated special needs plans for dual eligible individuals;

191.22 (2) testing risk adjustment models that may be more favorable to capturing the needs of
191.23 frail dually eligible individuals;

191.24 (3) requesting an exemption from the Medicare bidding process for fully integrated
191.25 special needs plans for the dually eligible;

191.26 (4) modifying the Medicare bid process to recognize additional costs of health home
191.27 services; and

191.28 (5) requesting permission for risk-sharing and gain-sharing.

191.29 (j) Intensive residential treatment services. This project would involve providing intensive
191.30 residential treatment services for individuals who have serious mental illness and who have
191.31 other complex needs. This proposal would allow such individuals to remain in these settings

192.1 after mental health symptoms have stabilized, in order to maintain their mental health and
192.2 avoid more costly or unnecessary hospital or other residential care due to their other complex
192.3 conditions. The commissioner may pursue a specialized rate for projects created under this
192.4 section.

192.5 (k) Seek federal Medicaid matching funds for Anoka-Metro Regional Treatment Center
192.6 (AMRTC). This project involves seeking Medicaid reimbursement for medical services
192.7 provided to patients to AMRTC, including requesting a waiver of United States Code, title
192.8 42, section 1396d, which prohibits Medicaid reimbursement for expenditures for services
192.9 provided by hospitals with more than 16 beds that are primarily focused on the treatment
192.10 of mental illness. This waiver would allow AMRTC to serve as a statewide resource to
192.11 provide diagnostics and treatment for people with the most complex conditions.

192.12 (l) Waivers to allow Medicaid eligibility for children under age 21 receiving care in
192.13 residential facilities. This proposal would seek Medicaid reimbursement for any
192.14 Medicaid-covered service for children who are placed in residential settings that are
192.15 determined to be "institutions for mental diseases," under United States Code, title 42,
192.16 section 1396d.

192.17 **EFFECTIVE DATE.** This section is effective January 1, 2023.

192.18 Sec. 12. Minnesota Statutes 2021 Supplement, section 256B.0371, subdivision 4, is
192.19 amended to read:

192.20 Subd. 4. **Dental utilization report.** (a) The commissioner shall submit an annual report
192.21 beginning March 15, 2022, and ending March 15, 2026, to the chairs and ranking minority
192.22 members of the legislative committees with jurisdiction over health and human services
192.23 policy and finance that includes the percentage for adults and children one through 20 years
192.24 of age for the most recent complete calendar year receiving at least one dental visit for both
192.25 fee-for-service and the prepaid medical assistance program. The report must include:

192.26 (1) statewide utilization for both fee-for-service and for the prepaid medical assistance
192.27 program;

192.28 (2) utilization by county;

192.29 (3) utilization by children receiving dental services through fee-for-service and through
192.30 a managed care plan or county-based purchasing plan;

192.31 (4) utilization by adults receiving dental services through fee-for-service and through a
192.32 managed care plan or county-based purchasing plan.

193.1 (b) The report must also include a description of any corrective action plans required to
193.2 be submitted under subdivision 2.

193.3 (c) The initial report due on March 15, 2022, must include the utilization metrics described
193.4 in paragraph (a) for each of the following calendar years: 2017, 2018, 2019, and 2020.

193.5 (d) In the annual report due on March 15, 2023, and in each report due thereafter, the
193.6 commissioner shall include the following:

193.7 (1) the number of dentists enrolled with the commissioner as a medical assistance dental
193.8 provider and the congressional district or districts in which the dentist provides services;

193.9 (2) the number of enrolled dentists who provided fee-for-service dental services to
193.10 medical assistance or MinnesotaCare patients within the previous calendar year in the
193.11 following increments: one to nine patients, ten to 100 patients, and over 100 patients;

193.12 (3) the number of enrolled dentists who provided dental services to medical assistance
193.13 or MinnesotaCare patients through a managed care plan or county-based purchasing plan
193.14 within the previous calendar year in the following increments: one to nine patients, ten to
193.15 100 patients, and over 100 patients; and

193.16 (4) the number of dentists who provided dental services to a new patient who was enrolled
193.17 in medical assistance or MinnesotaCare within the previous calendar year.

193.18 (e) The report due on March 15, 2023, must include the metrics described in paragraph
193.19 (d) for each of the following years: 2017, 2018, 2019, 2020, and 2021.

193.20 Sec. 13. Minnesota Statutes 2021 Supplement, section 256B.04, subdivision 14, is amended
193.21 to read:

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

193.26 (1) eyeglasses;

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

193.30 (3) hearing aids and supplies;

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

- 194.1 (i) hospital beds;
- 194.2 (ii) commodes;
- 194.3 (iii) glide-about chairs;
- 194.4 (iv) patient lift apparatus;
- 194.5 (v) wheelchairs and accessories;
- 194.6 (vi) oxygen administration equipment;
- 194.7 (vii) respiratory therapy equipment;
- 194.8 (viii) electronic diagnostic, therapeutic and life-support systems; and
- 194.9 (ix) allergen-reducing products as described in section 256B.0625, subdivision 67,
- 194.10 paragraph (c) or (d);
- 194.11 (5) nonemergency medical transportation level of need determinations, disbursement of
- 194.12 public transportation passes and tokens, and volunteer and recipient mileage and parking
- 194.13 reimbursements; and
- 194.14 (6) drugs.
- 194.15 (b) Rate changes ~~and recipient cost sharing~~ under this chapter and chapter 256L do not
- 194.16 affect contract payments under this subdivision unless specifically identified.
- 194.17 (c) The commissioner may not utilize volume purchase through competitive bidding
- 194.18 and negotiation under the provisions of chapter 16C for special transportation services or
- 194.19 incontinence products and related supplies.
- 194.20 **EFFECTIVE DATE.** This section is effective January 1, 2023.
- 194.21 Sec. 14. Minnesota Statutes 2021 Supplement, section 256B.04, subdivision 14, is amended
- 194.22 to read:
- 194.23 Subd. 14. **Competitive bidding.** (a) When determined to be effective, economical, and
- 194.24 feasible, the commissioner may utilize volume purchase through competitive bidding and
- 194.25 negotiation under the provisions of chapter 16C, to provide items under the medical assistance
- 194.26 program including but not limited to the following:
- 194.27 (1) eyeglasses;
- 194.28 (2) oxygen. The commissioner shall provide for oxygen needed in an emergency situation
- 194.29 on a short-term basis, until the vendor can obtain the necessary supply from the contract
- 194.30 dealer;

- 195.1 (3) hearing aids and supplies;
- 195.2 (4) durable medical equipment, including but not limited to:
- 195.3 (i) hospital beds;
- 195.4 (ii) commodes;
- 195.5 (iii) glide-about chairs;
- 195.6 (iv) patient lift apparatus;
- 195.7 (v) wheelchairs and accessories;
- 195.8 (vi) oxygen administration equipment;
- 195.9 (vii) respiratory therapy equipment;
- 195.10 (viii) electronic diagnostic, therapeutic and life-support systems; and
- 195.11 (ix) allergen-reducing products as described in section 256B.0625, subdivision 67,
- 195.12 paragraph (c) or (d);
- 195.13 (5) nonemergency medical transportation level of need determinations, disbursement of
- 195.14 public transportation passes and tokens, and volunteer and recipient mileage and parking
- 195.15 reimbursements; ~~and~~
- 195.16 (6) drugs; and
- 195.17 (7) quitline services as described in section 256B.0625, subdivision 68.
- 195.18 (b) Rate changes and recipient cost-sharing under this chapter and chapter 256L do not
- 195.19 affect contract payments under this subdivision unless specifically identified.
- 195.20 (c) The commissioner may not utilize volume purchase through competitive bidding
- 195.21 and negotiation under the provisions of chapter 16C for special transportation services or
- 195.22 incontinence products and related supplies.
- 195.23 Sec. 15. Minnesota Statutes 2020, section 256B.055, subdivision 17, is amended to read:
- 195.24 Subd. 17. **Adults who were in foster care at the age of 18.** (a) Medical assistance may
- 195.25 be paid for a person under 26 years of age who was in foster care under the commissioner's
- 195.26 responsibility on the date of attaining 18 years of age or older, and who was enrolled in
- 195.27 medical assistance under ~~the~~ a state plan or a waiver of ~~the~~ a plan while in foster care, in
- 195.28 accordance with section 2004 of the Affordable Care Act.
- 195.29 (b) Beginning January 1, 2023, medical assistance may be paid for a person under 26
- 195.30 years of age who was in foster care and enrolled in another state's Medicaid program while

196.1 in foster care, in accordance with Public Law 115-271, section 1002, the Substance
196.2 Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and
196.3 Communities Act.

196.4 **EFFECTIVE DATE.** This section is effective January 1, 2023.

196.5 Sec. 16. Minnesota Statutes 2020, section 256B.056, subdivision 3, is amended to read:

196.6 Subd. 3. **Asset limitations for certain individuals.** (a) To be eligible for medical
196.7 assistance, a person must not individually own more than ~~\$3,000~~ \$20,000 in assets, or if a
196.8 member of a household with two family members, husband and wife, or parent and child,
196.9 the household must not own more than ~~\$6,000~~ \$40,000 in assets, plus \$200 for each
196.10 additional legal dependent. In addition to these maximum amounts, an eligible individual
196.11 or family may accrue interest on these amounts, but they must be reduced to the maximum
196.12 at the time of an eligibility redetermination. The accumulation of the clothing and personal
196.13 needs allowance according to section 256B.35 must also be reduced to the maximum at the
196.14 time of the eligibility redetermination. The value of assets that are not considered in
196.15 determining eligibility for medical assistance is the value of those assets excluded under
196.16 the Supplemental Security Income program for aged, blind, and disabled persons, with the
196.17 following exceptions:

196.18 (1) household goods and personal effects are not considered;

196.19 (2) capital and operating assets of a trade or business that the local agency determines
196.20 are necessary to the person's ability to earn an income are not considered;

196.21 (3) motor vehicles are excluded to the same extent excluded by the Supplemental Security
196.22 Income program;

196.23 (4) assets designated as burial expenses are excluded to the same extent excluded by the
196.24 Supplemental Security Income program. Burial expenses funded by annuity contracts or
196.25 life insurance policies must irrevocably designate the individual's estate as contingent
196.26 beneficiary to the extent proceeds are not used for payment of selected burial expenses;

196.27 (5) for a person who no longer qualifies as an employed person with a disability due to
196.28 loss of earnings, assets allowed while eligible for medical assistance under section 256B.057,
196.29 subdivision 9, are not considered for 12 months, beginning with the first month of ineligibility
196.30 as an employed person with a disability, to the extent that the person's total assets remain
196.31 within the allowed limits of section 256B.057, subdivision 9, paragraph (d);

196.32 (6) a designated employment incentives asset account is disregarded when determining
196.33 eligibility for medical assistance for a person age 65 years or older under section 256B.055,

197.1 subdivision 7. An employment incentives asset account must only be designated by a person
197.2 who has been enrolled in medical assistance under section 256B.057, subdivision 9, for a
197.3 24-consecutive-month period. A designated employment incentives asset account contains
197.4 qualified assets owned by the person and the person's spouse in the last month of enrollment
197.5 in medical assistance under section 256B.057, subdivision 9. Qualified assets include
197.6 retirement and pension accounts, medical expense accounts, and up to \$17,000 of the person's
197.7 other nonexcluded assets. An employment incentives asset account is no longer designated
197.8 when a person loses medical assistance eligibility for a calendar month or more before
197.9 turning age 65. A person who loses medical assistance eligibility before age 65 can establish
197.10 a new designated employment incentives asset account by establishing a new
197.11 24-consecutive-month period of enrollment under section 256B.057, subdivision 9. The
197.12 income of a spouse of a person enrolled in medical assistance under section 256B.057,
197.13 subdivision 9, during each of the 24 consecutive months before the person's 65th birthday
197.14 must be disregarded when determining eligibility for medical assistance under section
197.15 256B.055, subdivision 7. Persons eligible under this clause are not subject to the provisions
197.16 in section 256B.059; ~~and~~

197.17 (7) effective July 1, 2009, certain assets owned by American Indians are excluded as
197.18 required by section 5006 of the American Recovery and Reinvestment Act of 2009, Public
197.19 Law 111-5. For purposes of this clause, an American Indian is any person who meets the
197.20 definition of Indian according to Code of Federal Regulations, title 42, section 447.50-; and

197.21 (8) for individuals who were enrolled in medical assistance during the COVID-19 federal
197.22 public health emergency declared by the United States Secretary of Health and Human
197.23 Services and who are subject to the asset limits established by this subdivision, assets in
197.24 excess of the limits must be disregarded until 95 days after the individual's first renewal
197.25 occurring after the expiration of the COVID-19 federal public health emergency declared
197.26 by the United States Secretary of Health and Human Services.

197.27 (b) No asset limit shall apply to persons eligible under section 256B.055, subdivision
197.28 15.

197.29 **EFFECTIVE DATE.** The amendment to paragraph (a) increasing the asset limits is
197.30 effective January 1, 2025, or upon federal approval, whichever is later. The amendment to
197.31 paragraph (a) adding clause (8) is effective July 1, 2022, or upon federal approval, whichever
197.32 is later. The commissioner of human services shall notify the revisor of statutes when federal
197.33 approval is obtained.

198.1 Sec. 17. Minnesota Statutes 2020, section 256B.056, subdivision 4, is amended to read:

198.2 Subd. 4. **Income.** (a) To be eligible for medical assistance, a person eligible under section
198.3 256B.055, subdivisions 7, 7a, and 12, may have income up to 100 percent of the federal
198.4 poverty guidelines, and effective January 1, 2025, income up to 133 percent of the federal
198.5 poverty guidelines. Effective January 1, 2000, and each successive January, recipients of
198.6 Supplemental Security Income may have an income up to the Supplemental Security Income
198.7 standard in effect on that date.

198.8 (b) To be eligible for medical assistance under section 256B.055, subdivision 3a, a parent
198.9 or caretaker relative may have an income up to 133 percent of the federal poverty guidelines
198.10 for the household size.

198.11 (c) To be eligible for medical assistance under section 256B.055, subdivision 15, a
198.12 person may have an income up to 133 percent of federal poverty guidelines for the household
198.13 size.

198.14 (d) To be eligible for medical assistance under section 256B.055, subdivision 16, a child
198.15 age 19 to 20 may have an income up to 133 percent of the federal poverty guidelines for
198.16 the household size.

198.17 (e) To be eligible for medical assistance under section 256B.055, subdivision 3a, a child
198.18 under age 19 may have income up to 275 percent of the federal poverty guidelines for the
198.19 household size.

198.20 (f) In computing income to determine eligibility of persons under paragraphs (a) to (e)
198.21 who are not residents of long-term care facilities, the commissioner shall disregard increases
198.22 in income as required by Public Laws 94-566, section 503; 99-272; and 99-509. For persons
198.23 eligible under paragraph (a), veteran aid and attendance benefits and Veterans Administration
198.24 unusual medical expense payments are considered income to the recipient.

198.25 Sec. 18. Minnesota Statutes 2020, section 256B.056, subdivision 7, is amended to read:

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

198.29 (b) For a person eligible for an insurance affordability program as defined in section
198.30 256B.02, subdivision 19, who reports a change that makes the person eligible for medical
198.31 assistance, eligibility is available for the month the change was reported and for three months
198.32 prior to the month the change was reported, if the person was eligible in those prior months.

199.1 (c) Once determined eligible for medical assistance, a child under the age of 21 is
199.2 continuously eligible for a period of up to 12 months, unless:

199.3 (1) the child reaches age 21;

199.4 (2) the child requests voluntary termination of coverage;

199.5 (3) the child ceases to be a resident of Minnesota;

199.6 (4) the child dies; or

199.7 (5) the agency determines the child's eligibility was erroneously granted due to agency
199.8 error or enrollee fraud, abuse, or perjury.

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

199.12 Sec. 19. Minnesota Statutes 2021 Supplement, section 256B.0625, subdivision 9, is
199.13 amended to read:

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

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

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

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

199.20 ~~(3) limited exams;~~

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

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

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

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

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

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

- 200.1 ~~(10) anterior fillings;~~
- 200.2 ~~(11) endodontics, limited to root canals on the anterior and premolars only;~~
- 200.3 ~~(12) removable prostheses, each dental arch limited to one every six years;~~
- 200.4 ~~(13) oral surgery, limited to extractions, biopsies, and incision and drainage of abscesses;~~
- 200.5 ~~(14) palliative treatment and sedative fillings for relief of pain;~~
- 200.6 ~~(15) full-mouth debridement, limited to one every five years; and~~
- 200.7 ~~(16) nonsurgical treatment for periodontal disease, including sealing and root planing~~
- 200.8 ~~once every two years for each quadrant, and routine periodontal maintenance procedures.~~
- 200.9 ~~(e) In addition to the services specified in paragraph (b), medical assistance covers the~~
- 200.10 ~~following services for adults, if provided in an outpatient hospital setting or freestanding~~
- 200.11 ~~ambulatory surgical center as part of outpatient dental surgery:~~
- 200.12 ~~(1) periodontics, limited to periodontal sealing and root planing once every two years;~~
- 200.13 ~~(2) general anesthesia; and~~
- 200.14 ~~(3) full-mouth survey once every five years.~~
- 200.15 ~~(d) Medical assistance covers medically necessary dental services for children and~~
- 200.16 ~~pregnant women. The following guidelines apply:~~
- 200.17 (1) posterior fillings are paid at the amalgam rate;
- 200.18 (2) application of sealants are covered once every five years per permanent molar ~~for~~
- 200.19 ~~children only;~~
- 200.20 (3) application of fluoride varnish is covered once every six months; and
- 200.21 (4) orthodontia is eligible for coverage for children only.
- 200.22 ~~(e) (b)~~ In addition to the services specified in ~~paragraphs (b) and (e)~~ paragraph (a),
- 200.23 medical assistance covers the following services ~~for adults:~~
- 200.24 (1) house calls or extended care facility calls for on-site delivery of covered services;
- 200.25 (2) behavioral management when additional staff time is required to accommodate
- 200.26 behavioral challenges and sedation is not used;
- 200.27 (3) oral or IV sedation, if the covered dental service cannot be performed safely without
- 200.28 it or would otherwise require the service to be performed under general anesthesia in a
- 200.29 hospital or surgical center; and

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

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

201.7 **EFFECTIVE DATE.** This section is effective January 1, 2023, or upon federal approval,
201.8 whichever is later. The commissioner of human services shall notify the revisor of statutes
201.9 when federal approval is obtained.

201.10 Sec. 20. Minnesota Statutes 2021 Supplement, section 256B.0625, subdivision 17, is
201.11 amended to read:

201.12 Subd. 17. **Transportation costs.** (a) "Nonemergency medical transportation service"
201.13 means motor vehicle transportation provided by a public or private person that serves
201.14 Minnesota health care program beneficiaries who do not require emergency ambulance
201.15 service, as defined in section 144E.001, subdivision 3, to obtain covered medical services.

201.16 (b) Medical assistance covers medical transportation costs incurred solely for obtaining
201.17 emergency medical care or transportation costs incurred by eligible persons in obtaining
201.18 emergency or nonemergency medical care when paid directly to an ambulance company,
201.19 nonemergency medical transportation company, or other recognized providers of
201.20 transportation services. Medical transportation must be provided by:

201.21 (1) nonemergency medical transportation providers who meet the requirements of this
201.22 subdivision;

201.23 (2) ambulances, as defined in section 144E.001, subdivision 2;

201.24 (3) taxicabs that meet the requirements of this subdivision;

201.25 (4) public transit, as defined in section 174.22, subdivision 7; or

201.26 (5) not-for-hire vehicles, including volunteer drivers, as defined in section 65B.472,
201.27 subdivision 1, paragraph (h).

201.28 (c) Medical assistance covers nonemergency medical transportation provided by
201.29 nonemergency medical transportation providers enrolled in the Minnesota health care
201.30 programs. All nonemergency medical transportation providers must comply with the
201.31 operating standards for special transportation service as defined in sections 174.29 to 174.30
201.32 and Minnesota Rules, chapter 8840, and all drivers must be individually enrolled with the

202.1 commissioner and reported on the claim as the individual who provided the service. All
202.2 nonemergency medical transportation providers shall bill for nonemergency medical
202.3 transportation services in accordance with Minnesota health care programs criteria. Publicly
202.4 operated transit systems, volunteers, and not-for-hire vehicles are exempt from the
202.5 requirements outlined in this paragraph.

202.6 (d) An organization may be terminated, denied, or suspended from enrollment if:

202.7 (1) the provider has not initiated background studies on the individuals specified in
202.8 section 174.30, subdivision 10, paragraph (a), clauses (1) to (3); or

202.9 (2) the provider has initiated background studies on the individuals specified in section
202.10 174.30, subdivision 10, paragraph (a), clauses (1) to (3), and:

202.11 (i) the commissioner has sent the provider a notice that the individual has been
202.12 disqualified under section 245C.14; and

202.13 (ii) the individual has not received a disqualification set-aside specific to the special
202.14 transportation services provider under sections 245C.22 and 245C.23.

202.15 (e) The administrative agency of nonemergency medical transportation must:

202.16 (1) adhere to the policies defined by the commissioner in consultation with the
202.17 Nonemergency Medical Transportation Advisory Committee;

202.18 (2) pay nonemergency medical transportation providers for services provided to
202.19 Minnesota health care programs beneficiaries to obtain covered medical services;

202.20 (3) provide data monthly to the commissioner on appeals, complaints, no-shows, canceled
202.21 trips, and number of trips by mode; and

202.22 (4) by July 1, 2016, in accordance with subdivision 18e, utilize a web-based single
202.23 administrative structure assessment tool that meets the technical requirements established
202.24 by the commissioner, reconciles trip information with claims being submitted by providers,
202.25 and ensures prompt payment for nonemergency medical transportation services.

202.26 (f) Until the commissioner implements the single administrative structure and delivery
202.27 system under subdivision 18e, clients shall obtain their level-of-service certificate from the
202.28 commissioner or an entity approved by the commissioner that does not dispatch rides for
202.29 clients using modes of transportation under paragraph (i), clauses (4), (5), (6), and (7).

202.30 (g) The commissioner may use an order by the recipient's attending physician, advanced
202.31 practice registered nurse, or a medical or mental health professional to certify that the
202.32 recipient requires nonemergency medical transportation services. Nonemergency medical

203.1 transportation providers shall perform driver-assisted services for eligible individuals, when
203.2 appropriate. Driver-assisted service includes passenger pickup at and return to the individual's
203.3 residence or place of business, assistance with admittance of the individual to the medical
203.4 facility, and assistance in passenger securement or in securing of wheelchairs, child seats,
203.5 or stretchers in the vehicle.

203.6 Nonemergency medical transportation providers must take clients to the health care
203.7 provider using the most direct route, and must not exceed 30 miles for a trip to a primary
203.8 care provider or 60 miles for a trip to a specialty care provider, unless the client receives
203.9 authorization from the local agency.

203.10 Nonemergency medical transportation providers may not bill for separate base rates for
203.11 the continuation of a trip beyond the original destination. Nonemergency medical
203.12 transportation providers must maintain trip logs, which include pickup and drop-off times,
203.13 signed by the medical provider or client, whichever is deemed most appropriate, attesting
203.14 to mileage traveled to obtain covered medical services. Clients requesting client mileage
203.15 reimbursement must sign the trip log attesting mileage traveled to obtain covered medical
203.16 services.

203.17 (h) The administrative agency shall use the level of service process established by the
203.18 commissioner in consultation with the Nonemergency Medical Transportation Advisory
203.19 Committee to determine the client's most appropriate mode of transportation. If public transit
203.20 or a certified transportation provider is not available to provide the appropriate service mode
203.21 for the client, the client may receive a onetime service upgrade.

203.22 (i) The covered modes of transportation are:

203.23 (1) client reimbursement, which includes client mileage reimbursement provided to
203.24 clients who have their own transportation, or to family or an acquaintance who provides
203.25 transportation to the client;

203.26 (2) volunteer transport, which includes transportation by volunteers using their own
203.27 vehicle;

203.28 (3) unassisted transport, which includes transportation provided to a client by a taxicab
203.29 or public transit. If a taxicab or public transit is not available, the client can receive
203.30 transportation from another nonemergency medical transportation provider;

203.31 (4) assisted transport, which includes transport provided to clients who require assistance
203.32 by a nonemergency medical transportation provider;

204.1 (5) lift-equipped/ramp transport, which includes transport provided to a client who is
204.2 dependent on a device and requires a nonemergency medical transportation provider with
204.3 a vehicle containing a lift or ramp;

204.4 (6) protected transport, which includes transport provided to a client who has received
204.5 a prescreening that has deemed other forms of transportation inappropriate and who requires
204.6 a provider: (i) with a protected vehicle that is not an ambulance or police car and has safety
204.7 locks, a video recorder, and a transparent thermoplastic partition between the passenger and
204.8 the vehicle driver; and (ii) who is certified as a protected transport provider; and

204.9 (7) stretcher transport, which includes transport for a client in a prone or supine position
204.10 and requires a nonemergency medical transportation provider with a vehicle that can transport
204.11 a client in a prone or supine position.

204.12 (j) The local agency shall be the single administrative agency and shall administer and
204.13 reimburse for modes defined in paragraph (i) according to paragraphs (m) and (n) when the
204.14 commissioner has developed, made available, and funded the web-based single administrative
204.15 structure, assessment tool, and level of need assessment under subdivision 18e. The local
204.16 agency's financial obligation is limited to funds provided by the state or federal government.

204.17 (k) The commissioner shall:

204.18 (1) in consultation with the Nonemergency Medical Transportation Advisory Committee,
204.19 verify that the mode and use of nonemergency medical transportation is appropriate;

204.20 (2) verify that the client is going to an approved medical appointment; and

204.21 (3) investigate all complaints and appeals.

204.22 (l) The administrative agency shall pay for the services provided in this subdivision and
204.23 seek reimbursement from the commissioner, if appropriate. As vendors of medical care,
204.24 local agencies are subject to the provisions in section 256B.041, the sanctions and monetary
204.25 recovery actions in section 256B.064, and Minnesota Rules, parts 9505.2160 to 9505.2245.

204.26 (m) Payments for nonemergency medical transportation must be paid based on the client's
204.27 assessed mode under paragraph (h), not the type of vehicle used to provide the service. The
204.28 medical assistance reimbursement rates for nonemergency medical transportation services
204.29 that are payable by or on behalf of the commissioner for nonemergency medical
204.30 transportation services are:

204.31 (1) \$0.22 per mile for client reimbursement;

205.1 (2) up to 100 percent of the Internal Revenue Service business deduction rate for volunteer
205.2 transport;

205.3 (3) equivalent to the standard fare for unassisted transport when provided by public
205.4 transit, and \$11 for the base rate and \$1.30 per mile when provided by a nonemergency
205.5 medical transportation provider;

205.6 (4) \$13 for the base rate and \$1.30 per mile for assisted transport;

205.7 (5) \$18 for the base rate and \$1.55 per mile for lift-equipped/ramp transport;

205.8 (6) \$75 for the base rate and \$2.40 per mile for protected transport; and

205.9 (7) \$60 for the base rate and \$2.40 per mile for stretcher transport, and \$9 per trip for
205.10 an additional attendant if deemed medically necessary.

205.11 (n) The base rate for nonemergency medical transportation services in areas defined
205.12 under RUCA to be super rural is equal to 111.3 percent of the respective base rate in
205.13 paragraph (m), clauses (1) to (7). The mileage rate for nonemergency medical transportation
205.14 services in areas defined under RUCA to be rural or super rural areas is:

205.15 (1) for a trip equal to 17 miles or less, equal to 125 percent of the respective mileage
205.16 rate in paragraph (m), clauses (1) to (7); and

205.17 (2) for a trip between 18 and 50 miles, equal to 112.5 percent of the respective mileage
205.18 rate in paragraph (m), clauses (1) to (7).

205.19 (o) For purposes of reimbursement rates for nonemergency medical transportation
205.20 services under paragraphs (m) and (n), the zip code of the recipient's place of residence
205.21 shall determine whether the urban, rural, or super rural reimbursement rate applies.

205.22 (p) For purposes of this subdivision, "rural urban commuting area" or "RUCA" means
205.23 a census-tract based classification system under which a geographical area is determined
205.24 to be urban, rural, or super rural.

205.25 (q) The commissioner, when determining reimbursement rates for nonemergency medical
205.26 transportation under paragraphs (m) and (n), shall exempt all modes of transportation listed
205.27 under paragraph (i) from Minnesota Rules, part 9505.0445, item R, subitem (2).

205.28 (r) Effective for the first day of each calendar quarter in which the price of gasoline as
205.29 posted publicly by the United States Energy Information Administration exceeds \$3.00 per
205.30 gallon, the commissioner shall adjust the rate paid per mile in paragraph (m) by one percent
205.31 up or down for every increase or decrease of ten cents for the price of gasoline. The increase
205.32 or decrease must be calculated using a base gasoline price of \$3.00. The percentage increase

206.1 or decrease must be calculated using the average of the most recently available price of all
206.2 grades of gasoline for Minnesota as posted publicly by the United States Energy Information
206.3 Administration.

206.4 **EFFECTIVE DATE.** This section is effective July 1, 2022.

206.5 Sec. 21. Minnesota Statutes 2020, section 256B.0625, subdivision 17a, is amended to
206.6 read:

206.7 Subd. 17a. **Payment for ambulance services.** (a) Medical assistance covers ambulance
206.8 services. Providers shall bill ambulance services according to Medicare criteria.
206.9 Nonemergency ambulance services shall not be paid as emergencies. Effective for services
206.10 rendered on or after July 1, 2001, medical assistance payments for ambulance services shall
206.11 be paid at the Medicare reimbursement rate or at the medical assistance payment rate in
206.12 effect on July 1, 2000, whichever is greater.

206.13 (b) Effective for services provided on or after July 1, 2016, medical assistance payment
206.14 rates for ambulance services identified in this paragraph are increased by five percent.
206.15 Capitation payments made to managed care plans and county-based purchasing plans for
206.16 ambulance services provided on or after January 1, 2017, shall be increased to reflect this
206.17 rate increase. The increased rate described in this paragraph applies to ambulance service
206.18 providers whose base of operations as defined in section 144E.10 is located:

206.19 (1) outside the metropolitan counties listed in section 473.121, subdivision 4, and outside
206.20 the cities of Duluth, Mankato, Moorhead, St. Cloud, and Rochester; or

206.21 (2) within a municipality with a population of less than 1,000.

206.22 (c) Effective for the first day of each calendar quarter in which the price of gasoline as
206.23 posted publicly by the United States Energy Information Administration exceeds \$3.00 per
206.24 gallon, the commissioner shall adjust the rate paid per mile in paragraphs (a) and (b) by one
206.25 percent up or down for every increase or decrease of ten cents for the price of gasoline. The
206.26 increase or decrease must be calculated using a base gasoline price of \$3.00. The percentage
206.27 increase or decrease must be calculated using the average of the most recently available
206.28 price of all grades of gasoline for Minnesota as posted publicly by the United States Energy
206.29 Information Administration.

206.30 **EFFECTIVE DATE.** This section is effective July 1, 2022.

207.1 Sec. 22. Minnesota Statutes 2020, section 256B.0625, subdivision 18h, is amended to
207.2 read:

207.3 Subd. 18h. **Nonemergency medical transportation provisions related to managed**
207.4 **care.** (a) The following nonemergency medical transportation subdivisions apply to managed
207.5 care plans and county-based purchasing plans:

207.6 (1) subdivision 17, paragraphs (a), (b), (i), and (n);

207.7 (2) subdivision 18; and

207.8 (3) subdivision 18a.

207.9 (b) A nonemergency medical transportation provider must comply with the operating
207.10 standards for special transportation service specified in sections 174.29 to 174.30 and
207.11 Minnesota Rules, chapter 8840. Publicly operated transit systems, volunteers, and not-for-hire
207.12 vehicles are exempt from the requirements in this paragraph.

207.13 (c) Managed care and county-based purchasing plans must provide a fuel adjustment
207.14 for nonemergency medical transportation payment rates when the price of gasoline exceeds
207.15 \$3.00 per gallon.

207.16 Sec. 23. Minnesota Statutes 2020, section 256B.0625, subdivision 22, is amended to read:

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

207.23 Sec. 24. Minnesota Statutes 2020, section 256B.0625, is amended by adding a subdivision
207.24 to read:

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

208.1 (b) The payment rates for coverage under this subdivision must be 100 percent of the
208.2 Medicare rate for continuous home care hospice services as published in the Centers for
208.3 Medicare and Medicaid Services annual final rule updating payments and policies for hospice
208.4 care. Payment for hospice respite and end-of-life care under this subdivision must be made
208.5 from state funds, though the commissioner shall seek to obtain federal financial participation
208.6 for the payments. Payment for hospice respite and end-of-life care must be paid to the
208.7 residential hospice facility and are not included in any limits or cap amount applicable to
208.8 hospice services payments to the elected hospice services provider.

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

208.12 **EFFECTIVE DATE.** This section is effective January 1, 2023.

208.13 Sec. 25. Minnesota Statutes 2020, section 256B.0625, subdivision 28b, is amended to
208.14 read:

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

208.21 **EFFECTIVE DATE.** This section is effective January 1, 2024, subject to federal
208.22 approval. The commissioner of human services shall notify the revisor of statutes when
208.23 federal approval is obtained.

208.24 Sec. 26. Minnesota Statutes 2021 Supplement, section 256B.0625, subdivision 30, is
208.25 amended to read:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

210.27 (j) For clinic services provided prior to January 1, 2015, the commissioner shall calculate
210.28 and pay monthly the proposed managed care supplemental payments to clinics, and clinics
210.29 shall conduct a timely review of the payment calculation data in order to finalize all
210.30 supplemental payments in accordance with federal law. Any issues arising from a clinic's
210.31 review must be reported to the commissioner by January 1, 2017. Upon final agreement
210.32 between the commissioner and a clinic on issues identified under this subdivision, and in

211.1 accordance with United States Code, title 42, section 1396a(bb), no supplemental payments
211.2 for managed care plan or county-based purchasing plan claims for services provided prior
211.3 to January 1, 2015, shall be made after June 30, 2017. If the commissioner and clinics are
211.4 unable to resolve issues under this subdivision, the parties shall submit the dispute to the
211.5 arbitration process under section 14.57.

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

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

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

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

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

211.26 (i) general social services and administrative costs;

211.27 (ii) retail pharmacy;

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

211.29 (iv) external lab and x-ray;

211.30 (v) navigation services;

211.31 (vi) health care taxes;

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

- 212.1 (viii) office entertainment costs, food, alcohol, and gifts;
- 212.2 (ix) contributions and donations;
- 212.3 (x) bad debts or losses on awards or contracts;
- 212.4 (xi) fines, penalties, damages, or other settlements;
- 212.5 (xii) fund-raising, investment management, and associated administrative costs;
- 212.6 (xiii) research and associated administrative costs;
- 212.7 (xiv) nonpaid workers;
- 212.8 (xv) lobbying;
- 212.9 (xvi) scholarships and student aid; and
- 212.10 (xvii) nonmedical assistance covered services;
- 212.11 (4) the commissioner shall review the list of nonallowable costs in the years between
- 212.12 the rebasing process established in clause (5), in consultation with the Minnesota Association
- 212.13 of Community Health Centers, FQHCs, and rural health clinics. The commissioner shall
- 212.14 publish the list and any updates in the Minnesota health care programs provider manual;
- 212.15 (5) the initial applicable base year organization encounter rates for FQHCs and rural
- 212.16 health clinics shall be computed for services delivered on or after January 1, 2021, and:
- 212.17 (i) must be determined using each FQHC's and rural health clinic's Medicare cost reports
- 212.18 from 2017 and 2018;
- 212.19 (ii) must be according to current applicable Medicare cost principles as applicable to
- 212.20 FQHCs and rural health clinics without the application of productivity screens and upper
- 212.21 payment limits or the Medicare prospective payment system FQHC aggregate mean upper
- 212.22 payment limit;
- 212.23 (iii) must be subsequently rebased every two years thereafter using the Medicare cost
- 212.24 reports that are three and four years prior to the rebasing year. Years in which organizational
- 212.25 cost or claims volume is reduced or altered due to a pandemic, disease, or other public health
- 212.26 emergency shall not be used as part of a base year when the base year includes more than
- 212.27 one year. The commissioner may use the Medicare cost reports of a year unaffected by a
- 212.28 pandemic, disease, or other public health emergency, or previous two consecutive years,
- 212.29 inflated to the base year as established under item (iv);
- 212.30 (iv) must be inflated to the base year using the inflation factor described in clause (6);
- 212.31 and

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

213.2 (6) the commissioner shall annually inflate the applicable organization encounter rates
213.3 for FQHCs and rural health clinics from the base year payment rate to the effective date by
213.4 using the CMS FQHC Market Basket inflator established under United States Code, title
213.5 42, section 1395m(o), less productivity;

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

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

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

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

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

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

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

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

214.10 (12) the commissioner, when establishing organization encounter rates for new FQHCs
214.11 and rural health clinics, shall consider the patient caseload of existing FQHCs and rural
214.12 health clinics in a 60-mile radius for organizations established outside of the seven-county
214.13 metropolitan area, and in a 30-mile radius for organizations in the seven-county metropolitan
214.14 area. If this information is not available, the commissioner may use Medicare cost reports
214.15 or audited financial statements to establish base rates;

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

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

214.23 (m) Effective July 1, 2022, an enrolled Indian Health Service facility or a Tribal health
214.24 center operating under a 638 contract or compact may elect to also enroll as a Tribal FQHC.
214.25 No requirements that otherwise apply to FQHCs covered in this subdivision apply to Tribal
214.26 FQHCs enrolled under this paragraph, except those necessary to comply with federal
214.27 regulations. The commissioner shall establish an alternative payment method for Tribal
214.28 FQHCs enrolled under this paragraph that uses the same method and rates applicable to a
214.29 Tribal facility or health center that does not enroll as a Tribal FQHC.

214.30 Sec. 27. Minnesota Statutes 2021 Supplement, section 256B.0625, subdivision 31, is
214.31 amended to read:

214.32 Subd. 31. **Medical supplies and equipment.** (a) Medical assistance covers medical
214.33 supplies and equipment. Separate payment outside of the facility's payment rate shall be
214.34 made for wheelchairs and wheelchair accessories for recipients who are residents of

215.1 intermediate care facilities for the developmentally disabled. Reimbursement for wheelchairs
215.2 and wheelchair accessories for ICF/DD recipients shall be subject to the same conditions
215.3 and limitations as coverage for recipients who do not reside in institutions. A wheelchair
215.4 purchased outside of the facility's payment rate is the property of the recipient.

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

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

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

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

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

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

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

215.22 (1) can withstand repeated use;

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

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

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

215.30 (f) Notwithstanding the requirement in paragraph (e) that an electronic tablet must be
215.31 locked to prevent use not as an augmentative communication device, a recipient of waiver
215.32 services may use an electronic tablet for a use not related to communication when the

216.1 recipient has been authorized under the waiver to receive one or more additional applications
216.2 that can be loaded onto the electronic tablet, such that allowing the additional use prevents
216.3 the purchase of a separate electronic tablet with waiver funds.

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

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

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

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

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

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

216.16 (ii) provide data to the health care provider necessary to appropriately diagnose or treat
216.17 the recipient's health condition that causes the seizure activity.

216.18 (j) For purposes of paragraph (i), "seizure detection device" means a United States Food
216.19 and Drug Administration approved monitoring device and any related service or subscription
216.20 supporting the prescribed use of the device, including technology that:

216.21 (1) provides ongoing patient monitoring and alert services that detects nocturnal seizure
216.22 activity and transmits notification of the seizure activity to a caregiver for appropriate
216.23 medical response; or

216.24 (2) collects data of the seizure activity of the recipient that can be used by a health care
216.25 provider to diagnose or appropriately treat a health care condition that causes the seizure
216.26 activity.

216.27 **EFFECTIVE DATE.** This section is effective January 1, 2023, or upon federal approval,
216.28 whichever is later. The commissioner of human services shall notify the revisor of statutes
216.29 when federal approval is obtained.

217.1 Sec. 28. Minnesota Statutes 2020, section 256B.0625, is amended by adding a subdivision
217.2 to read:

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

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

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

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

217.14 (3) mental health certified peer specialists under section 256B.0615;

217.15 (4) alcohol and drug counselors licensed under chapter 148F;

217.16 (5) recovery peers as defined in section 245F.02, subdivision 21;

217.17 (6) certified tobacco treatment specialists;

217.18 (7) community health workers;

217.19 (8) physicians;

217.20 (9) physician assistants;

217.21 (10) advanced practice registered nurses; or

217.22 (11) other licensed or nonlicensed professionals or paraprofessionals with training in
217.23 providing tobacco and nicotine cessation education and counseling services.

217.24 (c) Medical assistance covers telephone cessation counseling services provided through
217.25 a quitline. Notwithstanding subdivision 3b, quitline services may be provided through
217.26 audio-only communications. The commissioner may use volume purchasing for quitline
217.27 services consistent with section 256B.04, subdivision 14.

217.28 (d) Medical assistance must cover all prescription and over-the-counter pharmacotherapy
217.29 drugs approved by the United States Food and Drug Administration for cessation of tobacco
217.30 and nicotine use or treatment of tobacco and nicotine dependence, and that are subject to a
217.31 Medicaid drug rebate agreement.

- 218.1 (e) Services covered under this subdivision may be provided by telemedicine.
- 218.2 (f) The commissioner must not:
- 218.3 (1) restrict or limit the type, duration, or frequency of tobacco and nicotine cessation
- 218.4 services;
- 218.5 (2) prohibit the simultaneous use of multiple cessation services, including but not limited
- 218.6 to simultaneous use of counseling and drugs;
- 218.7 (3) require counseling prior to receiving drugs or as a condition of receiving drugs;
- 218.8 (4) limit pharmacotherapy drug dosage amounts for a dosing regimen for treatment of
- 218.9 a medically accepted indication, as defined in United States Code, title 42, section
- 218.10 1396r-8(k)(6); limit dosing frequency; or impose duration limits;
- 218.11 (5) prohibit simultaneous use of multiple drugs, including prescription and
- 218.12 over-the-counter drugs;
- 218.13 (6) require or authorize step therapy; or
- 218.14 (7) require or utilize prior authorization or require a co-payment or deductible for any
- 218.15 tobacco and nicotine cessation services and drugs covered under this subdivision.
- 218.16 (g) The commissioner must require all participating entities under contract with the
- 218.17 commissioner to comply with this subdivision when providing coverage, services, or care
- 218.18 management for medical assistance and MinnesotaCare enrollees. For purposes of this
- 218.19 subdivision, "participating entity" means any of the following:
- 218.20 (1) a health carrier as defined in section 62A.011, subdivision 2;
- 218.21 (2) a county-based purchasing plan established under section 256B.692;
- 218.22 (3) an accountable care organization or other entity participating as an integrated health
- 218.23 partnership under section 256B.0755;
- 218.24 (4) an entity operating a county integrated health care delivery network pilot project
- 218.25 authorized under section 256B.0756;
- 218.26 (5) a network of health care providers established to offer services under medical
- 218.27 assistance or MinnesotaCare; or
- 218.28 (6) any other entity that has a contract with the commissioner to cover, provide, or
- 218.29 manage health care services provided to medical assistance or MinnesotaCare enrollees on
- 218.30 a capitated or risk-based payment arrangement or under a reimbursement methodology with

219.1 substantial financial incentives to reduce the total cost of health care for a population of
219.2 patients that is enrolled with or assigned or attributed to the entity.

219.3 **EFFECTIVE DATE.** This section is effective January 1, 2023, or upon federal approval,
219.4 whichever is later. The commissioner of human services shall notify the revisor of statutes
219.5 when federal approval is obtained.

219.6 Sec. 29. Minnesota Statutes 2020, section 256B.0631, as amended by Laws 2021, First
219.7 Special Session chapter 7, article 1, section 17, is amended to read:

219.8 **256B.0631 MEDICAL ASSISTANCE CO-PAYMENTS.**

219.9 Subdivision 1. **Cost-sharing.** (a) Except as provided in subdivision 2, the medical
219.10 assistance benefit plan shall include the following cost-sharing for all recipients, effective
219.11 for services provided on or after September 1, 2011, through December 31, 2022:

219.12 (1) \$3 per nonpreventive visit, except as provided in paragraph (b). For purposes of this
219.13 subdivision, a visit means an episode of service which is required because of a recipient's
219.14 symptoms, diagnosis, or established illness, and which is delivered in an ambulatory setting
219.15 by a physician or physician assistant, chiropractor, podiatrist, nurse midwife, advanced
219.16 practice nurse, audiologist, optician, or optometrist;

219.17 (2) \$3.50 for nonemergency visits to a hospital-based emergency room, except that this
219.18 co-payment shall be increased to \$20 upon federal approval;

219.19 (3) \$3 per brand-name drug prescription, \$1 per generic drug prescription, and \$1 per
219.20 prescription for a brand-name multisource drug listed in preferred status on the preferred
219.21 drug list, subject to a \$12 per month maximum for prescription drug co-payments. No
219.22 co-payments shall apply to antipsychotic drugs when used for the treatment of mental illness;

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

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

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

220.3 (c) Notwithstanding paragraph (b), the commissioner, through the contracting process
220.4 under sections 256B.69 and 256B.692, may allow managed care plans and county-based
220.5 purchasing plans to waive the family deductible under paragraph (a), clause (4). The value
220.6 of the family deductible shall not be included in the capitation payment to managed care
220.7 plans and county-based purchasing plans. Managed care plans and county-based purchasing
220.8 plans shall certify annually to the commissioner the dollar value of the family deductible.

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

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

220.16 (f) Paragraphs (a) to (e) apply only for services provided through December 31, 2022.
220.17 Effective for services provided on or after January 1, 2023, the medical assistance program
220.18 shall not require deductibles, co-payments, coinsurance, or any other form of enrollee
220.19 cost-sharing.

220.20 Subd. 2. **Exceptions.** Co-payments and deductibles shall be subject, through December
220.21 31, 2022, to the following exceptions:

220.22 (1) children under the age of 21;

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

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

220.27 (4) recipients receiving hospice care;

220.28 (5) 100 percent federally funded services provided by an Indian health service;

220.29 (6) emergency services;

220.30 (7) family planning services;

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

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

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

221.5 (11) American Indians who meet the requirements in Code of Federal Regulations, title
221.6 42, sections 447.51 and 447.56;

221.7 (12) persons needing treatment for breast or cervical cancer as described under section
221.8 256B.057, subdivision 10; and

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

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

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

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

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

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

221.25 (d) Paragraphs (a) to (c) apply only for services provided through December 31, 2022.

221.26 **Sec. 30. Minnesota Statutes 2021 Supplement, section 256B.0631, subdivision 1, is**
221.27 **amended to read:**

221.28 **Subdivision 1. Cost-sharing.** (a) Except as provided in subdivision 2, the medical
221.29 assistance benefit plan ~~shall~~ must include the following cost-sharing for all recipients,
221.30 effective for services provided on or after September 1, 2011:

222.1 (1) \$3 per nonpreventive visit, except as provided in paragraph (b) and except that a
222.2 co-payment must not apply to tobacco and nicotine cessation services covered under section
222.3 256B.0625, subdivision 68. For purposes of this subdivision, a visit means an episode of
222.4 service which is required because of a recipient's symptoms, diagnosis, or established illness,
222.5 and which is delivered in an ambulatory setting by a physician or physician assistant,
222.6 chiropractor, podiatrist, nurse midwife, advanced practice nurse, audiologist, optician, or
222.7 optometrist;

222.8 (2) \$3.50 for nonemergency visits to a hospital-based emergency room, except that this
222.9 co-payment shall be increased to \$20 upon federal approval;

222.10 (3) \$3 per brand-name drug prescription, \$1 per generic drug prescription, and \$1 per
222.11 prescription for a brand-name multisource drug listed in preferred status on the preferred
222.12 drug list, subject to a \$12 per month maximum for prescription drug co-payments. ~~No~~
222.13 Co-payments ~~shall~~ must not apply to antipsychotic drugs when used for the treatment of
222.14 mental illness. Co-payments must not apply to drugs when used for tobacco and nicotine
222.15 cessation;

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

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

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

222.27 (c) Notwithstanding paragraph (b), the commissioner, through the contracting process
222.28 under sections 256B.69 and 256B.692, may allow managed care plans and county-based
222.29 purchasing plans to waive the family deductible under paragraph (a), clause (4). The value
222.30 of the family deductible ~~shall~~ must not be included in the capitation payment to managed
222.31 care plans and county-based purchasing plans. Managed care plans and county-based
222.32 purchasing plans ~~shall~~ must certify annually to the commissioner the dollar value of the
222.33 family deductible.

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

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

223.8 Sec. 31. **[256B.161] CLIENT ERROR OVERPAYMENT.**

223.9 Subdivision 1. Scope. (a) Subject to federal law and regulation, when a local agency or
223.10 the Department of Human Services determines a person under section 256.98, subdivision
223.11 4, is liable for recovery of medical assistance incorrectly paid as a result of client error or
223.12 when a recipient or former recipient receives medical assistance while an appeal is pending
223.13 pursuant to section 256.045, subdivision 10, and the recipient or former recipient is later
223.14 determined to have been ineligible for the medical assistance received or for less medical
223.15 assistance than was received during the pendency of the appeal, the local agency or the
223.16 Department of Human Services must:

223.17 (1) determine the eligibility months during which medical assistance was incorrectly
223.18 paid;

223.19 (2) redetermine eligibility for the incorrectly paid months using department policies and
223.20 procedures that were in effect during each eligibility month that was incorrectly paid; and

223.21 (3) assess an overpayment against persons liable for recovery under section 256.98,
223.22 subdivision 4, for the amount of incorrectly paid medical assistance pursuant to section
223.23 256.98, subdivision 3.

223.24 (b) Notwithstanding section 256.98, subdivision 4, medical assistance incorrectly paid
223.25 to a recipient as a result of client error when the recipient is under 21 years of age is not
223.26 recoverable from the recipient or recipient's estate. This section does not prohibit the state
223.27 agency from:

223.28 (1) receiving payment from a trust pursuant to United States Code, title 42, section
223.29 1396p(d)(4)(A) or (C), for medical assistance paid on behalf of the trust beneficiary for
223.30 services received at any age; or

223.31 (2) claiming against the designated beneficiary of an Achieving a Better Life Experience
223.32 (ABLE) account or the ABLE account itself pursuant to Code of Federal Regulations, title

224.1 26, section 1.529A-2(o), for the amount of the total medical assistance paid for the designated
224.2 beneficiary at any age after establishment of the ABLE account.

224.3 Subd. 2. **Recovering client error overpayment.** (a) The local agency or the Department
224.4 of Human Services must not attempt recovery of the overpayment amount pursuant to
224.5 chapter 270A or section 256.0471 when a person liable for a client error overpayment under
224.6 section 256.98, subdivision 4, voluntarily repays the overpayment amount or establishes a
224.7 payment plan in writing with the local agency or the Department of Human Services to
224.8 repay the overpayment amount within 90 days after receiving the overpayment notice or
224.9 after resolution of a fair hearing regarding the overpayment under section 256.045, whichever
224.10 is later. When a liable person agrees to a payment plan in writing with the local agency or
224.11 the Department of Human Services but has not repaid any amount six months after entering
224.12 the agreement, the local agency or Department of Human Services must pursue recovery
224.13 under paragraph (b).

224.14 (b) If the liable person does not voluntarily repay the overpayment amount or establish
224.15 a repayment agreement under paragraph (a), the local agency or the Department of Human
224.16 Services must attempt recovery of the overpayment amount pursuant to chapter 270A when
224.17 the overpayment amount is eligible for recovery as a public assistance debt under chapter
224.18 270A. For any overpaid amount of solely state-funded medical assistance, the local agency
224.19 or the Department of Human Services must attempt recovery pursuant to section 256.0471.

224.20 Subd. 3. **Writing off client error overpayment.** A local agency or the Department of
224.21 Human Services must not attempt to recover a client error overpayment of less than \$350,
224.22 unless the overpayment is for medical assistance received pursuant to section 256.045,
224.23 subdivision 10, during the pendency of an appeal or unless the recovery is from the recipient's
224.24 estate or the estate of the recipient's surviving spouse. A local agency or the Department of
224.25 Human Services may write off any remaining balance of a client error overpayment when
224.26 the overpayment has not been repaid five years after the effective date of the overpayment
224.27 and the local agency or the Department of Human Services determines it is no longer cost
224.28 effective to attempt recovery of the remaining balance.

224.29 Sec. 32. Minnesota Statutes 2020, section 256B.69, subdivision 4, is amended to read:

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

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

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

225.5 (1) persons eligible for medical assistance according to section 256B.055, subdivision
225.6 1;

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

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

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

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

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

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

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

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

225.25 (8) persons eligible for medical assistance according to section 256B.057, subdivision
225.26 10;

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

225.30 (10) persons who are absent from the state for more than 30 consecutive days but still
225.31 deemed a resident of Minnesota, identified in accordance with section 256B.056, subdivision
225.32 1, paragraph (b).

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

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

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

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

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

226.29 **EFFECTIVE DATE.** This section is effective January 1, 2023.

226.30 Sec. 33. Minnesota Statutes 2020, section 256B.69, subdivision 5c, is amended to read:

226.31 Subd. 5c. **Medical education and research fund.** (a) The commissioner of human
226.32 services shall transfer each year to the medical education and research fund established

227.1 under section 62J.692, an amount specified in this subdivision. The commissioner shall
227.2 calculate the following:

227.3 (1) an amount equal to the reduction in the prepaid medical assistance payments as
227.4 specified in this clause. After January 1, 2002, the county medical assistance capitation base
227.5 rate prior to plan specific adjustments is reduced 6.3 percent for Hennepin County, two
227.6 percent for the remaining metropolitan counties, and 1.6 percent for nonmetropolitan
227.7 Minnesota counties. Nursing facility and elderly waiver payments and demonstration project
227.8 payments operating under subdivision 23 are excluded from this reduction. The amount
227.9 calculated under this clause shall not be adjusted for periods already paid due to subsequent
227.10 changes to the capitation payments;

227.11 (2) beginning July 1, 2003, \$4,314,000 from the capitation rates paid under this section;

227.12 (3) beginning July 1, 2002, an additional \$12,700,000 from the capitation rates paid
227.13 under this section; and

227.14 (4) beginning July 1, 2003, an additional \$4,700,000 from the capitation rates paid under
227.15 this section.

227.16 (b) This subdivision shall be effective upon approval of a federal waiver which allows
227.17 federal financial participation in the medical education and research fund. The amount
227.18 specified under paragraph (a), clauses (1) to (4), shall not exceed the total amount transferred
227.19 for fiscal year 2009. Any excess shall first reduce the amounts specified under paragraph
227.20 (a), clauses (2) to (4). Any excess following this reduction shall proportionally reduce the
227.21 amount specified under paragraph (a), clause (1).

227.22 (c) Beginning September 1, 2011, of the amount in paragraph (a), the commissioner
227.23 shall transfer \$21,714,000 each fiscal year to the medical education and research fund.

227.24 (d) Beginning September 1, 2011, of the amount in paragraph (a), following the transfer
227.25 under paragraph (c), the commissioner shall transfer to the medical education research fund
227.26 ~~\$23,936,000 in fiscal years 2012 and 2013~~ and \$49,552,000 in fiscal year 2014 and thereafter.

227.27 (e) If the federal waiver described in paragraph (b) is not renewed, the transfer described
227.28 in paragraph (c) and corresponding payments under section 62J.692, subdivision 7, are
227.29 terminated effective the first month in which the waiver is no longer in effect, and the state
227.30 share of the amount described in paragraph (d) must be transferred to the medical education
227.31 and research fund and distributed according to the provisions of section 62J.692, subdivision
227.32 4a.

228.1 Sec. 34. Minnesota Statutes 2020, section 256B.69, subdivision 28, is amended to read:

228.2 Subd. 28. **Medicare special needs plans; medical assistance basic health care.** (a)

228.3 The commissioner may contract with demonstration providers and current or former sponsors
228.4 of qualified Medicare-approved special needs plans, to provide medical assistance basic
228.5 health care services to persons with disabilities, including those with developmental
228.6 disabilities. Basic health care services include:

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

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

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

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

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

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

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

229.3 (1) implementation efforts;

229.4 (2) consumer protections; and

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

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

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

229.17 **EFFECTIVE DATE.** This section is effective January 1, 2023.

229.18 Sec. 35. Minnesota Statutes 2020, section 256B.69, subdivision 36, is amended to read:

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

229.22 (b) The enrollee support system must:

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

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

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

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

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

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

230.10 (d) The commissioner may designate enrollment brokers to assist enrollees on selecting
230.11 a managed care organization and providing necessary enrollment information. For purposes
230.12 of this subdivision, "enrollment broker" means an individual or entity that performs choice
230.13 counseling or enrollment activities in accordance with Code of Federal Regulations, part
230.14 42, section 438.810, or both.

230.15 **EFFECTIVE DATE.** This section is effective January 1, 2023.

230.16 Sec. 36. Minnesota Statutes 2020, section 256B.692, subdivision 1, is amended to read:

230.17 Subdivision 1. **In general.** County boards or groups of county boards may elect to
230.18 purchase or provide health care services on behalf of persons eligible for medical assistance
230.19 who would otherwise be required to or may elect to participate in the prepaid medical
230.20 assistance program according to section 256B.69, subject to the opt-out provision of section
230.21 256B.69, subdivision 4, paragraph (a). Counties that elect to purchase or provide health
230.22 care under this section must provide all services included in prepaid managed care programs
230.23 according to section 256B.69, subdivisions 1 to 22. County-based purchasing under this
230.24 section is governed by section 256B.69, unless otherwise provided for under this section.

230.25 **EFFECTIVE DATE.** This section is effective January 1, 2023.

230.26 Sec. 37. Minnesota Statutes 2020, section 256B.6925, subdivision 1, is amended to read:

230.27 Subdivision 1. **Information provided by commissioner.** The commissioner shall provide
230.28 to each potential enrollee the following information:

230.29 (1) basic features of receiving services through managed care;

230.30 (2) which individuals are excluded from managed care enrollment, subject to ~~mandatory~~
230.31 ~~managed care enrollment~~ the opt-out provision of section 256B.69, subdivision 4, paragraph
230.32 (a), or who may choose to enroll voluntarily;

231.1 ~~(3) for mandatory and voluntary enrollment~~, the length of the enrollment period and
 231.2 information about an enrollee's right to disenroll in accordance with Code of Federal
 231.3 Regulations, part 42, section 438.56;

231.4 (4) the service area covered by each managed care organization;

231.5 (5) covered services, including services provided by the managed care organization and
 231.6 services provided by the commissioner;

231.7 (6) the provider directory and drug formulary for each managed care organization;

231.8 ~~(7) cost-sharing requirements;~~

231.9 (8) requirements for adequate access to services, including provider network adequacy
 231.10 standards;

231.11 (9) a managed care organization's responsibility for coordination of enrollee care; and

231.12 (10) quality and performance indicators, including enrollee satisfaction for each managed
 231.13 care organization, if available.

231.14 Sec. 38. Minnesota Statutes 2020, section 256B.6925, subdivision 1, is amended to read:

231.15 Subdivision 1. **Information provided by commissioner.** The commissioner shall provide
 231.16 to each potential enrollee the following information:

231.17 (1) basic features of receiving services through managed care;

231.18 (2) which individuals are excluded from managed care enrollment, subject to mandatory
 231.19 managed care enrollment, or who may choose to enroll voluntarily;

231.20 (3) for mandatory and voluntary enrollment, the length of the enrollment period and
 231.21 information about an enrollee's right to disenroll in accordance with Code of Federal
 231.22 Regulations, part 42, section 438.56;

231.23 (4) the service area covered by each managed care organization;

231.24 (5) covered services, including services provided by the managed care organization and
 231.25 services provided by the commissioner;

231.26 (6) the provider directory and drug formulary for each managed care organization;

231.27 ~~(7) cost-sharing requirements;~~

231.28 ~~(8)~~ (7) requirements for adequate access to services, including provider network adequacy
 231.29 standards;

232.1 ~~(9)~~ (8) a managed care organization's responsibility for coordination of enrollee care;
232.2 and
232.3 ~~(10)~~ (9) quality and performance indicators, including enrollee satisfaction for each
232.4 managed care organization, if available.

232.5 **EFFECTIVE DATE.** This section is effective January 1, 2023.

232.6 Sec. 39. Minnesota Statutes 2020, section 256B.6925, subdivision 2, is amended to read:

232.7 Subd. 2. **Information provided by managed care organization.** The commissioner
232.8 shall ensure that managed care organizations provide to each enrollee the following
232.9 information:

232.10 (1) an enrollee handbook within a reasonable time after receiving notice of the enrollee's
232.11 enrollment. The handbook must, at a minimum, include information on benefits provided,
232.12 how and where to access benefits, ~~cost-sharing requirements~~, how transportation is provided,
232.13 and other information as required by Code of Federal Regulations, part 42, section 438.10,
232.14 paragraph (g);

232.15 (2) a provider directory for the following provider types: physicians, specialists, hospitals,
232.16 pharmacies, behavioral health providers, and long-term supports and services providers, as
232.17 appropriate. The directory must include the provider's name, group affiliation, street address,
232.18 telephone number, website, specialty if applicable, whether the provider accepts new
232.19 enrollees, the provider's cultural and linguistic capabilities as identified in Code of Federal
232.20 Regulations, part 42, section 438.10, paragraph (h), and whether the provider's office
232.21 accommodates people with disabilities;

232.22 (3) a drug formulary that includes both generic and name brand medications that are
232.23 covered and each medication tier, if applicable;

232.24 (4) written notice of termination of a contracted provider. Within 15 calendar days after
232.25 receipt or issuance of the termination notice, the managed care organization must make a
232.26 good faith effort to provide notice to each enrollee who received primary care from, or was
232.27 seen on a regular basis by, the terminated provider; and

232.28 (5) upon enrollee request, the managed care organization's physician incentive plan.

232.29 **EFFECTIVE DATE.** This section is effective January 1, 2023.

233.1 Sec. 40. Minnesota Statutes 2020, section 256B.6928, subdivision 3, is amended to read:

233.2 Subd. 3. **Rate development standards.** (a) In developing capitation rates, the
233.3 commissioner shall:

233.4 (1) identify and develop base utilization and price data, including validated encounter
233.5 data and audited financial reports received from the managed care organizations that
233.6 demonstrate experience for the populations served by the managed care organizations, for
233.7 the three most recent and complete years before the rating period;

233.8 (2) develop and apply reasonable trend factors, including cost and utilization, to base
233.9 data that are developed from actual experience of the medical assistance population or a
233.10 similar population according to generally accepted actuarial practices and principles;

233.11 (3) develop the nonbenefit component of the rate to account for reasonable expenses
233.12 related to the managed care organization's administration; taxes; licensing and regulatory
233.13 fees; contribution to reserves; risk margin; cost of capital and other operational costs
233.14 associated with the managed care organization's provision of covered services to enrollees;

233.15 ~~(4) consider the value of cost-sharing for rate development purposes, regardless of
233.16 whether the managed care organization imposes the cost-sharing on the enrollee or the
233.17 cost-sharing is collected by the provider;~~

233.18 ~~(5)~~ (4) make appropriate and reasonable adjustments to account for changes to the base
233.19 data, programmatic changes, changes to nonbenefit components, and any other adjustment
233.20 necessary to establish actuarially sound rates. Each adjustment must reasonably support the
233.21 development of an accurate base data set for purposes of rate setting, reflect the health status
233.22 of the enrolled population, and be developed in accordance with generally accepted actuarial
233.23 principles and practices;

233.24 ~~(6)~~ (5) consider the managed care organization's past medical loss ratio in the development
233.25 of the capitation rates and consider the projected medical loss ratio; and

233.26 ~~(7)~~ (6) select a prospective or retrospective risk adjustment methodology that must be
233.27 developed in a budget-neutral manner consistent with generally accepted actuarial principles
233.28 and practices.

233.29 (b) The base data must be derived from the medical assistance population or, if data on
233.30 the medical assistance population is not available, derived from a similar population and
233.31 adjusted to make the utilization and price data comparable to the medical assistance
233.32 population. Data must be in accordance with actuarial standards for data quality and an
233.33 explanation of why that specific data is used must be provided in the rate certification. If

234.1 the commissioner is unable to base the rates on data that are within the three most recent
234.2 and complete years before the rating period, the commissioner may request an approval
234.3 from the Centers for Medicare and Medicaid Services for an exception. The request must
234.4 describe why an exception is necessary and describe the actions that the commissioner
234.5 intends to take to comply with the request.

234.6 **EFFECTIVE DATE.** This section is effective January 1, 2023.

234.7 Sec. 41. Minnesota Statutes 2020, section 256B.76, subdivision 1, is amended to read:

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

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

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

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

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

234.26 (c) Effective for services rendered on or after July 1, 2009, payment rates for physician
234.27 and professional services shall be reduced by five percent, except that for the period July
234.28 1, 2009, through June 30, 2010, payment rates shall be reduced by 6.5 percent for the medical
234.29 assistance and general assistance medical care programs, over the rates in effect on June
234.30 30, 2009. This reduction and the reductions in paragraph (d) do not apply to office or other
234.31 outpatient visits, preventive medicine visits and family planning visits billed by physicians,
234.32 advanced practice nurses, or physician assistants in a family planning agency or in one of
234.33 the following primary care practices: general practice, general internal medicine, general

235.1 pediatrics, general geriatrics, and family medicine. This reduction and the reductions in
235.2 paragraph (d) do not apply to federally qualified health centers, rural health centers, and
235.3 Indian health services. Effective October 1, 2009, payments made to managed care plans
235.4 and county-based purchasing plans under sections 256B.69, 256B.692, and 256L.12 shall
235.5 reflect the payment reduction described in this paragraph.

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

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

235.19 (f) Effective for services rendered on or after September 1, 2014, payment rates for
235.20 physician and professional services, including physical therapy, occupational therapy, speech
235.21 pathology, and mental health services shall be increased by five percent from the rates in
235.22 effect on August 31, 2014. In calculating this rate increase, the commissioner shall not
235.23 include in the base rate for August 31, 2014, the rate increase provided under section
235.24 256B.76, subdivision 7. This increase does not apply to federally qualified health centers,
235.25 rural health centers, and Indian health services. Payments made to managed care plans and
235.26 county-based purchasing plans shall not be adjusted to reflect payments under this paragraph.

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

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

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

236.7 Sec. 42. Minnesota Statutes 2020, section 256L.03, subdivision 1a, is amended to read:

236.8 Subd. 1a. **Children; MinnesotaCare health care reform waiver.** Children are eligible
236.9 for coverage of all services that are eligible for reimbursement under the medical assistance
236.10 program according to chapter 256B, except special education services and that abortion
236.11 services under MinnesotaCare shall be limited as provided under subdivision 1. ~~Children~~
236.12 ~~are exempt from the provisions of subdivision 5, regarding co-payments.~~ Children who are
236.13 lawfully residing in the United States but who are not "qualified noncitizens" under title IV
236.14 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, Public
236.15 Law 104-193, Statutes at Large, volume 110, page 2105, are eligible for coverage of all
236.16 services provided under the medical assistance program according to chapter 256B.

236.17 **EFFECTIVE DATE.** This section is effective January 1, 2023.

236.18 Sec. 43. Minnesota Statutes 2020, section 256L.03, subdivision 5, is amended to read:

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

236.22 (b) The commissioner shall adjust co-payments, coinsurance, and deductibles for covered
236.23 services in a manner sufficient to maintain the actuarial value of the benefit to 94 percent.
236.24 The cost-sharing changes described in this paragraph do not apply to eligible recipients or
236.25 services exempt from cost-sharing under state law. The cost-sharing changes described in
236.26 this paragraph shall not be implemented prior to January 1, 2016, or after December 31,
236.27 2022.

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

236.31 (d) Paragraphs (a) to (c) apply only to services provided through December 31, 2022.
236.32 Effective for services provided on or after January 1, 2023, the MinnesotaCare program

237.1 shall not require deductibles, co-payments, coinsurance, or any other form of enrollee
237.2 cost-sharing.

237.3 Sec. 44. Minnesota Statutes 2020, section 256L.03, subdivision 5, is amended to read:

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

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

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

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

237.17 Sec. 45. Minnesota Statutes 2020, section 256L.04, subdivision 1c, is amended to read:

237.18 Subd. 1c. **General requirements.** To be eligible for MinnesotaCare, a person must meet
237.19 the eligibility requirements of this section. A person eligible for MinnesotaCare ~~shall~~ with
237.20 an income less than or equal to 200 percent of the federal poverty guidelines must not be
237.21 considered a qualified individual under section 1312 of the Affordable Care Act, and is not
237.22 eligible for enrollment in a qualified health plan offered through MNsure under chapter
237.23 62V.

237.24 **EFFECTIVE DATE.** This section is effective January 1, 2025, or upon federal approval,
237.25 whichever is later, but only if the commissioner of human services certifies to the legislature
237.26 that implementation of this section will not result in federal penalties to federal basic health
237.27 program funding for MinnesotaCare enrollees with incomes not exceeding 200 percent of
237.28 the federal poverty guidelines. The commissioner of human services shall notify the revisor
237.29 of statutes when federal approval is obtained.

238.1 Sec. 46. Minnesota Statutes 2020, section 256L.04, subdivision 7a, is amended to read:

238.2 Subd. 7a. **Ineligibility.** Adults whose income is greater than the limits established under
238.3 this section may not enroll in the MinnesotaCare program, except as provided in subdivision
238.4 15.

238.5 **EFFECTIVE DATE.** This section is effective January 1, 2025, or upon federal approval,
238.6 whichever is later, but only if the commissioner of human services certifies to the legislature
238.7 that implementation of this section will not result in federal penalties to federal basic health
238.8 program funding for MinnesotaCare enrollees with incomes not exceeding 200 percent of
238.9 the federal poverty guidelines. The commissioner of human services shall notify the revisor
238.10 of statutes when federal approval is obtained.

238.11 Sec. 47. Minnesota Statutes 2020, section 256L.04, subdivision 10, is amended to read:

238.12 Subd. 10. **Citizenship requirements.** (a) Eligibility for MinnesotaCare is limited to
238.13 citizens or nationals of the United States and lawfully present noncitizens as defined in
238.14 Code of Federal Regulations, title 8, section 103.12. Undocumented noncitizens, with the
238.15 exception of children under age 19, are ineligible for MinnesotaCare. For purposes of this
238.16 subdivision, an undocumented noncitizen is an individual who resides in the United States
238.17 without the approval or acquiescence of the United States Citizenship and Immigration
238.18 Services. Families with children who are citizens or nationals of the United States must
238.19 cooperate in obtaining satisfactory documentary evidence of citizenship or nationality
238.20 according to the requirements of the federal Deficit Reduction Act of 2005, Public Law
238.21 109-171.

238.22 (b) Notwithstanding subdivisions 1 and 7, eligible persons include families and
238.23 individuals who are lawfully present and ineligible for medical assistance by reason of
238.24 immigration status and who have incomes equal to or less than 200 percent of federal poverty
238.25 guidelines.

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

238.27 Sec. 48. Minnesota Statutes 2020, section 256L.04, is amended by adding a subdivision
238.28 to read:

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

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

239.4 **EFFECTIVE DATE.** This section is effective January 1, 2025, or upon federal approval,
239.5 whichever is later, but only if the commissioner of human services certifies to the legislature
239.6 that implementation of this section will not result in federal penalties to federal basic health
239.7 program funding for MinnesotaCare enrollees with incomes not exceeding 200 percent of
239.8 the federal poverty guidelines. The commissioner of human services shall notify the revisor
239.9 of statutes when federal approval is obtained.

239.10 Sec. 49. Minnesota Statutes 2020, section 256L.07, subdivision 1, is amended to read:

239.11 Subdivision 1. **General requirements.** Individuals enrolled in MinnesotaCare under
239.12 section 256L.04, subdivision 1, and individuals enrolled in MinnesotaCare under section
239.13 256L.04, subdivision 7, whose income increases above 200 percent of the federal poverty
239.14 guidelines, are no longer eligible for the program and ~~shall~~ must be disenrolled by the
239.15 commissioner, unless the individuals continue MinnesotaCare enrollment through the public
239.16 option under section 256L.04, subdivision 15. For persons disenrolled under this subdivision,
239.17 MinnesotaCare coverage terminates the last day of the calendar month in which the
239.18 commissioner sends advance notice according to Code of Federal Regulations, title 42,
239.19 section 431.211, that indicates the income of a family or individual exceeds program income
239.20 limits.

239.21 **EFFECTIVE DATE.** This section is effective January 1, 2025, or upon federal approval,
239.22 whichever is later, but only if the commissioner of human services certifies to the legislature
239.23 that implementation of this section will not result in federal penalties to federal basic health
239.24 program funding for MinnesotaCare enrollees with incomes not exceeding 200 percent of
239.25 the federal poverty guidelines. The commissioner of human services shall notify the revisor
239.26 of statutes when federal approval is obtained.

239.27 Sec. 50. Minnesota Statutes 2021 Supplement, section 256L.15, subdivision 2, is amended
239.28 to read:

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

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

240.3 ~~(e) (b) Paragraph (b) (a) does not apply to:~~

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

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

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

240.9	Federal Poverty Guideline	Less than	Individual Premium
240.10	Greater than or Equal to		Amount
240.11	35%	55%	\$4
240.12	55%	80%	\$6
240.13	80%	90%	\$8
240.14	90%	100%	\$10
240.15	100%	110%	\$12
240.16	110%	120%	\$14
240.17	120%	130%	\$15
240.18	130%	140%	\$16
240.19	140%	150%	\$25
240.20	150%	160%	\$37
240.21	160%	170%	\$44
240.22	170%	180%	\$52
240.23	180%	190%	\$61
240.24	190%	200%	\$71
240.25	200%		\$80

240.26 ~~(e) (c) Beginning January 1, 2021 2023, the commissioner shall continue to charge~~
 240.27 ~~premiums in accordance with the simplified premium scale established to comply with the~~
 240.28 ~~American Rescue Plan Act of 2021, in effect from January 1, 2021, through December 31,~~
 240.29 ~~2022, for families and individuals eligible under section 256L.04, subdivisions 1 and 7. The~~
 240.30 ~~commissioner shall adjust the premium scale established under paragraph (d) as needed to~~
 240.31 ~~ensure that premiums do not exceed the amount that an individual would have been required~~
 240.32 ~~to pay if the individual was enrolled in an applicable benchmark plan in accordance with~~
 240.33 ~~the Code of Federal Regulations, title 42, section 600.505 (a)(1).~~

240.34 ~~(d) The commissioner shall establish a sliding premium scale for persons eligible through~~
 240.35 ~~the buy-in option under section 256L.04, subdivision 15. Beginning January 1, 2025, persons~~

241.1 eligible through the buy-in option shall pay premiums according to the premium scale
241.2 established by the commissioner. Persons 20 years of age or younger are exempt from
241.3 paying premiums.

241.4 **EFFECTIVE DATE.** This section is effective January 1, 2023, except that the sliding
241.5 premium scale established under paragraph (d) is effective January 1, 2025, or upon federal
241.6 approval, whichever is later, but only if the commissioner of human services certifies to the
241.7 legislature that implementation of paragraph (d) will not result in federal penalties to federal
241.8 basic health program funding for MinnesotaCare enrollees with incomes not exceeding 200
241.9 percent of the federal poverty guidelines. The commissioner of human services shall notify
241.10 the revisor of statutes when federal approval is obtained.

241.11 **Sec. 51. [256L.181] CLIENT ERROR OVERPAYMENT.**

241.12 Subdivision 1. **Scope.** (a) Subject to federal law and regulation, when a local agency or
241.13 the Department of Human Services determines a person under section 256.98, subdivision
241.14 4, is liable for recovery of medical assistance incorrectly paid as a result of client error or
241.15 when a recipient or former recipient receives medical assistance while an appeal is pending
241.16 pursuant to section 256.045, subdivision 10, and the recipient or former recipient is later
241.17 determined to have been ineligible for the medical assistance received or for less medical
241.18 assistance than was received during the pendency of the appeal, the local agency or the
241.19 Department of Human Services must:

241.20 (1) determine the eligibility months during which medical assistance was incorrectly
241.21 paid;

241.22 (2) redetermine eligibility for the incorrectly paid months using department policies and
241.23 procedures that were in effect during each eligibility month that was incorrectly paid; and

241.24 (3) assess an overpayment against persons liable for recovery under section 256.98,
241.25 subdivision 4, for the amount of incorrectly paid medical assistance pursuant to section
241.26 256.98, subdivision 3.

241.27 (b) Notwithstanding section 256.98, subdivision 4, medical assistance incorrectly paid
241.28 to a recipient as a result of client error when the recipient is under 21 years of age is not
241.29 recoverable from the recipient or recipient's estate. This section does not prohibit the state
241.30 agency from:

241.31 (1) receiving payment from a trust pursuant to United States Code, title 42, section
241.32 1396p(d)(4)(A) or (C), for medical assistance paid on behalf of the trust beneficiary for
241.33 services received at any age; or

242.1 (2) claiming against the designated beneficiary of an Achieving a Better Life Experience
242.2 (ABLE) account or the ABLE account itself pursuant to Code of Federal Regulations, title
242.3 26, section 1.529A-2(o), for the amount of the total medical assistance paid for the designated
242.4 beneficiary at any age after establishment of the ABLE account.

242.5 Subd. 2. **Recovering client error overpayment.** (a) The local agency or the Department
242.6 of Human Services must not attempt recovery of the overpayment amount pursuant to
242.7 chapter 270A or section 256.0471 when a person liable for a client error overpayment under
242.8 section 256.98, subdivision 4, voluntarily repays the overpayment amount or establishes a
242.9 payment plan in writing with the local agency or the Department of Human Services to
242.10 repay the overpayment amount within 90 days after receiving the overpayment notice or
242.11 after resolution of a fair hearing regarding the overpayment under section 256.045, whichever
242.12 is later. When a liable person agrees to a payment plan in writing with the local agency or
242.13 the Department of Human Services but has not repaid any amount six months after entering
242.14 the agreement, the local agency or Department of Human Services must pursue recovery
242.15 under paragraph (b).

242.16 (b) If the liable person does not voluntarily repay the overpayment amount or establish
242.17 a repayment agreement under paragraph (a), the local agency or the Department of Human
242.18 Services must attempt recovery of the overpayment amount pursuant to chapter 270A when
242.19 the overpayment amount is eligible for recovery as a public assistance debt under chapter
242.20 270A. For any overpaid amount of solely state-funded medical assistance, the local agency
242.21 or the Department of Human Services must attempt recovery pursuant to section 256.0471.

242.22 Subd. 3. **Writing off client error overpayment.** A local agency or the Department of
242.23 Human Services must not attempt to recover a client error overpayment of less than \$350,
242.24 unless the overpayment is for medical assistance received pursuant to section 256.045,
242.25 subdivision 10, during the pendency of an appeal or unless the recovery is from the recipient's
242.26 estate or the estate of the recipient's surviving spouse. A local agency or the Department of
242.27 Human Services may write off any remaining balance of a client error overpayment when
242.28 the overpayment has not been repaid five years after the effective date of the overpayment
242.29 and the local agency or the Department of Human Services determines it is no longer cost
242.30 effective to attempt recovery of the remaining balance.

242.31 Sec. 52. Laws 2015, chapter 71, article 14, section 2, subdivision 5, as amended by Laws
242.32 2015, First Special Session chapter 6, section 1, is amended to read:

242.33 **Subd. 5. Grant Programs**

243.1 The amounts that may be spent from this
 243.2 appropriation for each purpose are as follows:

243.3 **(a) Support Services Grants**

243.4 Appropriations by Fund

243.5	General	13,133,000	8,715,000
243.6	Federal TANF	96,311,000	96,311,000

243.7 **(b) Basic Sliding Fee Child Care Assistance**
 243.8 **Grants**

48,439,000 51,559,000

243.9 **Basic Sliding Fee Waiting List Allocation.**

243.10 Notwithstanding Minnesota Statutes, section
 243.11 119B.03, \$5,413,000 in fiscal year 2016 is to
 243.12 reduce the basic sliding fee program waiting
 243.13 list as follows:

243.14 (1) The calendar year 2016 allocation shall be
 243.15 increased to serve families on the waiting list.
 243.16 To receive funds appropriated for this purpose,
 243.17 a county must have:

243.18 (i) a waiting list in the most recent published
 243.19 waiting list month;

243.20 (ii) an average of at least ten families on the
 243.21 most recent six months of published waiting
 243.22 list; and

243.23 (iii) total expenditures in calendar year 2014
 243.24 that met or exceeded 80 percent of the county's
 243.25 available final allocation.

243.26 (2) Funds shall be distributed proportionately
 243.27 based on the average of the most recent six
 243.28 months of published waiting lists to counties
 243.29 that meet the criteria in clause (1).

243.30 (3) Allocations in calendar years 2017 and
 243.31 beyond shall be calculated using the allocation
 243.32 formula in Minnesota Statutes, section
 243.33 119B.03.

244.1 (4) The guaranteed floor for calendar year
 244.2 2017 shall be based on the revised calendar
 244.3 year 2016 allocation.

244.4 **Base Level Adjustment.** The general fund
 244.5 base is increased by \$810,000 in fiscal year
 244.6 2018 and increased by \$821,000 in fiscal year
 244.7 2019.

244.8	(c) Child Care Development Grants	1,737,000	1,737,000
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244.9	(d) Child Support Enforcement Grants	50,000	50,000
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244.10 (e) **Children's Services Grants**

244.11	Appropriations by Fund		
244.12	General	39,015,000	38,665,000
244.13	Federal TANF	140,000	140,000

244.14 **Safe Place for Newborns.** \$350,000 from the
 244.15 general fund in fiscal year 2016 is to distribute
 244.16 information on the Safe Place for Newborns
 244.17 law in Minnesota to increase public awareness
 244.18 of the law. This is a onetime appropriation.

244.19 **Child Protection.** \$23,350,000 in fiscal year
 244.20 2016 and \$23,350,000 in fiscal year 2017 are
 244.21 to address child protection staffing and
 244.22 services under Minnesota Statutes, section
 244.23 256M.41. \$1,650,000 in fiscal year 2016 and
 244.24 \$1,650,000 in fiscal year 2017 are for child
 244.25 protection grants to address child welfare
 244.26 disparities under Minnesota Statutes, section
 244.27 256E.28.

244.28 **Title IV-E Adoption Assistance.** Additional
 244.29 federal reimbursement to the state as a result
 244.30 of the Fostering Connections to Success and
 244.31 Increasing Adoptions Act's expanded
 244.32 eligibility for title IV-E adoption assistance is
 244.33 appropriated to the commissioner for

245.1 postadoption services, including a
 245.2 parent-to-parent support network.

245.3 **Adoption Assistance Incentive Grants.**

245.4 Federal funds available during fiscal years
 245.5 2016 and 2017 for adoption incentive grants
 245.6 are appropriated to the commissioner for
 245.7 postadoption services, including a
 245.8 parent-to-parent support network.

245.9 (f) Children and Community Service Grants	56,301,000	56,301,000
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245.10 (g) Children and Economic Support Grants	26,778,000	26,966,000
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245.11 **Mobile Food Shelf Grants.** (a) \$1,000,000
 245.12 in fiscal year 2016 and \$1,000,000 in fiscal
 245.13 year 2017 are for a grant to Hunger Solutions.
 245.14 This is a onetime appropriation and is
 245.15 available until June 30, 2017.

245.16 (b) Hunger Solutions shall award grants of up
 245.17 to \$75,000 on a competitive basis. Grant
 245.18 applications must include:

- 245.19 (1) the location of the project;
- 245.20 (2) a description of the mobile program,
 245.21 including size and scope;
- 245.22 (3) evidence regarding the unserved or
 245.23 underserved nature of the community in which
 245.24 the project is to be located;
- 245.25 (4) evidence of community support for the
 245.26 project;
- 245.27 (5) the total cost of the project;
- 245.28 (6) the amount of the grant request and how
 245.29 funds will be used;
- 245.30 (7) sources of funding or in-kind contributions
 245.31 for the project that will supplement any grant
 245.32 award;

246.1 (8) a commitment to mobile programs by the
246.2 applicant and an ongoing commitment to
246.3 maintain the mobile program; and

246.4 (9) any additional information requested by
246.5 Hunger Solutions.

246.6 (c) Priority may be given to applicants who:

246.7 (1) serve underserved areas;

246.8 (2) create a new or expand an existing mobile
246.9 program;

246.10 (3) serve areas where a high amount of need
246.11 is identified;

246.12 (4) provide evidence of strong support for the
246.13 project from citizens and other institutions in
246.14 the community;

246.15 (5) leverage funding for the project from other
246.16 private and public sources; and

246.17 (6) commit to maintaining the program on a
246.18 multilayer basis.

246.19 **Homeless Youth Act.** At least \$500,000 of
246.20 the appropriation for the Homeless Youth Act
246.21 must be awarded to providers in greater
246.22 Minnesota, with at least 25 percent of this
246.23 amount for new applicant providers. The
246.24 commissioner shall provide outreach and
246.25 technical assistance to greater Minnesota
246.26 providers and new providers to encourage
246.27 responding to the request for proposals.

246.28 **Stearns County Veterans Housing.** \$85,000
246.29 in fiscal year 2016 and \$85,000 in fiscal year
246.30 2017 are for a grant to Stearns County to
246.31 provide administrative funding in support of
246.32 a service provider serving veterans in Stearns
246.33 County. The administrative funding grant may

247.1 be used to support group residential housing
 247.2 services, corrections-related services, veteran
 247.3 services, and other social services related to
 247.4 the service provider serving veterans in
 247.5 Stearns County.

247.6 **Safe Harbor.** \$800,000 in fiscal year 2016
 247.7 and \$800,000 in fiscal year 2017 are from the
 247.8 general fund for emergency shelter and
 247.9 transitional and long-term housing beds for
 247.10 sexually exploited youth and youth at risk of
 247.11 sexual exploitation. Of this appropriation,
 247.12 \$150,000 in fiscal year 2016 and \$150,000 in
 247.13 fiscal year 2017 are from the general fund for
 247.14 statewide youth outreach workers connecting
 247.15 sexually exploited youth and youth at risk of
 247.16 sexual exploitation with shelter and services.

247.17 **Minnesota Food Assistance Program.**
 247.18 Unexpended funds for the Minnesota food
 247.19 assistance program for fiscal year 2016 do not
 247.20 cancel but are available for this purpose in
 247.21 fiscal year 2017.

247.22 **Base Level Adjustment.** The general fund
 247.23 base is decreased by \$816,000 in fiscal year
 247.24 2018 and is decreased by \$606,000 in fiscal
 247.25 year 2019.

247.26 (h) **Health Care Grants**

247.27	Appropriations by Fund		
247.28	General	536,000	2,482,000
247.29	Health Care Access	3,341,000	3,465,000

247.30 **Grants for Periodic Data Matching for**
 247.31 **Medical Assistance and MinnesotaCare.** Of
 247.32 the general fund appropriation, \$26,000 in
 247.33 fiscal year 2016 and \$1,276,000 in fiscal year
 247.34 2017 are for grants to counties for costs related

248.1 to periodic data matching for medical
 248.2 assistance and MinnesotaCare recipients under
 248.3 Minnesota Statutes, section 256B.0561. The
 248.4 commissioner must distribute these grants to
 248.5 counties in proportion to each county's number
 248.6 of cases in the prior year in the affected
 248.7 programs.

248.8 **Base Level Adjustment.** The general fund
 248.9 base is ~~increased by \$1,637,000 in fiscal year~~
 248.10 ~~2018 and increased by \$1,229,000 in fiscal~~
 248.11 ~~year 2019~~ maintained in fiscal years 2020 and
 248.12 2021.

248.13 **(i) Other Long-Term Care Grants** 1,551,000 3,069,000

248.14 **Transition Populations.** \$1,551,000 in fiscal
 248.15 year 2016 and \$1,725,000 in fiscal year 2017
 248.16 are for home and community-based services
 248.17 transition grants to assist in providing home
 248.18 and community-based services and treatment
 248.19 for transition populations under Minnesota
 248.20 Statutes, section 256.478.

248.21 **Base Level Adjustment.** The general fund
 248.22 base is increased by \$156,000 in fiscal year
 248.23 2018 and by \$581,000 in fiscal year 2019.

248.24 **(j) Aging and Adult Services Grants** 28,463,000 28,162,000

248.25 **Dementia Grants.** \$750,000 in fiscal year
 248.26 2016 and \$750,000 in fiscal year 2017 are for
 248.27 the Minnesota Board on Aging for regional
 248.28 and local dementia grants authorized in
 248.29 Minnesota Statutes, section 256.975,
 248.30 subdivision 11.

248.31 **(k) Deaf and Hard-of-Hearing Grants** 2,225,000 2,375,000

248.32 **Deaf, Deafblind, and Hard-of-Hearing**
 248.33 **Grants.** \$350,000 in fiscal year 2016 and
 248.34 \$500,000 in fiscal year 2017 are for deaf and

249.1 hard-of-hearing grants. The funds must be
 249.2 used to increase the number of deafblind
 249.3 Minnesotans receiving services under
 249.4 Minnesota Statutes, section 256C.261, and to
 249.5 provide linguistically and culturally
 249.6 appropriate mental health services to children
 249.7 who are deaf, deafblind, and hard-of-hearing.
 249.8 This is a onetime appropriation.

249.9 **Base Level Adjustment.** The general fund
 249.10 base is decreased by \$500,000 in fiscal year
 249.11 2018 and by \$500,000 in fiscal year 2019.

249.12 **(l) Disabilities Grants** 20,820,000 20,858,000

249.13 **State Quality Council.** \$573,000 in fiscal
 249.14 year 2016 and \$600,000 in fiscal year 2017
 249.15 are for the State Quality Council to provide
 249.16 technical assistance and monitoring of
 249.17 person-centered outcomes related to inclusive
 249.18 community living and employment. The
 249.19 funding must be used by the State Quality
 249.20 Council to assure a statewide plan for systems
 249.21 change in person-centered planning that will
 249.22 achieve desired outcomes including increased
 249.23 integrated employment and community living.

249.24 **(m) Adult Mental Health Grants**

249.25	Appropriations by Fund		
249.26	General	69,992,000	71,244,000
249.27	Health Care Access	1,575,000	2,473,000
249.28	Lottery Prize	1,733,000	1,733,000

249.29 **Funding Usage.** Up to 75 percent of a fiscal
 249.30 year's appropriation for adult mental health
 249.31 grants may be used to fund allocations in that
 249.32 portion of the fiscal year ending December
 249.33 31.

250.1 **Culturally Specific Mental Health Services.**

250.2 \$100,000 in fiscal year 2016 is for grants to
250.3 nonprofit organizations to provide resources
250.4 and referrals for culturally specific mental
250.5 health services to Southeast Asian veterans
250.6 born before 1965 who do not qualify for
250.7 services available to veterans formally
250.8 discharged from the United States armed
250.9 forces.

250.10 **Problem Gambling.** \$225,000 in fiscal year
250.11 2016 and \$225,000 in fiscal year 2017 are
250.12 from the lottery prize fund for a grant to the
250.13 state affiliate recognized by the National
250.14 Council on Problem Gambling. The affiliate
250.15 must provide services to increase public
250.16 awareness of problem gambling, education,
250.17 and training for individuals and organizations
250.18 providing effective treatment services to
250.19 problem gamblers and their families, and
250.20 research related to problem gambling.

250.21 **Sustainability Grants.** \$2,125,000 in fiscal
250.22 year 2016 and \$2,125,000 in fiscal year 2017
250.23 are for sustainability grants under Minnesota
250.24 Statutes, section 256B.0622, subdivision 11.

250.25 **Beltrami County Mental Health Services**
250.26 **Grant.** \$1,000,000 in fiscal year 2016 and
250.27 \$1,000,000 in fiscal year 2017 are from the
250.28 general fund for a grant to Beltrami County
250.29 to fund the planning and development of a
250.30 comprehensive mental health services program
250.31 under article 2, section 41, Comprehensive
250.32 Mental Health Program in Beltrami County.
250.33 This is a onetime appropriation.

250.34 **Base Level Adjustment.** The general fund
250.35 base is increased by \$723,000 in fiscal year

251.1 2018 and by \$723,000 in fiscal year 2019. The
 251.2 health care access fund base is decreased by
 251.3 \$1,723,000 in fiscal year 2018 and by
 251.4 \$1,723,000 in fiscal year 2019.

251.5 **(n) Child Mental Health Grants** 23,386,000 24,313,000

251.6 **Services and Supports for First Episode**
 251.7 **Psychosis.** \$177,000 in fiscal year 2017 is for
 251.8 grants under Minnesota Statutes, section
 251.9 245.4889, to mental health providers to pilot
 251.10 evidence-based interventions for youth at risk
 251.11 of developing or experiencing a first episode
 251.12 of psychosis and for a public awareness
 251.13 campaign on the signs and symptoms of
 251.14 psychosis. The base for these grants is
 251.15 \$236,000 in fiscal year 2018 and \$301,000 in
 251.16 fiscal year 2019.

251.17 **Adverse Childhood Experiences.** The base
 251.18 for grants under Minnesota Statutes, section
 251.19 245.4889, to children's mental health and
 251.20 family services collaboratives for adverse
 251.21 childhood experiences (ACEs) training grants
 251.22 and for an interactive Web site connection to
 251.23 support ACEs in Minnesota is \$363,000 in
 251.24 fiscal year 2018 and \$363,000 in fiscal year
 251.25 2019.

251.26 **Funding Usage.** Up to 75 percent of a fiscal
 251.27 year's appropriation for child mental health
 251.28 grants may be used to fund allocations in that
 251.29 portion of the fiscal year ending December
 251.30 31.

251.31 **Base Level Adjustment.** The general fund
 251.32 base is increased by \$422,000 in fiscal year
 251.33 2018 and is increased by \$487,000 in fiscal
 251.34 year 2019.

252.1 **(o) Chemical Dependency Treatment Support**
 252.2 **Grants** 1,561,000 1,561,000

252.3 **Chemical Dependency Prevention. \$150,000**
 252.4 in fiscal year 2016 and \$150,000 in fiscal year
 252.5 2017 are for grants to nonprofit organizations
 252.6 to provide chemical dependency prevention
 252.7 programs in secondary schools. When making
 252.8 grants, the commissioner must consider the
 252.9 expertise, prior experience, and outcomes
 252.10 achieved by applicants that have provided
 252.11 prevention programming in secondary
 252.12 education environments. An applicant for the
 252.13 grant funds must provide verification to the
 252.14 commissioner that the applicant has available
 252.15 and will contribute sufficient funds to match
 252.16 the grant given by the commissioner. This is
 252.17 a onetime appropriation.

252.18 **Fetal Alcohol Syndrome Grants. \$250,000**
 252.19 in fiscal year 2016 and \$250,000 in fiscal year
 252.20 2017 are for grants to be administered by the
 252.21 Minnesota Organization on Fetal Alcohol
 252.22 Syndrome to provide comprehensive,
 252.23 gender-specific services to pregnant and
 252.24 parenting women suspected of or known to
 252.25 use or abuse alcohol or other drugs. This
 252.26 appropriation is for grants to no fewer than
 252.27 three eligible recipients. Minnesota
 252.28 Organization on Fetal Alcohol Syndrome must
 252.29 report to the commissioner of human services
 252.30 annually by January 15 on the grants funded
 252.31 by this appropriation. The report must include
 252.32 measurable outcomes for the previous year,
 252.33 including the number of pregnant women
 252.34 served and the number of toxic-free babies
 252.35 born.

253.1 **Base Level Adjustment.** The general fund
253.2 base is decreased by \$150,000 in fiscal year
253.3 2018 and by \$150,000 in fiscal year 2019.

253.4 Sec. 53. Laws 2020, First Special Session chapter 7, section 1, subdivision 1, as amended
253.5 by Laws 2021, First Special Session chapter 7, article 2, section 71, is amended to read:

253.6 Subdivision 1. **Waivers and modifications; federal funding extension.** When the
253.7 peacetime emergency declared by the governor in response to the COVID-19 outbreak
253.8 expires, is terminated, or is rescinded by the proper authority, the following waivers and
253.9 modifications to human services programs issued by the commissioner of human services
253.10 pursuant to Executive Orders 20-11 and 20-12 that are required to comply with federal law
253.11 may remain in effect for the time period set out in applicable federal law or for the time
253.12 period set out in any applicable federally approved waiver or state plan amendment,
253.13 whichever is later:

253.14 (1) CV15: allowing telephone or video visits for waiver programs;

253.15 (2) CV17: preserving health care coverage for Medical Assistance and MinnesotaCare
253.16 as needed to comply with federal guidance from the Centers for Medicare and Medicaid
253.17 Services, and until the enrollee's first renewal following the resumption of medical assistance
253.18 and MinnesotaCare renewals after the end of the COVID-19 public health emergency
253.19 declared by the United States Secretary of Health and Human Services;

253.20 (3) CV18: implementation of federal changes to the Supplemental Nutrition Assistance
253.21 Program;

253.22 (4) CV20: eliminating cost-sharing for COVID-19 diagnosis and treatment;

253.23 (5) CV24: allowing telephone or video use for targeted case management visits;

253.24 (6) CV30: expanding telemedicine in health care, mental health, and substance use
253.25 disorder settings;

253.26 (7) CV37: implementation of federal changes to the Supplemental Nutrition Assistance
253.27 Program;

253.28 (8) CV39: implementation of federal changes to the Supplemental Nutrition Assistance
253.29 Program;

253.30 (9) CV42: implementation of federal changes to the Supplemental Nutrition Assistance
253.31 Program;

253.32 (10) CV43: expanding remote home and community-based waiver services;

254.1 (11) CV44: allowing remote delivery of adult day services;

254.2 (12) CV59: modifying eligibility period for the federally funded Refugee Cash Assistance
254.3 Program;

254.4 (13) CV60: modifying eligibility period for the federally funded Refugee Social Services
254.5 Program; and

254.6 (14) CV109: providing 15 percent increase for Minnesota Food Assistance Program and
254.7 Minnesota Family Investment Program maximum food benefits.

254.8 Sec. 54. Laws 2021, First Special Session chapter 7, article 1, section 36, is amended to
254.9 read:

254.10 Sec. 36. **RESPONSE TO COVID-19 PUBLIC HEALTH EMERGENCY.**

254.11 (a) Notwithstanding Minnesota Statutes, section 256B.057, subdivision 9, 256L.06,
254.12 subdivision 3, or any other provision to the contrary, the commissioner shall not collect any
254.13 unpaid premium for a coverage month that occurred during until the enrollee's first renewal
254.14 after the resumption of medical assistance renewals following the end of the COVID-19
254.15 public health emergency declared by the United States Secretary of Health and Human
254.16 Services.

254.17 (b) Notwithstanding any provision to the contrary, periodic data matching under
254.18 Minnesota Statutes, section 256B.0561, subdivision 2, may be suspended for up to ~~six~~ 12
254.19 months following the last day of resumption of medical assistance and MinnesotaCare
254.20 renewals after the end of the COVID-19 public health emergency declared by the United
254.21 States Secretary of Health and Human Services.

254.22 (c) Notwithstanding any provision to the contrary, the requirement for the commissioner
254.23 of human services to issue an annual report on periodic data matching under Minnesota
254.24 Statutes, section 256B.0561, is suspended for one year following the last day of the
254.25 COVID-19 public health emergency declared by the United States Secretary of Health and
254.26 Human Services.

254.27 (d) The commissioner of human services shall take necessary actions to comply with
254.28 federal guidance pertaining to the appropriate redetermination of medical assistance enrollee
254.29 eligibility following the end of the COVID-19 public health emergency declared by the
254.30 United States Secretary of Health and Human Services and may waive currently existing
254.31 Minnesota statutes to the minimum level necessary to achieve federal compliance. All

255.1 changes implemented must be reported to the chairs and ranking minority members of the
255.2 legislative committees with jurisdiction over human services within 90 days.

255.3 Sec. 55. **DENTAL HOME PILOT PROJECT.**

255.4 Subdivision 1. **Establishment; requirements.** (a) The commissioner of human services
255.5 shall establish a dental home pilot project to increase access of medical assistance and
255.6 MinnesotaCare enrollees to dental care, improve patient experience, and improve oral health
255.7 clinical outcomes, in a manner that sustains the financial viability of the dental workforce
255.8 and broader dental care delivery and financing system. Dental homes must provide
255.9 high-quality, patient-centered, comprehensive, and coordinated oral health services across
255.10 clinical and community-based settings, including virtual oral health care.

255.11 (b) The design and operation of the dental home pilot project must be consistent with
255.12 the recommendations made by the Dental Services Advisory Committee to the legislature
255.13 under Laws 2021, First Special Session chapter 7, article 1, section 33.

255.14 (c) The commissioner shall establish baseline requirements and performance measures
255.15 for dental homes participating in the pilot project. These baseline requirements and
255.16 performance measures must address access and patient experience and oral health clinical
255.17 outcomes.

255.18 Subd. 2. **Project design and timeline.** (a) The commissioner shall issue a preliminary
255.19 project description and a request for information to obtain stakeholder feedback and input
255.20 on project design issues, including but not limited to:

255.21 (1) the timeline for project implementation;

255.22 (2) the length of each project phase and the date for full project implementation;

255.23 (3) the number of providers to be selected for participation;

255.24 (4) grant amounts;

255.25 (5) criteria and procedures for any value-based payments;

255.26 (6) the extent to which pilot project requirements may vary with provider characteristics;

255.27 (7) procedures for data collection;

255.28 (8) the role of dental partners, such as dental professional organizations and educational
255.29 institutions;

255.30 (9) provider support and education; and

255.31 (10) other topics identified by the commissioner.

256.1 (b) The commissioner shall consider the feedback and input obtained in paragraph (a)
256.2 and shall develop and issue a request for proposals for participation in the pilot project.

256.3 (c) The pilot project must be implemented by July 1, 2023, and must include initial pilot
256.4 testing and the collection and analysis of data on baseline requirements and performance
256.5 measures to evaluate whether these requirements and measures are appropriate. Under this
256.6 phase, the commissioner shall provide grants to individual providers and provider networks
256.7 in addition to medical assistance and MinnesotaCare payments received for services provided.

256.8 (d) The pilot project may test and analyze value-based payments to providers to determine
256.9 whether varying payments based on dental home performance measures is appropriate and
256.10 effective.

256.11 (e) The commissioner shall ensure provider diversity in selecting project participants.
256.12 In selecting providers, the commissioner shall consider: geographic distribution; provider
256.13 size, type, and location; providers serving different priority populations; health equity issues;
256.14 and provider accessibility for patients with varying levels and types of disability.

256.15 (f) In designing and implementing the pilot project, the commissioner shall regularly
256.16 consult with project participants and other stakeholders, and as relevant shall continue to
256.17 seek the input of participants and other stakeholders on the topics listed in paragraph (a).

256.18 **Subd. 3. Reporting.** (a) The commissioner, beginning February 15, 2023, and each
256.19 February 15 thereafter for the duration of the demonstration project, shall report on the
256.20 design, implementation, operation, and results of the demonstration project to the chairs
256.21 and ranking minority members of the legislative committees with jurisdiction over health
256.22 care finance and policy.

256.23 (b) The commissioner, within six months from the date the pilot project ceases operation,
256.24 shall report to the chairs and ranking minority members of the legislative committees with
256.25 jurisdiction over health care finance and policy on the results of the demonstration project,
256.26 and shall include in the report recommendations on whether the demonstration project, or
256.27 specific features of the demonstration project, should be extended to all dental providers
256.28 serving medical assistance and MinnesotaCare enrollees.

256.29 **Sec. 56. SMALL EMPLOYER PUBLIC OPTION.**

256.30 The commissioner of human services, in consultation with representatives of small
256.31 employers, shall develop a small employer public option that allows employees of businesses
256.32 with fewer than 50 employees to receive employer contributions toward MinnesotaCare.
256.33 The commissioner shall determine whether the employer makes contributions to the

257.1 commissioner directly or the employee makes contributions through a qualified small
257.2 employer health reimbursement arrangement account or other arrangement. In determining
257.3 the structure of the small employer public option, the commissioner shall consult with
257.4 federal officials to determine which arrangement will result in the employer contributions
257.5 being tax deductible to the employer and not being considered taxable income to the
257.6 employee. The commissioner shall present recommendations for a small employer public
257.7 option to the chairs and ranking minority members of the legislative committees with
257.8 jurisdiction over health and human services policy and finance by December 15, 2023.

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

257.10 **Sec. 57. TRANSITION TO MINNESOTACARE PUBLIC OPTION.**

257.11 (a) The commissioner of human services shall continue to administer MinnesotaCare
257.12 as a basic health program in accordance with Minnesota Statutes, section 256L.02,
257.13 subdivision 5, and shall seek federal waivers, approvals, and law changes necessary to
257.14 implement this act.

257.15 (b) The commissioner shall present an implementation plan for the MinnesotaCare public
257.16 option under Minnesota Statutes, section 256L.04, subdivision 15, to the chairs and ranking
257.17 minority members of the legislative committees with jurisdiction over health care policy
257.18 and finance by December 15, 2023. The plan must include:

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

257.21 (2) recommendations for implementing any small employer option in a manner that
257.22 would allow any employee payments toward premiums to be pretax;

257.23 (3) recommendations for ensuring sufficient provider participation in MinnesotaCare;

257.24 (4) estimates of state costs related to the MinnesotaCare public option;

257.25 (5) a description of the proposed premium scale for persons eligible through the public
257.26 option, including an analysis of the extent to which the proposed premium scale:

257.27 (i) ensures affordable premiums for persons across the income spectrum enrolled under
257.28 the public option; and

257.29 (ii) avoids premium cliffs for persons transitioning to and enrolled under the public
257.30 option; and

258.1 (6) draft legislation that includes any additional policy and conforming changes necessary
258.2 to implement the MinnesotaCare public option and the implementation plan
258.3 recommendations.

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

258.5 Sec. 58. **REQUEST FOR FEDERAL APPROVAL.**

258.6 (a) The commissioner of human services shall seek any federal waivers, approvals, and
258.7 law changes necessary to implement this act, including but not limited to those waivers,
258.8 approvals, and law changes necessary to allow the state to:

258.9 (1) continue receiving federal basic health program payments for basic health
258.10 program-eligible MinnesotaCare enrollees and to receive other federal funding for the
258.11 MinnesotaCare public option;

258.12 (2) receive federal payments equal to the value of premium tax credits and cost-sharing
258.13 reductions that MinnesotaCare enrollees with household incomes greater than 200 percent
258.14 of the federal poverty guidelines would otherwise have received; and

258.15 (3) receive federal payments equal to the value of emergency medical assistance that
258.16 would otherwise have been paid to the state for covered services provided to eligible
258.17 enrollees.

258.18 (b) In implementing this section, the commissioner of human services shall consult with
258.19 the commissioner of commerce and the Board of Directors of MNsure and may contract
258.20 for technical and actuarial assistance.

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

258.22 Sec. 59. **DELIVERY REFORM ANALYSIS REPORT.**

258.23 (a) The commissioner of human services shall present to the chairs and ranking minority
258.24 members of the legislative committees with jurisdiction over health care policy and finance,
258.25 by January 15, 2024, a report comparing service delivery and payment system models for
258.26 delivering services to medical assistance enrollees for whom income eligibility is determined
258.27 using the modified adjusted gross income methodology under Minnesota Statutes, section
258.28 256B.056, subdivision 1a, paragraph (b), clause (1), and MinnesotaCare enrollees eligible
258.29 under Minnesota Statutes, chapter 256L. The report must compare the current delivery
258.30 model with at least two alternative models. The alternative models must include a state-based
258.31 model in which the state holds the plan risk as the insurer and may contract with a third-party

259.1 administrator for claims processing and plan administration. The alternative models may
259.2 include but are not limited to:

259.3 (1) expanding the use of integrated health partnerships under Minnesota Statutes, section
259.4 256B.0755;

259.5 (2) delivering care under fee-for-service through a primary care case management system;
259.6 and

259.7 (3) continuing to contract with managed care and county-based purchasing plans for
259.8 some or all enrollees under modified contracts.

259.9 (b) The report must include:

259.10 (1) a description of how each model would address:

259.11 (i) racial and other inequities in the delivery of health care and health care outcomes;

259.12 (ii) geographic inequities in the delivery of health care;

259.13 (iii) the provision of incentives for preventive care and other best practices;

259.14 (iv) reimbursement of providers for high-quality, value-based care at levels sufficient
259.15 to sustain or increase enrollee access to care; and

259.16 (v) transparency and simplicity for enrollees, health care providers, and policymakers;

259.17 (2) a comparison of the projected cost of each model; and

259.18 (3) an implementation timeline for each model that includes the earliest date by which
259.19 each model could be implemented if authorized during the 2024 legislative session and a
259.20 discussion of barriers to implementation.

259.21 **Sec. 60. RECOMMENDATIONS; OFFICE OF PATIENT PROTECTION.**

259.22 (a) The commissioners of human services, health, and commerce and the MNsure board
259.23 shall submit to the health care affordability board and the chairs and ranking minority
259.24 members of the legislative committees with primary jurisdiction over health and human
259.25 services finance and policy and commerce by January 15, 2023, a report on the organization
259.26 and duties of the Office of Patient Protection, to be established under Minnesota Statutes,
259.27 section 62J.89, subdivision 4. The report must include recommendations on how the office
259.28 shall:

259.29 (1) coordinate or consolidate within the office existing state agency patient protection
259.30 activities, including but not limited to the activities of ombudsman offices and the MNsure
259.31 board;

260.1 (2) enforce standards and procedures under Minnesota Statutes, chapter 62M, for
260.2 utilization review organizations;

260.3 (3) work with private sector and state agency consumer assistance programs to assist
260.4 consumers with questions or concerns relating to public programs and private insurance
260.5 coverage;

260.6 (4) establish and implement procedures to assist consumers aggrieved by restrictions on
260.7 patient choice, denials of services, and reductions in quality of care resulting from any final
260.8 action by a payer or provider; and

260.9 (5) make health plan company quality of care and patient satisfaction information and
260.10 other information collected by the office readily accessible to consumers on the board's
260.11 website.

260.12 (b) The commissioners and the MNsure board shall consult with stakeholders as they
260.13 develop the recommendations. The stakeholders consulted must include but are not limited
260.14 to organizations and individuals representing: underserved communities; persons with
260.15 disabilities; low-income Minnesotans; senior citizens; and public and private sector health
260.16 plan enrollees, including persons who purchase coverage through MNsure, health plan
260.17 companies, and public and private sector purchasers of health coverage.

260.18 (c) The commissioners and the MNsure board may contract with a third party to develop
260.19 the report and recommendations.

260.20 Sec. 61. **REPEALER.**

260.21 Minnesota Statutes 2020, section 256B.063, is repealed.

260.22 **EFFECTIVE DATE.** This section is effective January 1, 2023.

260.23

ARTICLE 4

260.24

HEALTH CARE POLICY

260.25 Section 1. Minnesota Statutes 2020, section 62J.2930, subdivision 3, is amended to read:

260.26 Subd. 3. **Consumer information.** (a) The information clearinghouse or another entity
260.27 designated by the commissioner shall provide consumer information to health plan company
260.28 enrollees to:

260.29 (1) assist enrollees in understanding their rights;

261.1 (2) explain and assist in the use of all available complaint systems, including internal
261.2 complaint systems within health carriers, community integrated service networks, and the
261.3 Departments of Health and Commerce;

261.4 (3) provide information on coverage options in each region of the state;

261.5 (4) provide information on the availability of purchasing pools and enrollee subsidies;
261.6 and

261.7 (5) help consumers use the health care system to obtain coverage.

261.8 (b) The information clearinghouse or other entity designated by the commissioner for
261.9 the purposes of this subdivision shall not:

261.10 (1) provide legal services to consumers;

261.11 (2) represent a consumer or enrollee; or

261.12 (3) serve as an advocate for consumers in disputes with health plan companies.

261.13 (c) Nothing in this subdivision shall interfere with the ombudsman program established
261.14 under section ~~256B.69, subdivision 20~~ 256B.6903, or other existing ombudsman programs.

261.15 Sec. 2. Minnesota Statutes 2020, section 256B.055, subdivision 2, is amended to read:

261.16 Subd. 2. **Subsidized foster children.** Medical assistance may be paid for a child eligible
261.17 for or receiving foster care maintenance payments under Title IV-E of the Social Security
261.18 Act, United States Code, title 42, sections 670 to 676, and for a child who is not eligible for
261.19 Title IV-E of the Social Security Act but who is ~~determined eligible for~~ placed in foster
261.20 care as determined by Minnesota Statutes or kinship assistance under chapter 256N.

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

261.22 Sec. 3. Minnesota Statutes 2020, section 256B.056, subdivision 3b, is amended to read:

261.23 Subd. 3b. **Treatment of trusts.** (a) It is the public policy of this state that individuals
261.24 use all available resources to pay for the cost of long-term care services, as defined in section
261.25 256B.0595, before turning to Minnesota health care program funds, and that trust instruments
261.26 should not be permitted to shield available resources of an individual or an individual's
261.27 spouse from such use.

261.28 ~~(a)~~ (b) A "medical assistance qualifying trust" is a revocable or irrevocable trust, or
261.29 similar legal device, established on or before August 10, 1993, by a person or the person's
261.30 spouse under the terms of which the person receives or could receive payments from the

262.1 trust principal or income and the trustee has discretion in making payments to the person
262.2 from the trust principal or income. Notwithstanding that definition, a medical assistance
262.3 qualifying trust does not include: (1) a trust set up by will; (2) a trust set up before April 7,
262.4 1986, solely to benefit a person with a developmental disability living in an intermediate
262.5 care facility for persons with developmental disabilities; or (3) a trust set up by a person
262.6 with payments made by the Social Security Administration pursuant to the United States
262.7 Supreme Court decision in *Sullivan v. Zebley*, 110 S. Ct. 885 (1990). The maximum amount
262.8 of payments that a trustee of a medical assistance qualifying trust may make to a person
262.9 under the terms of the trust is considered to be available assets to the person, without regard
262.10 to whether the trustee actually makes the maximum payments to the person and without
262.11 regard to the purpose for which the medical assistance qualifying trust was established.

262.12 ~~(b)~~ (c) Trusts established after August 10, 1993, are treated according to United States
262.13 Code, title 42, section 1396p(d).

262.14 ~~(e)~~ (d) For purposes of paragraph ~~(d)~~ (e), a pooled trust means a trust established under
262.15 United States Code, title 42, section 1396p(d)(4)(C).

262.16 ~~(d)~~ (e) A beneficiary's interest in a pooled trust is considered an available asset unless
262.17 the trust provides that upon the death of the beneficiary or termination of the trust during
262.18 the beneficiary's lifetime, whichever is sooner, the department receives any amount, up to
262.19 the amount of medical assistance benefits paid on behalf of the beneficiary, remaining in
262.20 the beneficiary's trust account after a deduction for reasonable administrative fees and
262.21 expenses, and an additional remainder amount. The retained remainder amount of the
262.22 subaccount must not exceed ten percent of the account value at the time of the beneficiary's
262.23 death or termination of the trust, and must only be used for the benefit of disabled individuals
262.24 who have a beneficiary interest in the pooled trust.

262.25 ~~(e)~~ (f) Trusts may be established on or after December 12, 2016, by a person who has
262.26 been determined to be disabled, according to United States Code, title 42, section
262.27 1396p(d)(4)(A), as amended by section 5007 of the 21st Century Cures Act, Public Law
262.28 114-255.

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

262.30 Sec. 4. Minnesota Statutes 2020, section 256B.056, subdivision 3c, is amended to read:

262.31 Subd. 3c. **Asset limitations for families and children.** (a) A household of two or more
262.32 persons must not own more than \$20,000 in total net assets, and a household of one person
262.33 must not own more than \$10,000 in total net assets. In addition to these maximum amounts,

263.1 an eligible individual or family may accrue interest on these amounts, but they must be
263.2 reduced to the maximum at the time of an eligibility redetermination. The value of assets
263.3 that are not considered in determining eligibility for medical assistance for families and
263.4 children is the value of those assets excluded under the AFDC state plan as of July 16, 1996,
263.5 as required by the Personal Responsibility and Work Opportunity Reconciliation Act of
263.6 1996 (PRWORA), Public Law 104-193, with the following exceptions:

263.7 (1) household goods and personal effects are not considered;

263.8 (2) capital and operating assets of a trade or business up to \$200,000 are not considered;

263.9 (3) one motor vehicle is excluded for each person of legal driving age who is employed
263.10 or seeking employment;

263.11 (4) assets designated as burial expenses are excluded to the same extent they are excluded
263.12 by the Supplemental Security Income program;

263.13 (5) court-ordered settlements up to \$10,000 are not considered;

263.14 (6) individual retirement accounts and funds are not considered;

263.15 (7) assets owned by children are not considered; and

263.16 (8) ~~effective July 1, 2009,~~ certain assets owned by American Indians are excluded as
263.17 required by section 5006 of the American Recovery and Reinvestment Act of 2009, Public
263.18 Law 111-5. For purposes of this clause, an American Indian is any person who meets the
263.19 definition of Indian according to Code of Federal Regulations, title 42, section 447.50.

263.20 (b) ~~Beginning January 1, 2014, this subdivision~~ Paragraph (a) applies only to parents
263.21 and caretaker relatives who qualify for medical assistance under subdivision 5.

263.22 (c) Eligibility for children under age 21 must be determined without regard to the asset
263.23 limitations described in paragraphs (a) and (b) and subdivision 3.

263.24 Sec. 5. Minnesota Statutes 2020, section 256B.056, subdivision 11, is amended to read:

263.25 Subd. 11. **Treatment of annuities.** (a) Any person requesting medical assistance payment
263.26 of long-term care services shall provide a complete description of any interest either the
263.27 person or the person's spouse has in annuities on a form designated by the department. The
263.28 form shall include a statement that the state becomes a preferred remainder beneficiary of
263.29 annuities or similar financial instruments by virtue of the receipt of medical assistance
263.30 payment of long-term care services. The person and the person's spouse shall furnish the
263.31 agency responsible for determining eligibility with complete current copies of their annuities

264.1 and related documents and complete the form designating the state as the preferred remainder
264.2 beneficiary for each annuity in which the person or the person's spouse has an interest.

264.3 (b) The department shall provide notice to the issuer of the department's right under this
264.4 section as a preferred remainder beneficiary under the annuity or similar financial instrument
264.5 for medical assistance furnished to the person or the person's spouse, and provide notice of
264.6 the issuer's responsibilities as provided in paragraph (c).

264.7 (c) An issuer of an annuity or similar financial instrument who receives notice of the
264.8 state's right to be named a preferred remainder beneficiary as described in paragraph (b)
264.9 shall provide confirmation to the requesting agency that the state has been made a preferred
264.10 remainder beneficiary. The issuer shall also notify the county agency when a change in the
264.11 amount of income or principal being withdrawn from the annuity or other similar financial
264.12 instrument or a change in the state's preferred remainder beneficiary designation under the
264.13 annuity or other similar financial instrument occurs. The county agency shall provide the
264.14 issuer with the name, address, and telephone number of a unit within the department that
264.15 the issuer can contact to comply with this paragraph.

264.16 (d) "Preferred remainder beneficiary" for purposes of this subdivision and sections
264.17 256B.0594 and 256B.0595 means the state is a remainder beneficiary in the first position
264.18 in an amount equal to the amount of medical assistance paid on behalf of the institutionalized
264.19 person, or is a remainder beneficiary in the second position if the institutionalized person
264.20 designates and is survived by a remainder beneficiary who is (1) a spouse who does not
264.21 reside in a medical institution, (2) a minor child, or (3) a child of any age who is blind or
264.22 permanently and totally disabled as defined in the Supplemental Security Income program.
264.23 Notwithstanding this paragraph, the state is the remainder beneficiary in the first position
264.24 if the spouse or child disposes of the remainder for less than fair market value.

264.25 (e) For purposes of this subdivision, "institutionalized person" and "long-term care
264.26 services" have the meanings given in section 256B.0595, subdivision 1, paragraph ~~(g)~~ (f).

264.27 (f) For purposes of this subdivision, "medical institution" means a skilled nursing facility,
264.28 intermediate care facility, intermediate care facility for persons with developmental
264.29 disabilities, nursing facility, or inpatient hospital.

264.30 Sec. 6. Minnesota Statutes 2020, section 256B.0595, subdivision 1, is amended to read:

264.31 Subdivision 1. **Prohibited transfers.** (a) Effective for transfers made after August 10,
264.32 1993, an institutionalized person, an institutionalized person's spouse, or any person, court,
264.33 or administrative body with legal authority to act in place of, on behalf of, at the direction

265.1 of, or upon the request of the institutionalized person or institutionalized person's spouse,
265.2 may not give away, sell, or dispose of, for less than fair market value, any asset or interest
265.3 therein, except assets other than the homestead that are excluded under the Supplemental
265.4 Security Income program, for the purpose of establishing or maintaining medical assistance
265.5 eligibility. This applies to all transfers, including those made by a community spouse after
265.6 the month in which the institutionalized spouse is determined eligible for medical assistance.
265.7 For purposes of determining eligibility for long-term care services, any transfer of such
265.8 assets within 36 months before or any time after an institutionalized person requests medical
265.9 assistance payment of long-term care services, or 36 months before or any time after a
265.10 medical assistance recipient becomes an institutionalized person, for less than fair market
265.11 value may be considered. Any such transfer is presumed to have been made for the purpose
265.12 of establishing or maintaining medical assistance eligibility and the institutionalized person
265.13 is ineligible for long-term care services for the period of time determined under subdivision
265.14 2, unless the institutionalized person furnishes convincing evidence to establish that the
265.15 transaction was exclusively for another purpose, or unless the transfer is permitted under
265.16 subdivision 3 or 4. In the case of payments from a trust or portions of a trust that are
265.17 considered transfers of assets under federal law, or in the case of any other disposal of assets
265.18 made on or after February 8, 2006, any transfers made within 60 months before or any time
265.19 after an institutionalized person requests medical assistance payment of long-term care
265.20 services and within 60 months before or any time after a medical assistance recipient becomes
265.21 an institutionalized person, may be considered.

265.22 (b) This section applies to transfers, for less than fair market value, of income or assets,
265.23 including assets that are considered income in the month received, such as inheritances,
265.24 court settlements, and retroactive benefit payments or income to which the institutionalized
265.25 person or the institutionalized person's spouse is entitled but does not receive due to action
265.26 by the institutionalized person, the institutionalized person's spouse, or any person, court,
265.27 or administrative body with legal authority to act in place of, on behalf of, at the direction
265.28 of, or upon the request of the institutionalized person or the institutionalized person's spouse.

265.29 (c) This section applies to payments for care or personal services provided by a relative,
265.30 unless the compensation was stipulated in a notarized, written agreement ~~which~~ that was
265.31 in existence when the service was performed, the care or services directly benefited the
265.32 person, and the payments made represented reasonable compensation for the care or services
265.33 provided. A notarized written agreement is not required if payment for the services was
265.34 made within 60 days after the service was provided.

266.1 ~~(d) This section applies to the portion of any asset or interest that an institutionalized~~
266.2 ~~person, an institutionalized person's spouse, or any person, court, or administrative body~~
266.3 ~~with legal authority to act in place of, on behalf of, at the direction of, or upon the request~~
266.4 ~~of the institutionalized person or the institutionalized person's spouse, transfers to any~~
266.5 ~~annuity that exceeds the value of the benefit likely to be returned to the institutionalized~~
266.6 ~~person or institutionalized person's spouse while alive, based on estimated life expectancy~~
266.7 ~~as determined according to the current actuarial tables published by the Office of the Chief~~
266.8 ~~Actuary of the Social Security Administration. The commissioner may adopt rules reducing~~
266.9 ~~life expectancies based on the need for long-term care. This section applies to an annuity~~
266.10 ~~purchased on or after March 1, 2002, that:~~

266.11 ~~(1) is not purchased from an insurance company or financial institution that is subject~~
266.12 ~~to licensing or regulation by the Minnesota Department of Commerce or a similar regulatory~~
266.13 ~~agency of another state;~~

266.14 ~~(2) does not pay out principal and interest in equal monthly installments; or~~

266.15 ~~(3) does not begin payment at the earliest possible date after annuitization.~~

266.16 ~~(e)~~ (d) Effective for transactions, including the purchase of an annuity, occurring on or
266.17 after February 8, 2006, by or on behalf of an institutionalized person who has applied for
266.18 or is receiving long-term care services or the institutionalized person's spouse shall be treated
266.19 as the disposal of an asset for less than fair market value unless the department is named a
266.20 preferred remainder beneficiary as described in section 256B.056, subdivision 11. Any
266.21 subsequent change to the designation of the department as a preferred remainder beneficiary
266.22 shall result in the annuity being treated as a disposal of assets for less than fair market value.
266.23 The amount of such transfer shall be the maximum amount the institutionalized person or
266.24 the institutionalized person's spouse could receive from the annuity or similar financial
266.25 instrument. Any change in the amount of the income or principal being withdrawn from the
266.26 annuity or other similar financial instrument at the time of the most recent disclosure shall
266.27 be deemed to be a transfer of assets for less than fair market value unless the institutionalized
266.28 person or the institutionalized person's spouse demonstrates that the transaction was for fair
266.29 market value. In the event a distribution of income or principal has been improperly
266.30 distributed or disbursed from an annuity or other retirement planning instrument of an
266.31 institutionalized person or the institutionalized person's spouse, a cause of action exists
266.32 against the individual receiving the improper distribution for the cost of medical assistance
266.33 services provided or the amount of the improper distribution, whichever is less.

267.1 ~~(f)~~ (e) Effective for transactions, including the purchase of an annuity, occurring on or
267.2 after February 8, 2006, by or on behalf of an institutionalized person applying for or receiving
267.3 long-term care services shall be treated as a disposal of assets for less than fair market value
267.4 unless it is:

267.5 (1) an annuity described in subsection (b) or (q) of section 408 of the Internal Revenue
267.6 Code of 1986; or

267.7 (2) purchased with proceeds from:

267.8 (i) an account or trust described in subsection (a), (c), or (p) of section 408 of the Internal
267.9 Revenue Code;

267.10 (ii) a simplified employee pension within the meaning of section 408(k) of the Internal
267.11 Revenue Code; or

267.12 (iii) a Roth IRA described in section 408A of the Internal Revenue Code; or

267.13 (3) an annuity that is irrevocable and nonassignable; is actuarially sound as determined
267.14 in accordance with actuarial publications of the Office of the Chief Actuary of the Social
267.15 Security Administration; and provides for payments in equal amounts during the term of
267.16 the annuity, with no deferral and no balloon payments made.

267.17 ~~(g)~~ (f) For purposes of this section, long-term care services include services in a nursing
267.18 facility, services that are eligible for payment according to section 256B.0625, subdivision
267.19 2, because they are provided in a swing bed, intermediate care facility for persons with
267.20 developmental disabilities, and home and community-based services provided pursuant to
267.21 chapter 256S and sections 256B.092 and 256B.49. For purposes of this subdivision and
267.22 subdivisions 2, 3, and 4, "institutionalized person" includes a person who is an inpatient in
267.23 a nursing facility or in a swing bed, or intermediate care facility for persons with
267.24 developmental disabilities or who is receiving home and community-based services under
267.25 chapter 256S and sections 256B.092 and 256B.49.

267.26 ~~(h)~~ (g) This section applies to funds used to purchase a promissory note, loan, or mortgage
267.27 unless the note, loan, or mortgage:

267.28 (1) has a repayment term that is actuarially sound;

267.29 (2) provides for payments to be made in equal amounts during the term of the loan, with
267.30 no deferral and no balloon payments made; and

267.31 (3) prohibits the cancellation of the balance upon the death of the lender.

268.1 (h) In the case of a promissory note, loan, or mortgage that does not meet an exception
268.2 in paragraph (g), clauses (1) to (3), the value of such note, loan, or mortgage shall be the
268.3 outstanding balance due as of the date of the institutionalized person's request for medical
268.4 assistance payment of long-term care services.

268.5 (i) This section applies to the purchase of a life estate interest in another person's home
268.6 unless the purchaser resides in the home for a period of at least one year after the date of
268.7 purchase.

268.8 (j) This section applies to transfers into a pooled trust that qualifies under United States
268.9 Code, title 42, section 1396p(d)(4)(C), by:

268.10 (1) a person age 65 or older or the person's spouse; or

268.11 (2) any person, court, or administrative body with legal authority to act in place of, on
268.12 behalf of, at the direction of, or upon the request of a person age 65 or older or the person's
268.13 spouse.

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

268.15 Sec. 7. Minnesota Statutes 2021 Supplement, section 256B.0625, subdivision 3b, is
268.16 amended to read:

268.17 Subd. 3b. **Telehealth services.** (a) Medical assistance covers medically necessary services
268.18 and consultations delivered by a health care provider through telehealth in the same manner
268.19 as if the service or consultation was delivered through in-person contact. Services or
268.20 consultations delivered through telehealth shall be paid at the full allowable rate.

268.21 (b) The commissioner may establish criteria that a health care provider must attest to in
268.22 order to demonstrate the safety or efficacy of delivering a particular service through
268.23 telehealth. The attestation may include that the health care provider:

268.24 (1) has identified the categories or types of services the health care provider will provide
268.25 through telehealth;

268.26 (2) has written policies and procedures specific to services delivered through telehealth
268.27 that are regularly reviewed and updated;

268.28 (3) has policies and procedures that adequately address patient safety before, during,
268.29 and after the service is delivered through telehealth;

268.30 (4) has established protocols addressing how and when to discontinue telehealth services;
268.31 and

269.1 (5) has an established quality assurance process related to delivering services through
269.2 telehealth.

269.3 (c) As a condition of payment, a licensed health care provider must document each
269.4 occurrence of a health service delivered through telehealth to a medical assistance enrollee.
269.5 Health care service records for services delivered through telehealth must meet the
269.6 requirements set forth in Minnesota Rules, part 9505.2175, subparts 1 and 2, and must
269.7 document:

269.8 (1) the type of service delivered through telehealth;

269.9 (2) the time the service began and the time the service ended, including an a.m. and p.m.
269.10 designation;

269.11 (3) the health care provider's basis for determining that telehealth is an appropriate and
269.12 effective means for delivering the service to the enrollee;

269.13 (4) the mode of transmission used to deliver the service through telehealth and records
269.14 evidencing that a particular mode of transmission was utilized;

269.15 (5) the location of the originating site and the distant site;

269.16 (6) if the claim for payment is based on a physician's consultation with another physician
269.17 through telehealth, the written opinion from the consulting physician providing the telehealth
269.18 consultation; and

269.19 (7) compliance with the criteria attested to by the health care provider in accordance
269.20 with paragraph (b).

269.21 (d) Telehealth visits, ~~as described in this subdivision provided through audio and visual~~
269.22 ~~communication~~, may be used to satisfy the face-to-face requirement for reimbursement
269.23 under the payment methods that apply to a federally qualified health center, rural health
269.24 clinic, Indian health service, 638 Tribal clinic, and certified community behavioral health
269.25 clinic, if the service would have otherwise qualified for payment if performed in person.

269.26 (e) For mental health services or assessments delivered through telehealth that are based
269.27 on an individual treatment plan, the provider may document the client's verbal approval or
269.28 electronic written approval of the treatment plan or change in the treatment plan in lieu of
269.29 the client's signature in accordance with Minnesota Rules, part 9505.0371.

269.30 (f) For purposes of this subdivision, unless otherwise covered under this chapter:

269.31 (1) "telehealth" means the delivery of health care services or consultations ~~through the~~
269.32 ~~use of~~ using real-time two-way interactive audio and visual communication or accessible

270.1 telemedicine video-based platforms to provide or support health care delivery and facilitate
 270.2 the assessment, diagnosis, consultation, treatment, education, and care management of a
 270.3 patient's health care. Telehealth includes the application of secure video conferencing;
 270.4 consisting of a real-time, full-motion synchronized video; store-and-forward technology;
 270.5 and synchronous interactions between a patient located at an originating site and a health
 270.6 care provider located at a distant site. Telehealth does not include communication between
 270.7 health care providers, or between a health care provider and a patient that consists solely
 270.8 of an audio-only communication, e-mail, or facsimile transmission or as specified by law;

270.9 (2) "health care provider" means:

270.10 (i) a health care provider as defined under section 62A.673;

270.11 (ii) a community paramedic as defined under section 144E.001, subdivision 5;

270.12 (iii) a community health worker who meets the criteria under subdivision 49, paragraph

270.13 (a);

270.14 (iv) a mental health certified peer specialist under section 256B.0615, subdivision 5;

270.15 (v) a mental health certified family peer specialist under section 256B.0616, subdivision
 270.16 5;

270.17 (vi) a mental health rehabilitation worker under section 256B.0623, subdivision 5,
 270.18 paragraph (a), clause (4), and paragraph (b);

270.19 (vii) a mental health behavioral aide under section 256B.0943, subdivision 7, paragraph
 270.20 (b), clause (3);

270.21 (viii) a treatment coordinator under section 245G.11, subdivision 7;

270.22 (ix) an alcohol and drug counselor under section 245G.11, subdivision 5; or

270.23 (x) a recovery peer under section 245G.11, subdivision 8; and

270.24 (3) "originating site," "distant site," and "store-and-forward technology" have the
 270.25 meanings given in section 62A.673, subdivision 2.

270.26 Sec. 8. Minnesota Statutes 2020, section 256B.0625, subdivision 64, is amended to read:

270.27 Subd. 64. **Investigational drugs, biological products, devices, and clinical**

270.28 **trials.** Medical assistance and the early periodic screening, diagnosis, and treatment (EPSDT)

270.29 program do not cover ~~the costs of any services that are incidental to, associated with, or~~

270.30 ~~resulting from the use of~~ investigational drugs, biological products, or devices as defined

270.31 in section 151.375 or any other treatment that is part of an approved clinical trial as defined

271.1 in section 62Q.526. Participation of an enrollee in an approved clinical trial does not preclude
271.2 coverage of medically necessary services covered under this chapter that are not related to
271.3 the approved clinical trial. Any items or services that are provided solely to satisfy data
271.4 collection and analysis for a clinical trial, and not for direct clinical management of the
271.5 enrollee, are not covered.

271.6 Sec. 9. **[256B.6903] OMBUDSPERSON FOR MANAGED CARE.**

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

271.9 (b) "Adverse benefit determination" has the meaning provided in Code of Federal
271.10 Regulations, title 42, section 438.400, subpart (b).

271.11 (c) "Appeal" means an oral or written request from an enrollee to the managed care
271.12 organization for review of an adverse benefit determination.

271.13 (d) "Commissioner" means the commissioner of human services.

271.14 (e) "Complaint" means an enrollee's informal expression of dissatisfaction about any
271.15 matter relating to the enrollee's prepaid health plan other than an adverse benefit
271.16 determination.

271.17 (f) "Data analyst" means the person employed by the ombudsperson that uses research
271.18 methodologies to conduct research on data collected from prepaid health plans, including
271.19 but not limited to scientific theory; hypothesis testing; survey research techniques; data
271.20 collection; data manipulation; and statistical analysis interpretation, including multiple
271.21 regression techniques.

271.22 (g) "Enrollee" means a person enrolled in a prepaid health plan under section 256B.69.
271.23 When applicable, an enrollee includes an enrollee's authorized representative.

271.24 (h) "External review" means the process described under Code of Federal Regulations,
271.25 title 42, section 438.408, subpart (f); and section 62Q.73, subdivision 2.

271.26 (i) "Grievance" means an enrollee's expression of dissatisfaction about any matter relating
271.27 to the enrollee's prepaid health plan other than an adverse benefit determination that follows
271.28 the procedures outlined in Code of Federal Regulations, title 42, part 438, subpart (f). A
271.29 grievance may include but is not limited to concerns relating to quality of care, services
271.30 provided, or failure to respect an enrollee's rights under a prepaid health plan.

272.1 (j) "Managed care advocate" means a county or Tribal employee who works with
272.2 managed care enrollees when the enrollee has service, billing, or access problems with the
272.3 enrollee's prepaid health plan.

272.4 (k) "Prepaid health plan" means a plan under contract with the commissioner according
272.5 to section 256B.69.

272.6 (l) "State fair hearing" means the appeals process mandated under section 256.045,
272.7 subdivision 3a.

272.8 Subd. 2. **Ombudsperson.** The commissioner must designate an ombudsperson to advocate
272.9 for enrollees. At the time of enrollment in a prepaid health plan, the local agency must
272.10 inform enrollees about the ombudsperson.

272.11 Subd. 3. **Duties and cost.** (a) The ombudsperson must work to ensure enrollees receive
272.12 covered services as described in the enrollee's prepaid health plan by:

272.13 (1) providing assistance and education to enrollees, when requested, regarding covered
272.14 health care benefits or services; billing and access; or the grievance, appeal, or state fair
272.15 hearing processes;

272.16 (2) with the enrollee's permission and within the ombudsperson's discretion, using an
272.17 informal review process to assist an enrollee with a resolution involving the enrollee's
272.18 prepaid health plan's benefits;

272.19 (3) assisting enrollees, when requested, with prepaid health plan grievances, appeals, or
272.20 the state fair hearing process;

272.21 (4) overseeing, reviewing, and approving documents used by enrollees relating to prepaid
272.22 health plans' grievances, appeals, and state fair hearings;

272.23 (5) reviewing all state fair hearings and requests by enrollees for external review;
272.24 overseeing entities under contract to provide external reviews, processes, and payments for
272.25 services; and utilizing aggregated results of external reviews to recommend health care
272.26 benefits policy changes; and

272.27 (6) providing trainings to managed care advocates.

272.28 (b) The ombudsperson must not charge an enrollee for the ombudsperson's services.

272.29 Subd. 4. **Powers.** In exercising the ombudsperson's authority under this section, the
272.30 ombudsperson may:

272.31 (1) gather information and evaluate any practice, policy, procedure, or action by a prepaid
272.32 health plan, state human services agency, county, or Tribe; and

- 273.1 (2) prescribe the methods by which complaints are to be made, received, and acted upon.
- 273.2 The ombudsperson's authority under this clause includes but is not limited to:
- 273.3 (i) determining the scope and manner of a complaint;
- 273.4 (ii) holding a prepaid health plan accountable to address a complaint in a timely manner
- 273.5 as outlined in state and federal laws;
- 273.6 (iii) requiring a prepaid health plan to respond in a timely manner to a request for data,
- 273.7 case details, and other information as needed to help resolve a complaint or to improve a
- 273.8 prepaid health plan's policy; and
- 273.9 (iv) making recommendations for policy, administrative, or legislative changes regarding
- 273.10 prepaid health plans to the proper partners.
- 273.11 Subd. 5. **Data.** (a) The data analyst must review and analyze prepaid health plan data
- 273.12 on denial, termination, and reduction notices (DTRs), grievances, appeals, and state fair
- 273.13 hearings by:
- 273.14 (1) analyzing, reviewing, and reporting on DTRs, grievances, appeals, and state fair
- 273.15 hearings data collected from each prepaid health plan;
- 273.16 (2) collaborating with the commissioner's partners and the Department of Health for the
- 273.17 Triennial Compliance Assessment under Code of Federal Regulations, title 42, section
- 273.18 438.358, subpart (b);
- 273.19 (3) reviewing state fair hearing decisions for policy or coverage issues that may affect
- 273.20 enrollees; and
- 273.21 (4) providing data required under Code of Federal Regulations, title 42, section 438.66
- 273.22 (2016), to the Centers for Medicare and Medicaid Services.
- 273.23 (b) The data analyst must share the data analyst's data observations and trends under
- 273.24 this subdivision with the ombudsperson, prepaid health plans, and commissioner's partners.
- 273.25 Subd. 6. **Collaboration and independence.** (a) The ombudsperson must work in
- 273.26 collaboration with the commissioner and the commissioner's partners when the
- 273.27 ombudsperson's collaboration does not otherwise interfere with the ombudsperson's duties
- 273.28 under this section.
- 273.29 (b) The ombudsperson may act independently of the commissioner when:
- 273.30 (1) providing information or testimony to the legislature; and
- 273.31 (2) contacting and making reports to federal and state officials.

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

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

274.5 Sec. 10. Minnesota Statutes 2020, section 256B.77, subdivision 13, is amended to read:

274.6 Subd. 13. **Ombudsman.** Enrollees shall have access to ombudsman services established
274.7 in section ~~256B.69, subdivision 20~~ 256B.6903, and advocacy services provided by the
274.8 ombudsman for mental health and developmental disabilities established in sections 245.91
274.9 to 245.97. The managed care ombudsman and the ombudsman for mental health and
274.10 developmental disabilities shall coordinate services provided to avoid duplication of services.
274.11 For purposes of the demonstration project, the powers and responsibilities of the Office of
274.12 Ombudsman for Mental Health and Developmental Disabilities, as provided in sections
274.13 245.91 to 245.97 are expanded to include all eligible individuals, health plan companies,
274.14 agencies, and providers participating in the demonstration project.

274.15 Sec. 11. **REPEALER.**

274.16 (a) Minnesota Statutes 2020, section 256B.057, subdivision 7, is repealed on July 1,
274.17 2022.

274.18 (b) Minnesota Statutes 2020, sections 256B.69, subdivision 20; 501C.0408, subdivision
274.19 4; and 501C.1206, are repealed the day following final enactment.

274.20 **ARTICLE 5**

274.21 **HEALTH-RELATED LICENSING BOARDS**

274.22 Section 1. Minnesota Statutes 2020, section 148B.33, is amended by adding a subdivision
274.23 to read:

274.24 Subd. 1a. **Supervision requirement; postgraduate experience.** The board must allow
274.25 an applicant to satisfy the requirement for supervised postgraduate experience in marriage
274.26 and family therapy with all required hours of supervision provided through real-time,
274.27 two-way interactive audio and visual communication.

274.28 **EFFECTIVE DATE.** This section is effective the day following final enactment and
274.29 applies to supervision requirements in effect on or after that date.

275.1 Sec. 2. Minnesota Statutes 2021 Supplement, section 148B.5301, subdivision 2, is amended
275.2 to read:

275.3 Subd. 2. **Supervision.** (a) To qualify as a LPCC, an applicant must have completed
275.4 4,000 hours of post-master's degree supervised professional practice in the delivery of
275.5 clinical services in the diagnosis and treatment of mental illnesses and disorders in both
275.6 children and adults. The supervised practice shall be conducted according to the requirements
275.7 in paragraphs (b) to (e).

275.8 (b) The supervision must have been received under a contract that defines clinical practice
275.9 and supervision from a mental health professional who is qualified according to section
275.10 245I.04, subdivision 2, or by a board-approved supervisor, who has at least two years of
275.11 postlicensure experience in the delivery of clinical services in the diagnosis and treatment
275.12 of mental illnesses and disorders. All supervisors must meet the supervisor requirements in
275.13 Minnesota Rules, part 2150.5010.

275.14 (c) The supervision must be obtained at the rate of two hours of supervision per 40 hours
275.15 of professional practice. The supervision must be evenly distributed over the course of the
275.16 supervised professional practice. At least 75 percent of the required supervision hours must
275.17 be received in person or through real-time, two-way interactive audio and visual
275.18 communication, and the board must allow an applicant to satisfy this supervision requirement
275.19 with all required hours of supervision received through real-time, two-way interactive audio
275.20 and visual communication. The remaining 25 percent of the required hours may be received
275.21 by telephone or by audio or audiovisual electronic device. At least 50 percent of the required
275.22 hours of supervision must be received on an individual basis. The remaining 50 percent
275.23 may be received in a group setting.

275.24 (d) The supervised practice must include at least 1,800 hours of clinical client contact.

275.25 (e) The supervised practice must be clinical practice. Supervision includes the observation
275.26 by the supervisor of the successful application of professional counseling knowledge, skills,
275.27 and values in the differential diagnosis and treatment of psychosocial function, disability,
275.28 or impairment, including addictions and emotional, mental, and behavioral disorders.

275.29 **EFFECTIVE DATE.** This section is effective the day following final enactment and
275.30 applies to supervision requirements in effect on or after that date.

275.31 Sec. 3. Minnesota Statutes 2020, section 148E.100, subdivision 3, is amended to read:

275.32 Subd. 3. **Types of supervision.** Of the 100 hours of supervision required under
275.33 subdivision 1:

276.1 (1) 50 hours must be provided through one-on-one supervision, ~~including: (i) a minimum~~
276.2 ~~of 25 hours of in-person supervision, and (ii) no more than 25 hours of supervision.~~ The
276.3 supervision must be provided either in person or via eye-to-eye electronic media, while
276.4 maintaining visual contact. The board must allow a licensed social worker to satisfy the
276.5 supervision requirement of this clause with all required hours of supervision provided via
276.6 eye-to-eye electronic media, while maintaining visual contact; and

276.7 (2) 50 hours must be provided through: (i) one-on-one supervision, or (ii) group
276.8 supervision. The supervision may be in person, by telephone, or via eye-to-eye electronic
276.9 media, while maintaining visual contact. The supervision must not be provided by e-mail.
276.10 Group supervision is limited to six supervisees.

276.11 **EFFECTIVE DATE.** This section is effective the day following final enactment and
276.12 applies to supervision requirements in effect on or after that date.

276.13 Sec. 4. Minnesota Statutes 2020, section 148E.105, subdivision 3, is amended to read:

276.14 Subd. 3. **Types of supervision.** Of the 100 hours of supervision required under
276.15 subdivision 1:

276.16 (1) 50 hours must be provided ~~though~~ through one-on-one supervision, ~~including: (i) a~~
276.17 ~~minimum of 25 hours of in-person supervision, and (ii) no more than 25 hours of supervision.~~
276.18 The supervision must be provided either in person or via eye-to-eye electronic media, while
276.19 maintaining visual contact. The board must allow a licensed graduate social worker to satisfy
276.20 the supervision requirement of this clause with all required hours of supervision provided
276.21 via eye-to-eye electronic media, while maintaining visual contact; and

276.22 (2) 50 hours must be provided through: (i) one-on-one supervision, or (ii) group
276.23 supervision. The supervision may be in person, by telephone, or via eye-to-eye electronic
276.24 media, while maintaining visual contact. The supervision must not be provided by e-mail.
276.25 Group supervision is limited to six supervisees.

276.26 **EFFECTIVE DATE.** This section is effective the day following final enactment and
276.27 applies to supervision requirements in effect on or after that date.

276.28 Sec. 5. Minnesota Statutes 2020, section 148E.106, subdivision 3, is amended to read:

276.29 Subd. 3. **Types of supervision.** Of the 200 hours of supervision required under
276.30 subdivision 1:

276.31 (1) 100 hours must be provided through one-on-one supervision, ~~including: (i) a minimum~~
276.32 ~~of 50 hours of in-person supervision, and (ii) no more than 50 hours of supervision.~~ The

277.1 supervision must be provided either in person or via eye-to-eye electronic media, while
277.2 maintaining visual contact. The board must allow a licensed graduate social worker to satisfy
277.3 the supervision requirement of this clause with all required hours of supervision provided
277.4 via eye-to-eye electronic media, while maintaining visual contact; and

277.5 (2) 100 hours must be provided through: (i) one-on-one supervision, or (ii) group
277.6 supervision. The supervision may be in person, by telephone, or via eye-to-eye electronic
277.7 media, while maintaining visual contact. The supervision must not be provided by e-mail.
277.8 Group supervision is limited to six supervisees.

277.9 **EFFECTIVE DATE.** This section is effective the day following final enactment and
277.10 applies to supervision requirements in effect on or after that date.

277.11 Sec. 6. Minnesota Statutes 2020, section 148E.110, subdivision 7, is amended to read:

277.12 Subd. 7. **Supervision; clinical social work practice after licensure as licensed**
277.13 **independent social worker.** Of the 200 hours of supervision required under subdivision
277.14 5:

277.15 (1) 100 hours must be provided through one-on-one supervision, ~~including.~~ The
277.16 supervision must be provided either in person or via eye-to-eye electronic media, while
277.17 maintaining visual contact. The board must allow a licensed independent social worker to
277.18 satisfy the supervision requirement of this clause with all required hours of supervision
277.19 provided via eye-to-eye electronic media, while maintaining visual contact; and

277.20 ~~(i) a minimum of 50 hours of in-person supervision; and~~

277.21 ~~(ii) no more than 50 hours of supervision via eye-to-eye electronic media, while~~
277.22 ~~maintaining visual contact; and~~

277.23 (2) 100 hours must be provided through:

277.24 (i) one-on-one supervision; or

277.25 (ii) group supervision.

277.26 The supervision may be in person, by telephone, or via eye-to-eye electronic media, while
277.27 maintaining visual contact. The supervision must not be provided by e-mail. Group
277.28 supervision is limited to six supervisees.

277.29 **EFFECTIVE DATE.** This section is effective the day following final enactment and
277.30 applies to supervision requirements in effect on or after that date.

278.1 Sec. 7. Minnesota Statutes 2020, section 150A.06, subdivision 1c, is amended to read:

278.2 Subd. 1c. **Specialty dentists.** (a) The board may grant one or more specialty licenses in
278.3 the specialty areas of dentistry that are recognized by the Commission on Dental
278.4 Accreditation.

278.5 (b) An applicant for a specialty license shall:

278.6 (1) have successfully completed a postdoctoral specialty program accredited by the
278.7 Commission on Dental Accreditation, or have announced a limitation of practice before
278.8 1967;

278.9 (2) have been certified by a specialty board approved by the Minnesota Board of
278.10 Dentistry, or provide evidence of having passed a clinical examination for licensure required
278.11 for practice in any state or Canadian province, or in the case of oral and maxillofacial
278.12 surgeons only, have a Minnesota medical license in good standing;

278.13 (3) have been in active practice or a postdoctoral specialty education program or United
278.14 States government service at least 2,000 hours in the 36 months prior to applying for a
278.15 specialty license;

278.16 (4) if requested by the board, be interviewed by a committee of the board, which may
278.17 include the assistance of specialists in the evaluation process, and satisfactorily respond to
278.18 questions designed to determine the applicant's knowledge of dental subjects and ability to
278.19 practice;

278.20 (5) if requested by the board, present complete records on a sample of patients treated
278.21 by the applicant. The sample must be drawn from patients treated by the applicant during
278.22 the 36 months preceding the date of application. The number of records shall be established
278.23 by the board. The records shall be reasonably representative of the treatment typically
278.24 provided by the applicant for each specialty area;

278.25 (6) at board discretion, pass a board-approved English proficiency test if English is not
278.26 the applicant's primary language;

278.27 (7) pass all components of the National Board Dental Examinations;

278.28 (8) pass the Minnesota Board of Dentistry jurisprudence examination;

278.29 (9) abide by professional ethical conduct requirements; and

278.30 (10) meet all other requirements prescribed by the Board of Dentistry.

278.31 (c) The application must include:

- 279.1 (1) a completed application furnished by the board;
- 279.2 ~~(2) at least two character references from two different dentists for each specialty area,~~
279.3 ~~one of whom must be a dentist practicing in the same specialty area, and the other from the~~
279.4 ~~director of each specialty program attended;~~
- 279.5 ~~(3) a licensed physician's statement attesting to the applicant's physical and mental~~
279.6 ~~condition;~~
- 279.7 ~~(4) a statement from a licensed ophthalmologist or optometrist attesting to the applicant's~~
279.8 ~~visual acuity;~~
- 279.9 ~~(5) (2) a nonrefundable fee; and~~
- 279.10 ~~(6) (3) a notarized, unmounted passport-type photograph, three inches by three inches,~~
279.11 ~~taken not more than six months before the date of application~~ copy of the applicant's
279.12 government issued photo identification card.

279.13 (d) A specialty dentist holding one or more specialty licenses is limited to practicing in
279.14 the dentist's designated specialty area or areas. The scope of practice must be defined by
279.15 each national specialty board recognized by the Commission on Dental Accreditation.

279.16 (e) A specialty dentist holding a general dental license is limited to practicing in the
279.17 dentist's designated specialty area or areas if the dentist has announced a limitation of
279.18 practice. The scope of practice must be defined by each national specialty board recognized
279.19 by the Commission on Dental Accreditation.

279.20 (f) All specialty dentists who have fulfilled the specialty dentist requirements and who
279.21 intend to limit their practice to a particular specialty area or areas may apply for one or more
279.22 specialty licenses.

279.23 Sec. 8. Minnesota Statutes 2020, section 150A.06, subdivision 2c, is amended to read:

279.24 Subd. 2c. **Guest license.** (a) The board shall grant a guest license to practice as a dentist,
279.25 dental hygienist, or licensed dental assistant if the following conditions are met:

279.26 (1) the dentist, dental hygienist, or dental assistant is currently licensed in good standing
279.27 in another United States jurisdiction;

279.28 (2) the dentist, dental hygienist, or dental assistant is currently engaged in the practice
279.29 of that person's respective profession in another United States jurisdiction;

279.30 (3) the dentist, dental hygienist, or dental assistant will limit that person's practice to a
279.31 public health setting in Minnesota that (i) is approved by the board; (ii) was established by

280.1 a nonprofit organization that is tax exempt under chapter 501(c)(3) of the Internal Revenue
280.2 Code of 1986; and (iii) provides dental care to patients who have difficulty accessing dental
280.3 care;

280.4 (4) the dentist, dental hygienist, or dental assistant agrees to treat indigent patients who
280.5 meet the eligibility criteria established by the clinic; and

280.6 (5) the dentist, dental hygienist, or dental assistant has applied to the board for a guest
280.7 license and has paid a nonrefundable license fee to the board ~~not to exceed \$75~~.

280.8 (b) A guest license must be renewed annually with the board and an annual renewal fee
280.9 ~~not to exceed \$75~~ must be paid to the board. Guest licenses expire on December 31 of each
280.10 year.

280.11 (c) A dentist, dental hygienist, or dental assistant practicing under a guest license under
280.12 this subdivision shall have the same obligations as a dentist, dental hygienist, or dental
280.13 assistant who is licensed in Minnesota and shall be subject to the laws and rules of Minnesota
280.14 and the regulatory authority of the board. If the board suspends or revokes the guest license
280.15 of, or otherwise disciplines, a dentist, dental hygienist, or dental assistant practicing under
280.16 this subdivision, the board shall promptly report such disciplinary action to the dentist's,
280.17 dental hygienist's, or dental assistant's regulatory board in the jurisdictions in which they
280.18 are licensed.

280.19 (d) The board may grant a guest license to a dentist, dental hygienist, or dental assistant
280.20 licensed in another United States jurisdiction to provide dental care to patients on a voluntary
280.21 basis without compensation for a limited period of time. The board shall not assess a fee
280.22 for the guest license for volunteer services issued under this paragraph.

280.23 (e) The board shall issue a guest license for volunteer services if:

280.24 (1) the board determines that the applicant's services will provide dental care to patients
280.25 who have difficulty accessing dental care;

280.26 (2) the care will be provided without compensation; and

280.27 (3) the applicant provides adequate proof of the status of all licenses to practice in other
280.28 jurisdictions. The board may require such proof on an application form developed by the
280.29 board.

280.30 (f) The guest license for volunteer services shall limit the licensee to providing dental
280.31 care services for a period of time not to exceed ten days in a calendar year. Guest licenses
280.32 expire on December 31 of each year.

281.1 (g) The holder of a guest license for volunteer services shall be subject to state laws and
281.2 rules regarding dentistry and the regulatory authority of the board. The board may revoke
281.3 the license of a dentist, dental hygienist, or dental assistant practicing under this subdivision
281.4 or take other regulatory action against the dentist, dental hygienist, or dental assistant. If an
281.5 action is taken, the board shall report the action to the regulatory board of those jurisdictions
281.6 where an active license is held by the dentist, dental hygienist, or dental assistant.

281.7 Sec. 9. Minnesota Statutes 2020, section 150A.06, subdivision 6, is amended to read:

281.8 Subd. 6. **Display of name and certificates.** (a) The renewal certificate of ~~every dentist,~~
281.9 ~~dental therapist, dental hygienist, or dental assistant~~ every licensee or registrant must be
281.10 conspicuously displayed in plain sight of patients in every office in which that person
281.11 practices. Duplicate renewal certificates may be obtained from the board.

281.12 (b) Near or on the entrance door to every office where dentistry is practiced, the name
281.13 of each dentist practicing there, as inscribed on the current license certificate, must be
281.14 displayed in plain sight.

281.15 (c) The board must allow the display of a mini-license for guest license holders
281.16 performing volunteer dental services. There is no fee for the mini-license for guest volunteers.

281.17 Sec. 10. Minnesota Statutes 2020, section 150A.06, is amended by adding a subdivision
281.18 to read:

281.19 Subd. 12. **Licensure by credentials for dental therapy.** (a) Any dental therapist may,
281.20 upon application and payment of a fee established by the board, apply for licensure based
281.21 on an evaluation of the applicant's education, experience, and performance record. The
281.22 applicant may be interviewed by the board to determine if the applicant:

281.23 (1) graduated with a baccalaureate or master's degree from a dental therapy program
281.24 accredited by the Commission on Dental Accreditation;

281.25 (2) provided evidence of successfully completing the board's jurisprudence examination;

281.26 (3) actively practiced at least 2,000 hours within 36 months of the application date or
281.27 passed a board-approved reentry program within 36 months of the application date;

281.28 (4) either:

281.29 (i) is currently licensed in another state or Canadian province and not subject to any
281.30 pending or final disciplinary action; or

282.1 (ii) was previously licensed in another state or Canadian province in good standing and
282.2 not subject to any final or pending disciplinary action at the time of surrender;

282.3 (5) passed a board-approved English proficiency test if English is not the applicant's
282.4 primary language required at the board's discretion; and

282.5 (6) met all curriculum equivalency requirements regarding dental therapy scope of
282.6 practice in Minnesota.

282.7 (b) The 2,000 practice hours required by clause (3) may count toward the 2,000 practice
282.8 hours required for consideration for advanced dental therapy certification, provided that all
282.9 other requirements of section 150A.106, subdivision 1, are met.

282.10 (c) The board, at its discretion, may waive specific licensure requirements in paragraph
282.11 (a).

282.12 (d) The board must license an applicant who fulfills the conditions of this subdivision
282.13 and demonstrates the minimum knowledge in dental subjects required for licensure under
282.14 subdivision 1d to practice the applicant's profession.

282.15 (e) The board must deny the application if the applicant does not demonstrate the
282.16 minimum knowledge in dental subjects required for licensure under subdivision 1d. If
282.17 licensure is denied, the board may notify the applicant of any specific remedy the applicant
282.18 could take to qualify for licensure. A denial does not prohibit the applicant from applying
282.19 for licensure under subdivision 1d.

282.20 (e) A candidate may appeal a denied application to the board according to subdivision
282.21 4a.

282.22 Sec. 11. Minnesota Statutes 2020, section 150A.09, is amended to read:

282.23 **150A.09 ~~REGISTRATION OF LICENSES AND OR~~ REGISTRATION**
282.24 **CERTIFICATES.**

282.25 Subdivision 1. **Registration information and procedure.** On or before the license
282.26 certificate expiration date every ~~licensed dentist, dental therapist, dental hygienist, and~~
282.27 ~~dental assistant~~ licensee or registrant shall ~~transmit to the executive secretary of the board,~~
282.28 ~~pertinent information~~ submit the renewal required by the board, together with the applicable
282.29 fee established by the board under section 150A.091. At least 30 days before a license
282.30 certificate expiration date, the board shall send a written notice stating the amount and due
282.31 date of the fee ~~and the information to be provided to every licensed dentist, dental therapist,~~
282.32 ~~dental hygienist, and dental assistant.~~

283.1 Subd. 3. **Current address, change of address.** Every ~~dentist, dental therapist, dental~~
 283.2 ~~hygienist, and dental assistant~~ licensee or registrant shall maintain with the board a correct
 283.3 and current mailing address and electronic mail address. For dentists engaged in the practice
 283.4 of dentistry, the postal address shall be that of the location of the primary dental practice.
 283.5 Within 30 days after changing postal or electronic mail addresses, every ~~dentist, dental~~
 283.6 ~~therapist, dental hygienist, and dental assistant~~ licensee or registrant shall provide the board
 283.7 ~~written notice of the new address either personally or by first class mail.~~

283.8 Subd. 4. **Duplicate certificates.** Duplicate licenses or duplicate certificates of ~~license~~
 283.9 renewal may be issued by the board upon satisfactory proof of the need for the duplicates
 283.10 and upon payment of the fee established by the board.

283.11 Subd. 5. **Late fee.** A late fee established by the board shall be paid if the ~~information~~
 283.12 ~~and~~ fee required by subdivision 1 is not received by ~~the executive secretary~~ of the board on
 283.13 or before the registration or ~~license~~ renewal date.

283.14 Sec. 12. Minnesota Statutes 2020, section 150A.091, subdivision 2, is amended to read:

283.15 Subd. 2. **Application and initial license or registration fees.** Each applicant shall
 283.16 submit with a license, advanced dental therapist certificate, or permit application a
 283.17 nonrefundable fee in the following amounts in order to administratively process an
 283.18 application:

283.19 (1) dentist, ~~\$140~~ \$308;

283.20 (2) full faculty dentist, ~~\$140~~ \$308;

283.21 (3) limited faculty dentist, \$140;

283.22 (4) resident dentist or dental provider, \$55;

283.23 (5) advanced dental therapist, \$100;

283.24 (6) dental therapist, ~~\$100~~ \$220;

283.25 (7) dental hygienist, ~~\$55~~ \$115;

283.26 (8) licensed dental assistant, ~~\$55; and~~ \$115;

283.27 (9) dental assistant with a ~~permit~~ registration as described in Minnesota Rules, part
 283.28 3100.8500, subpart 3, ~~\$15;~~ \$27; and

283.29 (10) guest license, \$50.

284.1 Sec. 13. Minnesota Statutes 2020, section 150A.091, subdivision 5, is amended to read:

284.2 Subd. 5. **Biennial license or permit registration renewal fees.** Each of the following
284.3 applicants shall submit with a biennial license or permit renewal application a fee as
284.4 established by the board, not to exceed the following amounts:

284.5 (1) dentist or full faculty dentist, \$475;

284.6 (2) dental therapist, \$300;

284.7 (3) dental hygienist, \$200;

284.8 (4) licensed dental assistant, \$150; and

284.9 (5) dental assistant with a permit registration as described in Minnesota Rules, part
284.10 3100.8500, subpart 3, \$24.

284.11 Sec. 14. Minnesota Statutes 2020, section 150A.091, subdivision 8, is amended to read:

284.12 Subd. 8. **Duplicate license or certificate fee.** Each applicant shall submit, with a request
284.13 for issuance of a duplicate of the original license, or of an annual or biennial renewal
284.14 certificate for a license or permit, a fee in the following amounts:

284.15 (1) original dentist, full faculty dentist, dental therapist, dental hygiene, or dental assistant
284.16 license, \$35; and

284.17 (2) annual or biennial renewal certificates, \$10; ~~and~~

284.18 ~~(3) wallet-sized license and renewal certificate, \$15.~~

284.19 Sec. 15. Minnesota Statutes 2020, section 150A.091, subdivision 9, is amended to read:

284.20 Subd. 9. **Licensure by credentials.** Each applicant for licensure as a dentist, dental
284.21 hygienist, or dental assistant by credentials pursuant to section 150A.06, subdivisions 4 and
284.22 8, and Minnesota Rules, part 3100.1400, shall submit with the license application a fee in
284.23 the following amounts:

284.24 (1) dentist, ~~\$725~~ \$893;

284.25 (2) dental hygienist, ~~\$175; and~~ \$235;

284.26 (3) dental assistant, ~~\$35.~~ \$71; and

284.27 (4) dental therapist, \$340.

285.1 Sec. 16. Minnesota Statutes 2020, section 150A.091, is amended by adding a subdivision
285.2 to read:

285.3 Subd. 21. **Failure to practice with a current license.** (a) If a licensee practices without
285.4 a current license and pursues reinstatement, the board may take the following administrative
285.5 actions based on the length of time practicing without a current license:

285.6 (1) for under one month, the board may not assess a penalty fee;

285.7 (2) for one month to six months, the board may assess a penalty of \$250;

285.8 (3) for over six months, the board may assess a penalty of \$500; and

285.9 (4) for over 12 months, the board may assess a penalty of \$1,000.

285.10 (b) In addition to the penalty fee, the board shall initiate the complaint process against
285.11 the licensee for failure to practice with a current license for over 12 months.

285.12 Sec. 17. Minnesota Statutes 2020, section 150A.091, is amended by adding a subdivision
285.13 to read:

285.14 Subd. 22. **Delegating regulated procedures to an individual with a terminated**
285.15 **license.** (a) If a dentist or dental therapist delegates regulated procedures to another dental
285.16 professional who had their license terminated, the board may take the following
285.17 administrative actions against the delegating dentist or dental therapist based on the length
285.18 of time they delegated regulated procedures:

285.19 (1) for under one month, the board may not assess a penalty fee;

285.20 (2) for one month to six months, the board may assess a penalty of \$100;

285.21 (3) for over six months, the board may assess a penalty of \$250; and

285.22 (4) for over 12 months, the board may assess a penalty of \$500.

285.23 (b) In addition to the penalty fee, the board shall initiate the complaint process against
285.24 a dentist or dental therapist who delegated regulated procedures to a dental professional
285.25 with a terminated license for over 12 months.

285.26 Sec. 18. Minnesota Statutes 2020, section 151.01, subdivision 27, is amended to read:

285.27 Subd. 27. **Practice of pharmacy.** "Practice of pharmacy" means:

285.28 (1) interpretation and evaluation of prescription drug orders;

286.1 (2) compounding, labeling, and dispensing drugs and devices (except labeling by a
286.2 manufacturer or packager of nonprescription drugs or commercially packaged legend drugs
286.3 and devices);

286.4 (3) participation in clinical interpretations and monitoring of drug therapy for assurance
286.5 of safe and effective use of drugs, including the performance of laboratory tests that are
286.6 waived under the federal Clinical Laboratory Improvement Act of 1988, United States Code,
286.7 title 42, section 263a et seq., provided that a pharmacist may interpret the results of laboratory
286.8 tests but may modify drug therapy only pursuant to a protocol or collaborative practice
286.9 agreement;

286.10 (4) participation in drug and therapeutic device selection; drug administration for first
286.11 dosage and medical emergencies; intramuscular and subcutaneous drug administration used
286.12 ~~for the treatment of alcohol or opioid dependence~~ under a prescription drug order; drug
286.13 regimen reviews; and drug or drug-related research;

286.14 (5) drug administration, through intramuscular and subcutaneous administration used
286.15 to treat mental illnesses as permitted under the following conditions:

286.16 (i) upon the order of a prescriber and the prescriber is notified after administration is
286.17 complete; or

286.18 (ii) pursuant to a protocol or collaborative practice agreement as defined by section
286.19 151.01, subdivisions 27b and 27c, and participation in the initiation, management,
286.20 modification, administration, and discontinuation of drug therapy is according to the protocol
286.21 or collaborative practice agreement between the pharmacist and a dentist, optometrist,
286.22 physician, podiatrist, or veterinarian, or an advanced practice registered nurse authorized
286.23 to prescribe, dispense, and administer under section 148.235. Any changes in drug therapy
286.24 or medication administration made pursuant to a protocol or collaborative practice agreement
286.25 must be documented by the pharmacist in the patient's medical record or reported by the
286.26 pharmacist to a practitioner responsible for the patient's care;

286.27 (6) participation in administration of influenza vaccines and vaccines approved by the
286.28 United States Food and Drug Administration related to COVID-19 or SARS-CoV-2 to all
286.29 eligible individuals six years of age and older and all other vaccines to patients 13 years of
286.30 age and older by written protocol with a physician licensed under chapter 147, a physician
286.31 assistant authorized to prescribe drugs under chapter 147A, or an advanced practice registered
286.32 nurse authorized to prescribe drugs under section 148.235, provided that:

286.33 (i) the protocol includes, at a minimum:

- 287.1 (A) the name, dose, and route of each vaccine that may be given;
- 287.2 (B) the patient population for whom the vaccine may be given;
- 287.3 (C) contraindications and precautions to the vaccine;
- 287.4 (D) the procedure for handling an adverse reaction;
- 287.5 (E) the name, signature, and address of the physician, physician assistant, or advanced
287.6 practice registered nurse;
- 287.7 (F) a telephone number at which the physician, physician assistant, or advanced practice
287.8 registered nurse can be contacted; and
- 287.9 (G) the date and time period for which the protocol is valid;
- 287.10 (ii) the pharmacist has successfully completed a program approved by the Accreditation
287.11 Council for Pharmacy Education specifically for the administration of immunizations or a
287.12 program approved by the board;
- 287.13 (iii) the pharmacist utilizes the Minnesota Immunization Information Connection to
287.14 assess the immunization status of individuals prior to the administration of vaccines, except
287.15 when administering influenza vaccines to individuals age nine and older;
- 287.16 (iv) the pharmacist reports the administration of the immunization to the Minnesota
287.17 Immunization Information Connection; and
- 287.18 (v) the pharmacist complies with guidelines for vaccines and immunizations established
287.19 by the federal Advisory Committee on Immunization Practices, except that a pharmacist
287.20 does not need to comply with those portions of the guidelines that establish immunization
287.21 schedules when administering a vaccine pursuant to a valid, patient-specific order issued
287.22 by a physician licensed under chapter 147, a physician assistant authorized to prescribe
287.23 drugs under chapter 147A, or an advanced practice registered nurse authorized to prescribe
287.24 drugs under section 148.235, provided that the order is consistent with the United States
287.25 Food and Drug Administration approved labeling of the vaccine;
- 287.26 (7) participation in the initiation, management, modification, and discontinuation of
287.27 drug therapy according to a written protocol or collaborative practice agreement between:
287.28 (i) one or more pharmacists and one or more dentists, optometrists, physicians, podiatrists,
287.29 or veterinarians; or (ii) one or more pharmacists and one or more physician assistants
287.30 authorized to prescribe, dispense, and administer under chapter 147A, or advanced practice
287.31 registered nurses authorized to prescribe, dispense, and administer under section 148.235.
287.32 Any changes in drug therapy made pursuant to a protocol or collaborative practice agreement

288.1 must be documented by the pharmacist in the patient's medical record or reported by the
288.2 pharmacist to a practitioner responsible for the patient's care;

288.3 (8) participation in the storage of drugs and the maintenance of records;

288.4 (9) patient counseling on therapeutic values, content, hazards, and uses of drugs and
288.5 devices;

288.6 (10) offering or performing those acts, services, operations, or transactions necessary
288.7 in the conduct, operation, management, and control of a pharmacy;

288.8 (11) participation in the initiation, management, modification, and discontinuation of
288.9 therapy with opiate antagonists, as defined in section 604A.04, subdivision 1, pursuant to:

288.10 (i) a written protocol as allowed under clause (7); or

288.11 (ii) a written protocol with a community health board medical consultant or a practitioner
288.12 designated by the commissioner of health, as allowed under section 151.37, subdivision 13;
288.13 ~~and~~

288.14 (12) prescribing self-administered hormonal contraceptives; nicotine replacement
288.15 medications; and opiate antagonists for the treatment of an acute opiate overdose pursuant
288.16 to section 151.37, subdivision 14, 15, or 16; and

288.17 (13) participation in the placement of drug monitoring devices according to a prescription,
288.18 protocol, or collaborative practice agreement.

288.19 Sec. 19. Minnesota Statutes 2020, section 153.16, subdivision 1, is amended to read:

288.20 Subdivision 1. **License requirements.** The board shall issue a license to practice podiatric
288.21 medicine to a person who meets the following requirements:

288.22 (a) The applicant for a license shall file a written notarized application on forms provided
288.23 by the board, showing to the board's satisfaction that the applicant is of good moral character
288.24 and satisfies the requirements of this section.

288.25 (b) The applicant shall present evidence satisfactory to the board of being a graduate of
288.26 a podiatric medical school approved by the board based upon its faculty, curriculum, facilities,
288.27 accreditation by a recognized national accrediting organization approved by the board, and
288.28 other relevant factors.

288.29 (c) The applicant must have received a passing score on each part of the national board
288.30 examinations, parts one and two, prepared and graded by the National Board of Podiatric

289.1 Medical Examiners. The passing score for each part of the national board examinations,
289.2 parts one and two, is as defined by the National Board of Podiatric Medical Examiners.

289.3 (d) Applicants graduating after ~~1986~~ 1990 from a podiatric medical school shall present
289.4 evidence of successful completion of a residency program approved by a national accrediting
289.5 podiatric medicine organization.

289.6 (e) The applicant shall appear in person before the board or its designated representative
289.7 to show that the applicant satisfies the requirements of this section, including knowledge
289.8 of laws, rules, and ethics pertaining to the practice of podiatric medicine. The board may
289.9 establish as internal operating procedures the procedures or requirements for the applicant's
289.10 personal presentation. Upon completion of all other application requirements, a doctor of
289.11 podiatric medicine applying for a temporary military license has six months in which to
289.12 comply with this subdivision.

289.13 (f) The applicant shall pay a fee established by the board by rule. The fee shall not be
289.14 refunded.

289.15 (g) The applicant must not have engaged in conduct warranting disciplinary action
289.16 against a licensee. If the applicant does not satisfy the requirements of this paragraph, the
289.17 board may refuse to issue a license unless it determines that the public will be protected
289.18 through issuance of a license with conditions and limitations the board considers appropriate.

289.19 (h) Upon payment of a fee as the board may require, an applicant who fails to pass an
289.20 examination and is refused a license is entitled to reexamination within one year of the
289.21 board's refusal to issue the license. No more than two reexaminations are allowed without
289.22 a new application for a license.

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

289.24 Sec. 20. **TEMPORARY REQUIREMENTS GOVERNING AMBULANCE SERVICE**
289.25 **OPERATIONS AND THE PROVISION OF EMERGENCY MEDICAL SERVICES.**

289.26 Subdivision 1. **Application.** Notwithstanding any law to the contrary in Minnesota
289.27 Statutes, chapter 144E, an ambulance service may operate according to this section, and
289.28 emergency medical technicians, advanced emergency medical technicians, and paramedics
289.29 may provide emergency medical services according to this section.

289.30 Subd. 2. **Definitions.** (a) The terms defined in this subdivision apply to this section.

289.31 (b) "Advanced emergency medical technician" has the meaning given in Minnesota
289.32 Statutes, section 144E.001, subdivision 5d.

290.1 (c) "Advanced life support" has the meaning given in Minnesota Statutes, section
290.2 144E.001, subdivision 1b.

290.3 (d) "Ambulance" has the meaning given in Minnesota Statutes, section 144E.001,
290.4 subdivision 2.

290.5 (e) "Ambulance service personnel" has the meaning given in Minnesota Statutes, section
290.6 144E.001, subdivision 3a.

290.7 (f) "Basic life support" has the meaning given in Minnesota Statutes, section 144E.001,
290.8 subdivision 4b.

290.9 (g) "Board" means the Emergency Medical Services Regulatory Board.

290.10 (h) "Emergency medical technician" has the meaning given in Minnesota Statutes, section
290.11 144E.001, subdivision 5c.

290.12 (i) "Paramedic" has the meaning given in Minnesota Statutes, section 144E.001,
290.13 subdivision 5e.

290.14 (j) "Primary service area" means the area designated by the board according to Minnesota
290.15 Statutes, section 144E.06, to be served by an ambulance service.

290.16 Subd. 3. **Staffing.** (a) For emergency ambulance calls in an ambulance service's primary
290.17 service area, an ambulance service must staff an ambulance that provides basic life support
290.18 with at least:

290.19 (1) one emergency medical technician, who must be in the patient compartment when
290.20 a patient is being transported; and

290.21 (2) one individual to drive the ambulance. The driver must hold a valid driver's license
290.22 from any state, must have attended an emergency vehicle driving course approved by the
290.23 ambulance service, and must have completed a course on cardiopulmonary resuscitation
290.24 approved by the ambulance service.

290.25 (b) For emergency ambulance calls in an ambulance service's primary service area, an
290.26 ambulance service must staff an ambulance that provides advanced life support with at least:

290.27 (1) one paramedic; one registered nurse who meets the requirements in Minnesota
290.28 Statutes, section 144E.001, subdivision 3a, clause (2); or one physician assistant who meets
290.29 the requirements in Minnesota Statutes, section 144E.001, subdivision 3a, clause (3), and
290.30 who must be in the patient compartment when a patient is being transported; and

290.31 (2) one individual to drive the ambulance. The driver must hold a valid driver's license
290.32 from any state, must have attended an emergency vehicle driving course approved by the

291.1 ambulance service, and must have completed a course on cardiopulmonary resuscitation
291.2 approved by the ambulance service.

291.3 (c) The ambulance service director and medical director must approve the staffing of
291.4 an ambulance according to this subdivision.

291.5 (d) An ambulance service staffing an ambulance according to this subdivision must
291.6 immediately notify the board in writing and in a manner prescribed by the board. The notice
291.7 must specify how the ambulance service is staffing its basic life support or advanced life
291.8 support ambulances and the time period the ambulance service plans to staff the ambulances
291.9 according to this subdivision. If an ambulance service continues to staff an ambulance
291.10 according to this subdivision after the date provided to the board in its initial notice, the
291.11 ambulance service must provide a new notice to the board in a manner that complies with
291.12 this paragraph.

291.13 (e) If an individual serving as a driver under this subdivision commits an act listed in
291.14 Minnesota Statutes, section 144E.27, subdivision 5, paragraph (a), the board may temporarily
291.15 suspend or prohibit the individual from driving an ambulance or place conditions on the
291.16 individual's ability to drive an ambulance using the procedures and authority in Minnesota
291.17 Statutes, section 144E.27, subdivisions 5 and 6.

291.18 **Subd. 4. Use of expired emergency medications and medical supplies.** (a) If an
291.19 ambulance service experiences a shortage of an emergency medication or medical supply,
291.20 ambulance service personnel may use an emergency medication or medical supply for up
291.21 to six months after the emergency medication's or medical supply's specified expiration
291.22 date, provided:

291.23 (1) the ambulance service director and medical director approve the use of the expired
291.24 emergency medication or medical supply;

291.25 (2) ambulance service personnel use an expired emergency medication or medical supply
291.26 only after depleting the ambulance service's supply of that emergency medication or medical
291.27 supply that is unexpired;

291.28 (3) the ambulance service has stored and maintained the expired emergency medication
291.29 or medical supply according to the manufacturer's instructions;

291.30 (4) if possible, ambulance service personnel obtain consent from the patient to use the
291.31 expired emergency medication or medical supply prior to its use; and

291.32 (5) when the ambulance service obtains a supply of that emergency medication or medical
291.33 supply that is unexpired, ambulance service personnel cease use of the expired emergency

292.1 medication or medical supply and instead use the unexpired emergency medication or
292.2 medical supply.

292.3 (b) Before approving the use of an expired emergency medication, an ambulance service
292.4 director and medical director must consult with the Board of Pharmacy regarding the safety
292.5 and efficacy of using the expired emergency medication.

292.6 (c) An ambulance service must keep a record of all expired emergency medications and
292.7 all expired medical supplies used and must submit that record in writing to the board in a
292.8 time and manner specified by the board. The record must list the specific expired emergency
292.9 medications and medical supplies used and the time period during which ambulance service
292.10 personnel used the expired emergency medication or medical supply.

292.11 Subd. 5. **Provision of emergency medical services after certification expires.** (a) At
292.12 the request of an emergency medical technician, advanced emergency medical technician,
292.13 or paramedic, and with the approval of the ambulance service director, an ambulance service
292.14 medical director may authorize the emergency medical technician, advanced emergency
292.15 medical technician, or paramedic to provide emergency medical services for the ambulance
292.16 service for up to three months after the certification of the emergency medical technician,
292.17 advanced emergency medical technician, or paramedic expires.

292.18 (b) An ambulance service must immediately notify the board each time its medical
292.19 director issues an authorization under paragraph (a). The notice must be provided in writing
292.20 and in a manner prescribed by the board and must include information on the time period
292.21 each emergency medical technician, advanced emergency medical technician, or paramedic
292.22 will provide emergency medical services according to an authorization under this subdivision;
292.23 information on why the emergency medical technician, advanced emergency medical
292.24 technician, or paramedic needs the authorization; and an attestation from the medical director
292.25 that the authorization is necessary to help the ambulance service adequately staff its
292.26 ambulances.

292.27 Subd. 6. **Reports.** The board must provide quarterly reports to the chairs and ranking
292.28 minority members of the legislative committees with jurisdiction over the board regarding
292.29 actions taken by ambulance services according to subdivisions 3, 4, and 5. The board must
292.30 submit reports by June 30, September 30, and December 31 of 2022; and by March 31, June
292.31 30, September 30, and December 31 of 2023. Each report must include the following
292.32 information:

292.33 (1) for each ambulance service staffing basic life support or advanced life support
292.34 ambulances according to subdivision 3, the primary service area served by the ambulance

293.1 service, the number of ambulances staffed according to subdivision 3, and the time period
293.2 the ambulance service has staffed and plans to staff the ambulances according to subdivision
293.3 3;

293.4 (2) for each ambulance service that authorized the use of an expired emergency
293.5 medication or medical supply according to subdivision 4, the expired emergency medications
293.6 and medical supplies authorized for use and the time period the ambulance service used
293.7 each expired emergency medication or medical supply; and

293.8 (3) for each ambulance service that authorized the provision of emergency medical
293.9 services according to subdivision 5, the number of emergency medical technicians, advanced
293.10 emergency medical technicians, and paramedics providing emergency medical services
293.11 under an expired certification and the time period each emergency medical technician,
293.12 advanced emergency medical technician, or paramedic provided and will provide emergency
293.13 medical services under an expired certification.

293.14 Subd. 7. **Expiration.** This section expires January 1, 2024.

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

293.16 Sec. 21. **REPEALER.**

293.17 Minnesota Statutes 2020, section 150A.091, subdivisions 3, 15, and 17, are repealed.

ARTICLE 6

PRESCRIPTION DRUGS

293.20 Section 1. Minnesota Statutes 2020, section 62A.02, subdivision 1, is amended to read:

293.21 Subdivision 1. **Filing.** For purposes of this section, "health plan" means a health plan
293.22 as defined in section 62A.011 or a policy of accident and sickness insurance as defined in
293.23 section 62A.01. No health plan shall be issued or delivered to any person in this state, nor
293.24 shall any application, rider, or endorsement be used in connection with the health plan, until
293.25 a copy of its form and of the classification of risks and the premium rates pertaining to the
293.26 form have been filed with the commissioner. The filing must include the health plan's
293.27 prescription drug formulary. Proposed revisions to the health plan's prescription drug
293.28 formulary must be filed with the commissioner no later than August 1 of the application
293.29 year. The filing for nongroup health plan forms shall include a statement of actuarial reasons
293.30 and data to support the rate. For health benefit plans as defined in section 62L.02, and for
293.31 health plans to be issued to individuals, the health carrier shall file with the commissioner
293.32 the information required in section 62L.08, subdivision 8. For group health plans for which

294.1 approval is sought for sales only outside of the small employer market as defined in section
294.2 62L.02, this section applies only to policies or contracts of accident and sickness insurance.
294.3 All forms intended for issuance in the individual or small employer market must be
294.4 accompanied by a statement as to the expected loss ratio for the form. Premium rates and
294.5 forms relating to specific insureds or proposed insureds, whether individuals or groups,
294.6 need not be filed, unless requested by the commissioner.

294.7 Sec. 2. Minnesota Statutes 2021 Supplement, section 62J.497, subdivision 1, is amended
294.8 to read:

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

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

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

294.16 (d) "Electronic media" has the meaning given under Code of Federal Regulations, title
294.17 45, part 160.103.

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

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

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

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

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

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

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

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

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

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

295.19 (o) "Pharmacy benefit manager" has the meaning given in section 62W.02, subdivision
295.20 15.

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

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

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

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

296.1 Sec. 3. Minnesota Statutes 2021 Supplement, section 62J.497, subdivision 3, is amended
296.2 to read:

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

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

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

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

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

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

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

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

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

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

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

296.28 **EFFECTIVE DATE.** This section is effective January 1, 2023.

297.1 Sec. 4. Minnesota Statutes 2020, section 62J.84, as amended by Laws 2021, chapter 30,
297.2 article 3, sections 5 to 9, is amended to read:

297.3 **62J.84 PRESCRIPTION DRUG PRICE TRANSPARENCY.**

297.4 Subdivision 1. **Short title.** This section may be cited as the "Prescription Drug Price
297.5 Transparency Act."

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

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

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

297.11 (1) an original, new drug application approved under United States Code, title 21, section
297.12 355(c), except for a generic drug as defined under Code of Federal Regulations, title 42,
297.13 section 447.502; or

297.14 (2) a biologics license application approved under United States Code, title ~~45~~ 42, section
297.15 262(a)(c).

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

297.17 (e) "Course of treatment" means the total dosage of a single prescription for a prescription
297.18 drug recommended by the Food and Drug Administration (FDA)-approved prescribing
297.19 label. If the FDA-approved prescribing label includes more than one recommended dosage
297.20 for a single course of treatment, the course of treatment is the maximum recommended
297.21 dosage on the FDA-approved prescribing label.

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

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

297.25 (2) an authorized generic as defined under Code of Federal Regulations, title ~~45~~ 42,
297.26 section 447.502; or

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

297.29 ~~(f)~~ (g) "Manufacturer" means a drug manufacturer licensed under section 151.252.

297.30 (h) "National Drug Code" means the three-segment code maintained by the FDA that
297.31 includes a labeler code, a product code, and a package code for a drug product and that has

298.1 been converted to an 11-digit format consisting of five digits in the first segment, four digits
298.2 in the second segment, and two digits in the third segment. A three-segment code shall be
298.3 considered converted to an 11-digit format when, as necessary, at least one "0" has been
298.4 added to the front of each segment containing less than the specified number of digits so
298.5 that each segment contains the specified number of digits.

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

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

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

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

298.17 (m) "Rebate" means a discount, chargeback, or other price concession that affects the
298.18 price of a prescription drug product, regardless of whether conferred through regular
298.19 aggregate payments, on a claim-by-claim basis at the point of sale, as part of retrospective
298.20 financial reconciliations including reconciliations that also reflect other contractual
298.21 arrangements, or by any other method. Rebate does not mean a bona fide service fee, as the
298.22 term is defined in Code of Federal Regulations, title 42, section 447.502.

298.23 (n) "30-day supply" means the total daily dosage units of a prescription drug
298.24 recommended by the prescribing label approved by the FDA for 30 days. If the
298.25 FDA-approved prescribing label includes more than one recommended daily dosage, the
298.26 30-day supply is based on the maximum recommended daily dosage on the FDA-approved
298.27 prescribing label.

298.28 Subd. 3. **Prescription drug price increases reporting.** (a) Beginning January 1, 2022,
298.29 a drug manufacturer must submit to the commissioner the information described in paragraph
298.30 (b) for each prescription drug for which the price was \$100 or greater for a 30-day supply
298.31 or for a course of treatment lasting less than 30 days and:

299.1 (1) for brand name drugs where there is an increase of ten percent or greater in the price
299.2 over the previous 12-month period or an increase of 16 percent or greater in the price over
299.3 the previous 24-month period; and

299.4 (2) for generic or biosimilar drugs where there is an increase of 50 percent or greater in
299.5 the price over the previous 12-month period.

299.6 (b) For each of the drugs described in paragraph (a), the manufacturer shall submit to
299.7 the commissioner no later than 60 days after the price increase goes into effect, in the form
299.8 and manner prescribed by the commissioner, the following information, if applicable:

299.9 (1) the name, description, and price of the drug and the net increase, expressed as a
299.10 percentage, with the following listed separately:

299.11 (i) National Drug Code;

299.12 (ii) product name;

299.13 (iii) dosage form;

299.14 (iv) strength; and

299.15 (v) package size;

299.16 (2) the factors that contributed to the price increase;

299.17 (3) the name of any generic version of the prescription drug available on the market;

299.18 (4) the introductory price of the prescription drug when it was introduced for sale in the
299.19 United States and the price of the drug on the last day of each of the five calendar years
299.20 preceding the price increase when it was approved for marketing by the Food and Drug
299.21 Administration and the net yearly increase, by calendar year, in the price of the prescription
299.22 drug during the previous five years;

299.23 (5) the direct costs incurred during the previous 12-month period by the manufacturer
299.24 that are associated with the prescription drug, listed separately:

299.25 (i) to manufacture the prescription drug;

299.26 (ii) to market the prescription drug, including advertising costs; and

299.27 (iii) to distribute the prescription drug;

299.28 (6) the number of units of the prescription drug sold during the previous 12-month period;

299.29 (7) the total rebate payable amount accrued for the prescription drug during the previous
299.30 12-month period;

300.1 ~~(6)~~ (8) the total sales revenue for the prescription drug during the previous 12-month
300.2 period;

300.3 ~~(7)~~ (9) the manufacturer's net profit attributable to the prescription drug during the
300.4 previous 12-month period;

300.5 ~~(8)~~ (10) the total amount of financial assistance the manufacturer has provided through
300.6 patient prescription assistance programs during the previous 12-month period, if applicable;

300.7 ~~(9)~~ (11) any agreement between a manufacturer and another entity contingent upon any
300.8 delay in offering to market a generic version of the prescription drug;

300.9 ~~(10)~~ (12) the patent expiration date of the prescription drug if it is under patent;

300.10 ~~(11)~~ (13) the name and location of the company that manufactured the drug; ~~and~~

300.11 ~~(12)~~ (14) if a brand name prescription drug, the ten highest prices paid for the prescription
300.12 drug during the previous calendar year in ~~any country other than~~ the ten countries, excluding
300.13 the United States-, that charged the highest single price for the prescription drug; and

300.14 (15) if the prescription drug was acquired by the manufacturer during the previous
300.15 12-month period, all of the following information:

300.16 (i) price at acquisition;

300.17 (ii) price in the calendar year prior to acquisition;

300.18 (iii) name of the company from which the drug was acquired;

300.19 (iv) date of acquisition; and

300.20 (v) acquisition price.

300.21 (c) The manufacturer may submit any documentation necessary to support the information
300.22 reported under this subdivision.

300.23 Subd. 4. **New prescription drug price reporting.** (a) Beginning January 1, 2022, no
300.24 later than 60 days after a manufacturer introduces a new prescription drug for sale in the
300.25 United States that is a new brand name drug with a price that is greater than the tier threshold
300.26 established by the Centers for Medicare and Medicaid Services for specialty drugs in the
300.27 Medicare Part D program for a 30-day supply or for a course of treatment lasting less than
300.28 30 days or a new generic or biosimilar drug with a price that is greater than the tier threshold
300.29 established by the Centers for Medicare and Medicaid Services for specialty drugs in the
300.30 Medicare Part D program for a 30-day supply or for a course of treatment lasting less than
300.31 30 days and is not at least 15 percent lower than the referenced brand name drug when the

301.1 generic or biosimilar drug is launched, the manufacturer must submit to the commissioner,
301.2 in the form and manner prescribed by the commissioner, the following information, if
301.3 applicable:

301.4 (1) the description of the drug, with the following listed separately:

301.5 (i) National Drug Code;

301.6 (ii) product name;

301.7 (iii) dosage form;

301.8 (iv) strength; and

301.9 (v) package size

301.10 ~~(1)~~ (2) the price of the prescription drug;

301.11 ~~(2)~~ (3) whether the Food and Drug Administration granted the new prescription drug a
301.12 breakthrough therapy designation or a priority review;

301.13 ~~(3)~~ (4) the direct costs incurred by the manufacturer that are associated with the
301.14 prescription drug, listed separately:

301.15 (i) to manufacture the prescription drug;

301.16 (ii) to market the prescription drug, including advertising costs; and

301.17 (iii) to distribute the prescription drug; and

301.18 ~~(4)~~ (5) the patent expiration date of the drug if it is under patent.

301.19 (b) The manufacturer may submit documentation necessary to support the information
301.20 reported under this subdivision.

301.21 **Subd. 5. Newly acquired prescription drug price reporting.** (a) Beginning January
301.22 1, 2022, the acquiring drug manufacturer must submit to the commissioner the information
301.23 described in paragraph (b) for each newly acquired prescription drug for which the price
301.24 was \$100 or greater for a 30-day supply or for a course of treatment lasting less than 30
301.25 days and:

301.26 (1) for a newly acquired brand name drug where there is an increase of ten percent or
301.27 greater in the price over the previous 12-month period or an increase of 16 percent or greater
301.28 in price over the previous 24-month period; and

301.29 (2) for a newly acquired generic or biosimilar drug where there is an increase of 50
301.30 percent or greater in the price over the previous 12-month period.

302.1 (b) For each of the drugs described in paragraph (a), the acquiring manufacturer shall
302.2 submit to the commissioner no later than 60 days after the acquiring manufacturer begins
302.3 to sell the newly acquired drug, in the form and manner prescribed by the commissioner,
302.4 the following information, if applicable:

302.5 (1) the description of the drug, with the following listed separately:

302.6 (i) National Drug Code;

302.7 (ii) product name;

302.8 (iii) dosage form;

302.9 (iv) strength; and

302.10 (v) package size

302.11 ~~(1)~~ (2) the price of the prescription drug at the time of acquisition and in the calendar
302.12 year prior to acquisition;

302.13 ~~(2)~~ (3) the name of the company from which the prescription drug was acquired, the
302.14 date acquired, and the purchase price;

302.15 ~~(3)~~ (4) the year the prescription drug was introduced to market and the price of the
302.16 prescription drug at the time of introduction;

302.17 ~~(4)~~ (5) the price of the prescription drug for the previous five years;

302.18 ~~(5)~~ (6) any agreement between a manufacturer and another entity contingent upon any
302.19 delay in offering to market a generic version of the manufacturer's drug; and

302.20 ~~(6)~~ (7) the patent expiration date of the drug if it is under patent.

302.21 (c) The manufacturer may submit any documentation necessary to support the information
302.22 reported under this subdivision.

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

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

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

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

303.4 (c) The commissioner shall not post to the department's website or a private entity
303.5 contracting with the commissioner shall not post any information described in this section
303.6 if the information is not public data under section 13.02, subdivision 8a; or is trade secret
303.7 information under section 13.37, subdivision 1, paragraph (b); or is trade secret information
303.8 pursuant to the Defend Trade Secrets Act of 2016, United States Code, title 18, section
303.9 1836, as amended. If a manufacturer believes information should be withheld from public
303.10 disclosure pursuant to this paragraph, the manufacturer must clearly and specifically identify
303.11 that information and describe the legal basis in writing when the manufacturer submits the
303.12 information under this section. If the commissioner disagrees with the manufacturer's request
303.13 to withhold information from public disclosure, the commissioner shall provide the
303.14 manufacturer written notice that the information will be publicly posted 30 days after the
303.15 date of the notice.

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

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

303.26 **Subd. 7. Consultation.** (a) The commissioner may consult with a private entity or
303.27 consortium that satisfies the standards of section 62U.04, subdivision 6, the University of
303.28 Minnesota, or the commissioner of commerce, as appropriate, in issuing the form and format
303.29 of the information reported under this section; in posting information pursuant to subdivision
303.30 6; and in taking any other action for the purpose of implementing this section.

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

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

304.3 (1) failing to submit timely reports or notices as required by this section;

304.4 (2) failing to provide information required under this section; or

304.5 (3) providing inaccurate or incomplete information under this section.

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

304.8 (c) The commissioner shall impose civil penalties under this section as provided in
304.9 section 144.99, subdivision 4.

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

304.13 (e) Civil penalties collected under this section shall be deposited in the health care access
304.14 fund.

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

304.20 (1) promoting transparency in pharmaceutical pricing for the state and other payers;

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

304.22 (3) assisting the state and other payers in the management of pharmaceutical costs.

304.23 (b) The report must include a summary of the information submitted to the commissioner
304.24 under subdivisions 3, 4, and 5.

304.25 Sec. 5. Minnesota Statutes 2020, section 62J.84, subdivision 2, is amended to read:

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

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

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

305.1 (1) an original, new drug application approved under United States Code, title 21, section
305.2 355(c), except for a generic drug as defined under Code of Federal Regulations, title 42,
305.3 section 447.502; or

305.4 (2) a biologics license application approved under United States Code, title 45, section
305.5 262(a)(c).

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

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

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

305.10 (2) an authorized generic as defined under Code of Federal Regulations, title 45, section
305.11 447.502; or

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

305.14 (f) "Manufacturer" means a drug manufacturer licensed under section 151.252, but does
305.15 not include an entity required to be licensed under that section solely because the entity
305.16 repackages or relabels drugs.

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

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

305.24 (i) "Prescription drug" or "drug" has the meaning provided in section 151.441, subdivision
305.25 8.

305.26 (j) "Price" means the wholesale acquisition cost as defined in United States Code, title
305.27 42, section 1395w-3a(c)(6)(B).

305.28 Sec. 6. Minnesota Statutes 2020, section 62J.84, subdivision 2, is amended to read:

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

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

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

306.4 (1) an original, new drug application approved under United States Code, title 21, section
306.5 355(c), except for a generic drug as defined under Code of Federal Regulations, title 42,
306.6 section 447.502; or

306.7 (2) a biologics license application approved under United States Code, title 45, section
306.8 262(a)(c).

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

306.10 (e) "Drug product family" means a group of one or more prescription drugs that share
306.11 a unique generic drug description or nontrade name and dosage form.

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

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

306.15 (2) an authorized generic as defined under Code of Federal Regulations, title 45, section
306.16 447.502; or

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

306.19 ~~(f)~~ (g) "Manufacturer" means a drug manufacturer licensed under section 151.252.

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

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

306.27 (j) "Pharmacy" or "pharmacy provider" means a place of business licensed by the Board
306.28 of Pharmacy under section 151.19 in which prescription drugs are prepared, compounded,
306.29 or dispensed under the supervision of a pharmacist.

306.30 (k) "Pharmacy benefits manager (PBM)" means an entity licensed to act as a pharmacy
306.31 benefits manager under section 62W.03.

307.1 ~~(j)~~ (l) "Prescription drug" or "drug" has the meaning provided in section 151.441,
307.2 subdivision 8.

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

307.5 (n) "Pricing Unit" means the smallest dispensable amount of a prescription drug product
307.6 that could be dispensed.

307.7 (o) "Reporting entity" means any manufacturer, pharmacy, pharmacy benefits manager,
307.8 wholesale drug distributor, or any other entity required to submit data under this section.

307.9 (p) "Wholesale drug distributor" or "wholesaler" means an entity that:

307.10 (1) is licensed to act as a wholesale drug distributor under section 151.47; and

307.11 (2) distributes prescription drugs, of which it is not the manufacturer, to persons or
307.12 entities other than a consumer or patient in the state.

307.13 Sec. 7. Minnesota Statutes 2021 Supplement, section 62J.84, subdivision 6, is amended
307.14 to read:

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

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

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

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

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

307.26 (c) The commissioner shall not post to the department's website or a private entity
307.27 contracting with the commissioner shall not post any information described in this section
307.28 if the information is not public data under section 13.02, subdivision 8a; or is trade secret
307.29 information under section 13.37, subdivision 1, paragraph (b), subject to section 62J.841,
307.30 subdivision 2, paragraph (e); or is trade secret information pursuant to the Defend Trade
307.31 Secrets Act of 2016, United States Code, title 18, section 1836, as amended, subject to

308.1 section 62J.841, subdivision 2, paragraph (e). If a manufacturer believes information should
308.2 be withheld from public disclosure pursuant to this paragraph, the manufacturer must clearly
308.3 and specifically identify that information and describe the legal basis in writing when the
308.4 manufacturer submits the information under this section. If the commissioner disagrees
308.5 with the manufacturer's request to withhold information from public disclosure, the
308.6 commissioner shall provide the manufacturer written notice that the information will be
308.7 publicly posted 30 days after the date of the notice.

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

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

308.18 Sec. 8. Minnesota Statutes 2021 Supplement, section 62J.84, subdivision 6, is amended
308.19 to read:

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

308.24 (1) a list of the prescription drugs reported under subdivisions 3, 4, ~~and 5~~, 11, 12, 13,
308.25 and 14 and the manufacturers of those prescription drugs; and

308.26 (2) information reported to the commissioner under subdivisions 3, 4, ~~and 5~~, 11, 12, 13,
308.27 and 14.

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

308.31 (c) The commissioner shall not post to the department's website or a private entity
308.32 contracting with the commissioner shall not post any information described in this section
308.33 if the information is not public data under section 13.02, subdivision 8a; or is trade secret

309.1 information under section 13.37, subdivision 1, paragraph (b); or is trade secret information
309.2 pursuant to the Defend Trade Secrets Act of 2016, United States Code, title 18, section
309.3 1836, as amended. If a manufacturer believes information should be withheld from public
309.4 disclosure pursuant to this paragraph, the manufacturer must clearly and specifically identify
309.5 that information and describe the legal basis in writing when the manufacturer submits the
309.6 information under this section. If the commissioner disagrees with the manufacturer's request
309.7 to withhold information from public disclosure, the commissioner shall provide the
309.8 manufacturer written notice that the information will be publicly posted 30 days after the
309.9 date of the notice.

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

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

309.20 Sec. 9. Minnesota Statutes 2020, section 62J.84, subdivision 7, is amended to read:

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

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

309.31 Sec. 10. Minnesota Statutes 2020, section 62J.84, subdivision 7, is amended to read:

309.32 Subd. 7. **Consultation.** (a) The commissioner may consult with a private entity or
309.33 consortium that satisfies the standards of section 62U.04, subdivision 6, the University of

310.1 Minnesota, or the commissioner of commerce, as appropriate, in issuing the form and format
310.2 of the information reported under this section; in posting information pursuant to subdivision
310.3 6; and in taking any other action for the purpose of implementing this section.

310.4 (b) The commissioner may consult with representatives of the ~~manufacturers~~ reporting
310.5 entities to establish a standard format for reporting information under this section and may
310.6 use existing reporting methodologies to establish a standard format to minimize
310.7 administrative burdens to the state and ~~manufacturers~~ reporting entities.

310.8 Sec. 11. Minnesota Statutes 2020, section 62J.84, subdivision 8, is amended to read:

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

310.11 (1) failing to submit timely reports or notices as required by this section and section
310.12 62J.841;

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

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

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

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

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

310.21 (d) The commissioner may remit or mitigate civil penalties under this section and section
310.22 62J.481 upon terms and conditions the commissioner considers proper and consistent with
310.23 public health and safety.

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

310.26 Sec. 12. Minnesota Statutes 2020, section 62J.84, subdivision 8, is amended to read:

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

310.29 (1) failing to register under subdivision 15;

310.30 ~~(+)~~ (2) failing to submit timely reports or notices as required by this section;

311.1 ~~(2)~~ (3) failing to provide information required under this section; or

311.2 ~~(3)~~ (4) providing inaccurate or incomplete information under this section.

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

311.5 (c) The commissioner shall impose civil penalties under this section as provided in
311.6 section 144.99, subdivision 4.

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

311.10 (e) Civil penalties collected under this section shall be deposited in the health care access
311.11 fund.

311.12 Sec. 13. Minnesota Statutes 2021 Supplement, section 62J.84, subdivision 9, is amended
311.13 to read:

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

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

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

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

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

311.27 Sec. 14. Minnesota Statutes 2021 Supplement, section 62J.84, subdivision 9, is amended
311.28 to read:

311.29 Subd. 9. **Legislative report.** (a) No later than May 15, 2022, and by January 15 of each
311.30 year thereafter, the commissioner shall report to the chairs and ranking minority members
311.31 of the legislative committees with jurisdiction over commerce and health and human services

312.1 policy and finance on the implementation of this section, including but not limited to the
312.2 effectiveness in addressing the following goals:

312.3 (1) promoting transparency in pharmaceutical pricing for the state and other payers;

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

312.5 (3) assisting the state and other payers in the management of pharmaceutical costs.

312.6 (b) The report must include a summary of the information submitted to the commissioner
312.7 under subdivisions 3, 4, ~~and 5~~, 11, 12, 13, and 14.

312.8 Sec. 15. Minnesota Statutes 2020, section 62J.84, is amended by adding a subdivision to
312.9 read:

312.10 Subd. 10. Notice of prescription drugs of substantial public interest. (a) No later than
312.11 January 31, 2023, and quarterly thereafter, the commissioner shall produce and post on the
312.12 department's website a list of prescription drugs that the department determines to represent
312.13 a substantial public interest and for which the department intends to request data under
312.14 subdivisions 11, 12, 13, and 14, subject to paragraph (c). The department shall base its
312.15 inclusion of prescription drugs on any information the department determines is relevant
312.16 to providing greater consumer awareness of the factors contributing to the cost of prescription
312.17 drugs in the state, and the department shall consider drug product families that include
312.18 prescription drugs:

312.19 (1) that triggered reporting under subdivisions 3, 4, or 5 during the previous calendar
312.20 quarter;

312.21 (2) for which average claims paid amounts exceeded 125 percent of the price as of the
312.22 claim incurred date during the most recent calendar quarter for which claims paid amounts
312.23 are available; or

312.24 (3) that are identified by members of the public during a public comment period process.

312.25 (b) No sooner than 30 days after publicly posting the list of prescription drugs under
312.26 paragraph (a), the department shall notify, via e-mail, reporting entities registered with the
312.27 department of the requirement to report under subdivisions 11, 12, 13, and 14.

312.28 (c) No more than 500 prescription drugs may be designated as having a substantial public
312.29 interest in any one notice.

313.1 Sec. 16. Minnesota Statutes 2020, section 62J.84, is amended by adding a subdivision to
313.2 read:

313.3 Subd. 11. **Manufacturer prescription drug substantial public interest reporting.** (a)
313.4 Beginning January 1, 2023, a manufacturer must submit to the commissioner the information
313.5 described in paragraph (b) for any prescription drug:

313.6 (1) included in a notification to report issued to the manufacturer by the department
313.7 under subdivision 10;

313.8 (2) which the manufacturer manufactures or repackages;

313.9 (3) for which the manufacturer sets the wholesale acquisition cost; and

313.10 (4) for which the manufacturer has not submitted data under subdivisions 3 or 5 during
313.11 the 120-day period prior to the date of the notification to report.

313.12 (b) For each of the drugs described in paragraph (a), the manufacturer shall submit to
313.13 the commissioner no later than 60 days after the date of the notification to report, in the
313.14 form and manner prescribed by the commissioner, the following information, if applicable:

313.15 (1) a description of the drug with the following listed separately:

313.16 (i) National Drug Code;

313.17 (ii) product name;

313.18 (iii) dosage form;

313.19 (iv) strength; and

313.20 (v) package size;

313.21 (2) the price of the drug product on the later of:

313.22 (i) the day one year prior to the date of the notification to report;

313.23 (ii) the introduced to market date; or

313.24 (iii) the acquisition date;

313.25 (3) the price of the drug product on the date of the notification to report;

313.26 (4) the introductory price of the prescription drug when it was introduced for sale in the
313.27 United States and the price of the drug on the last day of each of the five calendar years
313.28 preceding the date of the notification to report;

313.29 (5) the direct costs incurred during the 12-month period prior to the date of the notification
313.30 to report by the manufacturer that are associated with the prescription drug, listed separately:

- 314.1 (i) to manufacture the prescription drug;
- 314.2 (ii) to market the prescription drug, including advertising costs; and
- 314.3 (iii) to distribute the prescription drug;
- 314.4 (6) the number of units of the prescription drug sold during the 12-month period prior
314.5 to the date of the notification to report;
- 314.6 (7) the total sales revenue for the prescription drug during the 12-month period prior to
314.7 the date of the notification to report;
- 314.8 (8) the total rebate payable amount accrued for the prescription drug during the 12-month
314.9 period prior to the date of the notification to report;
- 314.10 (9) the manufacturer's net profit attributable to the prescription drug during the 12-month
314.11 period prior to the date of the notification to report;
- 314.12 (10) the total amount of financial assistance the manufacturer has provided through
314.13 patient prescription assistance programs during the 12-month period prior to the date of the
314.14 notification to report, if applicable;
- 314.15 (11) any agreement between a manufacturer and another entity contingent upon any
314.16 delay in offering to market a generic version of the prescription drug;
- 314.17 (12) the patent expiration date of the prescription drug if it is under patent;
- 314.18 (13) the name and location of the company that manufactured the drug;
- 314.19 (14) if a brand name prescription drug, the ten countries other than the United States
314.20 that paid the highest prices for the prescription drug during the previous calendar year and
314.21 their prices; and
- 314.22 (15) if the prescription drug was acquired by the manufacturer within the 12-month
314.23 period prior to the date of the notification to report, all of the following information:
- 314.24 (i) price at acquisition;
- 314.25 (ii) price in the calendar year prior to acquisition;
- 314.26 (iii) name of the company from which the drug was acquired;
- 314.27 (iv) date of acquisition; and
- 314.28 (v) acquisition price.
- 314.29 (c) The manufacturer may submit any documentation necessary to support the information
314.30 reported under this subdivision.

315.1 Sec. 17. Minnesota Statutes 2020, section 62J.84, is amended by adding a subdivision to
315.2 read:

315.3 Subd. 12. Pharmacy prescription drug substantial public interest reporting. (a)
315.4 Beginning January 1, 2023, a pharmacy must submit to the commissioner the information
315.5 described in paragraph (b) for any prescription drug included in a notification to report
315.6 issued to the pharmacy by the department under subdivision 10.

315.7 (b) For each of the drugs described in paragraph (a), the pharmacy shall submit to the
315.8 commissioner no later than 60 days after the date of the notification to report in the form
315.9 and manner prescribed by the commissioner the following information, if applicable:

315.10 (1) a description of the drug with the following listed separately:

315.11 (i) National Drug Code;

315.12 (ii) product name;

315.13 (iii) dosage form;

315.14 (iv) strength; and

315.15 (v) package size;

315.16 (2) the number of units of the drug acquired during the 12-month period prior to the date
315.17 of the notification to report;

315.18 (3) the total spent before rebates by the pharmacy to acquire the drug during the 12-month
315.19 period prior to the date of the notification to report;

315.20 (4) the total rebate receivable amount accrued by the pharmacy for the drug during the
315.21 12-month period prior to the date of the notification to report;

315.22 (5) the number of pricing units of the drug dispensed by the pharmacy during the
315.23 12-month period prior to the date of the notification to report;

315.24 (6) the total payment receivable by the pharmacy for dispensing the drug, including
315.25 ingredient cost, dispensing fee, and administrative fees, during the 12-month period prior
315.26 to the date of the notification to report;

315.27 (7) the total rebate payable amount accrued by the pharmacy for the drug during the
315.28 12-month period prior to the date of the notification to report; and

315.29 (8) the average cash price paid by consumers per pricing unit for prescriptions dispensed
315.30 where no claim was submitted to a health care service plan or health insurer during the
315.31 12-month period prior to the date of the notification to report.

316.1 (c) The pharmacy may submit any documentation necessary to support the information
316.2 reported under this subdivision.

316.3 Sec. 18. Minnesota Statutes 2020, section 62J.84, is amended by adding a subdivision to
316.4 read:

316.5 Subd. 13. **Pharmacy benefit manager (PBM) prescription drug substantial public**
316.6 **interest reporting.** (a) Beginning January 1, 2023, a PBM as defined in section 62W.02,
316.7 subdivision 14, must submit to the commissioner the information described in paragraph
316.8 (b) for any prescription drug included in a notification to report issued to the PBM by the
316.9 department under subdivision 10.

316.10 (b) For each of the drugs described in paragraph (a), the PBM shall submit to the
316.11 commissioner no later than 60 days after the date of the notification to report, in the form
316.12 and manner prescribed by the commissioner, the following information, if applicable:

316.13 (1) a description of the drug with the following listed separately:

316.14 (i) National Drug Code;

316.15 (ii) product name;

316.16 (iii) dosage form;

316.17 (iv) strength; and

316.18 (v) package size;

316.19 (2) the number of pricing units of the drug product filled for which the PBM administered
316.20 claims during the 12-month period prior to the date of the notification to report;

316.21 (3) the total reimbursement amount accrued and payable to pharmacies for pricing units
316.22 of the drug product filled for which the PBM administered claims during the 12-month
316.23 period prior to the date of the notification to report;

316.24 (4) the total reimbursement or administrative fee amount or both accrued and receivable
316.25 from payers for pricing units of the drug product filled for which the PBM administered
316.26 claims during the 12-month period prior to the date of the notification to report;

316.27 (5) the total rebate receivable amount accrued by the PBM for the drug product during
316.28 the 12-month period prior to the date of the notification to report; and

316.29 (6) the total rebate payable amount accrued by the PBM for the drug product during the
316.30 12-month period prior to the date of the notification to report.

317.1 (c) The PBM may submit any documentation necessary to support the information
317.2 reported under this subdivision.

317.3 Sec. 19. Minnesota Statutes 2020, section 62J.84, is amended by adding a subdivision to
317.4 read:

317.5 **Subd. 14. Wholesaler prescription drug substantial public interest reporting.** (a)
317.6 Beginning January 1, 2023, a wholesaler must submit to the commissioner the information
317.7 described in paragraph (b) for any prescription drug included in a notification to report
317.8 issued to the wholesaler by the department under subdivision 10.

317.9 (b) For each of the drugs described in paragraph (a), the wholesaler shall submit to the
317.10 commissioner no later than 60 days after the date of the notification to report, in the form
317.11 and manner prescribed by the commissioner, the following information, if applicable:

317.12 (1) a description of the drug with the following listed separately:

317.13 (i) National Drug Code;

317.14 (ii) product name;

317.15 (iii) dosage form;

317.16 (iv) strength; and

317.17 (v) package size;

317.18 (2) the number of units of the drug product acquired by the wholesale drug distributor
317.19 during the 12-month period prior to the date of the notification to report;

317.20 (3) the total spent before rebates by the wholesale drug distributor to acquire the drug
317.21 product during the 12-month period prior to the date of the notification to report;

317.22 (4) the total rebate receivable amount accrued by the wholesale drug distributor for the
317.23 drug product during the 12-month period prior to the date of the notification to report;

317.24 (5) the number of units of the drug product sold by the wholesale drug distributor during
317.25 the 12-month period prior to the date of the notification to report;

317.26 (6) gross revenue from sales in the United States generated by the wholesale drug
317.27 distributor for the drug product during the 12-month period prior to the date of the notification
317.28 to report; and

317.29 (7) total rebate payable amount accrued by the wholesale drug distributor for the drug
317.30 product during the 12-month period prior to the date of the notification to report.

318.1 (c) The wholesaler may submit any documentation necessary to support the information
318.2 reported under this subdivision.

318.3 Sec. 20. Minnesota Statutes 2020, section 62J.84, is amended by adding a subdivision to
318.4 read:

318.5 Subd. 15. **Registration requirement.** Beginning January 1, 2023, a reporting entity
318.6 subject to this chapter shall register with the department in a form and manner prescribed
318.7 by the commissioner.

318.8 Sec. 21. Minnesota Statutes 2020, section 62J.84, is amended by adding a subdivision to
318.9 read:

318.10 Subd. 16. **Rulemaking.** For the purposes of this section, the commissioner may use the
318.11 expedited rulemaking process under section 14.389.

318.12 Sec. 22. **[62J.841] REPORTING PRESCRIPTION DRUG PRICES; FORMULARY**
318.13 **DEVELOPMENT AND PRICE STABILITY.**

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

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

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

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

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

318.23 Subd. 2. **Price reporting.** (a) Beginning July 31, 2023, and by July 31 each year
318.24 thereafter, a manufacturer must report to the commissioner the information in paragraph
318.25 (b) for every drug with a wholesale acquisition cost of \$100 or more for a 30-day supply
318.26 or for a course of treatment lasting less than 30 days, as applicable to the next calendar year.

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

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

318.30 (2) brand name, if applicable;

319.1 (3) generic name, if applicable;

319.2 (4) wholesale acquisition cost for one unit;

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

319.4 (6) average wholesale price; and

319.5 (7) status as brand name or generic.

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

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

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

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

319.16 Subd. 3. **Public posting of prescription drug price information.** By October 1 of each
319.17 year, beginning October 1, 2023, the commissioner must post the information reported
319.18 under subdivision 2 on the department website, as required by section 62J.84, subdivision
319.19 6.

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

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

319.27 Sec. 23. **[62J.841] DEFINITIONS.**

319.28 Subdivision 1. **Scope.** For purposes of sections 62J.841 to 62J.845, the following
319.29 definitions apply.

319.30 Subd. 2. **Consumer Price Index.** "Consumer Price Index" means the Consumer Price
319.31 Index, Annual Average, for All Urban Consumers, CPI-U: U.S. City Average, All Items,

320.1 reported by the United States Department of Labor, Bureau of Labor Statistics, or its
320.2 successor or, if the index is discontinued, an equivalent index reported by a federal authority
320.3 or, if no such index is reported, "Consumer Price Index" means a comparable index chosen
320.4 by the Bureau of Labor Statistics.

320.5 Subd. 3. **Generic or off-patent drug.** "Generic or off-patent drug" means any prescription
320.6 drug for which any exclusive marketing rights granted under the Federal Food, Drug, and
320.7 Cosmetic Act; section 351 of the federal Public Health Service Act; and federal patent law
320.8 have expired, including any drug-device combination product for the delivery of a generic
320.9 drug.

320.10 Subd. 4. **Manufacturer.** "Manufacturer" has the meaning provided in section 151.01,
320.11 subdivision 14a.

320.12 Subd. 5. **Prescription drug.** "Prescription drug" means a drug for human use subject
320.13 to United States Code, title 21, section 353(b)(1).

320.14 Subd. 6. **Wholesale acquisition cost.** "Wholesale acquisition cost" has the meaning
320.15 provided in United States Code, title 42, section 1395w-3a.

320.16 Subd. 7. **Wholesale distributor.** "Wholesale distributor" has the meaning provided in
320.17 section 151.441, subdivision 14.

320.18 **Sec. 24. [62J.842] EXCESSIVE PRICE INCREASES PROHIBITED.**

320.19 Subdivision 1. **Prohibition.** No manufacturer shall impose, or cause to be imposed, an
320.20 excessive price increase, whether directly or through a wholesale distributor, pharmacy, or
320.21 similar intermediary, on the sale of any generic or off-patent drug sold, dispensed, or
320.22 delivered to any consumer in the state.

320.23 Subd. 2. **Excessive price increase.** A price increase is excessive for purposes of this
320.24 section when:

320.25 (1) the price increase, adjusted for inflation utilizing the Consumer Price Index, exceeds:

320.26 (i) 15 percent of the wholesale acquisition cost over the immediately preceding calendar
320.27 year; or

320.28 (ii) 40 percent of the wholesale acquisition cost over the immediately preceding three
320.29 calendar years; and

320.30 (2) the price increase, adjusted for inflation utilizing the Consumer Price Index, exceeds
320.31 \$30 for:

321.1 (i) a 30-day supply of the drug; or

321.2 (ii) a course of treatment lasting less than 30 days.

321.3 Subd. 3. **Exemption.** It is not a violation of this section for a wholesale distributor or
321.4 pharmacy to increase the price of a generic or off-patent drug if the price increase is directly
321.5 attributable to additional costs for the drug imposed on the wholesale distributor or pharmacy
321.6 by the manufacturer of the drug.

321.7 Sec. 25. **[62J.843] REGISTERED AGENT AND OFFICE WITHIN THE STATE.**

321.8 Any manufacturer that sells, distributes, delivers, or offers for sale any generic or
321.9 off-patent drug in the state is required to maintain a registered agent and office within the
321.10 state.

321.11 Sec. 26. **[62J.844] ENFORCEMENT.**

321.12 Subdivision 1. **Notification.** The commissioner of management and budget and any
321.13 other state agency that provides or purchases a pharmacy benefit, except the Department
321.14 of Human Services, and any entity under contract with a state agency to provide a pharmacy
321.15 benefit other than an entity under contract with the Department of Human Services, shall
321.16 notify the manufacturer of a generic or off-patent drug, the attorney general, and the Board
321.17 of Pharmacy of any price increase in violation of section 62J.842.

321.18 Subd. 2. **Submission of drug cost statement and other information by manufacturer;**
321.19 **investigation by attorney general.** (a) Within 45 days of receiving a notice under subdivision
321.20 1, the manufacturer of the generic or off-patent drug shall submit a drug cost statement to
321.21 the attorney general. The statement must:

321.22 (1) itemize the cost components related to production of the drug;

321.23 (2) identify the circumstances and timing of any increase in materials or manufacturing
321.24 costs that caused any increase during the preceding calendar year, or preceding three calendar
321.25 years as applicable, in the price of the drug; and

321.26 (3) provide any other information that the manufacturer believes to be relevant to a
321.27 determination of whether a violation of section 62J.842 has occurred.

321.28 (b) The attorney general may investigate whether a violation of section 62J.842 has
321.29 occurred, is occurring, or is about to occur, in accordance with section 8.31, subdivision 2.

321.30 Subd. 3. **Petition to court.** (a) On petition of the attorney general, a court may issue an
321.31 order:

- 322.1 (1) compelling the manufacturer of a generic or off-patent drug to:
- 322.2 (i) provide the drug cost statement required under subdivision 2, paragraph (a); and
- 322.3 (ii) answer interrogatories, produce records or documents, or be examined under oath,
- 322.4 as required by the attorney general under subdivision 2, paragraph (b);
- 322.5 (2) restraining or enjoining a violation of sections 62J.841 to 62J.845, including issuing
- 322.6 an order requiring that drug prices be restored to levels that comply with section 62J.842;
- 322.7 (3) requiring the manufacturer to provide an accounting to the attorney general of all
- 322.8 revenues resulting from a violation of section 62J.842;
- 322.9 (4) requiring the manufacturer to repay to all consumers, including any third-party payers,
- 322.10 any money acquired as a result of a price increase that violates section 62J.842;
- 322.11 (5) notwithstanding section 16A.151, if a manufacturer is unable to determine the
- 322.12 individual transactions necessary to provide the repayments described in clause (4), requiring
- 322.13 that all revenues generated from a violation of section 62J.842 be remitted to the state and
- 322.14 deposited into a special fund to be used for initiatives to reduce the cost to consumers of
- 322.15 acquiring prescription drugs;
- 322.16 (6) imposing a civil penalty of up to \$10,000 per day for each violation of section 62J.842;
- 322.17 (7) providing for the attorney general's recovery of its costs and disbursements incurred
- 322.18 in bringing an action against a manufacturer found in violation of section 62J.842, including
- 322.19 the costs of investigation and reasonable attorney's fees; and
- 322.20 (8) providing any other appropriate relief, including any other equitable relief as
- 322.21 determined by the court.

322.22 (b) For purposes of paragraph (a), clause (6), every individual transaction in violation

322.23 of section 62J.842 must be considered a separate violation.

322.24 Subd. 4. **Private right of action.** Any action brought pursuant to section 8.31, subdivision

322.25 3a, by a person injured by a violation of this section is for the benefit of the public.

322.26 Sec. 27. **[62J.845] PROHIBITION ON WITHDRAWAL OF GENERIC OR**

322.27 **OFF-PATENT DRUGS FOR SALE.**

322.28 Subdivision 1. **Prohibition.** A manufacturer of a generic or off-patent drug is prohibited

322.29 from withdrawing that drug from sale or distribution within this state for the purpose of

322.30 avoiding the prohibition on excessive price increases under section 62J.842.

323.1 Subd. 2. **Notice to board and attorney general.** Any manufacturer that intends to
323.2 withdraw a generic or off-patent drug from sale or distribution within the state shall provide
323.3 a written notice of withdrawal to the Board of Pharmacy and the attorney general at least
323.4 180 days prior to the withdrawal.

323.5 Subd. 3. **Financial penalty.** The attorney general shall assess a penalty of \$500,000 on
323.6 any manufacturer of a generic or off-patent drug that it determines has failed to comply
323.7 with the requirements of this section.

323.8 Sec. 28. **[62J.846] SEVERABILITY.**

323.9 If any provision of sections 62J.841 to 62J.845 or the application thereof to any person
323.10 or circumstance is held invalid for any reason in a court of competent jurisdiction, the
323.11 invalidity does not affect other provisions or any other application of sections 62J.841 to
323.12 62J.845 that can be given effect without the invalid provision or application.

323.13 Sec. 29. **[62J.85] CITATION.**

323.14 Sections 62J.85 to 62J.95 may be cited as the "Prescription Drug Affordability Act."

323.15 Sec. 30. **[62J.86] DEFINITIONS.**

323.16 Subdivision 1. **Definitions.** For the purposes of sections 62J.85 to 62J.95, the following
323.17 terms have the meanings given.

323.18 Subd. 2. **Advisory council.** "Advisory council" means the Prescription Drug Affordability
323.19 Advisory Council established under section 62J.88.

323.20 Subd. 3. **Biologic.** "Biologic" means a drug that is produced or distributed in accordance
323.21 with a biologics license application approved under Code of Federal Regulations, title 42,
323.22 section 447.502.

323.23 Subd. 4. **Biosimilar.** "Biosimilar" has the meaning provided in section 62J.84, subdivision
323.24 2, paragraph (b).

323.25 Subd. 5. **Board.** "Board" means the Prescription Drug Affordability Board established
323.26 under section 62J.87.

323.27 Subd. 6. **Brand name drug.** "Brand name drug" has the meaning provided in section
323.28 62J.84, subdivision 2, paragraph (c).

323.29 Subd. 7. **Generic drug.** "Generic drug" has the meaning provided in section 62J.84,
323.30 subdivision 2, paragraph (e).

324.1 Subd. 8. **Group purchaser.** "Group purchaser" has the meaning given in section 62J.03,
324.2 subdivision 6, and includes pharmacy benefit managers as defined in section 62W.02,
324.3 subdivision 15.

324.4 Subd. 9. **Manufacturer.** "Manufacturer" means an entity that:

324.5 (1) engages in the manufacture of a prescription drug product or enters into a lease with
324.6 another manufacturer to market and distribute a prescription drug product under the entity's
324.7 own name; and

324.8 (2) sets or changes the wholesale acquisition cost of the prescription drug product it
324.9 manufactures or markets.

324.10 Subd. 10. **Prescription drug product.** "Prescription drug product" means a brand name
324.11 drug, a generic drug, a biologic, or a biosimilar.

324.12 Subd. 11. **Wholesale acquisition cost or WAC.** "Wholesale acquisition cost" or "WAC"
324.13 has the meaning given in United States Code, title 42, section 1395W-3a(c)(6)(B).

324.14 Sec. 31. **[62J.87] PRESCRIPTION DRUG AFFORDABILITY BOARD.**

324.15 Subdivision 1. **Establishment.** The commissioner of commerce shall establish the
324.16 Prescription Drug Affordability Board, which shall be governed as a board under section
324.17 15.012, paragraph (a), to protect consumers, state and local governments, health plan
324.18 companies, providers, pharmacies, and other health care system stakeholders from
324.19 unaffordable costs of certain prescription drugs.

324.20 Subd. 2. **Membership.** (a) The Prescription Drug Affordability Board consists of nine
324.21 members appointed as follows:

324.22 (1) seven voting members appointed by the governor;

324.23 (2) one nonvoting member appointed by the majority leader of the senate; and

324.24 (3) one nonvoting member appointed by the speaker of the house.

324.25 (b) All members appointed must have knowledge and demonstrated expertise in
324.26 pharmaceutical economics and finance or health care economics and finance. A member
324.27 must not be an employee of, a board member of, or a consultant to a manufacturer or trade
324.28 association for manufacturers or a pharmacy benefit manager or trade association for
324.29 pharmacy benefit managers.

324.30 (c) Initial appointments must be made by January 1, 2023.

325.1 Subd. 3. **Terms.** (a) Board appointees shall serve four-year terms, except that initial
325.2 appointees shall serve staggered terms of two, three, or four years as determined by lot by
325.3 the secretary of state. A board member shall serve no more than two consecutive terms.

325.4 (b) A board member may resign at any time by giving written notice to the board.

325.5 Subd. 4. **Chair; other officers.** (a) The governor shall designate an acting chair from
325.6 the members appointed by the governor. The acting chair shall convene the first meeting
325.7 of the board.

325.8 (b) The board shall elect a chair to replace the acting chair at the first meeting of the
325.9 board by a majority of the members. The chair shall serve for one year.

325.10 (c) The board shall elect a vice-chair and other officers from its membership as it deems
325.11 necessary.

325.12 Subd. 5. **Staff; technical assistance.** (a) The board shall hire an executive director and
325.13 other staff, who shall serve in the unclassified service. The executive director must have
325.14 knowledge and demonstrated expertise in pharmacoeconomics, pharmacology, health policy,
325.15 health services research, medicine, or a related field or discipline. The board may employ
325.16 or contract for professional and technical assistance as the board deems necessary to perform
325.17 the board's duties.

325.18 (b) The attorney general shall provide legal services to the board.

325.19 Subd. 6. **Compensation.** The board members shall not receive compensation but may
325.20 receive reimbursement for expenses as authorized under section 15.059, subdivision 3.

325.21 Subd. 7. **Meetings.** (a) Meetings of the board are subject to chapter 13D. The board shall
325.22 meet publicly at least every three months to review prescription drug product information
325.23 submitted to the board under section 62J.90. If there are no pending submissions, the chair
325.24 of the board may cancel or postpone the required meeting. The board may meet in closed
325.25 session when reviewing proprietary information as determined under the standards developed
325.26 in accordance with section 62J.91, subdivision 4.

325.27 (b) The board shall announce each public meeting at least two weeks prior to the
325.28 scheduled date of the meeting. Any materials for the meeting must be made public at least
325.29 one week prior to the scheduled date of the meeting.

325.30 (c) At each public meeting, the board shall provide the opportunity for comments from
325.31 the public, including the opportunity for written comments to be submitted to the board
325.32 prior to a decision by the board.

326.1 Sec. 32. **[62J.88] PRESCRIPTION DRUG AFFORDABILITY ADVISORY**
326.2 **COUNCIL.**

326.3 **Subdivision 1. Establishment.** The governor shall appoint a 12-member stakeholder
326.4 advisory council to provide advice to the board on drug cost issues and to represent
326.5 stakeholders' views. The members of the advisory council shall be appointed based on their
326.6 knowledge and demonstrated expertise in one or more of the following areas: the
326.7 pharmaceutical business; practice of medicine; patient perspectives; health care cost trends
326.8 and drivers; clinical and health services research; and the health care marketplace.

326.9 **Subd. 2. Membership.** The council's membership shall consist of the following:

326.10 (1) two members representing patients and health care consumers;

326.11 (2) two members representing health care providers;

326.12 (3) one member representing health plan companies;

326.13 (4) two members representing employers, with one member representing large employers
326.14 and one member representing small employers;

326.15 (5) one member representing government employee benefit plans;

326.16 (6) one member representing pharmaceutical manufacturers;

326.17 (7) one member who is a health services clinical researcher;

326.18 (8) one member who is a pharmacologist; and

326.19 (9) one member representing the commissioner of health with expertise in health
326.20 economics.

326.21 **Subd. 3. Terms.** (a) The initial appointments to the advisory council must be made by
326.22 January 1, 2023. The initial appointed advisory council members shall serve staggered terms
326.23 of two, three, or four years determined by lot by the secretary of state. Following the initial
326.24 appointments, the advisory council members shall serve four-year terms.

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

326.26 **Subd. 4. Compensation.** Advisory council members may be compensated according to
326.27 section 15.059.

326.28 **Subd. 5. Meetings.** Meetings of the advisory council are subject to chapter 13D. The
326.29 advisory council shall meet publicly at least every three months to advise the board on drug
326.30 cost issues related to the prescription drug product information submitted to the board under
326.31 section 62J.90.

327.1 Subd. 6. **Exemption.** Notwithstanding section 15.059, the advisory council shall not
327.2 expire.

327.3 Sec. 33. **[62J.89] CONFLICTS OF INTEREST.**

327.4 Subdivision 1. **Definition.** (a) For purposes of this section, "conflict of interest" means
327.5 a financial or personal association that has the potential to bias or have the appearance of
327.6 biasing a person's decisions in matters related to the board or the advisory council, or in the
327.7 conduct of the board's or council's activities.

327.8 (b) A conflict of interest includes any instance in which a person or a person's immediate
327.9 family member has received or could receive a direct or indirect financial benefit of any
327.10 amount deriving from the result or findings of a decision or determination of the board.

327.11 (c) For purposes of this section, a person's immediate family member includes a spouse,
327.12 parent, child, or other legal dependent, or an in-law of any of the preceding individuals.

327.13 (d) For purposes of this section, a financial benefit includes honoraria, fees, stock, the
327.14 value of stock holdings, and any direct financial benefit deriving from the finding of a review
327.15 conducted under sections 62J.85 to 62J.95.

327.16 (e) Ownership of securities is not a conflict of interest if the securities are: (1) part of a
327.17 diversified mutual or exchange traded fund; or (2) in a tax-deferred or tax-exempt retirement
327.18 account that is administered by an independent trustee.

327.19 Subd. 2. **General.** (a) A board or advisory council member, board staff member, or
327.20 third-party contractor must disclose any conflicts of interest to the appointing authority or
327.21 the board prior to the acceptance of an appointment, an offer of employment, or a contractual
327.22 agreement. The information disclosed must include the type, nature, and magnitude of the
327.23 interests involved.

327.24 (b) A board member, board staff member, or third-party contractor with a conflict of
327.25 interest relating to any prescription drug product under review must recuse themselves from
327.26 any discussion, review, decision, or determination made by the board relating to the
327.27 prescription drug product.

327.28 (c) Any conflict of interest must be disclosed in advance of the first meeting after the
327.29 conflict is identified or within five days after the conflict is identified, whichever is earlier.

327.30 Subd. 3. **Prohibitions.** Board members, board staff, or third-party contractors are
327.31 prohibited from accepting gifts, bequeaths, or donations of services or property that raise

328.1 the specter of a conflict of interest or have the appearance of injecting bias into the activities
328.2 of the board.

328.3 **Sec. 34. [62J.90] PRESCRIPTION DRUG PRICE INFORMATION; DECISION**
328.4 **TO CONDUCT COST REVIEW.**

328.5 **Subdivision 1. Drug price information from the commissioner of health and other**
328.6 **sources.** (a) The commissioner of health shall provide to the board the information reported
328.7 to the commissioner by drug manufacturers under section 62J.84, subdivisions 3, 4, and 5.
328.8 The commissioner shall provide this information to the board within 30 days of the date the
328.9 information is received from drug manufacturers.

328.10 (b) The board shall subscribe to one or more prescription drug pricing files, such as
328.11 Medispan or FirstDatabank, or as otherwise determined by the board.

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

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

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

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

328.21 (4) generic drugs for which the WAC:

328.22 (i) is \$100 or more, after adjusting for changes in the CPI, for:

328.23 (A) a 30-day supply lasting a patient for a period of 30 consecutive days based on the
328.24 recommended dosage approved for labeling by the United States Food and Drug
328.25 Administration (FDA);

328.26 (B) a supply lasting a patient for fewer than 30 days based on recommended dosage
328.27 approved for labeling by the FDA; or

328.28 (C) one unit of the drug if the labeling approved by the FDA does not recommend a
328.29 finite dosage; and

329.1 (ii) has increased by 200 percent or more during the immediate preceding 12-month
329.2 period, as determined by the difference between the resulting WAC and the average of the
329.3 WAC reported over the preceding 12 months, after adjusting for changes in the CPI.

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

329.8 (c) The board shall make available to the public the names and related price information
329.9 of the prescription drug products identified under this subdivision, with the exception of
329.10 information determined by the board to be proprietary under the standards developed by
329.11 the board under section 62J.91, subdivision 4.

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

329.14 (b) The board shall consider requests by the public for the board to proceed with a cost
329.15 review of any prescription drug product identified under this section.

329.16 (c) If there is no consensus among the members of the board on whether or not to initiate
329.17 a cost review of a prescription drug product, any member of the board may request a vote
329.18 to determine whether or not to review the cost of the prescription drug product.

329.19 **Sec. 35. [62J.91] PRESCRIPTION DRUG PRODUCT REVIEWS.**

329.20 Subdivision 1. **General.** Once the board decides to proceed with a cost review of a
329.21 prescription drug product, the board shall conduct the review and make a determination as
329.22 to whether appropriate utilization of the prescription drug under review, based on utilization
329.23 that is consistent with the United States Food and Drug Administration (FDA) label or
329.24 standard medical practice, has led or will lead to affordability challenges for the state health
329.25 care system or for patients.

329.26 Subd. 2. **Review considerations.** In reviewing the cost of a prescription drug product,
329.27 the board may consider the following factors:

329.28 (1) the price at which the prescription drug product has been and will be sold in the state;

329.29 (2) the average monetary price concession, discount, or rebate the manufacturer provides
329.30 to a group purchaser in this state as reported by the manufacturer and the group purchaser,
329.31 expressed as a percent of the WAC for the prescription drug product under review;

329.32 (3) the price at which therapeutic alternatives have been or will be sold in the state;

330.1 (4) the average monetary price concession, discount, or rebate the manufacturer provides
330.2 or is expected to provide to a group purchaser or group purchasers in the state for therapeutic
330.3 alternatives;

330.4 (5) the cost to group purchasers based on patient access consistent with the FDA-labeled
330.5 indications;

330.6 (6) the impact on patient access resulting from the cost of the prescription drug product
330.7 relative to insurance benefit design;

330.8 (7) the current or expected dollar value of drug-specific patient access programs supported
330.9 by manufacturers;

330.10 (8) the relative financial impacts to health, medical, or other social services costs that
330.11 can be quantified and compared to baseline effects of existing therapeutic alternatives;

330.12 (9) the average patient co-pay or other cost-sharing for the prescription drug product in
330.13 the state;

330.14 (10) any information a manufacturer chooses to provide; and

330.15 (11) any other factors as determined by the board.

330.16 Subd. 3. **Further review factors.** If, after considering the factors described in subdivision
330.17 2, the board is unable to determine whether a prescription drug product will produce or has
330.18 produced an affordability challenge, the board may consider:

330.19 (1) manufacturer research and development costs, as indicated on the manufacturer's
330.20 federal tax filing for the most recent tax year, in proportion to the manufacturer's sales in
330.21 the state;

330.22 (2) the portion of direct-to-consumer marketing costs eligible for favorable federal tax
330.23 treatment in the most recent tax year that is specific to the prescription drug product under
330.24 review, multiplied by the ratio of total manufacturer in-state sales to total manufacturer
330.25 sales in the United States for the product under review;

330.26 (3) gross and net manufacturer revenues for the most recent tax year;

330.27 (4) any information and research related to the manufacturer's selection of the introductory
330.28 price or price increase, including but not limited to:

330.29 (i) life cycle management;

330.30 (ii) market competition and context; and

330.31 (iii) projected revenue; and

331.1 (5) any additional factors determined by the board to be relevant.

331.2 Subd. 4. **Public data; proprietary information.** (a) Any submission made to the board
331.3 related to a drug cost review must be made available to the public with the exception of
331.4 information determined by the board to be proprietary.

331.5 (b) The board shall establish the standards for the information to be considered proprietary
331.6 under paragraph (a) and section 62J.90, subdivision 2, including standards for heightened
331.7 consideration of proprietary information for submissions for a cost review of a drug that is
331.8 not yet approved by the FDA.

331.9 (c) Prior to the board establishing the standards under paragraph (b), the public must be
331.10 provided notice and the opportunity to submit comments.

331.11 Sec. 36. **[62J.92] DETERMINATIONS; COMPLIANCE; REMEDIES.**

331.12 Subdivision 1. **Upper payment limit.** (a) In the event the board finds that the spending
331.13 on a prescription drug product reviewed under section 62J.91 creates an affordability
331.14 challenge for the state health care system or for patients, the board shall establish an upper
331.15 payment limit after considering:

331.16 (1) the cost of administering the drug;

331.17 (2) the cost of delivering the drug to consumers;

331.18 (3) the range of prices at which the drug is sold in the United States according to one or
331.19 more pricing files accessed under section 62J.90, subdivision 1, and the range at which
331.20 pharmacies are reimbursed in Canada; and

331.21 (4) any other relevant pricing and administrative cost information for the drug.

331.22 (b) The upper payment limit must apply to all public and private purchases, payments,
331.23 and payer reimbursements for the prescription drug products received by an individual in
331.24 the state in person, by mail, or by other means.

331.25 Subd. 2. **Noncompliance.** (a) The failure of an entity to comply with an upper payment
331.26 limit established by the board under this section shall be referred to the Office of the Attorney
331.27 General.

331.28 (b) If the Office of the Attorney General finds that an entity was noncompliant with the
331.29 upper payment limit requirements, the attorney general may pursue remedies consistent
331.30 with chapter 8 or appropriate criminal charges if there is evidence of intentional profiteering.

332.1 (c) An entity that obtains price concessions from a drug manufacturer that result in a
332.2 lower net cost to the stakeholder than the upper payment limit established by the board must
332.3 not be considered to be in noncompliance.

332.4 (d) The Office of the Attorney General may provide guidance to stakeholders concerning
332.5 activities that could be considered noncompliant.

332.6 Subd. 3. Appeals. (a) Persons affected by a decision of the board may request an appeal
332.7 of the board's decision within 30 days of the date of the decision. The board shall hear the
332.8 appeal and render a decision within 60 days of the hearing.

332.9 (b) All appeal decisions are subject to judicial review in accordance with chapter 14.

332.10 Sec. 37. **[62J.93] REPORTS.**

332.11 Beginning March 1, 2023, and each March 1 thereafter, the board shall submit a report
332.12 to the governor and legislature on general price trends for prescription drug products and
332.13 the number of prescription drug products that were subject to the board's cost review and
332.14 analysis, including the result of any analysis and the number and disposition of appeals and
332.15 judicial reviews.

332.16 Sec. 38. **[62J.94] ERISA PLANS AND MEDICARE DRUG PLANS.**

332.17 (a) Nothing in sections 62J.85 to 62J.95 shall be construed to require ERISA plans or
332.18 Medicare Part D plans to comply with decisions of the board. ERISA plans or Medicare
332.19 Part D plans may choose to exceed the upper payment limit established by the board under
332.20 section 62J.92.

332.21 (b) Providers who dispense and administer drugs in the state must bill all payers no more
332.22 than the upper payment limit without regard to whether or not an ERISA plan or Medicare
332.23 Part D plan chooses to reimburse the provider in an amount greater than the upper payment
332.24 limit established by the board.

332.25 (c) For purposes of this section, an ERISA plan or group health plan is an employee
332.26 welfare benefit plan established or maintained by an employer or an employee organization,
332.27 or both, that provides employer sponsored health coverage to employees and the employee's
332.28 dependents and is subject to the Employee Retirement Income Security Act of 1974 (ERISA).

332.29 Sec. 39. **[62J.95] SEVERABILITY.**

332.30 If any provision of sections 62J.85 to 62J.94 or the application thereof to any person or
332.31 circumstance is held invalid for any reason in a court of competent jurisdiction, the invalidity

333.1 does not affect other provisions or any other application of sections 62J.85 to 62J.94 that
333.2 can be given effect without the invalid provision or application.

333.3 **Sec. 40. [62Q.1842] PROHIBITION ON USE OF STEP THERAPY FOR**
333.4 **ANTIRETROVIRAL DRUGS.**

333.5 Subdivision 1. **Definitions.** (a) For purposes of this section, the following definitions
333.6 apply.

333.7 (b) "Health plan" has the meaning given in section 62Q.01, subdivision 3, and includes
333.8 health coverage provided by a managed care plan or a county-based purchasing plan
333.9 participating in a public program under chapter 256B or 256L or an integrated health
333.10 partnership under section 256B.0755.

333.11 (c) "Step therapy protocol" has the meaning given in section 62Q.184.

333.12 Subd. 2. **Prohibition on use of step therapy protocols.** A health plan that covers
333.13 antiretroviral drugs that are medically necessary for the prevention of HIV/AIDS, including
333.14 preexposure prophylaxis and postexposure prophylaxis, must not limit or exclude coverage
333.15 for the antiretroviral drugs by requiring prior authorization or by requiring an enrollee to
333.16 follow a step therapy protocol.

333.17 **Sec. 41. [62Q.481] COST-SHARING FOR PRESCRIPTION DRUGS AND RELATED**
333.18 **MEDICAL SUPPLIES TO TREAT CHRONIC DISEASE.**

333.19 Subdivision 1. **Cost-sharing limits.** (a) A health plan must limit the amount of any
333.20 enrollee cost-sharing for prescription drugs prescribed to treat a chronic disease to no more
333.21 than \$25 per one-month supply for each prescription drug and to no more than \$50 per
333.22 month in total for all related medical supplies. Coverage under this section must not be
333.23 subject to any deductible.

333.24 (b) If application of this section before an enrollee has met their plan's deductible would
333.25 result in health savings account ineligibility under United States Code, title 26, section 223,
333.26 then this section must apply to that specific prescription drug or related medical supply only
333.27 after the enrollee has met their plan's deductible.

333.28 Subd. 2. **Definitions.** (a) For purposes of this section, the following terms have the
333.29 meanings given.

333.30 (b) "Chronic disease" means diabetes, asthma, and allergies requiring the use of
333.31 epinephrine auto-injectors.

334.1 (c) "Cost-sharing" means co-payments and coinsurance.

334.2 (d) "Related medical supplies" means syringes, insulin pens, insulin pumps, epinephrine
334.3 auto-injectors, test strips, glucometers, continuous glucose monitors, and other medical
334.4 supply items necessary to effectively and appropriately administer a prescription drug
334.5 prescribed to treat a chronic disease.

334.6 **EFFECTIVE DATE.** This section is effective January 1, 2023, and applies to health
334.7 plans offered, issued, or renewed on or after that date.

334.8 Sec. 42. **[62Q.524] COVERAGE FOR DRUGS TO PREVENT THE ACQUISITION**
334.9 **OF HUMAN IMMUNODEFICIENCY VIRUS.**

334.10 (a) A health plan that provides prescription drug coverage must provide coverage in
334.11 accordance with this section for:

334.12 (1) any antiretroviral drug approved by the United States Food and Drug Administration
334.13 (FDA) for preventing the acquisition of human immunodeficiency virus (HIV) that is
334.14 prescribed, dispensed, or administered by a pharmacist who meets the requirements described
334.15 in section 151.37, subdivision 17; and

334.16 (2) any laboratory testing necessary for therapy that uses the drugs described in clause
334.17 (1) that is ordered, performed, and interpreted by a pharmacist who meets the requirements
334.18 described in section 151.37, subdivision 17.

334.19 (b) A health plan must provide the same terms of prescription drug coverage for drugs
334.20 to prevent the acquisition of HIV that are prescribed or administered by a pharmacist if the
334.21 pharmacist meets the requirements described in section 151.37, subdivision 17, as would
334.22 apply had the drug been prescribed or administered by a physician, physician assistant, or
334.23 advanced practice registered nurse. The health plan may require pharmacists or pharmacies
334.24 to meet reasonable medical management requirements when providing the services described
334.25 in paragraph (a) if other providers are required to meet the same requirements.

334.26 (c) A health plan must reimburse an in-network pharmacist or pharmacy for the drugs
334.27 and testing described in paragraph (a) at a rate equal to the rate of reimbursement provided
334.28 to a physician, physician assistant, or advanced practice registered nurse if providing similar
334.29 services.

334.30 (d) A health plan is not required to cover the drugs and testing described in paragraph
334.31 (a) if provided by a pharmacist or pharmacy that is out-of-network unless the health plan
334.32 covers similar services provided by out-of-network providers. A health plan must ensure

335.1 that the health plan's provider network includes in-network pharmacies that provide the
335.2 services described in paragraph (a).

335.3 Sec. 43. [62Q.83] PRESCRIPTION DRUG BENEFIT TRANSPARENCY AND
335.4 MANAGEMENT.

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

335.7 (b) "Drug" has the meaning given in section 151.01, subdivision 5.

335.8 (c) "Enrollee contract term" means the 12-month term during which benefits associated
335.9 with health plan company products are in effect. For managed care plans and county-based
335.10 purchasing plans under section 256B.69 and chapter 256L, enrollee contract term means a
335.11 single calendar quarter.

335.12 (d) "Formulary" means a list of prescription drugs developed by clinical and pharmacy
335.13 experts that represents the health plan company's medically appropriate and cost-effective
335.14 prescription drugs approved for use.

335.15 (e) "Health plan company" has the meaning given in section 62Q.01, subdivision 4, and
335.16 includes an entity that performs pharmacy benefits management for the health plan company.
335.17 For purposes of this paragraph, "pharmacy benefits management" means the administration
335.18 or management of prescription drug benefits provided by the health plan company for the
335.19 benefit of the plan's enrollees and may include but is not limited to procurement of
335.20 prescription drugs, clinical formulary development and management services, claims
335.21 processing, and rebate contracting and administration.

335.22 (f) "Prescription" has the meaning given in section 151.01, subdivision 16a.

335.23 Subd. 2. Prescription drug benefit disclosure. (a) A health plan company that provides
335.24 prescription drug benefit coverage and uses a formulary must make the plan's formulary
335.25 and related benefit information available by electronic means and, upon request, in writing
335.26 at least 30 days before annual renewal dates.

335.27 (b) Formularies must be organized and disclosed consistent with the most recent version
335.28 of the United States Pharmacopeia's (USP) Model Guidelines.

335.29 (c) For each item or category of items on the formulary, the specific enrollee benefit
335.30 terms must be identified, including enrollee cost-sharing and expected out-of-pocket costs.

335.31 Subd. 3. Formulary changes. (a) Once a formulary has been established, a health plan
335.32 company may, at any time during the enrollee's contract term:

336.1 (1) expand its formulary by adding drugs to the formulary;

336.2 (2) reduce co-payments or coinsurance; or

336.3 (3) move a drug to a benefit category that reduces an enrollee's cost.

336.4 (b) A health plan company may remove a brand name drug from the plan's formulary
336.5 or place a brand name drug in a benefit category that increases an enrollee's cost only upon
336.6 the addition to the formulary of a generic or multisource brand name drug rated as
336.7 therapeutically equivalent according to the FDA Orange Book or a biologic drug rated as
336.8 interchangeable according to the FDA Purple Book at a lower cost to the enrollee, and upon
336.9 at least a 60-day notice to prescribers, pharmacists, and affected enrollees.

336.10 (c) A health plan company may change utilization review requirements or move drugs
336.11 to a benefit category that increases an enrollee's cost during the enrollee's contract term
336.12 upon at least a 60-day notice to prescribers, pharmacists, and affected enrollees, provided
336.13 that these changes do not apply to enrollees who are currently taking the drugs affected by
336.14 these changes for the duration of the enrollee's contract term.

336.15 (d) A health plan company may remove any drugs from the plan's formulary that have
336.16 been deemed unsafe by the Food and Drug Administration; that have been withdrawn by
336.17 either the Food and Drug Administration or the product manufacturer; or when an
336.18 independent source of research, clinical guidelines, or evidence-based standards has issued
336.19 drug-specific warnings or recommended changes in drug usage.

336.20 (e) The state employee group insurance program and coverage offered through that
336.21 program are exempt from the requirements of this subdivision.

336.22 Subd. 4. **Not severable.** (a) The provisions of this section are not severable from the
336.23 amendments and enactments in this act to sections 62A.02, subdivision 1; 62J.84,
336.24 subdivisions 2, 6, 7, 8, and 9; 62J.841; and 151.071, subdivision 2.

336.25 (b) If any amendment or enactment listed in paragraph (a) or its application to any
336.26 individual, entity, or circumstance is found to be void for any reason, this section is also
336.27 void.

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

336.30 Sec. 44. **[62W.0751] ALTERNATIVE BIOLOGICAL PRODUCTS.**

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

337.1 (b) "Biological product" has the meaning given in section 151.01, subdivision 40.

337.2 (c) "Biosimilar" or "biosimilar product" has the meaning given in section 151.01,
337.3 subdivision 43.

337.4 (d) "Interchangeable biological product" has the meaning given in section 151.01,
337.5 subdivision 41.

337.6 (e) "Reference biological product" has the meaning given in section 151.01, subdivision
337.7 44.

337.8 **Subd. 2. Pharmacy and provider choice related to dispensing reference biological**
337.9 **products, interchangeable biological products, or biosimilar products. (a)**

337.10 Notwithstanding paragraph (b), a pharmacy benefit manager or health carrier must not
337.11 require or demonstrate a preference for a reference biological product administered to a
337.12 patient by a physician or health care provider or any product that is biosimilar to the reference
337.13 biological product or an interchangeable biological product administered to a patient by a
337.14 physician or health care provider.

337.15 (b) If a pharmacy benefit manager or health carrier elects coverage of a product listed
337.16 in paragraph (a), and there are two or less biosimilar products available relative to the
337.17 reference product, the pharmacy benefit manager or health carrier must elect equivalent
337.18 coverage for all of the products that are biosimilar to the reference biological product or
337.19 interchangeable biological product.

337.20 (c) If a pharmacy benefit manager or health carrier elects coverage of a product listed
337.21 in paragraph (a), and there are greater than two biosimilar products available relative to the
337.22 reference product, the pharmacy benefit manager or health carrier must elect preferential
337.23 coverage for all of the products that are biosimilar to the reference biological or
337.24 interchangeable biological products.

337.25 (d) A pharmacy benefit manager or health carrier must not impose limits on access to a
337.26 product required to be covered under paragraph (b) that are more restrictive than limits
337.27 imposed on access to a product listed in paragraph (a), or that otherwise have the same
337.28 effect as giving preferred status to a product listed in paragraph (a) over the product required
337.29 to be covered under paragraph (b).

337.30 (e) This section only applies to new administrations of a reference biological product.
337.31 Nothing in this section requires switching from a prescribed reference biological product
337.32 for a patient on an active course of treatment.

338.1 Subd. 3. **Exemption.** The state employee group insurance program, and coverage offered
338.2 through that program, are exempt from the requirements of this section.

338.3 **EFFECTIVE DATE.** This section is effective January 1, 2023.

338.4 Sec. 45. **[62W.15] CLINICIAN-ADMINISTERED DRUGS.**

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

338.7 (b) "Affiliated pharmacy" means a pharmacy in which a pharmacy benefit manager or
338.8 health carrier has an ownership interest either directly or indirectly, or through an affiliate
338.9 or subsidiary.

338.10 (c) "Clinician-administered drug" means an outpatient prescription drug other than a
338.11 vaccine that:

338.12 (1) cannot reasonably be self-administered by the patient to whom the drug is prescribed
338.13 or by an individual assisting the patient with self-administration; and

338.14 (2) is typically administered:

338.15 (i) by a health care provider authorized to administer the drug, including when acting
338.16 under a physician's delegation and supervision; and

338.17 (ii) in a physician's office, hospital outpatient infusion center, or other clinical setting.

338.18 Subd. 2. **Prohibition on requiring coverage as a pharmacy benefit.** A pharmacy
338.19 benefit manager or health carrier shall not require that a clinician-administered drug or the
338.20 administration of a clinician-administered drug be covered as a pharmacy benefit.

338.21 Subd. 3. **Enrollee choice.** A pharmacy benefit manager or health carrier:

338.22 (1) shall permit an enrollee to obtain a clinician-administered drug from a health care
338.23 provider authorized to administer the drug, or a pharmacy;

338.24 (2) shall not interfere with the enrollee's right to obtain a clinician-administered drug
338.25 from their provider or pharmacy of choice, and shall not offer financial or other incentives
338.26 to influence the enrollee's choice of a provider or pharmacy;

338.27 (3) shall not require clinician-administered drugs to be dispensed by a pharmacy selected
338.28 by the pharmacy benefit manager or health carrier; and

338.29 (4) shall not limit or exclude coverage for a clinician-administered drug when it is not
338.30 dispensed by a pharmacy selected by the pharmacy benefit manager or health carrier, if the
338.31 drug would otherwise be covered.

339.1 Subd. 4. Cost-sharing and reimbursement. A pharmacy benefit manager or health
339.2 carrier:

339.3 (1) may impose coverage or benefit limitations on an enrollee who obtains a
339.4 clinician-administered drug from a health care provider authorized to administer the drug,
339.5 or a pharmacy, only if these limitations would also be imposed were the drug to be obtained
339.6 from an affiliated pharmacy or a pharmacy selected by the pharmacy benefit manager or
339.7 health carrier; and

339.8 (2) may impose cost-sharing requirements on an enrollee who obtains a
339.9 clinician-administered drug from a health care provider authorized to administer the drug,
339.10 or a pharmacy, only if these requirements would also be imposed were the drug to be obtained
339.11 from an affiliated pharmacy or a pharmacy selected by the pharmacy benefit manager or
339.12 health carrier.

339.13 Subd. 5. Other requirements. A pharmacy benefit manager or health carrier:

339.14 (1) shall not require or encourage the dispensing of a clinician-administered drug to an
339.15 enrollee in a manner that is inconsistent with the supply chain security controls and chain
339.16 of distribution set by the federal Drug Supply Chain Security Act, United States Code, title
339.17 21, section 360eee, et seq.;

339.18 (2) shall not require a specialty pharmacy to dispense a clinician-administered medication
339.19 directly to a patient with the intention that the patient will transport the medication to a
339.20 health care provider for administration; and

339.21 (3) may offer, but shall not require:

339.22 (i) the use of a home infusion pharmacy to dispense or administer clinician-administered
339.23 drugs to enrollees; and

339.24 (ii) the use of an infusion site external to the enrollee's provider office or clinic.

339.25 **EFFECTIVE DATE.** This section is effective January 1, 2023.

339.26 Sec. 46. Minnesota Statutes 2020, section 151.01, subdivision 23, is amended to read:

339.27 Subd. 23. **Practitioner.** "Practitioner" means a licensed doctor of medicine, licensed
339.28 doctor of osteopathic medicine duly licensed to practice medicine, licensed doctor of
339.29 dentistry, licensed doctor of optometry, licensed podiatrist, licensed veterinarian, licensed
339.30 advanced practice registered nurse, or licensed physician assistant. For purposes of sections
339.31 151.15, subdivision 4; 151.211, subdivision 3; 151.252, subdivision 3; 151.37, subdivision
339.32 2, paragraph (b); and 151.461, "practitioner" also means a dental therapist authorized to

340.1 dispense and administer under chapter 150A. For purposes of sections 151.252, subdivision
340.2 3, and 151.461, "practitioner" also means a pharmacist authorized to prescribe
340.3 self-administered hormonal contraceptives, nicotine replacement medications, or opiate
340.4 antagonists under section 151.37, subdivision 14, 15, or 16, or authorized to prescribe drugs
340.5 to prevent the acquisition of human immunodeficiency virus (HIV) under section 151.37,
340.6 subdivision 17.

340.7 Sec. 47. Minnesota Statutes 2020, section 151.01, subdivision 27, is amended to read:

340.8 Subd. 27. **Practice of pharmacy.** "Practice of pharmacy" means:

340.9 (1) interpretation and evaluation of prescription drug orders;

340.10 (2) compounding, labeling, and dispensing drugs and devices (except labeling by a
340.11 manufacturer or packager of nonprescription drugs or commercially packaged legend drugs
340.12 and devices);

340.13 (3) participation in clinical interpretations and monitoring of drug therapy for assurance
340.14 of safe and effective use of drugs, including the performance of laboratory tests that are
340.15 waived under the federal Clinical Laboratory Improvement Act of 1988, United States Code,
340.16 title 42, section 263a et seq., provided that a pharmacist may interpret the results of laboratory
340.17 tests but may modify drug therapy only pursuant to a protocol or collaborative practice
340.18 agreement;

340.19 (4) participation in drug and therapeutic device selection; drug administration for first
340.20 dosage and medical emergencies; intramuscular and subcutaneous administration used for
340.21 the treatment of alcohol or opioid dependence; drug regimen reviews; and drug or
340.22 drug-related research;

340.23 (5) drug administration, through intramuscular and subcutaneous administration used
340.24 to treat mental illnesses as permitted under the following conditions:

340.25 (i) upon the order of a prescriber and the prescriber is notified after administration is
340.26 complete; or

340.27 (ii) pursuant to a protocol or collaborative practice agreement as defined by section
340.28 151.01, subdivisions 27b and 27c, and participation in the initiation, management,
340.29 modification, administration, and discontinuation of drug therapy is according to the protocol
340.30 or collaborative practice agreement between the pharmacist and a dentist, optometrist,
340.31 physician, podiatrist, or veterinarian, or an advanced practice registered nurse authorized
340.32 to prescribe, dispense, and administer under section 148.235. Any changes in drug therapy
340.33 or medication administration made pursuant to a protocol or collaborative practice agreement

341.1 must be documented by the pharmacist in the patient's medical record or reported by the
341.2 pharmacist to a practitioner responsible for the patient's care;

341.3 (6) participation in administration of influenza vaccines and vaccines approved by the
341.4 United States Food and Drug Administration related to COVID-19 or SARS-CoV-2 to all
341.5 eligible individuals six years of age and older and all other vaccines to patients 13 years of
341.6 age and older by written protocol with a physician licensed under chapter 147, a physician
341.7 assistant authorized to prescribe drugs under chapter 147A, or an advanced practice registered
341.8 nurse authorized to prescribe drugs under section 148.235, provided that:

341.9 (i) the protocol includes, at a minimum:

341.10 (A) the name, dose, and route of each vaccine that may be given;

341.11 (B) the patient population for whom the vaccine may be given;

341.12 (C) contraindications and precautions to the vaccine;

341.13 (D) the procedure for handling an adverse reaction;

341.14 (E) the name, signature, and address of the physician, physician assistant, or advanced
341.15 practice registered nurse;

341.16 (F) a telephone number at which the physician, physician assistant, or advanced practice
341.17 registered nurse can be contacted; and

341.18 (G) the date and time period for which the protocol is valid;

341.19 (ii) the pharmacist has successfully completed a program approved by the Accreditation
341.20 Council for Pharmacy Education specifically for the administration of immunizations or a
341.21 program approved by the board;

341.22 (iii) the pharmacist utilizes the Minnesota Immunization Information Connection to
341.23 assess the immunization status of individuals prior to the administration of vaccines, except
341.24 when administering influenza vaccines to individuals age nine and older;

341.25 (iv) the pharmacist reports the administration of the immunization to the Minnesota
341.26 Immunization Information Connection; and

341.27 (v) the pharmacist complies with guidelines for vaccines and immunizations established
341.28 by the federal Advisory Committee on Immunization Practices, except that a pharmacist
341.29 does not need to comply with those portions of the guidelines that establish immunization
341.30 schedules when administering a vaccine pursuant to a valid, patient-specific order issued
341.31 by a physician licensed under chapter 147, a physician assistant authorized to prescribe
341.32 drugs under chapter 147A, or an advanced practice registered nurse authorized to prescribe

342.1 drugs under section 148.235, provided that the order is consistent with the United States
342.2 Food and Drug Administration approved labeling of the vaccine;

342.3 (7) participation in the initiation, management, modification, and discontinuation of
342.4 drug therapy according to a written protocol or collaborative practice agreement between:
342.5 (i) one or more pharmacists and one or more dentists, optometrists, physicians, podiatrists,
342.6 or veterinarians; or (ii) one or more pharmacists and one or more physician assistants
342.7 authorized to prescribe, dispense, and administer under chapter 147A, or advanced practice
342.8 registered nurses authorized to prescribe, dispense, and administer under section 148.235.
342.9 Any changes in drug therapy made pursuant to a protocol or collaborative practice agreement
342.10 must be documented by the pharmacist in the patient's medical record or reported by the
342.11 pharmacist to a practitioner responsible for the patient's care;

342.12 (8) participation in the storage of drugs and the maintenance of records;

342.13 (9) patient counseling on therapeutic values, content, hazards, and uses of drugs and
342.14 devices;

342.15 (10) offering or performing those acts, services, operations, or transactions necessary
342.16 in the conduct, operation, management, and control of a pharmacy;

342.17 (11) participation in the initiation, management, modification, and discontinuation of
342.18 therapy with opiate antagonists, as defined in section 604A.04, subdivision 1, pursuant to:
342.19 (i) a written protocol as allowed under clause (7); or
342.20 (ii) a written protocol with a community health board medical consultant or a practitioner
342.21 designated by the commissioner of health, as allowed under section 151.37, subdivision 13;
342.22 ~~and~~

342.23 (12) prescribing self-administered hormonal contraceptives; nicotine replacement
342.24 medications; and opiate antagonists for the treatment of an acute opiate overdose pursuant
342.25 to section 151.37, subdivision 14, 15, or 16-;

342.26 (13) prescribing, dispensing, and administering drugs for preventing the acquisition of
342.27 human immunodeficiency virus (HIV) if the pharmacist meets the requirements under
342.28 section 151.37, subdivision 17; and

342.29 (14) ordering, conducting, and interpreting laboratory tests necessary for therapies that
342.30 use drugs for preventing the acquisition of HIV, if the pharmacist meets the requirements
342.31 under section 151.37, subdivision 17.

343.1 Sec. 48. Minnesota Statutes 2020, section 151.01, is amended by adding a subdivision to
343.2 read:

343.3 Subd. 43. **Biosimilar product.** "Biosimilar product" or "interchangeable biologic product"
343.4 means a biological product that the United States Food and Drug Administration has licensed
343.5 and determined to be biosimilar under United States Code, title 42, section 262(i)(2).

343.6 **EFFECTIVE DATE.** This section is effective January 1, 2023.

343.7 Sec. 49. Minnesota Statutes 2020, section 151.01, is amended by adding a subdivision to
343.8 read:

343.9 Subd. 44. **Reference biological product.** "Reference biological product" means the
343.10 single biological product for which the United States Food and Drug Administration has
343.11 approved an initial biological product license application, against which other biological
343.12 products are evaluated for licensure as biosimilar products or interchangeable biological
343.13 products.

343.14 **EFFECTIVE DATE.** This section is effective January 1, 2023.

343.15 Sec. 50. Minnesota Statutes 2020, section 151.071, subdivision 1, is amended to read:

343.16 Subdivision 1. **Forms of disciplinary action.** When the board finds that a licensee,
343.17 registrant, or applicant has engaged in conduct prohibited under subdivision 2, it may do
343.18 one or more of the following:

343.19 (1) deny the issuance of a license or registration;

343.20 (2) refuse to renew a license or registration;

343.21 (3) revoke the license or registration;

343.22 (4) suspend the license or registration;

343.23 (5) impose limitations, conditions, or both on the license or registration, including but
343.24 not limited to: the limitation of practice to designated settings; the limitation of the scope
343.25 of practice within designated settings; the imposition of retraining or rehabilitation
343.26 requirements; the requirement of practice under supervision; the requirement of participation
343.27 in a diversion program such as that established pursuant to section 214.31 or the conditioning
343.28 of continued practice on demonstration of knowledge or skills by appropriate examination
343.29 or other review of skill and competence;

343.30 (6) impose a civil penalty not exceeding \$10,000 for each separate violation, except that
343.31 a civil penalty not exceeding \$25,000 may be imposed for each separate violation of section

344.1 62J.842, the amount of the civil penalty to be fixed so as to deprive a licensee or registrant
344.2 of any economic advantage gained by reason of the violation, to discourage similar violations
344.3 by the licensee or registrant or any other licensee or registrant, or to reimburse the board
344.4 for the cost of the investigation and proceeding, including but not limited to, fees paid for
344.5 services provided by the Office of Administrative Hearings, legal and investigative services
344.6 provided by the Office of the Attorney General, court reporters, witnesses, reproduction of
344.7 records, board members' per diem compensation, board staff time, and travel costs and
344.8 expenses incurred by board staff and board members; and

344.9 (7) reprimand the licensee or registrant.

344.10 Sec. 51. Minnesota Statutes 2020, section 151.071, subdivision 2, is amended to read:

344.11 Subd. 2. **Grounds for disciplinary action.** The following conduct is prohibited and is
344.12 grounds for disciplinary action:

344.13 (1) failure to demonstrate the qualifications or satisfy the requirements for a license or
344.14 registration contained in this chapter or the rules of the board. The burden of proof is on
344.15 the applicant to demonstrate such qualifications or satisfaction of such requirements;

344.16 (2) obtaining a license by fraud or by misleading the board in any way during the
344.17 application process or obtaining a license by cheating, or attempting to subvert the licensing
344.18 examination process. Conduct that subverts or attempts to subvert the licensing examination
344.19 process includes, but is not limited to: (i) conduct that violates the security of the examination
344.20 materials, such as removing examination materials from the examination room or having
344.21 unauthorized possession of any portion of a future, current, or previously administered
344.22 licensing examination; (ii) conduct that violates the standard of test administration, such as
344.23 communicating with another examinee during administration of the examination, copying
344.24 another examinee's answers, permitting another examinee to copy one's answers, or
344.25 possessing unauthorized materials; or (iii) impersonating an examinee or permitting an
344.26 impersonator to take the examination on one's own behalf;

344.27 (3) for a pharmacist, pharmacy technician, pharmacist intern, applicant for a pharmacist
344.28 or pharmacy license, or applicant for a pharmacy technician or pharmacist intern registration,
344.29 conviction of a felony reasonably related to the practice of pharmacy. Conviction as used
344.30 in this subdivision includes a conviction of an offense that if committed in this state would
344.31 be deemed a felony without regard to its designation elsewhere, or a criminal proceeding
344.32 where a finding or verdict of guilt is made or returned but the adjudication of guilt is either
344.33 withheld or not entered thereon. The board may delay the issuance of a new license or

345.1 registration if the applicant has been charged with a felony until the matter has been
345.2 adjudicated;

345.3 (4) for a facility, other than a pharmacy, licensed or registered by the board, if an owner
345.4 or applicant is convicted of a felony reasonably related to the operation of the facility. The
345.5 board may delay the issuance of a new license or registration if the owner or applicant has
345.6 been charged with a felony until the matter has been adjudicated;

345.7 (5) for a controlled substance researcher, conviction of a felony reasonably related to
345.8 controlled substances or to the practice of the researcher's profession. The board may delay
345.9 the issuance of a registration if the applicant has been charged with a felony until the matter
345.10 has been adjudicated;

345.11 (6) disciplinary action taken by another state or by one of this state's health licensing
345.12 agencies:

345.13 (i) revocation, suspension, restriction, limitation, or other disciplinary action against a
345.14 license or registration in another state or jurisdiction, failure to report to the board that
345.15 charges or allegations regarding the person's license or registration have been brought in
345.16 another state or jurisdiction, or having been refused a license or registration by any other
345.17 state or jurisdiction. The board may delay the issuance of a new license or registration if an
345.18 investigation or disciplinary action is pending in another state or jurisdiction until the
345.19 investigation or action has been dismissed or otherwise resolved; and

345.20 (ii) revocation, suspension, restriction, limitation, or other disciplinary action against a
345.21 license or registration issued by another of this state's health licensing agencies, failure to
345.22 report to the board that charges regarding the person's license or registration have been
345.23 brought by another of this state's health licensing agencies, or having been refused a license
345.24 or registration by another of this state's health licensing agencies. The board may delay the
345.25 issuance of a new license or registration if a disciplinary action is pending before another
345.26 of this state's health licensing agencies until the action has been dismissed or otherwise
345.27 resolved;

345.28 (7) for a pharmacist, pharmacy, pharmacy technician, or pharmacist intern, violation of
345.29 any order of the board, of any of the provisions of this chapter or any rules of the board or
345.30 violation of any federal, state, or local law or rule reasonably pertaining to the practice of
345.31 pharmacy;

345.32 (8) for a facility, other than a pharmacy, licensed by the board, violations of any order
345.33 of the board, of any of the provisions of this chapter or the rules of the board or violation
345.34 of any federal, state, or local law relating to the operation of the facility;

346.1 (9) engaging in any unethical conduct; conduct likely to deceive, defraud, or harm the
346.2 public, or demonstrating a willful or careless disregard for the health, welfare, or safety of
346.3 a patient; or pharmacy practice that is professionally incompetent, in that it may create
346.4 unnecessary danger to any patient's life, health, or safety, in any of which cases, proof of
346.5 actual injury need not be established;

346.6 (10) aiding or abetting an unlicensed person in the practice of pharmacy, except that it
346.7 is not a violation of this clause for a pharmacist to supervise a properly registered pharmacy
346.8 technician or pharmacist intern if that person is performing duties allowed by this chapter
346.9 or the rules of the board;

346.10 (11) for an individual licensed or registered by the board, adjudication as mentally ill
346.11 or developmentally disabled, or as a chemically dependent person, a person dangerous to
346.12 the public, a sexually dangerous person, or a person who has a sexual psychopathic
346.13 personality, by a court of competent jurisdiction, within or without this state. Such
346.14 adjudication shall automatically suspend a license for the duration thereof unless the board
346.15 orders otherwise;

346.16 (12) for a pharmacist or pharmacy intern, engaging in unprofessional conduct as specified
346.17 in the board's rules. In the case of a pharmacy technician, engaging in conduct specified in
346.18 board rules that would be unprofessional if it were engaged in by a pharmacist or pharmacist
346.19 intern or performing duties specifically reserved for pharmacists under this chapter or the
346.20 rules of the board;

346.21 (13) for a pharmacy, operation of the pharmacy without a pharmacist present and on
346.22 duty except as allowed by a variance approved by the board;

346.23 (14) for a pharmacist, the inability to practice pharmacy with reasonable skill and safety
346.24 to patients by reason of illness, use of alcohol, drugs, narcotics, chemicals, or any other type
346.25 of material or as a result of any mental or physical condition, including deterioration through
346.26 the aging process or loss of motor skills. In the case of registered pharmacy technicians,
346.27 pharmacist interns, or controlled substance researchers, the inability to carry out duties
346.28 allowed under this chapter or the rules of the board with reasonable skill and safety to
346.29 patients by reason of illness, use of alcohol, drugs, narcotics, chemicals, or any other type
346.30 of material or as a result of any mental or physical condition, including deterioration through
346.31 the aging process or loss of motor skills;

346.32 (15) for a pharmacist, pharmacy, pharmacist intern, pharmacy technician, medical gas
346.33 dispenser, or controlled substance researcher, revealing a privileged communication from
346.34 or relating to a patient except when otherwise required or permitted by law;

347.1 (16) for a pharmacist or pharmacy, improper management of patient records, including
347.2 failure to maintain adequate patient records, to comply with a patient's request made pursuant
347.3 to sections 144.291 to 144.298, or to furnish a patient record or report required by law;

347.4 (17) fee splitting, including without limitation:

347.5 (i) paying, offering to pay, receiving, or agreeing to receive, a commission, rebate,
347.6 kickback, or other form of remuneration, directly or indirectly, for the referral of patients;

347.7 (ii) referring a patient to any health care provider as defined in sections 144.291 to
347.8 144.298 in which the licensee or registrant has a financial or economic interest as defined
347.9 in section 144.6521, subdivision 3, unless the licensee or registrant has disclosed the
347.10 licensee's or registrant's financial or economic interest in accordance with section 144.6521;
347.11 and

347.12 (iii) any arrangement through which a pharmacy, in which the prescribing practitioner
347.13 does not have a significant ownership interest, fills a prescription drug order and the
347.14 prescribing practitioner is involved in any manner, directly or indirectly, in setting the price
347.15 for the filled prescription that is charged to the patient, the patient's insurer or pharmacy
347.16 benefit manager, or other person paying for the prescription or, in the case of veterinary
347.17 patients, the price for the filled prescription that is charged to the client or other person
347.18 paying for the prescription, except that a veterinarian and a pharmacy may enter into such
347.19 an arrangement provided that the client or other person paying for the prescription is notified,
347.20 in writing and with each prescription dispensed, about the arrangement, unless such
347.21 arrangement involves pharmacy services provided for livestock, poultry, and agricultural
347.22 production systems, in which case client notification would not be required;

347.23 (18) engaging in abusive or fraudulent billing practices, including violations of the
347.24 federal Medicare and Medicaid laws or state medical assistance laws or rules;

347.25 (19) engaging in conduct with a patient that is sexual or may reasonably be interpreted
347.26 by the patient as sexual, or in any verbal behavior that is seductive or sexually demeaning
347.27 to a patient;

347.28 (20) failure to make reports as required by section 151.072 or to cooperate with an
347.29 investigation of the board as required by section 151.074;

347.30 (21) knowingly providing false or misleading information that is directly related to the
347.31 care of a patient unless done for an accepted therapeutic purpose such as the dispensing and
347.32 administration of a placebo;

348.1 (22) aiding suicide or aiding attempted suicide in violation of section 609.215 as
348.2 established by any of the following:

348.3 (i) a copy of the record of criminal conviction or plea of guilty for a felony in violation
348.4 of section 609.215, subdivision 1 or 2;

348.5 (ii) a copy of the record of a judgment of contempt of court for violating an injunction
348.6 issued under section 609.215, subdivision 4;

348.7 (iii) a copy of the record of a judgment assessing damages under section 609.215,
348.8 subdivision 5; or

348.9 (iv) a finding by the board that the person violated section 609.215, subdivision 1 or 2.
348.10 The board must investigate any complaint of a violation of section 609.215, subdivision 1
348.11 or 2;

348.12 (23) for a pharmacist, practice of pharmacy under a lapsed or nonrenewed license. For
348.13 a pharmacist intern, pharmacy technician, or controlled substance researcher, performing
348.14 duties permitted to such individuals by this chapter or the rules of the board under a lapsed
348.15 or nonrenewed registration. For a facility required to be licensed under this chapter, operation
348.16 of the facility under a lapsed or nonrenewed license or registration; ~~and~~

348.17 (24) for a pharmacist, pharmacist intern, or pharmacy technician, termination or discharge
348.18 from the health professionals services program for reasons other than the satisfactory
348.19 completion of the program; and

348.20 (25) for a drug manufacturer, failure to comply with section 62J.841.

348.21 Sec. 52. Minnesota Statutes 2020, section 151.071, subdivision 2, is amended to read:

348.22 Subd. 2. **Grounds for disciplinary action.** The following conduct is prohibited and is
348.23 grounds for disciplinary action:

348.24 (1) failure to demonstrate the qualifications or satisfy the requirements for a license or
348.25 registration contained in this chapter or the rules of the board. The burden of proof is on
348.26 the applicant to demonstrate such qualifications or satisfaction of such requirements;

348.27 (2) obtaining a license by fraud or by misleading the board in any way during the
348.28 application process or obtaining a license by cheating, or attempting to subvert the licensing
348.29 examination process. Conduct that subverts or attempts to subvert the licensing examination
348.30 process includes, but is not limited to: (i) conduct that violates the security of the examination
348.31 materials, such as removing examination materials from the examination room or having
348.32 unauthorized possession of any portion of a future, current, or previously administered

349.1 licensing examination; (ii) conduct that violates the standard of test administration, such as
349.2 communicating with another examinee during administration of the examination, copying
349.3 another examinee's answers, permitting another examinee to copy one's answers, or
349.4 possessing unauthorized materials; or (iii) impersonating an examinee or permitting an
349.5 impersonator to take the examination on one's own behalf;

349.6 (3) for a pharmacist, pharmacy technician, pharmacist intern, applicant for a pharmacist
349.7 or pharmacy license, or applicant for a pharmacy technician or pharmacist intern registration,
349.8 conviction of a felony reasonably related to the practice of pharmacy. Conviction as used
349.9 in this subdivision includes a conviction of an offense that if committed in this state would
349.10 be deemed a felony without regard to its designation elsewhere, or a criminal proceeding
349.11 where a finding or verdict of guilt is made or returned but the adjudication of guilt is either
349.12 withheld or not entered thereon. The board may delay the issuance of a new license or
349.13 registration if the applicant has been charged with a felony until the matter has been
349.14 adjudicated;

349.15 (4) for a facility, other than a pharmacy, licensed or registered by the board, if an owner
349.16 or applicant is convicted of a felony reasonably related to the operation of the facility. The
349.17 board may delay the issuance of a new license or registration if the owner or applicant has
349.18 been charged with a felony until the matter has been adjudicated;

349.19 (5) for a controlled substance researcher, conviction of a felony reasonably related to
349.20 controlled substances or to the practice of the researcher's profession. The board may delay
349.21 the issuance of a registration if the applicant has been charged with a felony until the matter
349.22 has been adjudicated;

349.23 (6) disciplinary action taken by another state or by one of this state's health licensing
349.24 agencies:

349.25 (i) revocation, suspension, restriction, limitation, or other disciplinary action against a
349.26 license or registration in another state or jurisdiction, failure to report to the board that
349.27 charges or allegations regarding the person's license or registration have been brought in
349.28 another state or jurisdiction, or having been refused a license or registration by any other
349.29 state or jurisdiction. The board may delay the issuance of a new license or registration if an
349.30 investigation or disciplinary action is pending in another state or jurisdiction until the
349.31 investigation or action has been dismissed or otherwise resolved; and

349.32 (ii) revocation, suspension, restriction, limitation, or other disciplinary action against a
349.33 license or registration issued by another of this state's health licensing agencies, failure to
349.34 report to the board that charges regarding the person's license or registration have been

350.1 brought by another of this state's health licensing agencies, or having been refused a license
350.2 or registration by another of this state's health licensing agencies. The board may delay the
350.3 issuance of a new license or registration if a disciplinary action is pending before another
350.4 of this state's health licensing agencies until the action has been dismissed or otherwise
350.5 resolved;

350.6 (7) for a pharmacist, pharmacy, pharmacy technician, or pharmacist intern, violation of
350.7 any order of the board, of any of the provisions of this chapter or any rules of the board or
350.8 violation of any federal, state, or local law or rule reasonably pertaining to the practice of
350.9 pharmacy;

350.10 (8) for a facility, other than a pharmacy, licensed by the board, violations of any order
350.11 of the board, of any of the provisions of this chapter or the rules of the board or violation
350.12 of any federal, state, or local law relating to the operation of the facility;

350.13 (9) engaging in any unethical conduct; conduct likely to deceive, defraud, or harm the
350.14 public, or demonstrating a willful or careless disregard for the health, welfare, or safety of
350.15 a patient; or pharmacy practice that is professionally incompetent, in that it may create
350.16 unnecessary danger to any patient's life, health, or safety, in any of which cases, proof of
350.17 actual injury need not be established;

350.18 (10) aiding or abetting an unlicensed person in the practice of pharmacy, except that it
350.19 is not a violation of this clause for a pharmacist to supervise a properly registered pharmacy
350.20 technician or pharmacist intern if that person is performing duties allowed by this chapter
350.21 or the rules of the board;

350.22 (11) for an individual licensed or registered by the board, adjudication as mentally ill
350.23 or developmentally disabled, or as a chemically dependent person, a person dangerous to
350.24 the public, a sexually dangerous person, or a person who has a sexual psychopathic
350.25 personality, by a court of competent jurisdiction, within or without this state. Such
350.26 adjudication shall automatically suspend a license for the duration thereof unless the board
350.27 orders otherwise;

350.28 (12) for a pharmacist or pharmacy intern, engaging in unprofessional conduct as specified
350.29 in the board's rules. In the case of a pharmacy technician, engaging in conduct specified in
350.30 board rules that would be unprofessional if it were engaged in by a pharmacist or pharmacist
350.31 intern or performing duties specifically reserved for pharmacists under this chapter or the
350.32 rules of the board;

350.33 (13) for a pharmacy, operation of the pharmacy without a pharmacist present and on
350.34 duty except as allowed by a variance approved by the board;

351.1 (14) for a pharmacist, the inability to practice pharmacy with reasonable skill and safety
351.2 to patients by reason of illness, use of alcohol, drugs, narcotics, chemicals, or any other type
351.3 of material or as a result of any mental or physical condition, including deterioration through
351.4 the aging process or loss of motor skills. In the case of registered pharmacy technicians,
351.5 pharmacist interns, or controlled substance researchers, the inability to carry out duties
351.6 allowed under this chapter or the rules of the board with reasonable skill and safety to
351.7 patients by reason of illness, use of alcohol, drugs, narcotics, chemicals, or any other type
351.8 of material or as a result of any mental or physical condition, including deterioration through
351.9 the aging process or loss of motor skills;

351.10 (15) for a pharmacist, pharmacy, pharmacist intern, pharmacy technician, medical gas
351.11 dispenser, or controlled substance researcher, revealing a privileged communication from
351.12 or relating to a patient except when otherwise required or permitted by law;

351.13 (16) for a pharmacist or pharmacy, improper management of patient records, including
351.14 failure to maintain adequate patient records, to comply with a patient's request made pursuant
351.15 to sections 144.291 to 144.298, or to furnish a patient record or report required by law;

351.16 (17) fee splitting, including without limitation:

351.17 (i) paying, offering to pay, receiving, or agreeing to receive, a commission, rebate,
351.18 kickback, or other form of remuneration, directly or indirectly, for the referral of patients;

351.19 (ii) referring a patient to any health care provider as defined in sections 144.291 to
351.20 144.298 in which the licensee or registrant has a financial or economic interest as defined
351.21 in section 144.6521, subdivision 3, unless the licensee or registrant has disclosed the
351.22 licensee's or registrant's financial or economic interest in accordance with section 144.6521;
351.23 and

351.24 (iii) any arrangement through which a pharmacy, in which the prescribing practitioner
351.25 does not have a significant ownership interest, fills a prescription drug order and the
351.26 prescribing practitioner is involved in any manner, directly or indirectly, in setting the price
351.27 for the filled prescription that is charged to the patient, the patient's insurer or pharmacy
351.28 benefit manager, or other person paying for the prescription or, in the case of veterinary
351.29 patients, the price for the filled prescription that is charged to the client or other person
351.30 paying for the prescription, except that a veterinarian and a pharmacy may enter into such
351.31 an arrangement provided that the client or other person paying for the prescription is notified,
351.32 in writing and with each prescription dispensed, about the arrangement, unless such
351.33 arrangement involves pharmacy services provided for livestock, poultry, and agricultural
351.34 production systems, in which case client notification would not be required;

352.1 (18) engaging in abusive or fraudulent billing practices, including violations of the
352.2 federal Medicare and Medicaid laws or state medical assistance laws or rules;

352.3 (19) engaging in conduct with a patient that is sexual or may reasonably be interpreted
352.4 by the patient as sexual, or in any verbal behavior that is seductive or sexually demeaning
352.5 to a patient;

352.6 (20) failure to make reports as required by section 151.072 or to cooperate with an
352.7 investigation of the board as required by section 151.074;

352.8 (21) knowingly providing false or misleading information that is directly related to the
352.9 care of a patient unless done for an accepted therapeutic purpose such as the dispensing and
352.10 administration of a placebo;

352.11 (22) aiding suicide or aiding attempted suicide in violation of section 609.215 as
352.12 established by any of the following:

352.13 (i) a copy of the record of criminal conviction or plea of guilty for a felony in violation
352.14 of section 609.215, subdivision 1 or 2;

352.15 (ii) a copy of the record of a judgment of contempt of court for violating an injunction
352.16 issued under section 609.215, subdivision 4;

352.17 (iii) a copy of the record of a judgment assessing damages under section 609.215,
352.18 subdivision 5; or

352.19 (iv) a finding by the board that the person violated section 609.215, subdivision 1 or 2.
352.20 The board must investigate any complaint of a violation of section 609.215, subdivision 1
352.21 or 2;

352.22 (23) for a pharmacist, practice of pharmacy under a lapsed or nonrenewed license. For
352.23 a pharmacist intern, pharmacy technician, or controlled substance researcher, performing
352.24 duties permitted to such individuals by this chapter or the rules of the board under a lapsed
352.25 or nonrenewed registration. For a facility required to be licensed under this chapter, operation
352.26 of the facility under a lapsed or nonrenewed license or registration; ~~and~~

352.27 (24) for a pharmacist, pharmacist intern, or pharmacy technician, termination or discharge
352.28 from the health professionals services program for reasons other than the satisfactory
352.29 completion of the program; and

352.30 (25) for a manufacturer, a violation of section 62J.842 or 62J.845.

353.1 Sec. 53. Minnesota Statutes 2021 Supplement, section 151.335, is amended to read:

353.2 **151.335 DELIVERY THROUGH COMMON CARRIER; COMPLIANCE WITH**
353.3 **TEMPERATURE REQUIREMENTS.**

353.4 In addition to complying with the requirements of Minnesota Rules, part 6800.3000, a
353.5 mail order or specialty pharmacy that employs the United States Postal Service or other
353.6 common carrier to deliver a filled prescription directly to a patient must ensure that the drug
353.7 is delivered in compliance with temperature requirements established by the manufacturer
353.8 of the drug. The methods used to ensure compliance must include but are not limited to
353.9 enclosing in each medication's packaging a device recognized by the United States
353.10 Pharmacopeia by which the patient can easily detect improper storage or temperature
353.11 variations. The pharmacy must develop written policies and procedures that are consistent
353.12 with United States Pharmacopeia, chapters 1079 and 1118, and with nationally recognized
353.13 standards issued by standard-setting or accreditation organizations recognized by the board
353.14 through guidance. The policies and procedures must be provided to the board upon request.

353.15 Sec. 54. Minnesota Statutes 2020, section 151.37, is amended by adding a subdivision to
353.16 read:

353.17 Subd. 17. **Drugs for preventing the acquisition of HIV.** (a) A pharmacist is authorized
353.18 to prescribe and administer drugs to prevent the acquisition of human immunodeficiency
353.19 virus (HIV) in accordance with this subdivision.

353.20 (b) By January 1, 2023, the board of pharmacy shall develop a standardized protocol
353.21 for a pharmacist to follow in prescribing the drugs described in paragraph (a). In developing
353.22 the protocol, the board may consult with community health advocacy groups, the board of
353.23 medical practice, the board of nursing, the commissioner of health, professional pharmacy
353.24 associations, and professional associations for physicians, physician assistants, and advanced
353.25 practice registered nurses.

353.26 (c) Before a pharmacist is authorized to prescribe a drug described in paragraph (a), the
353.27 pharmacist must successfully complete a training program specifically developed for
353.28 prescribing drugs for preventing the acquisition of HIV that is offered by a college of
353.29 pharmacy, a continuing education provider that is accredited by the Accreditation Council
353.30 for Pharmacy Education, or a program approved by the board. To maintain authorization
353.31 to prescribe, the pharmacist shall complete continuing education requirements as specified
353.32 by the board.

354.1 (d) Before prescribing a drug described in paragraph (a), the pharmacist shall follow the
354.2 appropriate standardized protocol developed under paragraph (b) and, if appropriate, may
354.3 dispense to a patient a drug described in paragraph (a).

354.4 (e) Before dispensing a drug described under paragraph (a) that is prescribed by the
354.5 pharmacist, the pharmacist must provide counseling to the patient on the use of the drugs
354.6 and must provide the patient with a fact sheet that includes the indications and
354.7 contraindications for the use of these drugs, the appropriate method for using these drugs,
354.8 the need for medical follow up, and any other additional information listed in Minnesota
354.9 Rules, part 6800.0910, subpart 2, that is required to be provided to a patient during the
354.10 counseling process.

354.11 (f) A pharmacist is prohibited from delegating the prescribing authority provided under
354.12 this subdivision to any other person. A pharmacist intern registered under section 151.101
354.13 may prepare the prescription, but before the prescription is processed or dispensed, a
354.14 pharmacist authorized to prescribe under this subdivision must review, approve, and sign
354.15 the prescription.

354.16 (g) Nothing in this subdivision prohibits a pharmacist from participating in the initiation,
354.17 management, modification, and discontinuation of drug therapy according to a protocol as
354.18 authorized in this section and in section 151.01, subdivision 27.

354.19 Sec. 55. Minnesota Statutes 2020, section 151.555, as amended by Laws 2021, chapter
354.20 30, article 5, sections 2 to 5, is amended to read:

354.21 **151.555 PRESCRIPTION DRUG MEDICATION REPOSITORY PROGRAM.**

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

354.24 (b) "Central repository" means a wholesale distributor that meets the requirements under
354.25 subdivision 3 and enters into a contract with the Board of Pharmacy in accordance with this
354.26 section.

354.27 (c) "Distribute" means to deliver, other than by administering or dispensing.

354.28 (d) "Donor" means:

354.29 (1) a health care facility as defined in this subdivision;

354.30 (2) a skilled nursing facility licensed under chapter 144A;

354.31 (3) an assisted living facility licensed under chapter 144G;

355.1 (4) a pharmacy licensed under section 151.19, and located either in the state or outside
355.2 the state;

355.3 (5) a drug wholesaler licensed under section 151.47;

355.4 (6) a drug manufacturer licensed under section 151.252; or

355.5 (7) an individual at least 18 years of age, provided that the drug or medical supply that
355.6 is donated was obtained legally and meets the requirements of this section for donation.

355.7 (e) "Drug" means any prescription drug that has been approved for medical use in the
355.8 United States, is listed in the United States Pharmacopoeia or National Formulary, and
355.9 meets the criteria established under this section for donation; or any over-the-counter
355.10 medication that meets the criteria established under this section for donation. This definition
355.11 includes cancer drugs and antirejection drugs, but does not include controlled substances,
355.12 as defined in section 152.01, subdivision 4, or a prescription drug that can only be dispensed
355.13 to a patient registered with the drug's manufacturer in accordance with federal Food and
355.14 Drug Administration requirements.

355.15 (f) "Health care facility" means:

355.16 (1) a physician's office or health care clinic where licensed practitioners provide health
355.17 care to patients;

355.18 (2) a hospital licensed under section 144.50;

355.19 (3) a pharmacy licensed under section 151.19 and located in Minnesota; or

355.20 (4) a nonprofit community clinic, including a federally qualified health center; a rural
355.21 health clinic; public health clinic; or other community clinic that provides health care utilizing
355.22 a sliding fee scale to patients who are low-income, uninsured, or underinsured.

355.23 (g) "Local repository" means a health care facility that elects to accept donated drugs
355.24 and medical supplies and meets the requirements of subdivision 4.

355.25 (h) "Medical supplies" or "supplies" means any prescription ~~and~~ or nonprescription
355.26 medical supplies needed to administer a ~~prescription~~ drug.

355.27 (i) "Original, sealed, unopened, tamper-evident packaging" means packaging that is
355.28 sealed, unopened, and tamper-evident, including a manufacturer's original unit dose or
355.29 unit-of-use container, a repackager's original unit dose or unit-of-use container, or unit-dose
355.30 packaging prepared by a licensed pharmacy according to the standards of Minnesota Rules,
355.31 part 6800.3750.

356.1 (j) "Practitioner" has the meaning given in section 151.01, subdivision 23, except that
356.2 it does not include a veterinarian.

356.3 Subd. 2. **Establishment; contract and oversight.** (a) By January 1, 2020, the Board of
356.4 Pharmacy shall establish a ~~drug~~ medication repository program, through which donors may
356.5 donate a drug or medical supply for use by an individual who meets the eligibility criteria
356.6 specified under subdivision 5.

356.7 (b) The board shall contract with a central repository that meets the requirements of
356.8 subdivision 3 to implement and administer the ~~prescription drug~~ medication repository
356.9 program. The contract must:

356.10 (1) require the board to transfer to the central repository any money appropriated by the
356.11 legislature for the purpose of operating the medication repository program and require the
356.12 central repository to spend any money transferred only for purposes specified in the contract;

356.13 (2) require the central repository to report the following performance measures to the
356.14 board:

356.15 (i) the number of individuals served and the types of medications these individuals
356.16 received;

356.17 (ii) the number of clinics, pharmacies, and long-term care facilities with which the central
356.18 repository partnered;

356.19 (iii) the number and cost of medications accepted for inventory, disposed of, and
356.20 dispensed to individuals in need; and

356.21 (iv) locations within the state to which medications are shipped or delivered; and

356.22 (3) require the board to annually audit the expenditure by the central repository of any
356.23 funds appropriated by the legislature and transferred by the board to ensure that this funding
356.24 is used only for purposes specified in the contract.

356.25 Subd. 3. **Central repository requirements.** (a) The board may publish a request for
356.26 proposal for participants who meet the requirements of this subdivision and are interested
356.27 in acting as the central repository for the ~~drug~~ medication repository program. If the board
356.28 publishes a request for proposal, it shall follow all applicable state procurement procedures
356.29 in the selection process. The board may also work directly with the University of Minnesota
356.30 to establish a central repository.

357.1 (b) To be eligible to act as the central repository, the participant must be a wholesale
357.2 drug distributor located in Minnesota, licensed pursuant to section 151.47, and in compliance
357.3 with all applicable federal and state statutes, rules, and regulations.

357.4 (c) The central repository shall be subject to inspection by the board pursuant to section
357.5 151.06, subdivision 1.

357.6 (d) The central repository shall comply with all applicable federal and state laws, rules,
357.7 and regulations pertaining to the ~~drug~~ medication repository program, drug storage, and
357.8 dispensing. The facility must maintain in good standing any state license or registration that
357.9 applies to the facility.

357.10 Subd. 4. **Local repository requirements.** (a) To be eligible for participation in the ~~drug~~
357.11 medication repository program, a health care facility must agree to comply with all applicable
357.12 federal and state laws, rules, and regulations pertaining to the ~~drug~~ medication repository
357.13 program, drug storage, and dispensing. The facility must also agree to maintain in good
357.14 standing any required state license or registration that may apply to the facility.

357.15 (b) A local repository may elect to participate in the program by submitting the following
357.16 information to the central repository on a form developed by the board and made available
357.17 on the board's website:

357.18 (1) the name, street address, and telephone number of the health care facility and any
357.19 state-issued license or registration number issued to the facility, including the issuing state
357.20 agency;

357.21 (2) the name and telephone number of a responsible pharmacist or practitioner who is
357.22 employed by or under contract with the health care facility; and

357.23 (3) a statement signed and dated by the responsible pharmacist or practitioner indicating
357.24 that the health care facility meets the eligibility requirements under this section and agrees
357.25 to comply with this section.

357.26 (c) Participation in the ~~drug~~ medication repository program is voluntary. A local
357.27 repository may withdraw from participation in the ~~drug~~ medication repository program at
357.28 any time by providing written notice to the central repository on a form developed by the
357.29 board and made available on the board's website. The central repository shall provide the
357.30 board with a copy of the withdrawal notice within ten business days from the date of receipt
357.31 of the withdrawal notice.

358.1 Subd. 5. **Individual eligibility and application requirements.** (a) To be eligible for
358.2 the ~~drug~~ drug medication repository program, an individual must submit to a local repository an
358.3 intake application form that is signed by the individual and attests that the individual:

358.4 (1) is a resident of Minnesota;

358.5 (2) is uninsured and is not enrolled in the medical assistance program under chapter
358.6 256B or the MinnesotaCare program under chapter 256L, has no prescription drug coverage,
358.7 or is underinsured;

358.8 (3) acknowledges that the drugs or medical supplies to be received through the program
358.9 may have been donated; and

358.10 (4) consents to a waiver of the child-resistant packaging requirements of the federal
358.11 Poison Prevention Packaging Act.

358.12 (b) Upon determining that an individual is eligible for the program, the local repository
358.13 shall furnish the individual with an identification card. The card shall be valid for one year
358.14 from the date of issuance and may be used at any local repository. A new identification card
358.15 may be issued upon expiration once the individual submits a new application form.

358.16 (c) The local repository shall send a copy of the intake application form to the central
358.17 repository by regular mail, facsimile, or secured e-mail within ten days from the date the
358.18 application is approved by the local repository.

358.19 (d) The board shall develop and make available on the board's website an application
358.20 form and the format for the identification card.

358.21 Subd. 6. **Standards and procedures for accepting donations of drugs and supplies.** (a)
358.22 A donor may donate ~~prescription~~ drugs or medical supplies to the central repository or a
358.23 local repository if the drug or supply meets the requirements of this section as determined
358.24 by a pharmacist or practitioner who is employed by or under contract with the central
358.25 repository or a local repository.

358.26 (b) A ~~prescription~~ drug is eligible for donation under the ~~drug~~ drug medication repository
358.27 program if the following requirements are met:

358.28 (1) the donation is accompanied by a ~~drug~~ drug medication repository donor form described
358.29 under paragraph (d) that is signed by an individual who is authorized by the donor to attest
358.30 to the donor's knowledge in accordance with paragraph (d);

358.31 (2) the drug's expiration date is at least six months after the date the drug was donated.
358.32 If a donated drug bears an expiration date that is less than six months from the donation

359.1 date, the drug may be accepted and distributed if the drug is in high demand and can be
359.2 dispensed for use by a patient before the drug's expiration date;

359.3 (3) the drug is in its original, sealed, unopened, tamper-evident packaging that includes
359.4 the expiration date. Single-unit-dose drugs may be accepted if the single-unit-dose packaging
359.5 is unopened;

359.6 (4) the drug or the packaging does not have any physical signs of tampering, misbranding,
359.7 deterioration, compromised integrity, or adulteration;

359.8 (5) the drug does not require storage temperatures other than normal room temperature
359.9 as specified by the manufacturer or United States Pharmacopoeia, unless the drug is being
359.10 donated directly by its manufacturer, a wholesale drug distributor, or a pharmacy located
359.11 in Minnesota; and

359.12 (6) the ~~prescription~~ drug is not a controlled substance.

359.13 (c) A medical supply is eligible for donation under the ~~drug~~ medication repository
359.14 program if the following requirements are met:

359.15 (1) the supply has no physical signs of tampering, misbranding, or alteration and there
359.16 is no reason to believe it has been adulterated, tampered with, or misbranded;

359.17 (2) the supply is in its original, unopened, sealed packaging;

359.18 (3) the donation is accompanied by a ~~drug~~ medication repository donor form described
359.19 under paragraph (d) that is signed by an individual who is authorized by the donor to attest
359.20 to the donor's knowledge in accordance with paragraph (d); and

359.21 (4) if the supply bears an expiration date, the date is at least six months later than the
359.22 date the supply was donated. If the donated supply bears an expiration date that is less than
359.23 six months from the date the supply was donated, the supply may be accepted and distributed
359.24 if the supply is in high demand and can be dispensed for use by a patient before the supply's
359.25 expiration date.

359.26 (d) The board shall develop the ~~drug~~ medication repository donor form and make it
359.27 available on the board's website. The form must state that to the best of the donor's knowledge
359.28 the donated drug or supply has been properly stored under appropriate temperature and
359.29 humidity conditions and that the drug or supply has never been opened, used, tampered
359.30 with, adulterated, or misbranded.

359.31 (e) Donated drugs and supplies may be shipped or delivered to the premises of the central
359.32 repository or a local repository, and shall be inspected by a pharmacist or an authorized

360.1 practitioner who is employed by or under contract with the repository and who has been
360.2 designated by the repository to accept donations. A drop box must not be used to deliver
360.3 or accept donations.

360.4 (f) The central repository and local repository shall inventory all drugs and supplies
360.5 donated to the repository. For each drug, the inventory must include the drug's name, strength,
360.6 quantity, manufacturer, expiration date, and the date the drug was donated. For each medical
360.7 supply, the inventory must include a description of the supply, its manufacturer, the date
360.8 the supply was donated, and, if applicable, the supply's brand name and expiration date.

360.9 Subd. 7. **Standards and procedures for inspecting and storing donated ~~prescription~~**
360.10 **drugs and supplies.** (a) A pharmacist or authorized practitioner who is employed by or
360.11 under contract with the central repository or a local repository shall inspect all donated
360.12 ~~prescription~~ drugs and supplies before the drug or supply is dispensed to determine, to the
360.13 extent reasonably possible in the professional judgment of the pharmacist or practitioner,
360.14 that the drug or supply is not adulterated or misbranded, has not been tampered with, is safe
360.15 and suitable for dispensing, has not been subject to a recall, and meets the requirements for
360.16 donation. The pharmacist or practitioner who inspects the drugs or supplies shall sign an
360.17 inspection record stating that the requirements for donation have been met. If a local
360.18 repository receives drugs and supplies from the central repository, the local repository does
360.19 not need to reinspect the drugs and supplies.

360.20 (b) The central repository and local repositories shall store donated drugs and supplies
360.21 in a secure storage area under environmental conditions appropriate for the drug or supply
360.22 being stored. Donated drugs and supplies may not be stored with nondonated inventory.

360.23 (c) The central repository and local repositories shall dispose of all ~~prescription~~ drugs
360.24 and medical supplies that are not suitable for donation in compliance with applicable federal
360.25 and state statutes, regulations, and rules concerning hazardous waste.

360.26 (d) In the event that controlled substances or ~~prescription~~ drugs that can only be dispensed
360.27 to a patient registered with the drug's manufacturer are shipped or delivered to a central or
360.28 local repository for donation, the shipment delivery must be documented by the repository
360.29 and returned immediately to the donor or the donor's representative that provided the drugs.

360.30 (e) Each repository must develop drug and medical supply recall policies and procedures.
360.31 If a repository receives a recall notification, the repository shall destroy all of the drug or
360.32 medical supply in its inventory that is the subject of the recall and complete a record of
360.33 destruction form in accordance with paragraph (f). If a drug or medical supply that is the
360.34 subject of a Class I or Class II recall has been dispensed, the repository shall immediately

361.1 notify the recipient of the recalled drug or medical supply. A drug that potentially is subject
361.2 to a recall need not be destroyed if its packaging bears a lot number and that lot of the drug
361.3 is not subject to the recall. If no lot number is on the drug's packaging, it must be destroyed.

361.4 (f) A record of destruction of donated drugs and supplies that are not dispensed under
361.5 subdivision 8, are subject to a recall under paragraph (e), or are not suitable for donation
361.6 shall be maintained by the repository for at least two years. For each drug or supply destroyed,
361.7 the record shall include the following information:

361.8 (1) the date of destruction;

361.9 (2) the name, strength, and quantity of the drug destroyed; and

361.10 (3) the name of the person or firm that destroyed the drug.

361.11 Subd. 8. **Dispensing requirements.** (a) Donated drugs and supplies may be dispensed
361.12 if the drugs or supplies are prescribed by a practitioner for use by an eligible individual and
361.13 are dispensed by a pharmacist or practitioner. A repository shall dispense drugs and supplies
361.14 to eligible individuals in the following priority order: (1) individuals who are uninsured;
361.15 (2) individuals with no prescription drug coverage; and (3) individuals who are underinsured.
361.16 A repository shall dispense donated ~~prescription~~ drugs in compliance with applicable federal
361.17 and state laws and regulations for dispensing ~~prescription~~ drugs, including all requirements
361.18 relating to packaging, labeling, record keeping, drug utilization review, and patient
361.19 counseling.

361.20 (b) Before dispensing or administering a drug or supply, the pharmacist or practitioner
361.21 shall visually inspect the drug or supply for adulteration, misbranding, tampering, and date
361.22 of expiration. Drugs or supplies that have expired or appear upon visual inspection to be
361.23 adulterated, misbranded, or tampered with in any way must not be dispensed or administered.

361.24 (c) Before a drug or supply is dispensed or administered to an individual, the individual
361.25 must sign a drug repository recipient form acknowledging that the individual understands
361.26 the information stated on the form. The board shall develop the form and make it available
361.27 on the board's website. The form must include the following information:

361.28 (1) that the drug or supply being dispensed or administered has been donated and may
361.29 have been previously dispensed;

361.30 (2) that a visual inspection has been conducted by the pharmacist or practitioner to ensure
361.31 that the drug or supply has not expired, has not been adulterated or misbranded, and is in
361.32 its original, unopened packaging; and

362.1 (3) that the dispensing pharmacist, the dispensing or administering practitioner, the
362.2 central repository or local repository, the Board of Pharmacy, and any other participant of
362.3 the ~~drug~~ medication repository program cannot guarantee the safety of the drug or medical
362.4 supply being dispensed or administered and that the pharmacist or practitioner has determined
362.5 that the drug or supply is safe to dispense or administer based on the accuracy of the donor's
362.6 form submitted with the donated drug or medical supply and the visual inspection required
362.7 to be performed by the pharmacist or practitioner before dispensing or administering.

362.8 Subd. 9. **Handling fees.** (a) The central or local repository may charge the individual
362.9 receiving a drug or supply a handling fee of no more than 250 percent of the medical
362.10 assistance program dispensing fee for each drug or medical supply dispensed or administered
362.11 by that repository.

362.12 (b) A repository that dispenses or administers a drug or medical supply through the drug
362.13 repository program shall not receive reimbursement under the medical assistance program
362.14 or the MinnesotaCare program for that dispensed or administered drug or supply.

362.15 Subd. 10. **Distribution of donated drugs and supplies.** (a) The central repository and
362.16 local repositories may distribute drugs and supplies donated under the drug repository
362.17 program to other participating repositories for use pursuant to this program.

362.18 (b) A local repository that elects not to dispense donated drugs or supplies must transfer
362.19 all donated drugs and supplies to the central repository. A copy of the donor form that was
362.20 completed by the original donor under subdivision 6 must be provided to the central
362.21 repository at the time of transfer.

362.22 Subd. 11. **Forms and record-keeping requirements.** (a) The following forms developed
362.23 for the administration of this program shall be utilized by the participants of the program
362.24 and shall be available on the board's website:

362.25 (1) intake application form described under subdivision 5;

362.26 (2) local repository participation form described under subdivision 4;

362.27 (3) local repository withdrawal form described under subdivision 4;

362.28 (4) ~~drug~~ medication repository donor form described under subdivision 6;

362.29 (5) record of destruction form described under subdivision 7; and

362.30 (6) ~~drug~~ medication repository recipient form described under subdivision 8.

362.31 (b) All records, including drug inventory, inspection, and disposal of donated ~~prescription~~
362.32 drugs and medical supplies, must be maintained by a repository for a minimum of two years.

363.1 Records required as part of this program must be maintained pursuant to all applicable
363.2 practice acts.

363.3 (c) Data collected by the ~~drug~~ medication repository program from all local repositories
363.4 shall be submitted quarterly or upon request to the central repository. Data collected may
363.5 consist of the information, records, and forms required to be collected under this section.

363.6 (d) The central repository shall submit reports to the board as required by the contract
363.7 or upon request of the board.

363.8 Subd. 12. **Liability.** (a) The manufacturer of a drug or supply is not subject to criminal
363.9 or civil liability for injury, death, or loss to a person or to property for causes of action
363.10 described in clauses (1) and (2). A manufacturer is not liable for:

363.11 (1) the intentional or unintentional alteration of the drug or supply by a party not under
363.12 the control of the manufacturer; or

363.13 (2) the failure of a party not under the control of the manufacturer to transfer or
363.14 communicate product or consumer information or the expiration date of the donated drug
363.15 or supply.

363.16 (b) A health care facility participating in the program, a pharmacist dispensing a drug
363.17 or supply pursuant to the program, a practitioner dispensing or administering a drug or
363.18 supply pursuant to the program, or a donor of a drug or medical supply is immune from
363.19 civil liability for an act or omission that causes injury to or the death of an individual to
363.20 whom the drug or supply is dispensed and no disciplinary action by a health-related licensing
363.21 board shall be taken against a pharmacist or practitioner so long as the drug or supply is
363.22 donated, accepted, distributed, and dispensed according to the requirements of this section.
363.23 This immunity does not apply if the act or omission involves reckless, wanton, or intentional
363.24 misconduct, or malpractice unrelated to the quality of the drug or medical supply.

363.25 Subd. 13. **Drug returned for credit.** Nothing in this section allows a long-term care
363.26 facility to donate a drug to a central or local repository when federal or state law requires
363.27 the drug to be returned to the pharmacy that initially dispensed it, so that the pharmacy can
363.28 credit the payer for the amount of the drug returned.

363.29 Subd. 14. **Cooperation.** The central repository, as approved by the Board of Pharmacy,
363.30 may enter into an agreement with another state that has an established drug repository or
363.31 drug donation program if the other state's program includes regulations to ensure the purity,
363.32 integrity, and safety of the drugs and supplies donated, to permit the central repository to
363.33 offer to another state program inventory that is not needed by a Minnesota resident and to

364.1 accept inventory from another state program to be distributed to local repositories and
364.2 dispensed to Minnesota residents in accordance with this program.

364.3 Subd. 15. Funding. The central repository may seek grants and other funds from nonprofit
364.4 charitable organizations, the federal government, and other sources to fund the ongoing
364.5 operations of the medication repository program.

364.6 Sec. 56. Minnesota Statutes 2020, section 152.125, is amended to read:

364.7 **152.125 INTRACTABLE PAIN.**

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

364.10 (b) "Drug diversion" means the unlawful transfer of prescription drugs from their licit
364.11 medical purpose to the illicit marketplace.

364.12 (c) "Intractable pain" means a pain state in which the cause of the pain cannot be removed
364.13 or otherwise treated with the consent of the patient and in which, in the generally accepted
364.14 course of medical practice, no relief or cure of the cause of the pain is possible, or none has
364.15 been found after reasonable efforts. Conditions associated with intractable pain include but
364.16 are not limited to cancer and the recovery period, sickle cell disease, noncancer pain, rare
364.17 diseases, orphan diseases, severe injuries, and health conditions requiring the provision of
364.18 palliative care or hospice care. Reasonable efforts for relieving or curing the cause of the
364.19 pain may be determined on the basis of, but are not limited to, the following:

364.20 (1) when treating a nonterminally ill patient for intractable pain, an evaluation conducted
364.21 by the attending physician and one or more physicians specializing in pain medicine or the
364.22 treatment of the area, system, or organ of the body confirmed or perceived as the source of
364.23 the intractable pain; or

364.24 (2) when treating a terminally ill patient, an evaluation conducted by the attending
364.25 physician who does so in accordance with the standard of care and the level of care, skill,
364.26 and treatment that would be recognized by a reasonably prudent physician under similar
364.27 conditions and circumstances.

364.28 (d) "Palliative care" has the meaning provided in section 144A.75, subdivision 12.

364.29 (e) "Rare disease" means a disease, disorder, or condition that affects fewer than 200,000
364.30 individuals in the United States and is chronic, serious, life altering, or life threatening.

365.1 Subd. 1a. **Criteria for the evaluation and treatment of intractable pain.** The evaluation
365.2 and treatment of intractable pain when treating a nonterminally ill patient is governed by
365.3 the following criteria:

365.4 (1) a diagnosis of intractable pain by the treating physician and either by a physician
365.5 specializing in pain medicine or a physician treating the area, system, or organ of the body
365.6 that is the source of the pain is sufficient to meet the definition of intractable pain; and

365.7 (2) the cause of the diagnosis of intractable pain must not interfere with medically
365.8 necessary treatment including but not limited to prescribing or administering a controlled
365.9 substance in Schedules II to V of section 152.02.

365.10 **Subd. 2. Prescription and administration of controlled substances for intractable**
365.11 **pain.** (a) Notwithstanding any other provision of this chapter, a physician, advanced practice
365.12 registered nurse, or physician assistant may prescribe or administer a controlled substance
365.13 in Schedules II to V of section 152.02 to ~~an individual~~ a patient in the course of the
365.14 physician's, advanced practice registered nurse's, or physician assistant's treatment of the
365.15 ~~individual~~ patient for a diagnosed condition causing intractable pain. No physician, advanced
365.16 practice registered nurse, or physician assistant shall be subject to disciplinary action by
365.17 the Board of Medical Practice or Board of Nursing for appropriately prescribing or
365.18 administering a controlled substance in Schedules II to V of section 152.02 in the course
365.19 of treatment of ~~an individual~~ a patient for intractable pain, provided the physician, advanced
365.20 practice registered nurse, or physician assistant:

365.21 (1) keeps accurate records of the purpose, use, prescription, and disposal of controlled
365.22 substances, writes accurate prescriptions, and prescribes medications in conformance with
365.23 chapter 147- or 148 or in accordance with the current standard of care; and

365.24 (2) enters into a patient-provider agreement that meets the criteria in subdivision 5.

365.25 (b) No physician, advanced practice registered nurse, or physician assistant, acting in
365.26 good faith and based on the needs of the patient, shall be subject to any civil or criminal
365.27 action or investigation, disenrollment, or termination by the commissioner of health or
365.28 human services solely for prescribing a dosage that equates to an upward deviation from
365.29 morphine milligram equivalent dosage recommendations or thresholds specified in state or
365.30 federal opioid prescribing guidelines or policies, including but not limited to the Guideline
365.31 for Prescribing Opioids for Chronic Pain issued by the Centers for Disease Control and
365.32 Prevention, Minnesota opioid prescribing guidelines, the Minnesota opioid prescribing
365.33 improvement program, and the Minnesota quality improvement program established under
365.34 section 256B.0638.

366.1 (c) A physician, advanced practice registered nurse, or physician assistant treating
366.2 intractable pain by prescribing, dispensing, or administering a controlled substance in
366.3 Schedules II to V of section 152.02 that includes but is not opioid analgesics must not taper
366.4 a patient's medication dosage solely to meet a predetermined morphine milligram equivalent
366.5 dosage recommendation or threshold if the patient is stable and compliant with the treatment
366.6 plan, is experiencing no serious harm from the level of medication currently being prescribed
366.7 or previously prescribed, and is in compliance with the patient-provider agreement as
366.8 described in subdivision 5.

366.9 (d) A physician's, advanced practice registered nurse's, or physician assistant's decision
366.10 to taper a patient's medication dosage must be based on factors other than a morphine
366.11 milligram equivalent recommendation or threshold.

366.12 (e) No pharmacist, health plan company, or pharmacy benefit manager shall refuse to
366.13 fill a prescription for an opiate issued by a licensed practitioner with the authority to prescribe
366.14 opiates solely based on the prescription exceeding a predetermined morphine milligram
366.15 equivalent dosage recommendation or threshold.

366.16 Subd. 3. **Limits on applicability.** This section does not apply to:

366.17 (1) a physician's, advanced practice registered nurse's, or physician assistant's treatment
366.18 of ~~an individual~~ a patient for chemical dependency resulting from the use of controlled
366.19 substances in Schedules II to V of section 152.02;

366.20 (2) the prescription or administration of controlled substances in Schedules II to V of
366.21 section 152.02 to ~~an individual~~ a patient whom the physician, advanced practice registered
366.22 nurse, or physician assistant knows to be using the controlled substances for nontherapeutic
366.23 or drug diversion purposes;

366.24 (3) the prescription or administration of controlled substances in Schedules II to V of
366.25 section 152.02 for the purpose of terminating the life of ~~an individual~~ a patient having
366.26 intractable pain; or

366.27 (4) the prescription or administration of a controlled substance in Schedules II to V of
366.28 section 152.02 that is not a controlled substance approved by the United States Food and
366.29 Drug Administration for pain relief.

366.30 Subd. 4. **Notice of risks.** Prior to treating ~~an individual~~ a patient for intractable pain in
366.31 accordance with subdivision 2, a physician, advanced practice registered nurse, or physician
366.32 assistant shall discuss with the ~~individual~~ patient or the patient's legal guardian, if applicable,
366.33 the risks associated with the controlled substances in Schedules II to V of section 152.02

367.1 to be prescribed or administered in the course of the physician's, advanced practice registered
367.2 nurse's, or physician assistant's treatment of ~~an individual~~ a patient, and document the
367.3 discussion in the ~~individual's~~ patient's record as required in the patient-provider agreement
367.4 described in subdivision 5.

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

367.11 (b) The agreement must be signed by the patient or the patient's legal guardian, if
367.12 applicable, and the physician, advanced practice registered nurse, or physician assistant and
367.13 included in the patient's medical records. A copy of the signed agreement must be provided
367.14 to the patient.

367.15 (c) The agreement must be reviewed by the patient and the physician, advanced practice
367.16 registered nurse, or physician assistant annually. If there is a change in the patient's treatment
367.17 plan, the agreement must be updated and a revised agreement must be signed by the patient
367.18 or the patient's legal guardian. A copy of the revised agreement must be included in the
367.19 patient's medical record and a copy must be provided to the patient.

367.20 (d) A patient-provider agreement is not required in an emergency or inpatient hospital
367.21 setting.

367.22 Sec. 57. Minnesota Statutes 2021 Supplement, section 256B.0625, subdivision 13, is
367.23 amended to read:

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

367.30 (b) The dispensed quantity of a prescription drug must not exceed a 34-day supply,
367.31 unless authorized by the commissioner or the drug appears on the 90-day supply list published
367.32 by the commissioner. The 90-day supply list shall be published by the commissioner on the
367.33 department's website. The commissioner may add to, delete from, and otherwise modify

368.1 the 90-day supply list after providing public notice and the opportunity for a 15-day public
368.2 comment period. The 90-day supply list may include cost-effective generic drugs and shall
368.3 not include controlled substances.

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

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

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

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

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

368.32 (e) Effective January 1, 2006, medical assistance shall not cover drugs that are coverable
368.33 under Medicare Part D as defined in the Medicare Prescription Drug, Improvement, and
368.34 Modernization Act of 2003, Public Law 108-173, section 1860D-2(e), for individuals eligible

369.1 for drug coverage as defined in the Medicare Prescription Drug, Improvement, and
369.2 Modernization Act of 2003, Public Law 108-173, section 1860D-1(a)(3)(A). For these
369.3 individuals, medical assistance may cover drugs from the drug classes listed in United States
369.4 Code, title 42, section 1396r-8(d)(2), subject to this subdivision and subdivisions 13a to
369.5 13g, except that drugs listed in United States Code, title 42, section 1396r-8(d)(2)(E), shall
369.6 not be covered.

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

369.11 (g) Notwithstanding paragraph (a), medical assistance covers self-administered hormonal
369.12 contraceptives prescribed and dispensed by a licensed pharmacist in accordance with section
369.13 151.37, subdivision 14; nicotine replacement medications prescribed and dispensed by a
369.14 licensed pharmacist in accordance with section 151.37, subdivision 15; and opiate antagonists
369.15 used for the treatment of an acute opiate overdose prescribed and dispensed by a licensed
369.16 pharmacist in accordance with section 151.37, subdivision 16.

369.17 (h) Medical assistance coverage of, and reimbursement for, antiretroviral drugs to prevent
369.18 the acquisition of human immunodeficiency virus (HIV) and any laboratory testing necessary
369.19 for therapy that uses these drugs must meet the requirements that would otherwise apply to
369.20 a health plan under section 62Q.524.

369.21 Sec. 58. Minnesota Statutes 2020, section 256B.0625, subdivision 13f, is amended to read:

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

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

369.32 (1) the commissioner must provide information to the Formulary Committee on the
369.33 impact that placing the drug on prior authorization may have on the quality of patient care

370.1 and on program costs, information regarding whether the drug is subject to clinical abuse
370.2 or misuse, and relevant data from the state Medicaid program if such data is available;

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

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

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

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

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

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

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

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

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

370.25 (e) Notwithstanding this subdivision, the commissioner may automatically require prior
370.26 authorization, for a period not to exceed 180 days, for any drug that is approved by the
370.27 United States Food and Drug Administration on or after July 1, 2005. The 180-day period
370.28 begins no later than the first day that a drug is available for shipment to pharmacies within
370.29 the state. The Formulary Committee shall recommend to the commissioner general criteria
370.30 to be used for the prior authorization of the drugs, but the committee is not required to
370.31 review each individual drug. In order to continue prior authorizations for a drug after the
370.32 180-day period has expired, the commissioner must follow the provisions of this subdivision.

371.1 (f) Prior authorization under this subdivision shall comply with ~~section~~ sections 62Q.184
371.2 and 62Q.1842.

371.3 (g) Any step therapy protocol requirements established by the commissioner must comply
371.4 with ~~section~~ sections 62Q.1841 and 62Q.1842.

371.5 **Sec. 59. STUDY OF PHARMACY AND PROVIDER CHOICE OF BIOLOGICAL**
371.6 **PRODUCTS.**

371.7 The commissioner of health, within the limits of existing resources, shall analyze the
371.8 effect of Minnesota Statutes, section 62W.0751, on the net price for different payors of
371.9 biological products, interchangeable biological products, and biosimilar products. The
371.10 commissioner of health shall report findings to the chairs and ranking minority members
371.11 of the legislative committees with jurisdiction over health and human services finance and
371.12 policy and insurance by December 15, 2024.

371.13 **ARTICLE 7**

371.14 **HEALTH INSURANCE**

371.15 Section 1. Minnesota Statutes 2020, section 62A.25, subdivision 2, is amended to read:

371.16 Subd. 2. **Required coverage.** (a) Every policy, plan, certificate or contract to which this
371.17 section applies shall provide benefits for reconstructive surgery when such service is
371.18 incidental to or follows surgery resulting from injury, sickness or other diseases of the
371.19 involved part or when such service is performed on a covered dependent child because of
371.20 congenital disease or anomaly which has resulted in a functional defect as determined by
371.21 the attending physician.

371.22 (b) The coverage limitations on reconstructive surgery in paragraph (a) do not apply to
371.23 reconstructive breast surgery: (1) following mastectomies; or (2) if the patient has been
371.24 diagnosed with ectodermal dysplasia and has congenitally absent breast tissue or nipples.
371.25 ~~In these cases, Coverage for reconstructive surgery must be provided if the mastectomy is~~
371.26 ~~medically necessary as determined by the attending physician.~~

371.27 (c) Reconstructive surgery benefits include all stages of reconstruction ~~of the breast on~~
371.28 ~~which the mastectomy has been performed,~~ including surgery and reconstruction of the
371.29 other breast to produce a symmetrical appearance, and prosthesis and physical complications
371.30 at all stages ~~of a mastectomy,~~ including lymphedemas, in a manner determined in consultation
371.31 with the attending physician and patient. Coverage may be subject to annual deductible,

372.1 co-payment, and coinsurance provisions as may be deemed appropriate and as are consistent
372.2 with those established for other benefits under the plan or coverage. Coverage may not:

372.3 (1) deny to a patient eligibility, or continued eligibility, to enroll or to renew coverage
372.4 under the terms of the plan, solely for the purpose of avoiding the requirements of this
372.5 section; and

372.6 (2) penalize or otherwise reduce or limit the reimbursement of an attending provider, or
372.7 provide monetary or other incentives to an attending provider to induce the provider to
372.8 provide care to an individual participant or beneficiary in a manner inconsistent with this
372.9 section.

372.10 Written notice of the availability of the coverage must be delivered to the participant upon
372.11 enrollment and annually thereafter.

372.12 **EFFECTIVE DATE.** This section is effective January 1, 2023, and applies to health
372.13 plans offered, issued, or sold on or after that date.

372.14 **Sec. 2. [62A.255] COVERAGE OF LYMPHEDEMA TREATMENT.**

372.15 Subdivision 1. **Scope of coverage.** This section applies to all health plans that are sold,
372.16 issued, or renewed to a Minnesota resident.

372.17 Subd. 2. **Required coverage.** (a) Each health plan must provide coverage for lymphedema
372.18 treatment, including coverage for compression treatment items, complex decongestive
372.19 therapy, and outpatient self-management training and education during lymphedema treatment
372.20 if prescribed by a licensed health care professional. Lymphedema compression treatment
372.21 items include: (1) compression garments, stockings, and sleeves; (2) compression devices;
372.22 and (3) bandaging systems, components, and supplies that are primarily and customarily
372.23 used in the treatment of lymphedema.

372.24 (b) If applicable to the enrollee's health plan, a health carrier may require the prescribing
372.25 health care professional to be within the enrollee's health plan provider network if the
372.26 provider network meets network adequacy requirements under section 62K.10.

372.27 (c) A health plan must not apply any cost-sharing requirements, benefit limitations, or
372.28 service limitations for lymphedema treatment and compression treatment items that place
372.29 a greater financial burden on the enrollee or are more restrictive than cost-sharing
372.30 requirements or limitations applied by the health plan to other similar services or benefits.

372.31 **EFFECTIVE DATE.** This section is effective January 1, 2023, and applies to any health
372.32 plan issued, sold, or renewed on or after that date.

373.1 Sec. 3. Minnesota Statutes 2020, section 62A.28, subdivision 2, is amended to read:

373.2 Subd. 2. **Required coverage.** Every policy, plan, certificate, or contract referred to in
373.3 subdivision 1 ~~issued or renewed after August 1, 1987,~~ must provide coverage for scalp hair
373.4 prostheses worn for hair loss suffered as a result of alopecia areata or ectodermal dysplasias.

373.5 The coverage required by this section is subject to the co-payment, coinsurance,
373.6 deductible, and other enrollee cost-sharing requirements that apply to similar types of items
373.7 under the policy, plan, certificate, or contract and may be limited to one prosthesis per
373.8 benefit year.

373.9 **EFFECTIVE DATE.** This section is effective January 1, 2023, and applies to health
373.10 plans offered, issued, or sold on or after that date.

373.11 Sec. 4. Minnesota Statutes 2020, section 62A.30, is amended by adding a subdivision to
373.12 read:

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

373.17 **EFFECTIVE DATE.** This section is effective January 1, 2023, and applies to health
373.18 plans offered, issued, or sold on or after that date.

373.19 Sec. 5. **[62A.3096] COVERAGE FOR ECTODERMAL DYSPLASIAS.**

373.20 Subdivision 1. **Definition.** For purposes of this chapter, "ectodermal dysplasias" means
373.21 a genetic disorder involving the absence or deficiency of tissues and structures derived from
373.22 the embryonic ectoderm.

373.23 Subd. 2. **Coverage.** A health plan must provide coverage for the treatment of ectodermal
373.24 dysplasias.

373.25 Subd. 3. **Dental coverage.** (a) A health plan must provide coverage for dental treatments
373.26 related to ectodermal dysplasias. Covered dental treatments must include but are not limited
373.27 to bone grafts, dental implants, orthodontia, dental prosthodontics, and dental maintenance.

373.28 (b) If a dental treatment is eligible for coverage under a dental insurance plan or other
373.29 health plan, the coverage under this subdivision is secondary.

373.30 **EFFECTIVE DATE.** This section is effective January 1, 2023, and applies to health
373.31 plans offered, issued, or sold on or after that date.

374.1 Sec. 6. [62Q.451] UNRESTRICTED ACCESS TO SERVICES FOR THE
374.2 DIAGNOSIS, MONITORING, AND TREATMENT OF RARE DISEASES.

374.3 (a) No health plan company may restrict the choice of an enrollee as to where the enrollee
374.4 receives services from a licensed health care provider related to the diagnosis, monitoring,
374.5 and treatment of a rare disease or condition. Except as provided in paragraph (b), for purposes
374.6 of this section, "rare disease or condition" means any disease or condition:

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

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

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

374.13 (4) for which a pediatric patient:

374.14 (i) has received two or more clinical consultations from a primary care provider or
374.15 specialty provider;

374.16 (ii) has a delay in skill acquisition and development, regression in skill acquisition,
374.17 failure to thrive, or multisystemic involvement; and

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

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

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

374.26 (d) This section does not apply to health plan coverage provided through the State
374.27 Employee Group Insurance Program (SEGIP) under chapter 43A.

374.28 **EFFECTIVE DATE.** This section is effective January 1, 2023, and applies to health
374.29 plans offered, issued, or renewed on or after that date.

375.1 Sec. 7. Minnesota Statutes 2020, section 256B.0625, is amended by adding a subdivision
375.2 to read:

375.3 Subd. 68. **Services for the diagnosis, monitoring, and treatment of rare**
375.4 **diseases.** Medical assistance coverage for services related to the diagnosis, monitoring, and
375.5 treatment of a rare disease or condition must meet the requirements in section 62Q.451.

375.6 **EFFECTIVE DATE.** This section is effective January 1, 2023.

375.7 Sec. 8. Minnesota Statutes 2020, section 256B.0625, is amended by adding a subdivision
375.8 to read:

375.9 Subd. 69. **Ectodermal dysplasias.** Medical assistance and MinnesotaCare cover treatment
375.10 for ectodermal dysplasias. Coverage must meet the requirements of sections 62A.25, 62A.28,
375.11 and 62A.3096.

375.12 **EFFECTIVE DATE.** This section is effective January 1, 2023.

375.13 Sec. 9. Minnesota Statutes 2020, section 256B.0631, subdivision 2, is amended to read:

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

375.16 (1) children under the age of 21;

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

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

375.21 (4) recipients receiving hospice care;

375.22 (5) 100 percent federally funded services provided by an Indian health service;

375.23 (6) emergency services;

375.24 (7) family planning services;

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

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

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

376.3 (11) American Indians who meet the requirements in Code of Federal Regulations, title
376.4 42, sections 447.51 and 447.56;

376.5 (12) persons needing treatment for breast or cervical cancer as described under section
376.6 256B.057, subdivision 10; ~~and~~

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

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

376.14 **EFFECTIVE DATE.** This section is effective January 1, 2023.

376.15 Sec. 10. Minnesota Statutes 2020, section 256L.03, subdivision 5, is amended to read:

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

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

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

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

376.30 **EFFECTIVE DATE.** This section is effective January 1, 2023.

377.1 **ARTICLE 8**

377.2 **MISCELLANEOUS**

377.3 Section 1. Minnesota Statutes 2020, section 34A.01, subdivision 4, is amended to read:

377.4 Subd. 4. **Food.** "Food" means every ingredient used for, entering into the consumption
 377.5 of, or used or intended for use in the preparation of food, drink, confectionery, or condiment
 377.6 for humans or other animals, whether simple, mixed, or compound; and articles used as
 377.7 components of these ingredients, except that edible cannabinoid products, as defined in
 377.8 section 151.72, subdivision 1, paragraph (c), are not food.

377.9 Sec. 2. Minnesota Statutes 2020, section 137.68, is amended to read:

377.10 **137.68 MINNESOTA RARE DISEASE ADVISORY COUNCIL ON RARE**
 377.11 **DISEASES.**

377.12 Subdivision 1. **Establishment.** ~~The University of Minnesota is requested to establish~~
 377.13 There is established an advisory council on rare diseases to provide advice on policies,
 377.14 access, equity, research, diagnosis, treatment, and education related to rare diseases. The
 377.15 advisory council is established in honor of Chloe Barnes and her experiences in the health
 377.16 care system. For purposes of this section, "rare disease" has the meaning given in United
 377.17 States Code, title 21, section 360bb. The council shall be called the ~~Chloe Barnes Advisory~~
 377.18 ~~Council on Rare Diseases~~ Minnesota Rare Disease Advisory Council. The Council on
 377.19 Disability shall house the advisory council.

377.20 Subd. 2. **Membership.** (a) The advisory council ~~may~~ shall consist of at least 17 public
 377.21 members who reflect statewide representation and are appointed by the Board of Regents
 377.22 ~~or a designee~~ the governor according to paragraph (b) and four members of the legislature
 377.23 appointed according to paragraph (c).

377.24 (b) ~~The Board of Regents or a designee is requested to~~ The governor shall appoint at
 377.25 least the following public members according to section 15.059:

377.26 (1) three physicians licensed and practicing in the state with experience researching,
 377.27 diagnosing, or treating rare diseases, including one specializing in pediatrics;

377.28 (2) one registered nurse or advanced practice registered nurse licensed and practicing
 377.29 in the state with experience treating rare diseases;

377.30 (3) at least two hospital administrators, or their designees, from hospitals in the state
 377.31 that provide care to persons diagnosed with a rare disease. One administrator or designee

378.1 appointed under this clause must represent a hospital in which the scope of service focuses
378.2 on rare diseases of pediatric patients;

378.3 (4) three persons age 18 or older who either have a rare disease or are a caregiver of a
378.4 person with a rare disease. One person appointed under this clause must reside in rural
378.5 Minnesota;

378.6 (5) a representative of a rare disease patient organization that operates in the state;

378.7 (6) a social worker with experience providing services to persons diagnosed with a rare
378.8 disease;

378.9 (7) a pharmacist with experience with drugs used to treat rare diseases;

378.10 (8) a dentist licensed and practicing in the state with experience treating rare diseases;

378.11 (9) a representative of the biotechnology industry;

378.12 (10) a representative of health plan companies;

378.13 (11) a medical researcher with experience conducting research on rare diseases; ~~and~~

378.14 (12) a genetic counselor with experience providing services to persons diagnosed with
378.15 a rare disease or caregivers of those persons; and

378.16 (13) representatives with other areas of expertise as identified by the advisory council.

378.17 (c) The advisory council shall include two members of the senate, one appointed by the
378.18 majority leader and one appointed by the minority leader; and two members of the house
378.19 of representatives, one appointed by the speaker of the house and one appointed by the
378.20 minority leader.

378.21 (d) The commissioner of health or a designee, a representative of Mayo Medical School,
378.22 and a representative of the University of Minnesota Medical School shall serve as ex officio,
378.23 nonvoting members of the advisory council.

378.24 (e) ~~Initial appointments to the advisory council shall be made no later than September~~
378.25 ~~1, 2019.~~ Notwithstanding section 15.059, members appointed according to paragraph (b)
378.26 shall serve for a term of three years, except that the initial members appointed according to
378.27 paragraph (b) shall have an initial term of two, three, or four years determined by lot by the
378.28 chairperson. Members appointed according to paragraph (b) shall serve until their successors
378.29 have been appointed.

378.30 (f) Members may be reappointed for additional terms according to the advisory council's
378.31 operating procedures.

379.1 Subd. 3. **Meetings.** ~~The Board of Regents or a designee is requested to convene the first~~
379.2 ~~meeting of the advisory council no later than October 1, 2019.~~ The advisory council shall
379.3 meet at the call of the chairperson or at the request of a majority of advisory council members.
379.4 Meetings of the advisory council are subject to section 13D.01, and notice of its meetings
379.5 is governed by section 13D.04.

379.6 Subd. 3a. **Chairperson; executive director; staff; executive committee.** (a) The
379.7 advisory council shall elect a chairperson and other officers as it deems necessary and in
379.8 accordance with the advisory council's operating procedures.

379.9 (b) The advisory council shall be governed by an executive committee elected by the
379.10 members of the advisory council. One member of the executive committee must be the
379.11 advisory council chairperson.

379.12 (c) The advisory council shall appoint an executive director. The executive director
379.13 serves as an ex officio nonvoting member of the executive committee. The advisory council
379.14 may delegate to the executive director any powers and duties under this section that do not
379.15 require advisory council approval. The executive director serves in the unclassified service
379.16 and may be removed at any time by a majority vote of the advisory council. The executive
379.17 director may employ and direct staff necessary to carry out advisory council mandates,
379.18 policies, activities, and objectives.

379.19 (d) The executive committee may appoint additional subcommittees and work groups
379.20 as necessary to fulfill the duties of the advisory council.

379.21 Subd. 4. **Duties.** (a) The advisory council's duties may include, but are not limited to:

379.22 (1) in conjunction with the state's medical schools, the state's schools of public health,
379.23 and hospitals in the state that provide care to persons diagnosed with a rare disease,
379.24 developing resources or recommendations relating to quality of and access to treatment and
379.25 services in the state for persons with a rare disease, including but not limited to:

379.26 (i) a list of existing, publicly accessible resources on research, diagnosis, treatment, and
379.27 education relating to rare diseases;

379.28 (ii) identifying best practices for rare disease care implemented in other states, at the
379.29 national level, and at the international level that will improve rare disease care in the state
379.30 and seeking opportunities to partner with similar organizations in other states and countries;

379.31 (iii) identifying and addressing problems faced by patients with a rare disease when
379.32 changing health plans, including recommendations on how to remove obstacles faced by

380.1 these patients to finding a new health plan and how to improve the ease and speed of finding
380.2 a new health plan that meets the needs of patients with a rare disease; ~~and~~

380.3 (iv) identifying and addressing barriers faced by patients with a rare disease to obtaining
380.4 care, caused by prior authorization requirements in private and public health plans; and

380.5 ~~(iv)~~ (v) identifying, recommending, and implementing best practices to ensure health
380.6 care providers are adequately informed of the most effective strategies for recognizing and
380.7 treating rare diseases; and

380.8 (2) advising, consulting, and cooperating with the Department of Health, including the
380.9 Advisory Committee on Heritable and Congenital Disorders; the Department of Human
380.10 Services, including the Drug Utilization Review Board and the Drug Formulary Committee;
380.11 and other agencies of state government in developing recommendations, information, and
380.12 programs for the public and the health care community relating to diagnosis, treatment, and
380.13 awareness of rare diseases;

380.14 (3) advising on policy issues and advancing policy initiatives at the state and federal
380.15 levels; and

380.16 (4) receiving funds and issuing grants.

380.17 (b) The advisory council shall collect additional topic areas for study and evaluation
380.18 from the general public. In order for the advisory council to study and evaluate a topic, the
380.19 topic must be approved for study and evaluation by the advisory council.

380.20 Subd. 5. **Conflict of interest.** Advisory council members are subject to the ~~Board of~~
380.21 ~~Regents policy on conflicts~~ advisory council's conflict of interest policy as outlined in the
380.22 advisory council's operating procedures.

380.23 Subd. 6. **Annual report.** By January 1 of each year, beginning January 1, 2020, the
380.24 advisory council shall report to the chairs and ranking minority members of the legislative
380.25 committees with jurisdiction over higher education and health care policy on the advisory
380.26 council's activities under subdivision 4 and other issues on which the advisory council may
380.27 choose to report.

380.28 Sec. 3. Minnesota Statutes 2020, section 151.72, subdivision 1, is amended to read:

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

380.31 (b) "Certified hemp" means hemp plants that have been tested and found to meet the
380.32 requirements of chapter 18K and the rules adopted thereunder.

381.1 (c) "Edible cannabinoid product" means any product that is intended to be eaten or
381.2 consumed as a beverage by humans, contains a cannabinoid in combination with food
381.3 ingredients, and is not a drug.

381.4 ~~(b)~~ (d) "Hemp" has the meaning given to "industrial hemp" in section 18K.02, subdivision
381.5 3.

381.6 (e) "Label" has the meaning given in section 151.01, subdivision 18.

381.7 ~~(e)~~ (f) "Labeling" means all labels and other written, printed, or graphic matter that are:

381.8 (1) affixed to the immediate container in which a product regulated under this section
381.9 is sold; ~~or~~

381.10 (2) provided, in any manner, with the immediate container, including but not limited to
381.11 outer containers, wrappers, package inserts, brochures, or pamphlets; or

381.12 (3) provided on that portion of a manufacturer's website that is linked by a scannable
381.13 barcode or matrix barcode.

381.14 (g) "Matrix barcode" means a code that stores data in a two-dimensional array of
381.15 geometrically shaped dark and light cells capable of being read by the camera on a
381.16 smartphone or other mobile device.

381.17 (h) "Nonintoxicating cannabinoid" means substances extracted from certified hemp
381.18 plants that do not produce intoxicating effects when consumed by any route of administration.

381.19 Sec. 4. Minnesota Statutes 2020, section 151.72, subdivision 2, is amended to read:

381.20 Subd. 2. **Scope.** (a) This section applies to the sale of any product that contains
381.21 ~~nonintoxicating~~ cannabinoids extracted from hemp ~~other than food~~ and that is an edible
381.22 cannabinoid product or is intended for human or animal consumption by any route of
381.23 administration.

381.24 (b) This section does not apply to any product dispensed by a registered medical cannabis
381.25 manufacturer pursuant to sections 152.22 to 152.37.

381.26 (c) The board must have no authority over food products, as defined in section 34A.01,
381.27 subdivision 4, that do not contain cannabinoids extracted or derived from hemp.

381.28 Sec. 5. Minnesota Statutes 2020, section 151.72, subdivision 3, is amended to read:

381.29 Subd. 3. **Sale of cannabinoids derived from hemp.** (a) Notwithstanding any other
381.30 section of this chapter, a product containing nonintoxicating cannabinoids, including an

382.1 edible cannabinoid product, may be sold for human or animal consumption only if all of
382.2 the requirements of this section are met, provided that a product sold for human or animal
382.3 consumption does not contain more than 0.3 percent of any tetrahydrocannabinol and an
382.4 edible cannabinoid product does not contain an amount of any tetrahydrocannabinol that
382.5 exceeds the limits established in subdivision 5a, paragraph (f).

382.6 (b) No other substance extracted or otherwise derived from hemp may be sold for human
382.7 consumption if the substance is intended:

382.8 (1) for external or internal use in the diagnosis, cure, mitigation, treatment, or prevention
382.9 of disease in humans or other animals; or

382.10 (2) to affect the structure or any function of the bodies of humans or other animals.

382.11 (c) No product containing any cannabinoid or tetrahydrocannabinol extracted or otherwise
382.12 derived from hemp may be sold to any individual who is under the age of 21.

382.13 (d) Products that meet the requirements of this section are not controlled substances
382.14 under section 152.02.

382.15 Sec. 6. Minnesota Statutes 2020, section 151.72, subdivision 4, is amended to read:

382.16 Subd. 4. **Testing requirements.** (a) A manufacturer of a product regulated under this
382.17 section must submit representative samples of the product to an independent, accredited
382.18 laboratory in order to certify that the product complies with the standards adopted by the
382.19 board. Testing must be consistent with generally accepted industry standards for herbal and
382.20 botanical substances, and, at a minimum, the testing must confirm that the product:

382.21 (1) contains the amount or percentage of cannabinoids that is stated on the label of the
382.22 product;

382.23 (2) does not contain more than trace amounts of any mold, residual solvents, pesticides,
382.24 fertilizers, or heavy metals; and

382.25 (3) does not contain a ~~delta-9 tetrahydrocannabinol concentration that exceeds the~~
382.26 ~~concentration permitted for industrial hemp as defined in section 18K.02, subdivision 3~~
382.27 more than 0.3 percent of any tetrahydrocannabinol.

382.28 (b) Upon the request of the board, the manufacturer of the product must provide the
382.29 board with the results of the testing required in this section.

382.30 (c) Testing of the hemp from which the nonintoxicating cannabinoid was derived, or
382.31 possession of a certificate of analysis for such hemp, does not meet the testing requirements
382.32 of this section.

383.1 Sec. 7. Minnesota Statutes 2021 Supplement, section 151.72, subdivision 5, is amended
383.2 to read:

383.3 Subd. 5. **Labeling requirements.** (a) A product regulated under this section must bear
383.4 a label that contains, at a minimum:

383.5 (1) the name, location, contact phone number, and website of the manufacturer of the
383.6 product;

383.7 (2) the name and address of the independent, accredited laboratory used by the
383.8 manufacturer to test the product; and

383.9 (3) an accurate statement of the amount or percentage of cannabinoids found in each
383.10 unit of the product meant to be consumed; ~~or.~~

383.11 ~~(4) instead of the information required in clauses (1) to (3), a scannable bar code or QR~~
383.12 ~~code that links to the manufacturer's website.~~

383.13 (b) The information in paragraph (a) may be provided on an outer package if the
383.14 immediate container that holds the product is too small to contain all of the information.

383.15 (c) The information required in paragraph (a) may be provided through the use of a
383.16 scannable barcode or matrix barcode that links to a page on the manufacturer's website if
383.17 that page contains all of the information required by this subdivision.

383.18 (d) The label must also include a statement stating that ~~this~~ the product does not claim

383.19 to diagnose, treat, cure, or prevent any disease and has not been evaluated or approved by

383.20 the United States Food and Drug Administration (FDA) unless the product has been so

383.21 approved.

383.22 ~~(b)~~ (e) The information required to be on the label by this subdivision must be prominently

383.23 and conspicuously placed ~~and~~ on the label or displayed on the website in terms that can be

383.24 easily read and understood by the consumer.

383.25 ~~(e)~~ (f) The label labeling must not contain any claim that the product may be used or is

383.26 effective for the prevention, treatment, or cure of a disease or that it may be used to alter

383.27 the structure or function of human or animal bodies, unless the claim has been approved by

383.28 the FDA.

384.1 Sec. 8. Minnesota Statutes 2020, section 151.72, is amended by adding a subdivision to
384.2 read:

384.3 Subd. 5a. **Additional requirements for edible cannabinoid products.** (a) In addition
384.4 to the testing and labeling requirements under subdivisions 4 and 5, an edible cannabinoid
384.5 must meet the requirements of this subdivision.

384.6 (b) An edible cannabinoid product must not:

384.7 (1) bear the likeness or contain cartoon-like characteristics of a real or fictional person,
384.8 animal, or fruit that appeals to children;

384.9 (2) be modeled after a brand of products primarily consumed by or marketed to children;

384.10 (3) be made by applying an extracted or concentrated hemp-derived cannabinoid to a
384.11 commercially available candy or snack food item;

384.12 (4) contain an ingredient, other than a hemp-derived cannabinoid, that is not approved
384.13 by the United States Food and Drug Administration for use in food;

384.14 (5) be packaged in a way that resembles the trademarked, characteristic, or
384.15 product-specialized packaging of any commercially available food product; or

384.16 (6) be packaged in a container that includes a statement, artwork, or design that could
384.17 reasonably mislead any person to believe that the package contains anything other than an
384.18 edible cannabinoid product.

384.19 (c) An edible cannabinoid product must be prepackaged in packaging or a container that
384.20 is child-resistant, tamper-evident, and opaque or placed in packaging or a container that is
384.21 child-resistant, tamper-evident, and opaque at the final point of sale to a customer. The
384.22 requirement that packaging be child-resistant does not apply to an edible cannabinoid product
384.23 that is intended to be consumed as a beverage and which contains no more than a trace
384.24 amount of any tetrahydrocannabinol.

384.25 (d) If an edible cannabinoid product is intended for more than a single use or contains
384.26 multiple servings, each serving must be indicated by scoring, wrapping, or other indicators
384.27 designating the individual serving size.

384.28 (e) A label containing at least the following information must be affixed to the packaging
384.29 or container of all edible cannabinoid products sold to consumers:

384.30 (1) the serving size;

384.31 (2) the cannabinoid profile per serving and in total;

385.1 (3) a list of ingredients, including identification of any major food allergens declared
385.2 by name; and

385.3 (4) the following statement: "Keep this product out of reach of children."

385.4 (f) An edible cannabinoid product must not contain more than five milligrams of any
385.5 tetrahydrocannabinol in a single serving, or more than a total of 50 milligrams of any
385.6 tetrahydrocannabinol per package.

385.7 Sec. 9. Minnesota Statutes 2020, section 151.72, subdivision 6, is amended to read:

385.8 Subd. 6. **Enforcement.** (a) A product ~~sold~~ regulated under this section, including an
385.9 edible cannabinoid product, shall be considered an adulterated drug if:

385.10 (1) it consists, in whole or in part, of any filthy, putrid, or decomposed substance;

385.11 (2) it has been produced, prepared, packed, or held under unsanitary conditions where
385.12 it may have been rendered injurious to health, or where it may have been contaminated with
385.13 filth;

385.14 (3) its container is composed, in whole or in part, of any poisonous or deleterious
385.15 substance that may render the contents injurious to health;

385.16 (4) it contains any food additives, color additives, or excipients that have been found by
385.17 the FDA to be unsafe for human or animal consumption; ~~or~~

385.18 (5) it contains an amount or percentage of nonintoxicating cannabinoids that is different
385.19 than the amount or percentage stated on the label;

385.20 (6) it contains more than 0.3 percent of any tetrahydrocannabinol or, if the product is
385.21 an edible cannabinoid product, an amount of tetrahydrocannabinol that exceeds the limits
385.22 established in subdivision 5a, paragraph (f); or

385.23 (7) it contains more than trace amounts of mold, residual solvents, pesticides, fertilizers,
385.24 or heavy metals.

385.25 (b) A product ~~sold~~ regulated under this section shall be considered a misbranded drug
385.26 if the product's labeling is false or misleading in any manner or in violation of the
385.27 requirements of this section.

385.28 (c) The board's authority to issue cease and desist orders under section 151.06; to embargo
385.29 adulterated and misbranded drugs under section 151.38; and to seek injunctive relief under
385.30 section 214.11, extends to any violation of this section.

386.1 Sec. 10. Minnesota Statutes 2020, section 152.01, subdivision 23, is amended to read:

386.2 Subd. 23. **Analog.** (a) Except as provided in paragraph (b), "analog" means a substance,
386.3 the chemical structure of which is substantially similar to the chemical structure of a
386.4 controlled substance in Schedule I or II:

386.5 (1) that has a stimulant, depressant, or hallucinogenic effect on the central nervous system
386.6 that is substantially similar to or greater than the stimulant, depressant, or hallucinogenic
386.7 effect on the central nervous system of a controlled substance in Schedule I or II; or

386.8 (2) with respect to a particular person, if the person represents or intends that the substance
386.9 have a stimulant, depressant, or hallucinogenic effect on the central nervous system that is
386.10 substantially similar to or greater than the stimulant, depressant, or hallucinogenic effect
386.11 on the central nervous system of a controlled substance in Schedule I or II.

386.12 (b) "Analog" does not include:

386.13 (1) a controlled substance;

386.14 (2) any substance for which there is an approved new drug application under the Federal
386.15 Food, Drug, and Cosmetic Act; or

386.16 (3) with respect to a particular person, any substance, if an exemption is in effect for
386.17 investigational use, for that person, as provided by United States Code, title 21, section 355,
386.18 and the person is registered as a controlled substance researcher as required under section
386.19 152.12, subdivision 3, to the extent conduct with respect to the substance is pursuant to the
386.20 exemption and registration; or

386.21 (4) marijuana or tetrahydrocannabinols naturally contained in a plant of the genus
386.22 cannabis or in the resinous extractives of the plant.

386.23 **EFFECTIVE DATE.** This section is effective August 1, 2022, and applies to crimes
386.24 committed on or after that date.

386.25 Sec. 11. Minnesota Statutes 2020, section 152.02, subdivision 2, is amended to read:

386.26 Subd. 2. **Schedule I.** (a) Schedule I consists of the substances listed in this subdivision.

386.27 (b) Opiates. Unless specifically excepted or unless listed in another schedule, any of the
386.28 following substances, including their analogs, isomers, esters, ethers, salts, and salts of
386.29 isomers, esters, and ethers, whenever the existence of the analogs, isomers, esters, ethers,
386.30 and salts is possible:

386.31 (1) acetylmethadol;

- 387.1 (2) allylprodine;
- 387.2 (3) alphacetylmethadol (except levo-alphacetylmethadol, also known as levomethadyl
- 387.3 acetate);
- 387.4 (4) alphameprodine;
- 387.5 (5) alphamethadol;
- 387.6 (6) alpha-methylfentanyl benzethidine;
- 387.7 (7) betacetylmethadol;
- 387.8 (8) betameprodine;
- 387.9 (9) betamethadol;
- 387.10 (10) betaprodine;
- 387.11 (11) clonitazene;
- 387.12 (12) dextromoramide;
- 387.13 (13) diampromide;
- 387.14 (14) diethylambutene;
- 387.15 (15) difenoxin;
- 387.16 (16) dimenoxadol;
- 387.17 (17) dimepheptanol;
- 387.18 (18) dimethylambutene;
- 387.19 (19) dioxaphetyl butyrate;
- 387.20 (20) dipipanone;
- 387.21 (21) ethylmethylthiambutene;
- 387.22 (22) etonitazene;
- 387.23 (23) etoxeridine;
- 387.24 (24) furethidine;
- 387.25 (25) hydroxypethidine;
- 387.26 (26) ketobemidone;
- 387.27 (27) levomoramide;

- 388.1 (28) levophenacymorphan;
- 388.2 (29) 3-methylfentanyl;
- 388.3 (30) acetyl-alpha-methylfentanyl;
- 388.4 (31) alpha-methylthiofentanyl;
- 388.5 (32) benzylfentanyl beta-hydroxyfentanyl;
- 388.6 (33) beta-hydroxy-3-methylfentanyl;
- 388.7 (34) 3-methylthiofentanyl;
- 388.8 (35) thenylfentanyl;
- 388.9 (36) thiofentanyl;
- 388.10 (37) para-fluorofentanyl;
- 388.11 (38) morpheridine;
- 388.12 (39) 1-methyl-4-phenyl-4-propionoxypiperidine;
- 388.13 (40) noracymethadol;
- 388.14 (41) norlevorphanol;
- 388.15 (42) normethadone;
- 388.16 (43) norpipanone;
- 388.17 (44) 1-(2-phenylethyl)-4-phenyl-4-acetoxypiperidine (PEPAP);
- 388.18 (45) phenadoxone;
- 388.19 (46) phenampromide;
- 388.20 (47) phenomorphan;
- 388.21 (48) phenoperidine;
- 388.22 (49) piritramide;
- 388.23 (50) proheptazine;
- 388.24 (51) properidine;
- 388.25 (52) propiram;
- 388.26 (53) racemoramide;
- 388.27 (54) tilidine;

- 389.1 (55) trimeperidine;
- 389.2 (56) N-(1-Phenethylpiperidin-4-yl)-N-phenylacetamide (acetyl fentanyl);
- 389.3 (57) 3,4-dichloro-N-[(1R,2R)-2-(dimethylamino)cyclohexyl]-N-
- 389.4 methylbenzamide(U47700);
- 389.5 (58) N-phenyl-N-[1-(2-phenylethyl)piperidin-4-yl]furan-2-carboxamide(furanylfentanyl);
- 389.6 (59) 4-(4-bromophenyl)-4-dimethylamino-1-phenethylcyclohexanol (bromadol);
- 389.7 (60) N-(1-phenethylpiperidin-4-yl)-N-phenylcyclopropanecarboxamide (Cyclopropyl
- 389.8 fentanyl);
- 389.9 (61) N-(1-phenethylpiperidin-4-yl)-N-phenylbutanamide) (butyryl fentanyl);
- 389.10 (62) 1-cyclohexyl-4-(1,2-diphenylethyl)piperazine) (MT-45);
- 389.11 (63) N-(1-phenethylpiperidin-4-yl)-N-phenylcyclopentanecarboxamide (cyclopentyl
- 389.12 fentanyl);
- 389.13 (64) N-(1-phenethylpiperidin-4-yl)-N-phenylisobutyramide (isobutyryl fentanyl);
- 389.14 (65) N-(1-phenethylpiperidin-4-yl)-N-phenylpentanamide (valeryl fentanyl);
- 389.15 (66) N-(4-chlorophenyl)-N-(1-phenethylpiperidin-4-yl)isobutyramide
- 389.16 (para-chloroisobutyryl fentanyl);
- 389.17 (67) N-(4-fluorophenyl)-N-(1-phenethylpiperidin-4-yl)butyramide (para-fluorobutyryl
- 389.18 fentanyl);
- 389.19 (68) N-(4-methoxyphenyl)-N-(1-phenethylpiperidin-4-yl)butyramide
- 389.20 (para-methoxybutyryl fentanyl);
- 389.21 (69) N-(2-fluorophenyl)-2-methoxy-N-(1-phenethylpiperidin-4-yl)acetamide (ocfentanil);
- 389.22 (70) N-(4-fluorophenyl)-N-(1-phenethylpiperidin-4-yl)isobutyramide (4-fluoroisobutyryl
- 389.23 fentanyl or para-fluoroisobutyryl fentanyl);
- 389.24 (71) N-(1-phenethylpiperidin-4-yl)-N-phenylacrylamide (acryl fentanyl or
- 389.25 acryloylfentanyl);
- 389.26 (72) 2-methoxy-N-(1-phenethylpiperidin-4-yl)-N-phenylacetamide (methoxyacetyl
- 389.27 fentanyl);
- 389.28 (73) N-(2-fluorophenyl)-N-(1-phenethylpiperidin-4-yl)propionamide (ortho-fluorofentanyl
- 389.29 or 2-fluorofentanyl);

390.1 (74) N-(1-phenethylpiperidin-4-yl)-N-phenyltetrahydrofuran-2-carboxamide
390.2 (tetrahydrofuranyl fentanyl); and

390.3 (75) Fentanyl-related substances, their isomers, esters, ethers, salts and salts of isomers,
390.4 esters and ethers, meaning any substance not otherwise listed under another federal
390.5 Administration Controlled Substance Code Number or not otherwise listed in this section,
390.6 and for which no exemption or approval is in effect under section 505 of the Federal Food,
390.7 Drug, and Cosmetic Act, United States Code , title 21, section 355, that is structurally related
390.8 to fentanyl by one or more of the following modifications:

390.9 (i) replacement of the phenyl portion of the phenethyl group by any monocycle, whether
390.10 or not further substituted in or on the monocycle;

390.11 (ii) substitution in or on the phenethyl group with alkyl, alkenyl, alkoxy, hydroxyl, halo,
390.12 haloalkyl, amino, or nitro groups;

390.13 (iii) substitution in or on the piperidine ring with alkyl, alkenyl, alkoxy, ester, ether,
390.14 hydroxyl, halo, haloalkyl, amino, or nitro groups;

390.15 (iv) replacement of the aniline ring with any aromatic monocycle whether or not further
390.16 substituted in or on the aromatic monocycle; or

390.17 (v) replacement of the N-propionyl group by another acyl group.

390.18 (c) Opium derivatives. Any of the following substances, their analogs, salts, isomers,
390.19 and salts of isomers, unless specifically excepted or unless listed in another schedule,
390.20 whenever the existence of the analogs, salts, isomers, and salts of isomers is possible:

390.21 (1) acetorphine;

390.22 (2) acetyldihydrocodeine;

390.23 (3) benzylmorphine;

390.24 (4) codeine methylbromide;

390.25 (5) codeine-n-oxide;

390.26 (6) cyprenorphine;

390.27 (7) desomorphine;

390.28 (8) dihydromorphine;

390.29 (9) drotebanol;

390.30 (10) etorphine;

- 391.1 (11) heroin;
- 391.2 (12) hydromorphenol;
- 391.3 (13) methylodesorphine;
- 391.4 (14) methyldihydromorphine;
- 391.5 (15) morphine methylbromide;
- 391.6 (16) morphine methylsulfonate;
- 391.7 (17) morphine-n-oxide;
- 391.8 (18) myrophine;
- 391.9 (19) nicocodeine;
- 391.10 (20) nicomorphine;
- 391.11 (21) normorphine;
- 391.12 (22) pholcodine; and
- 391.13 (23) thebacon.
- 391.14 (d) Hallucinogens. Any material, compound, mixture or preparation which contains any
391.15 quantity of the following substances, their analogs, salts, isomers (whether optical, positional,
391.16 or geometric), and salts of isomers, unless specifically excepted or unless listed in another
391.17 schedule, whenever the existence of the analogs, salts, isomers, and salts of isomers is
391.18 possible:
- 391.19 (1) methylenedioxy amphetamine;
- 391.20 (2) methylenedioxymethamphetamine;
- 391.21 (3) methylenedioxy-N-ethylamphetamine (MDEA);
- 391.22 (4) n-hydroxy-methylenedioxyamphetamine;
- 391.23 (5) 4-bromo-2,5-dimethoxyamphetamine (DOB);
- 391.24 (6) 2,5-dimethoxyamphetamine (2,5-DMA);
- 391.25 (7) 4-methoxyamphetamine;
- 391.26 (8) 5-methoxy-3, 4-methylenedioxyamphetamine;
- 391.27 (9) alpha-ethyltryptamine;
- 391.28 (10) bufotenine;

- 392.1 (11) diethyltryptamine;
- 392.2 (12) dimethyltryptamine;
- 392.3 (13) 3,4,5-trimethoxyamphetamine;
- 392.4 (14) 4-methyl-2, 5-dimethoxyamphetamine (DOM);
- 392.5 (15) ibogaine;
- 392.6 (16) lysergic acid diethylamide (LSD);
- 392.7 (17) mescaline;
- 392.8 (18) parahexyl;
- 392.9 (19) N-ethyl-3-piperidyl benzilate;
- 392.10 (20) N-methyl-3-piperidyl benzilate;
- 392.11 (21) psilocybin;
- 392.12 (22) psilocyn;
- 392.13 (23) tenocyclidine (TCP or TCP);
- 392.14 (24) N-ethyl-1-phenyl-cyclohexylamine (PCE);
- 392.15 (25) 1-(1-phenylcyclohexyl) pyrrolidine (PCPy);
- 392.16 (26) 1-[1-(2-thienyl)cyclohexyl]-pyrrolidine (TCPy);
- 392.17 (27) 4-chloro-2,5-dimethoxyamphetamine (DOC);
- 392.18 (28) 4-ethyl-2,5-dimethoxyamphetamine (DOET);
- 392.19 (29) 4-iodo-2,5-dimethoxyamphetamine (DOI);
- 392.20 (30) 4-bromo-2,5-dimethoxyphenethylamine (2C-B);
- 392.21 (31) 4-chloro-2,5-dimethoxyphenethylamine (2C-C);
- 392.22 (32) 4-methyl-2,5-dimethoxyphenethylamine (2C-D);
- 392.23 (33) 4-ethyl-2,5-dimethoxyphenethylamine (2C-E);
- 392.24 (34) 4-iodo-2,5-dimethoxyphenethylamine (2C-I);
- 392.25 (35) 4-propyl-2,5-dimethoxyphenethylamine (2C-P);
- 392.26 (36) 4-isopropylthio-2,5-dimethoxyphenethylamine (2C-T-4);
- 392.27 (37) 4-propylthio-2,5-dimethoxyphenethylamine (2C-T-7);

- 393.1 (38) 2-(8-bromo-2,3,6,7-tetrahydrofuro [2,3-f][1]benzofuran-4-yl)ethanamine
393.2 (2-CB-FLY);
- 393.3 (39) bromo-benzodifuranyl-isopropylamine (Bromo-DragonFLY);
- 393.4 (40) alpha-methyltryptamine (AMT);
- 393.5 (41) N,N-diisopropyltryptamine (DiPT);
- 393.6 (42) 4-acetoxy-N,N-dimethyltryptamine (4-AcO-DMT);
- 393.7 (43) 4-acetoxy-N,N-diethyltryptamine (4-AcO-DET);
- 393.8 (44) 4-hydroxy-N-methyl-N-propyltryptamine (4-HO-MPT);
- 393.9 (45) 4-hydroxy-N,N-dipropyltryptamine (4-HO-DPT);
- 393.10 (46) 4-hydroxy-N,N-diallyltryptamine (4-HO-DALT);
- 393.11 (47) 4-hydroxy-N,N-diisopropyltryptamine (4-HO-DiPT);
- 393.12 (48) 5-methoxy-N,N-diisopropyltryptamine (5-MeO-DiPT);
- 393.13 (49) 5-methoxy- α -methyltryptamine (5-MeO-AMT);
- 393.14 (50) 5-methoxy-N,N-dimethyltryptamine (5-MeO-DMT);
- 393.15 (51) 5-methylthio-N,N-dimethyltryptamine (5-MeS-DMT);
- 393.16 (52) 5-methoxy-N-methyl-N-isopropyltryptamine (5-MeO-MiPT);
- 393.17 (53) 5-methoxy- α -ethyltryptamine (5-MeO-AET);
- 393.18 (54) 5-methoxy-N,N-dipropyltryptamine (5-MeO-DPT);
- 393.19 (55) 5-methoxy-N,N-diethyltryptamine (5-MeO-DET);
- 393.20 (56) 5-methoxy-N,N-diallyltryptamine (5-MeO-DALT);
- 393.21 (57) methoxetamine (MXE);
- 393.22 (58) 5-iodo-2-aminoindane (5-IAI);
- 393.23 (59) 5,6-methylenedioxy-2-aminoindane (MDAI);
- 393.24 (60) 2-(4-bromo-2,5-dimethoxyphenyl)-N-(2-methoxybenzyl)ethanamine (25B-NBOMe);
- 393.25 (61) 2-(4-chloro-2,5-dimethoxyphenyl)-N-(2-methoxybenzyl)ethanamine (25C-NBOMe);
- 393.26 (62) 2-(4-iodo-2,5-dimethoxyphenyl)-N-(2-methoxybenzyl)ethanamine (25I-NBOMe);
- 393.27 (63) 2-(2,5-Dimethoxyphenyl)ethanamine (2C-H);

- 394.1 (64) 2-(4-Ethylthio-2,5-dimethoxyphenyl)ethanamine (2C-T-2);
- 394.2 (65) N,N-Dipropyltryptamine (DPT);
- 394.3 (66) 3-[1-(Piperidin-1-yl)cyclohexyl]phenol (3-HO-PCP);
- 394.4 (67) N-ethyl-1-(3-methoxyphenyl)cyclohexanamine (3-MeO-PCE);
- 394.5 (68) 4-[1-(3-methoxyphenyl)cyclohexyl]morpholine (3-MeO-PCMo);
- 394.6 (69) 1-[1-(4-methoxyphenyl)cyclohexyl]-piperidine (methoxydine, 4-MeO-PCP);
- 394.7 (70) 2-(2-Chlorophenyl)-2-(ethylamino)cyclohexan-1-one (N-Ethylorketamine,
394.8 ethketamine, NENK);
- 394.9 (71) methylenedioxy-N,N-dimethylamphetamine (MDDMA);
- 394.10 (72) 3-(2-Ethyl(methyl)aminoethyl)-1H-indol-4-yl (4-AcO-MET); and
- 394.11 (73) 2-Phenyl-2-(methylamino)cyclohexanone (deschloroketamine).
- 394.12 (e) Peyote. All parts of the plant presently classified botanically as *Lophophora williamsii*
394.13 Lemaire, whether growing or not, the seeds thereof, any extract from any part of the plant,
394.14 and every compound, manufacture, salts, derivative, mixture, or preparation of the plant,
394.15 its seeds or extracts. The listing of peyote as a controlled substance in Schedule I does not
394.16 apply to the nondrug use of peyote in bona fide religious ceremonies of the American Indian
394.17 Church, and members of the American Indian Church are exempt from registration. Any
394.18 person who manufactures peyote for or distributes peyote to the American Indian Church,
394.19 however, is required to obtain federal registration annually and to comply with all other
394.20 requirements of law.
- 394.21 (f) Central nervous system depressants. Unless specifically excepted or unless listed in
394.22 another schedule, any material compound, mixture, or preparation which contains any
394.23 quantity of the following substances, their analogs, salts, isomers, and salts of isomers
394.24 whenever the existence of the analogs, salts, isomers, and salts of isomers is possible:
- 394.25 (1) mecloqualone;
- 394.26 (2) methaqualone;
- 394.27 (3) gamma-hydroxybutyric acid (GHB), including its esters and ethers;
- 394.28 (4) flunitrazepam;
- 394.29 (5) 2-(2-Methoxyphenyl)-2-(methylamino)cyclohexanone (2-MeO-2-deschloroketamine,
394.30 methoxyketamine);

- 395.1 (6) tianeptine;
- 395.2 (7) clonazolam;
- 395.3 (8) etizolam;
- 395.4 (9) flubromazolam; and
- 395.5 (10) flubromazepam.
- 395.6 (g) Stimulants. Unless specifically excepted or unless listed in another schedule, any
- 395.7 material compound, mixture, or preparation which contains any quantity of the following
- 395.8 substances, their analogs, salts, isomers, and salts of isomers whenever the existence of the
- 395.9 analogs, salts, isomers, and salts of isomers is possible:
- 395.10 (1) aminorex;
- 395.11 (2) cathinone;
- 395.12 (3) fenethylamine;
- 395.13 (4) methcathinone;
- 395.14 (5) methylaminorex;
- 395.15 (6) N,N-dimethylamphetamine;
- 395.16 (7) N-benzylpiperazine (BZP);
- 395.17 (8) methylmethcathinone (mephedrone);
- 395.18 (9) 3,4-methylenedioxy-N-methylcathinone (methydone);
- 395.19 (10) methoxymethcathinone (methedrone);
- 395.20 (11) methylenedioxypyrovalerone (MDPV);
- 395.21 (12) 3-fluoro-N-methylcathinone (3-FMC);
- 395.22 (13) methylethcathinone (MEC);
- 395.23 (14) 1-benzofuran-6-ylpropan-2-amine (6-APB);
- 395.24 (15) dimethylmethcathinone (DMMC);
- 395.25 (16) fluoroamphetamine;
- 395.26 (17) fluoromethamphetamine;
- 395.27 (18) α -methylaminobutyrophenone (MABP or buphedrone);
- 395.28 (19) 1-(1,3-benzodioxol-5-yl)-2-(methylamino)butan-1-one (butylone);

- 396.1 (20) 2-(methylamino)-1-(4-methylphenyl)butan-1-one (4-MEMABP or BZ-6378);
- 396.2 (21) 1-(naphthalen-2-yl)-2-(pyrrolidin-1-yl) pentan-1-one (naphthylpyrovalerone or
396.3 naphyrone);
- 396.4 (22) (alpha-pyrrolidinopentiophenone (alpha-PVP);
- 396.5 (23) (RS)-1-(4-methylphenyl)-2-(1-pyrrolidinyl)-1-hexanone (4-Me-PHP or MPHP);
- 396.6 (24) 2-(1-pyrrolidinyl)-hexanophenone (Alpha-PHP);
- 396.7 (25) 4-methyl-N-ethylcathinone (4-MEC);
- 396.8 (26) 4-methyl-alpha-pyrrolidinopropiophenone (4-MePPP);
- 396.9 (27) 2-(methylamino)-1-phenylpentan-1-one (pentedrone);
- 396.10 (28) 1-(1,3-benzodioxol-5-yl)-2-(methylamino)pentan-1-one (pentylone);
- 396.11 (29) 4-fluoro-N-methylcathinone (4-FMC);
- 396.12 (30) 3,4-methylenedioxy-N-ethylcathinone (ethylone);
- 396.13 (31) alpha-pyrrolidinobutiophenone (α -PBP);
- 396.14 (32) 5-(2-Aminopropyl)-2,3-dihydrobenzofuran (5-APDB);
- 396.15 (33) 1-phenyl-2-(1-pyrrolidinyl)-1-heptanone (PV8);
- 396.16 (34) 6-(2-Aminopropyl)-2,3-dihydrobenzofuran (6-APDB);
- 396.17 (35) 4-methyl-alpha-ethylaminopentiophenone (4-MEAPP);
- 396.18 (36) 4'-chloro-alpha-pyrrolidinopropiophenone (4'-chloro-PPP);
- 396.19 (37) 1-(1,3-Benzodioxol-5-yl)-2-(dimethylamino)butan-1-one (dibutylone, bk-DMBDB);
- 396.20 (38) 1-(3-chlorophenyl) piperazine (meta-chlorophenylpiperazine or mCPP);
- 396.21 (39) 1-(1,3-benzodioxol-5-yl)-2-(ethylamino)-pentan-1-one (N-ethylpentylone, ephylone);
- 396.22 and
- 396.23 (40) any other substance, except bupropion or compounds listed under a different
396.24 schedule, that is structurally derived from 2-aminopropan-1-one by substitution at the
396.25 1-position with either phenyl, naphthyl, or thiophene ring systems, whether or not the
396.26 compound is further modified in any of the following ways:
- 396.27 (i) by substitution in the ring system to any extent with alkyl, alkylenedioxy, alkoxy,
396.28 haloalkyl, hydroxyl, or halide substituents, whether or not further substituted in the ring
396.29 system by one or more other univalent substituents;

- 397.1 (ii) by substitution at the 3-position with an acyclic alkyl substituent;
- 397.2 (iii) by substitution at the 2-amino nitrogen atom with alkyl, dialkyl, benzyl, or
397.3 methoxybenzyl groups; or
- 397.4 (iv) by inclusion of the 2-amino nitrogen atom in a cyclic structure.
- 397.5 (h) ~~Marijuana~~, Synthetic tetrahydrocannabinols, and synthetic cannabinoids. Unless
397.6 specifically excepted or unless listed in another schedule, any ~~natural~~ or synthetic material,
397.7 compound, mixture, or preparation that contains any quantity of the following substances,
397.8 their analogs, isomers, esters, ethers, salts, and salts of isomers, esters, and ethers, whenever
397.9 the existence of the isomers, esters, ethers, or salts is possible:
- 397.10 ~~(1) marijuana;~~
- 397.11 ~~(2) (1) synthetic tetrahydrocannabinols naturally contained in a plant of the genus~~
397.12 ~~Cannabis, that are the synthetic equivalents of the substances contained in the cannabis~~
397.13 ~~plant or in the resinous extractives of the plant, or synthetic substances with similar chemical~~
397.14 ~~structure and pharmacological activity to those substances contained in the plant or resinous~~
397.15 ~~extract, including, but not limited to, 1 cis or trans tetrahydrocannabinol, 6 cis or trans~~
397.16 ~~tetrahydrocannabinol, and 3,4 cis or trans tetrahydrocannabinol; and~~
- 397.17 ~~(3) (2) synthetic cannabinoids, including the following substances:~~
- 397.18 (i) Naphthoylindoles, which are any compounds containing a 3-(1-naphthoyl)indole
397.19 structure with substitution at the nitrogen atom of the indole ring by an alkyl, haloalkyl,
397.20 alkenyl, cycloalkylmethyl, cycloalkylethyl, 1-(N-methyl-2-piperidinyl)methyl or
397.21 2-(4-morpholinyl)ethyl group, whether or not further substituted in the indole ring to any
397.22 extent and whether or not substituted in the naphthyl ring to any extent. Examples of
397.23 naphthoylindoles include, but are not limited to:
- 397.24 (A) 1-Pentyl-3-(1-naphthoyl)indole (JWH-018 and AM-678);
- 397.25 (B) 1-Butyl-3-(1-naphthoyl)indole (JWH-073);
- 397.26 (C) 1-Pentyl-3-(4-methoxy-1-naphthoyl)indole (JWH-081);
- 397.27 (D) 1-[2-(4-morpholinyl)ethyl]-3-(1-naphthoyl)indole (JWH-200);
- 397.28 (E) 1-Propyl-2-methyl-3-(1-naphthoyl)indole (JWH-015);
- 397.29 (F) 1-Hexyl-3-(1-naphthoyl)indole (JWH-019);
- 397.30 (G) 1-Pentyl-3-(4-methyl-1-naphthoyl)indole (JWH-122);
- 397.31 (H) 1-Pentyl-3-(4-ethyl-1-naphthoyl)indole (JWH-210);

- 398.1 (I) 1-Pentyl-3-(4-chloro-1-naphthoyl)indole (JWH-398);
- 398.2 (J) 1-(5-fluoropentyl)-3-(1-naphthoyl)indole (AM-2201).
- 398.3 (ii) Naphthylmethylindeles, which are any compounds containing a
- 398.4 1H-indol-3-yl-(1-naphthyl)methane structure with substitution at the nitrogen atom of the
- 398.5 indole ring by an alkyl, haloalkyl, alkenyl, cycloalkylmethyl, cycloalkylethyl,
- 398.6 1-(N-methyl-2-piperidinyl)methyl or 2-(4-morpholinyl)ethyl group, whether or not further
- 398.7 substituted in the indole ring to any extent and whether or not substituted in the naphthyl
- 398.8 ring to any extent. Examples of naphthylmethylindeles include, but are not limited to:
- 398.9 (A) 1-Pentyl-1H-indol-3-yl-(1-naphthyl)methane (JWH-175);
- 398.10 (B) 1-Pentyl-1H-indol-3-yl-(4-methyl-1-naphthyl)methane (JWH-184).
- 398.11 (iii) Naphthoylpyrroles, which are any compounds containing a 3-(1-naphthoyl)pyrrole
- 398.12 structure with substitution at the nitrogen atom of the pyrrole ring by an alkyl, haloalkyl,
- 398.13 alkenyl, cycloalkylmethyl, cycloalkylethyl, 1-(N-methyl-2-piperidinyl)methyl or
- 398.14 2-(4-morpholinyl)ethyl group whether or not further substituted in the pyrrole ring to any
- 398.15 extent, whether or not substituted in the naphthyl ring to any extent. Examples of
- 398.16 naphthoylpyrroles include, but are not limited to,
- 398.17 (5-(2-fluorophenyl)-1-pentylpyrrol-3-yl)-naphthalen-1-ylmethanone (JWH-307).
- 398.18 (iv) Naphthylmethylindenes, which are any compounds containing a naphthylideneindene
- 398.19 structure with substitution at the 3-position of the indene ring by an alkyl, haloalkyl, alkenyl,
- 398.20 cycloalkylmethyl, cycloalkylethyl, 1-(N-methyl-2-piperidinyl)methyl or
- 398.21 2-(4-morpholinyl)ethyl group whether or not further substituted in the indene ring to any
- 398.22 extent, whether or not substituted in the naphthyl ring to any extent. Examples of
- 398.23 naphthylmethylindenes include, but are not limited to,
- 398.24 E-1-[1-(1-naphthalenylmethylene)-1H-inden-3-yl]pentane (JWH-176).
- 398.25 (v) Phenylacetylindeles, which are any compounds containing a 3-phenylacetylindole
- 398.26 structure with substitution at the nitrogen atom of the indole ring by an alkyl, haloalkyl,
- 398.27 alkenyl, cycloalkylmethyl, cycloalkylethyl, 1-(N-methyl-2-piperidinyl)methyl or
- 398.28 2-(4-morpholinyl)ethyl group whether or not further substituted in the indole ring to any
- 398.29 extent, whether or not substituted in the phenyl ring to any extent. Examples of
- 398.30 phenylacetylindeles include, but are not limited to:
- 398.31 (A) 1-(2-cyclohexylethyl)-3-(2-methoxyphenylacetyl)indole (RCS-8);
- 398.32 (B) 1-pentyl-3-(2-methoxyphenylacetyl)indole (JWH-250);
- 398.33 (C) 1-pentyl-3-(2-methylphenylacetyl)indole (JWH-251);

- 399.1 (D) 1-pentyl-3-(2-chlorophenylacetyl)indole (JWH-203).
- 399.2 (vi) Cyclohexylphenols, which are compounds containing a
- 399.3 2-(3-hydroxycyclohexyl)phenol structure with substitution at the 5-position of the phenolic
- 399.4 ring by an alkyl, haloalkyl, alkenyl, cycloalkylmethyl, cycloalkylethyl,
- 399.5 1-(N-methyl-2-piperidinyl)methyl or 2-(4-morpholinyl)ethyl group whether or not substituted
- 399.6 in the cyclohexyl ring to any extent. Examples of cyclohexylphenols include, but are not
- 399.7 limited to:
- 399.8 (A) 5-(1,1-dimethylheptyl)-2-[(1R,3S)-3-hydroxycyclohexyl]-phenol (CP 47,497);
- 399.9 (B) 5-(1,1-dimethyloctyl)-2-[(1R,3S)-3-hydroxycyclohexyl]-phenol
- 399.10 (Cannabicyclohexanol or CP 47,497 C8 homologue);
- 399.11 (C) 5-(1,1-dimethylheptyl)-2-[(1R,2R)-5-hydroxy-2-(3-hydroxypropyl)cyclohexyl]
- 399.12 -phenol (CP 55,940).
- 399.13 (vii) Benzoylindoles, which are any compounds containing a 3-(benzoyl)indole structure
- 399.14 with substitution at the nitrogen atom of the indole ring by an alkyl, haloalkyl, alkenyl,
- 399.15 cycloalkylmethyl, cycloalkylethyl, 1-(N-methyl-2-piperidinyl)methyl or
- 399.16 2-(4-morpholinyl)ethyl group whether or not further substituted in the indole ring to any
- 399.17 extent and whether or not substituted in the phenyl ring to any extent. Examples of
- 399.18 benzoylindoles include, but are not limited to:
- 399.19 (A) 1-Pentyl-3-(4-methoxybenzoyl)indole (RCS-4);
- 399.20 (B) 1-(5-fluoropentyl)-3-(2-iodobenzoyl)indole (AM-694);
- 399.21 (C) (4-methoxyphenyl-[2-methyl-1-(2-(4-morpholinyl)ethyl)indol-3-yl]methanone (WIN
- 399.22 48,098 or Pravadoline).
- 399.23 (viii) Others specifically named:
- 399.24 (A) (6aR,10aR)-9-(hydroxymethyl)-6,6-dimethyl-3-(2-methyloctan-2-yl)
- 399.25 -6a,7,10,10a-tetrahydrobenzo[c]chromen-1-ol (HU-210);
- 399.26 (B) (6aS,10aS)-9-(hydroxymethyl)-6,6-dimethyl-3-(2-methyloctan-2-yl)
- 399.27 -6a,7,10,10a-tetrahydrobenzo[c]chromen-1-ol (Dexanabinol or HU-211);
- 399.28 (C) 2,3-dihydro-5-methyl-3-(4-morpholinylmethyl)pyrrolo[1,2,3-de]
- 399.29 -1,4-benzoxazin-6-yl-1-naphthalenylmethanone (WIN 55,212-2);
- 399.30 (D) (1-pentylindol-3-yl)-(2,2,3,3-tetramethylcyclopropyl)methanone (UR-144);

- 400.1 (E) (1-(5-fluoropentyl)-1H-indol-3-yl)(2,2,3,3-tetramethylcyclopropyl)methanone
400.2 (XLR-11);
- 400.3 (F) 1-pentyl-N-tricyclo[3.3.1.1^{3,7}]dec-1-yl-1H-indazole-3-carboxamide
400.4 (AKB-48(APINACA));
- 400.5 (G) N-((3s,5s,7s)-adamantan-1-yl)-1-(5-fluoropentyl)-1H-indazole-3-carboxamide
400.6 (5-Fluoro-AKB-48);
- 400.7 (H) 1-pentyl-8-quinolinyl ester-1H-indole-3-carboxylic acid (PB-22);
- 400.8 (I) 8-quinolinyl ester-1-(5-fluoropentyl)-1H-indole-3-carboxylic acid (5-Fluoro PB-22);
- 400.9 (J) N-[(1S)-1-(aminocarbonyl)-2-methylpropyl]-1-pentyl-1H-indazole-3-carboxamide
400.10 (AB-PINACA);
- 400.11 (K) N-[(1S)-1-(aminocarbonyl)-2-methylpropyl]-1-[(4-fluorophenyl)methyl]-
400.12 1H-indazole-3-carboxamide (AB-FUBINACA);
- 400.13 (L) N-[(1S)-1-(aminocarbonyl)-2-methylpropyl]-1-(cyclohexylmethyl)-1H-
400.14 indazole-3-carboxamide(AB-CHMINACA);
- 400.15 (M) (S)-methyl 2-(1-(5-fluoropentyl)-1H-indazole-3-carboxamido)-3-methylbutanoate
400.16 (5-fluoro-AMB);
- 400.17 (N) [1-(5-fluoropentyl)-1H-indazol-3-yl](naphthalen-1-yl) methanone (THJ-2201);
- 400.18 (O) (1-(5-fluoropentyl)-1H-benzo[d]imidazol-2-yl)(naphthalen-1-yl)methanone
400.19 (FUBIMINA);
- 400.20 (P) (7-methoxy-1-(2-morpholinoethyl)-N-((1S,2S,4R)-1,3,3-trimethylbicyclo
400.21 [2.2.1]heptan-2-yl)-1H-indole-3-carboxamide (MN-25 or UR-12);
- 400.22 (Q) (S)-N-(1-amino-3-methyl-1-oxobutan-2-yl)-1-(5-fluoropentyl)
400.23 -1H-indole-3-carboxamide (5-fluoro-ABICA);
- 400.24 (R) N-(1-amino-3-phenyl-1-oxopropan-2-yl)-1-(5-fluoropentyl)
400.25 -1H-indole-3-carboxamide;
- 400.26 (S) N-(1-amino-3-phenyl-1-oxopropan-2-yl)-1-(5-fluoropentyl)
400.27 -1H-indazole-3-carboxamide;
- 400.28 (T) methyl 2-(1-(cyclohexylmethyl)-1H-indole-3-carboxamido)-3,3-dimethylbutanoate;
- 400.29 (U) N-(1-amino-3,3-dimethyl-1-oxobutan-2-yl)-1(cyclohexylmethyl)-1
400.30 H-indazole-3-carboxamide (MAB-CHMINACA);

- 401.1 (V) N-(1-Amino-3,3-dimethyl-1-oxo-2-butanyl)-1-pentyl-1H-indazole-3-carboxamide
401.2 (ADB-PINACA);
- 401.3 (W) methyl (1-(4-fluorobenzyl)-1H-indazole-3-carbonyl)-L-valinate (FUB-AMB);
- 401.4 (X) N-[(1S)-2-amino-2-oxo-1-(phenylmethyl)ethyl]-1-(cyclohexylmethyl)-1H-Indazole-
401.5 3-carboxamide. (APP-CHMINACA);
- 401.6 (Y) quinolin-8-yl 1-(4-fluorobenzyl)-1H-indole-3-carboxylate (FUB-PB-22); and
- 401.7 (Z) methyl N-[1-(cyclohexylmethyl)-1H-indole-3-carbonyl]valinate (MMB-CHMICA).
- 401.8 (ix) Additional substances specifically named:
- 401.9 (A) 1-(5-fluoropentyl)-N-(2-phenylpropan-2-yl)-1
401.10 H-pyrrolo[2,3-B]pyridine-3-carboxamide (5F-CUMYL-P7AICA);
- 401.11 (B) 1-(4-cyanobutyl)-N-(2- phenylpropan-2-yl)-1 H-indazole-3-carboxamide
401.12 (4-CN-Cumyl-Butinaca);
- 401.13 (C) naphthalen-1-yl-1-(5-fluoropentyl)-1-H-indole-3-carboxylate (NM2201; CBL2201);
- 401.14 (D) N-(1-amino-3-methyl-1-oxobutan-2-yl)-1-(5-fluoropentyl)-1
401.15 H-indazole-3-carboxamide (5F-ABPINACA);
- 401.16 (E) methyl-2-(1-(cyclohexylmethyl)-1H-indole-3-carboxamido)-3,3-dimethylbutanoate
401.17 (MDMB CHMICA);
- 401.18 (F) methyl 2-(1-(5-fluoropentyl)-1H-indazole-3-carboxamido)-3,3-dimethylbutanoate
401.19 (5F-ADB; 5F-MDMB-PINACA); and
- 401.20 (G) N-(1-amino-3,3-dimethyl-1-oxobutan-2-yl)-1-(4-fluorobenzyl)
401.21 1H-indazole-3-carboxamide (ADB-FUBINACA).
- 401.22 (i) A controlled substance analog, to the extent that it is implicitly or explicitly intended
401.23 for human consumption.
- 401.24 **EFFECTIVE DATE.** This section is effective August 1, 2022, and applies to crimes
401.25 committed on or after that date.

401.26 Sec. 12. Minnesota Statutes 2020, section 152.02, subdivision 3, is amended to read:

401.27 Subd. 3. **Schedule II.** (a) Schedule II consists of the substances listed in this subdivision.

401.28 (b) Unless specifically excepted or unless listed in another schedule, any of the following
401.29 substances whether produced directly or indirectly by extraction from substances of vegetable

- 402.1 origin or independently by means of chemical synthesis, or by a combination of extraction
402.2 and chemical synthesis:
- 402.3 (1) Opium and opiate, and any salt, compound, derivative, or preparation of opium or
402.4 opiate.
- 402.5 (i) Excluding:
- 402.6 (A) apomorphine;
- 402.7 (B) thebaine-derived butorphanol;
- 402.8 (C) dextrophan;
- 402.9 (D) nalbuphine;
- 402.10 (E) nalmefene;
- 402.11 (F) naloxegol;
- 402.12 (G) naloxone;
- 402.13 (H) naltrexone; and
- 402.14 (I) their respective salts;
- 402.15 (ii) but including the following:
- 402.16 (A) opium, in all forms and extracts;
- 402.17 (B) codeine;
- 402.18 (C) dihydroetorphine;
- 402.19 (D) ethylmorphine;
- 402.20 (E) etorphine hydrochloride;
- 402.21 (F) hydrocodone;
- 402.22 (G) hydromorphone;
- 402.23 (H) metopon;
- 402.24 (I) morphine;
- 402.25 (J) oxycodone;
- 402.26 (K) oxymorphone;
- 402.27 (L) thebaine;
- 402.28 (M) oripavine;

403.1 (2) any salt, compound, derivative, or preparation thereof which is chemically equivalent
403.2 or identical with any of the substances referred to in clause (1), except that these substances
403.3 shall not include the isoquinoline alkaloids of opium;

403.4 (3) opium poppy and poppy straw;

403.5 (4) coca leaves and any salt, cocaine compound, derivative, or preparation of coca leaves
403.6 (including cocaine and ecgonine and their salts, isomers, derivatives, and salts of isomers
403.7 and derivatives), and any salt, compound, derivative, or preparation thereof which is
403.8 chemically equivalent or identical with any of these substances, except that the substances
403.9 shall not include decocainized coca leaves or extraction of coca leaves, which extractions
403.10 do not contain cocaine or ecgonine;

403.11 (5) concentrate of poppy straw (the crude extract of poppy straw in either liquid, solid,
403.12 or powder form which contains the phenanthrene alkaloids of the opium poppy).

403.13 (c) Any of the following opiates, including their isomers, esters, ethers, salts, and salts
403.14 of isomers, esters and ethers, unless specifically excepted, or unless listed in another schedule,
403.15 whenever the existence of such isomers, esters, ethers and salts is possible within the specific
403.16 chemical designation:

403.17 (1) alfentanil;

403.18 (2) alphaprodine;

403.19 (3) anileridine;

403.20 (4) bezitramide;

403.21 (5) bulk dextropropoxyphene (nondosage forms);

403.22 (6) carfentanil;

403.23 (7) dihydrocodeine;

403.24 (8) dihydromorphinone;

403.25 (9) diphenoxylate;

403.26 (10) fentanyl;

403.27 (11) isomethadone;

403.28 (12) levo-alpha-acetylmethadol (LAAM);

403.29 (13) levomethorphan;

403.30 (14) levorphanol;

- 404.1 (15) metazocine;
- 404.2 (16) methadone;
- 404.3 (17) methadone - intermediate, 4-cyano-2-dimethylamino-4, 4-diphenylbutane;
- 404.4 (18) moramide - intermediate, 2-methyl-3-morpholino-1, 1-diphenyl-propane-carboxylic
- 404.5 acid;
- 404.6 (19) pethidine;
- 404.7 (20) pethidine - intermediate - a, 4-cyano-1-methyl-4-phenylpiperidine;
- 404.8 (21) pethidine - intermediate - b, ethyl-4-phenylpiperidine-4-carboxylate;
- 404.9 (22) pethidine - intermediate - c, 1-methyl-4-phenylpiperidine-4-carboxylic acid;
- 404.10 (23) phenazocine;
- 404.11 (24) piminodine;
- 404.12 (25) racemethorphan;
- 404.13 (26) racemorphan;
- 404.14 (27) remifentanil;
- 404.15 (28) sufentanil;
- 404.16 (29) tapentadol;
- 404.17 (30) 4-Anilino-N-phenethylpiperidine.
- 404.18 (d) Unless specifically excepted or unless listed in another schedule, any material,
- 404.19 compound, mixture, or preparation which contains any quantity of the following substances
- 404.20 having a stimulant effect on the central nervous system:
- 404.21 (1) amphetamine, its salts, optical isomers, and salts of its optical isomers;
- 404.22 (2) methamphetamine, its salts, isomers, and salts of its isomers;
- 404.23 (3) phenmetrazine and its salts;
- 404.24 (4) methylphenidate;
- 404.25 (5) lisdexamfetamine.
- 404.26 (e) Unless specifically excepted or unless listed in another schedule, any material,
- 404.27 compound, mixture, or preparation which contains any quantity of the following substances
- 404.28 having a depressant effect on the central nervous system, including its salts, isomers, and

405.1 salts of isomers whenever the existence of such salts, isomers, and salts of isomers is possible
405.2 within the specific chemical designation:

405.3 (1) amobarbital;

405.4 (2) glutethimide;

405.5 (3) secobarbital;

405.6 (4) pentobarbital;

405.7 (5) phencyclidine;

405.8 (6) phencyclidine immediate precursors:

405.9 (i) 1-phenylcyclohexylamine;

405.10 (ii) 1-piperidinocyclohexanecarbonitrile;

405.11 (7) phenylacetone.

405.12 (f) Cannabis and cannabinoids:

405.13 (1) nabilone;

405.14 (2) unless specifically excepted or unless listed in another schedule, any natural material,
405.15 compound, mixture, or preparation that contains any quantity of the following substances,
405.16 their analogs, isomers, esters, ethers, salts, and salts of isomers, esters, and ethers, whenever
405.17 the existence of the isomers, esters, ethers, or salts is possible:

405.18 (i) marijuana; and

405.19 (ii) tetrahydrocannabinols naturally contained in a plant of the genus cannabis or in the
405.20 resinous extractives of the plant, except that a product containing tetrahydrocannabinols is
405.21 not included if it meets the requirements of section 151.72; and

405.22 ~~(2)~~ (3) dronabinol [(-)-delta-9-trans-tetrahydrocannabinol (delta-9-THC)] in an oral
405.23 solution in a drug product approved for marketing by the United States Food and Drug
405.24 Administration.

405.25 **EFFECTIVE DATE.** This section is effective August 1, 2022, and applies to crimes
405.26 committed on or after that date.

405.27 Sec. 13. Minnesota Statutes 2020, section 152.11, is amended by adding a subdivision to
405.28 read:

405.29 **Subd. 5. Exception.** References in this section to Schedule II controlled substances do
405.30 not extend to marijuana or tetrahydrocannabinols.

406.1 Sec. 14. Minnesota Statutes 2020, section 152.12, is amended by adding a subdivision to
406.2 read:

406.3 Subd. 6. **Exception.** References in this section to Schedule II controlled substances do
406.4 not extend to marijuana or tetrahydrocannabinols.

406.5 Sec. 15. Minnesota Statutes 2020, section 152.125, subdivision 3, is amended to read:

406.6 Subd. 3. **Limits on applicability.** This section does not apply to:

406.7 (1) a physician's treatment of an individual for chemical dependency resulting from the
406.8 use of controlled substances in Schedules II to V of section 152.02;

406.9 (2) the prescription or administration of controlled substances in Schedules II to V of
406.10 section 152.02 to an individual whom the physician knows to be using the controlled
406.11 substances for nontherapeutic purposes;

406.12 (3) the prescription or administration of controlled substances in Schedules II to V of
406.13 section 152.02 for the purpose of terminating the life of an individual having intractable
406.14 pain; ~~or~~

406.15 (4) the prescription or administration of a controlled substance in Schedules II to V of
406.16 section 152.02 that is not a controlled substance approved by the United States Food and
406.17 Drug Administration for pain relief; or

406.18 (5) the administration of medical cannabis under sections 152.22 to 152.37.

406.19 Sec. 16. Minnesota Statutes 2020, section 152.32, subdivision 1, is amended to read:

406.20 Subdivision 1. **Presumption Presumptions.** (a) There is a presumption that a patient
406.21 enrolled in the registry program under sections 152.22 to 152.37 is engaged in the authorized
406.22 use of medical cannabis.

406.23 (b) The presumption in paragraph (a) may be rebutted by evidence that conduct related
406.24 to use of medical cannabis was not for the purpose of treating or alleviating the patient's
406.25 qualifying medical condition or symptoms associated with the patient's qualifying medical
406.26 condition.

406.27 (c) Sections 152.22 to 152.37 do not create any positive conflict with federal drug laws
406.28 or regulations and are consistent with United States Code, title 21, section 903.

407.1 Sec. 17. Minnesota Statutes 2020, section 152.32, subdivision 2, is amended to read:

407.2 Subd. 2. **Criminal and civil protections.** (a) Subject to section 152.23, the following
407.3 are not violations under this chapter:

407.4 (1) use or possession of medical cannabis or medical cannabis products by a patient
407.5 enrolled in the registry program, or possession by a registered designated caregiver or the
407.6 parent, legal guardian, or spouse of a patient if the parent, legal guardian, or spouse is listed
407.7 on the registry verification;

407.8 (2) possession, dosage determination, or sale of medical cannabis or medical cannabis
407.9 products by a medical cannabis manufacturer, employees of a manufacturer, a laboratory
407.10 conducting testing on medical cannabis, or employees of the laboratory; and

407.11 (3) possession of medical cannabis or medical cannabis products by any person while
407.12 carrying out the duties required under sections 152.22 to 152.37.

407.13 (b) Medical cannabis obtained and distributed pursuant to sections 152.22 to 152.37 and
407.14 associated property is not subject to forfeiture under sections 609.531 to 609.5316.

407.15 (c) The commissioner, the commissioner's staff, the commissioner's agents or contractors,
407.16 and any health care practitioner are not subject to any civil or disciplinary penalties by the
407.17 Board of Medical Practice, the Board of Nursing, or by any business, occupational, or
407.18 professional licensing board or entity, solely for the participation in the registry program
407.19 under sections 152.22 to 152.37. A pharmacist licensed under chapter 151 is not subject to
407.20 any civil or disciplinary penalties by the Board of Pharmacy when acting in accordance
407.21 with the provisions of sections 152.22 to 152.37. Nothing in this section affects a professional
407.22 licensing board from taking action in response to violations of any other section of law.

407.23 (d) Notwithstanding any law to the contrary, the commissioner, the governor of
407.24 Minnesota, or an employee of any state agency may not be held civilly or criminally liable
407.25 for any injury, loss of property, personal injury, or death caused by any act or omission
407.26 while acting within the scope of office or employment under sections 152.22 to 152.37.

407.27 (e) Federal, state, and local law enforcement authorities are prohibited from accessing
407.28 the patient registry under sections 152.22 to 152.37 except when acting pursuant to a valid
407.29 search warrant.

407.30 (f) Notwithstanding any law to the contrary, neither the commissioner nor a public
407.31 employee may release data or information about an individual contained in any report,
407.32 document, or registry created under sections 152.22 to 152.37 or any information obtained
407.33 about a patient participating in the program, except as provided in sections 152.22 to 152.37.

408.1 (g) No information contained in a report, document, or registry or obtained from a patient
408.2 under sections 152.22 to 152.37 may be admitted as evidence in a criminal proceeding
408.3 unless independently obtained or in connection with a proceeding involving a violation of
408.4 sections 152.22 to 152.37.

408.5 (h) Notwithstanding section 13.09, any person who violates paragraph (e) or (f) is guilty
408.6 of a gross misdemeanor.

408.7 (i) An attorney may not be subject to disciplinary action by the Minnesota Supreme
408.8 Court or professional responsibility board for providing legal assistance to prospective or
408.9 registered manufacturers or others related to activity that is no longer subject to criminal
408.10 penalties under state law pursuant to sections 152.22 to 152.37.

408.11 (j) Possession of a registry verification or application for enrollment in the program by
408.12 a person entitled to possess or apply for enrollment in the registry program does not constitute
408.13 probable cause or reasonable suspicion, nor shall it be used to support a search of the person
408.14 or property of the person possessing or applying for the registry verification, or otherwise
408.15 subject the person or property of the person to inspection by any governmental agency.

408.16 (k) Subject to section 152.23, the listing of tetrahydrocannabinols as a Schedule I
408.17 controlled substance under this chapter does not apply to protected activities specified in
408.18 this subdivision.

408.19 Sec. 18. Minnesota Statutes 2021 Supplement, section 363A.50, is amended to read:

408.20 **363A.50 NONDISCRIMINATION IN ACCESS TO TRANSPLANTS.**

408.21 Subdivision 1. **Definitions.** (a) For purposes of this section, the following terms have
408.22 the meanings given unless the context clearly requires otherwise.

408.23 (b) "Anatomical gift" has the meaning given in section 525A.02, subdivision 4.

408.24 (c) "Auxiliary aids and services" include, but are not limited to:

408.25 (1) qualified interpreters or other effective methods of making aurally delivered materials
408.26 available to individuals with hearing impairments and to non-English-speaking individuals;

408.27 (2) qualified readers, taped texts, texts in accessible electronic format, or other effective
408.28 methods of making visually delivered materials available to individuals with visual
408.29 impairments;

408.30 (3) the provision of information in a format that is accessible for individuals with
408.31 cognitive, neurological, developmental, intellectual, or physical disabilities;

409.1 (4) the provision of supported decision-making services; and

409.2 (5) the acquisition or modification of equipment or devices.

409.3 (d) "Covered entity" means:

409.4 (1) any licensed provider of health care services, including licensed health care
409.5 practitioners, hospitals, nursing facilities, laboratories, intermediate care facilities, psychiatric
409.6 residential treatment facilities, institutions for individuals with intellectual or developmental
409.7 disabilities, and prison health centers; or

409.8 (2) any entity responsible for matching anatomical gift donors to potential recipients.

409.9 (e) "Disability" has the meaning given in section 363A.03, subdivision 12.

409.10 (f) "Organ transplant" means the transplantation or infusion of a part of a human body
409.11 into the body of another for the purpose of treating or curing a medical condition.

409.12 (g) "Qualified individual" means an individual who, with or without available support
409.13 networks, the provision of auxiliary aids and services, or reasonable modifications to policies
409.14 or practices, meets the essential eligibility requirements for the receipt of an anatomical
409.15 gift.

409.16 (h) "Reasonable modifications" include, but are not limited to:

409.17 (1) communication with individuals responsible for supporting an individual with
409.18 postsurgical and post-transplantation care, including medication; and

409.19 (2) consideration of support networks available to the individual, including family,
409.20 friends, and home and community-based services, including home and community-based
409.21 services funded through Medicaid, Medicare, another health plan in which the individual
409.22 is enrolled, or any program or source of funding available to the individual, in determining
409.23 whether the individual is able to comply with post-transplant medical requirements.

409.24 (i) "Supported decision making" has the meaning given in section 524.5-102, subdivision
409.25 16a.

409.26 Subd. 2. **Prohibition of discrimination.** (a) A covered entity may not, on the basis of
409.27 a qualified individual's race, ethnicity, mental disability, or physical disability:

409.28 (1) deem an individual ineligible to receive an anatomical gift or organ transplant;

409.29 (2) deny medical or related organ transplantation services, including evaluation, surgery,
409.30 counseling, and postoperative treatment and care;

410.1 (3) refuse to refer the individual to a transplant center or other related specialist for the
410.2 purpose of evaluation or receipt of an anatomical gift or organ transplant;

410.3 (4) refuse to place an individual on an organ transplant waiting list or place the individual
410.4 at a lower-priority position on the list than the position at which the individual would have
410.5 been placed if not for the individual's race, ethnicity, or disability; or

410.6 (5) decline insurance coverage for any procedure associated with the receipt of the
410.7 anatomical gift or organ transplant, including post-transplantation and postinfusion care.

410.8 (b) Notwithstanding paragraph (a), a covered entity may take an individual's disability
410.9 into account when making treatment or coverage recommendations or decisions, solely to
410.10 the extent that the physical or mental disability has been found by a physician, following
410.11 an individualized evaluation of the potential recipient to be medically significant to the
410.12 provision of the anatomical gift or organ transplant. The provisions of this section may not
410.13 be deemed to require referrals or recommendations for, or the performance of, organ
410.14 transplants that are not medically appropriate given the individual's overall health condition.

410.15 (c) If an individual has the necessary support system to assist the individual in complying
410.16 with post-transplant medical requirements, an individual's inability to independently comply
410.17 with those requirements may not be deemed to be medically significant for the purposes of
410.18 paragraph (b).

410.19 (d) A covered entity must make reasonable modifications to policies, practices, or
410.20 procedures, when such modifications are necessary to make services such as
410.21 transplantation-related counseling, information, coverage, or treatment available to qualified
410.22 individuals with disabilities, unless the entity can demonstrate that making such modifications
410.23 would fundamentally alter the nature of such services.

410.24 (e) A covered entity must take such steps as may be necessary to ensure that no qualified
410.25 individual with a disability is denied services such as transplantation-related counseling,
410.26 information, coverage, or treatment because of the absence of auxiliary aids and services,
410.27 unless the entity can demonstrate that taking such steps would fundamentally alter the nature
410.28 of the services being offered or result in an undue burden. A covered entity is not required
410.29 to provide supported decision-making services.

410.30 (f) A covered entity must otherwise comply with the requirements of Titles II and III of
410.31 the Americans with Disabilities Act of 1990, the Americans with Disabilities Act
410.32 Amendments Act of 2008, and the Minnesota Human Rights Act.

410.33 (g) The provisions of this section apply to each part of the organ transplant process.

411.1 Subd. 3. **Remedies.** In addition to all other remedies available under this chapter, any
411.2 individual who has been subjected to discrimination in violation of this section may initiate
411.3 a civil action in a court of competent jurisdiction to enjoin violations of this section.

411.4 Sec. 19. Laws 2020, First Special Session chapter 7, section 1, subdivision 5, as amended
411.5 by Laws 2021, First Special Session chapter 7, article 2, section 73, is amended to read:

411.6 Subd. 5. **Waivers and modifications; extension for 365 days.** When the peacetime
411.7 emergency declared by the governor in response to the COVID-19 outbreak expires, is
411.8 terminated, or is rescinded by the proper authority, waiver CV23: modifying background
411.9 study requirements, issued by the commissioner of human services pursuant to Executive
411.10 Orders 20-11 and 20-12, including any amendments to the modification issued before the
411.11 peacetime emergency expires, shall remain in effect ~~for 365 days after the peacetime~~
411.12 ~~emergency ends~~ until January 1, 2023.

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

411.14 Sec. 20. **FEDERAL SCHEDULE I EXEMPTION APPLICATION FOR MEDICAL**
411.15 **USE OF CANNABIS.**

411.16 By September 1, 2022, the commissioner of health shall apply to the Drug Enforcement
411.17 Administration's Office of Diversion Control for an exception under Code of Federal
411.18 Regulations, title 21, section 1307.03, and request formal written acknowledgment that the
411.19 listing of marijuana, marijuana extract, and tetrahydrocannabinols as controlled substances
411.20 in federal Schedule I does not apply to the protected activities in Minnesota Statutes, section
411.21 152.32, subdivision 2, pursuant to the medical cannabis program established under Minnesota
411.22 Statutes, sections 152.22 to 152.37. The application must include the list of presumptions
411.23 in Minnesota Statutes, section 152.32, subdivision 1.

411.24 Sec. 21. **REVISOR INSTRUCTION.**

411.25 The revisor of statutes shall renumber as Minnesota Statutes, section 256.4835, the
411.26 Minnesota Rare Disease Advisory Council that is currently coded as Minnesota Statutes,
411.27 section 137.68. The revisor shall also make necessary cross-reference changes consistent
411.28 with the renumbering.

411.29 **ARTICLE 9**

411.30 **FORECAST ADJUSTMENTS**

411.31 Section 1. **HUMAN SERVICES APPROPRIATION.**

412.1 The dollar amounts shown in the columns marked "Appropriations" are added to or, if
 412.2 shown in parentheses, are subtracted from the appropriations in Laws 2021, First Special
 412.3 Session chapter 7, article 16, from the general fund or any fund named to the Department
 412.4 of Human Services for the purposes specified in this article, to be available for the fiscal
 412.5 year indicated for each purpose. The figures "2022" and "2023" used in this article mean
 412.6 that the appropriations listed under them are available for the fiscal years ending June 30,
 412.7 2022, or June 30, 2023, respectively. "The first year" is fiscal year 2022. "The second year"
 412.8 is fiscal year 2023. "The biennium" is fiscal years 2022 and 2023.

412.9 **APPROPRIATIONS**

412.10 **Available for the Year**

412.11 **Ending June 30**

412.12 **2022**

2023

412.13 **Sec. 2. COMMISSIONER OF HUMAN**
 412.14 **SERVICES**

412.15 Subdivision 1. Total Appropriation **\$ (585,901,000) \$ 182,791,000**

412.16 Appropriations by Fund

412.17 General Fund (406,629,000) 185,395,000

412.18 Health Care Access
 412.19 Fund (86,146,000) (11,799,000)

412.20 Federal TANF (93,126,000) 9,195,000

412.21 Subd. 2. Forecasted Programs

412.22 (a) MFIP/DWP

412.23 Appropriations by Fund

412.24 General Fund 72,106,000 (14,397,000)

412.25 Federal TANF (93,126,000) 9,195,000

412.26 (b) MFIP Child Care Assistance (103,347,000) (73,738,000)

412.27 (c) General Assistance (4,175,000) (1,488,000)

412.28 (d) Minnesota Supplemental Aid 318,000 1,613,000

412.29 (e) Housing Support (1,994,000) 9,257,000

412.30 (f) Northstar Care for Children (9,613,000) (4,865,000)

412.31 (g) MinnesotaCare (86,146,000) (11,799,000)

412.32 These appropriations are from the health care
 412.33 access fund.

413.1 **(h) Medical Assistance**

413.2 Appropriations by Fund

413.3 General Fund (348,364,000) 292,880,000

413.4 Health Care Access

413.5 Fund -0- -0-

413.6 **(i) Alternative Care Program** -0- -0-

413.7 **(j) Behavioral Health Fund** (11,560,000) (23,867,000)

413.8 **Subd. 3. Technical Activities** -0- -0-

413.9 These appropriations are from the federal

413.10 TANF fund.

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

413.12 **ARTICLE 10**

413.13 **APPROPRIATIONS**

413.14 Section 1. **HEALTH AND HUMAN SERVICES APPROPRIATIONS.**

413.15 The sums shown in the columns marked "Appropriations" are added to or, if shown in
 413.16 parentheses, subtracted from the appropriations in Laws 2021, First Special Session chapter
 413.17 7, article 16, to the agencies and for the purposes specified in this article. The appropriations
 413.18 are from the general fund or other named fund and are available for the fiscal years indicated
 413.19 for each purpose. The figures "2022" and "2023" used in this article mean that the addition
 413.20 to or subtraction from the appropriation listed under them is available for the fiscal year
 413.21 ending June 30, 2022, or June 30, 2023, respectively. Base adjustments mean the addition
 413.22 to or subtraction from the base level adjustment set in Laws 2021, First Special Session
 413.23 chapter 7, article 16. Supplemental appropriations and reductions to appropriations for the
 413.24 fiscal year ending June 30, 2022, are effective the day following final enactment unless a
 413.25 different effective date is explicit.

413.26 **APPROPRIATIONS**

413.27 **Available for the Year**

413.28 **Ending June 30**

413.29 **2022** **2023**

413.30 **Sec. 2. COMMISSIONER OF HUMAN**
 413.31 **SERVICES**

414.1	<u>Subdivision 1. Total Appropriation</u>		<u>\$ 32,461,000</u>	<u>\$ 308,754,000</u>
414.2	<u>Appropriations by Fund</u>			
414.3		<u>2022</u>	<u>2023</u>	
414.4	<u>General</u>	<u>34,397,000</u>	<u>402,226,000</u>	
414.5	<u>Health Care Access</u>	<u>(1,936,000)</u>	<u>(88,042,000)</u>	
414.6	<u>Federal TANF</u>	<u>-0-</u>	<u>7,000</u>	
414.7	<u>Opiate Epidemic</u>			
414.8	<u>Response</u>	<u>-0-</u>	<u>760,000</u>	
414.9	<u>Subd. 2. Central Office; Operations</u>			
414.10	<u>Appropriations by Fund</u>			
414.11	<u>General</u>	<u>397,000</u>	<u>96,487,000</u>	
414.12	<u>Health Care Access</u>	<u>-0-</u>	<u>13,729,000</u>	
414.13	<u>(a) Background Studies. (1) \$1,779,000 in</u>			
414.14	<u>fiscal year 2023 is to provide a credit to</u>			
414.15	<u>providers who paid for emergency background</u>			
414.16	<u>studies in NETStudy 2.0. This is a onetime</u>			
414.17	<u>appropriation.</u>			
414.18	<u>(2) \$1,851,000 in fiscal year 2023 is to fund</u>			
414.19	<u>the costs of reprocessing emergency studies</u>			
414.20	<u>conducted under interagency agreements. This</u>			
414.21	<u>is a onetime appropriation.</u>			
414.22	<u>(b) Supporting Drug Pricing Litigation</u>			
414.23	<u>Costs.</u> \$228,000 in fiscal year 2022 is for costs			
414.24	<u>to comply with litigation requirements related</u>			
414.25	<u>to pharmaceutical drug price litigation. This</u>			
414.26	<u>is a onetime appropriation.</u>			
414.27	<u>(c) Base Level Adjustment.</u> The general fund			
414.28	<u>base is increased \$11,846,000 in fiscal year</u>			
414.29	<u>2024 and \$9,359,000 in fiscal year 2025. The</u>			
414.30	<u>health care access fund base is increased</u>			
414.31	<u>\$1,551,000 in fiscal year 2024 and \$1,455,000</u>			
414.32	<u>in fiscal year 2025.</u>			
414.33	<u>Subd. 3. Central Office; Children and Families</u>		<u>-0-</u>	<u>21,992,000</u>

415.1 **(a) Foster Care Federal Cash Assistance**
 415.2 **Benefits Plan.** \$373,000 in fiscal year 2023
 415.3 is for the commissioner to develop the foster
 415.4 care federal cash assistance benefits plan. The
 415.5 base for this appropriation is \$342,000 in fiscal
 415.6 year 2024 and \$127,000 in fiscal year 2025.

415.7 **(b) Base Level Adjustment.** The general fund
 415.8 base is increased \$7,823,000 in fiscal year
 415.9 2024 and \$7,578,000 in fiscal year 2025.

415.10 **Subd. 4. Central Office; Health Care**

415.11	<u>Appropriations by Fund</u>		
415.12	<u>General</u>	<u>-0-</u>	<u>4,500,000</u>
415.13	<u>Health Care Access</u>	<u>-0-</u>	<u>2,475,000</u>

415.14 **(a) Interactive Voice Response and**
 415.15 **Improving Access for Applications and**
 415.16 **Forms.** \$1,350,000 in fiscal year 2023 is for
 415.17 the improvement of accessibility to Minnesota
 415.18 health care programs applications, forms, and
 415.19 other consumer support resources and services
 415.20 to enrollees with limited English proficiency.
 415.21 This is a onetime appropriation and is
 415.22 available until June 30, 2025.

415.23 **(b) Community-Driven Improvements.**
 415.24 \$680,000 in fiscal year 2023 is for Minnesota
 415.25 health care program enrollee engagement
 415.26 activities.

415.27 **(c) Responding to COVID-19 in Minnesota**
 415.28 **Health Care Programs.** \$1,000,000 in fiscal
 415.29 year 2023 is for contract assistance relating to
 415.30 the resumption of eligibility and
 415.31 redetermination processes in Minnesota health
 415.32 care programs after the expiration of the
 415.33 federal public health emergency. Contracts
 415.34 entered into under this section are for

416.1 emergency acquisition and are not subject to
 416.2 solicitation requirements under Minnesota
 416.3 Statutes, section 16C.10, subdivision 2. This
 416.4 is a onetime appropriation and is available
 416.5 until June 30, 2025.

416.6 **(d) Initial PACE Implementation Funding.**
 416.7 \$270,000 in fiscal year 2023 is from the
 416.8 general fund to complete the initial actuarial
 416.9 and administrative work necessary to
 416.10 recommend a financing mechanism for the
 416.11 operation of PACE under Minnesota Statutes,
 416.12 section 256B.69, subdivision 23, paragraph
 416.13 (e).

416.14 **(e) Base Level Adjustment.** The general fund
 416.15 base is increased \$3,607,000 in fiscal year
 416.16 2024 and \$5,123,000 in fiscal year 2025. The
 416.17 health care access fund base is increased
 416.18 \$4,357,000 in fiscal year 2024 and \$7,550,000
 416.19 in fiscal year 2025.

416.20 <u>Subd. 5. Central Office; Continuing Care</u>	<u>-0-</u>	<u>177,000</u>
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416.21 **(a) Lifesharing Services.** \$57,000 in fiscal
 416.22 year 2023 is for engaging stakeholders and
 416.23 developing recommendations regarding
 416.24 establishing a lifesharing service under the
 416.25 state's medical assistance disability waivers
 416.26 and elderly waiver. The base for this
 416.27 appropriation is \$43,000 in fiscal year 2024.

416.28 **(b) Initial PACE Implementation Funding.**
 416.29 \$120,000 in fiscal year 2023 is to complete
 416.30 the initial actuarial and administrative work
 416.31 necessary to recommend a financing
 416.32 mechanism for the operation of PACE under
 416.33 Minnesota Statutes, section 256B.69,
 416.34 subdivision 23, paragraph (e).

417.1 (c) Base Level Adjustment. The general fund
 417.2 base is increased \$43,000 in fiscal year 2024.

417.3 Subd. 6. Central Office; Community Supports

417.4	<u>Appropriations by Fund</u>		
417.5	<u>General</u>	<u>-0-</u>	<u>8,531,000</u>
417.6	<u>Opioid Epidemic</u>		
417.7	<u>Response</u>	<u>-0-</u>	<u>760,000</u>

417.8 (a) SEIU Health Care Arbitration Award.
 417.9 \$5,444 in fiscal year 2023 is for arbitration
 417.10 awards resulting from a SEIU grievance. This
 417.11 is a onetime appropriation.

417.12 (b) Lifesharing Services. \$57,000 in fiscal
 417.13 year 2023 is from the general fund for
 417.14 engaging stakeholders and developing
 417.15 recommendations regarding establishing a
 417.16 lifesharing service under the state's medical
 417.17 assistance disability waivers and elderly
 417.18 waiver. The general fund base for this
 417.19 appropriation is \$43,000 in fiscal year 2024.

417.20 (c) Intermediate Care Facilities for Persons
 417.21 with Developmental Disabilities; Rate
 417.22 Study. \$250,000 in fiscal year 2023 is from
 417.23 the general fund for a study of medical
 417.24 assistance rates for intermediate care facilities
 417.25 for persons with developmental disabilities
 417.26 under Minnesota Statutes, sections 256B.5011
 417.27 to 256B.5015. This is a onetime appropriation.

417.28 (d) Online tool accessibility and capacity
 417.29 expansion. \$395,000 in fiscal year 2023 is to
 417.30 expand the accessibility and capacity of online
 417.31 tools for people receiving services and direct
 417.32 support workers. The base for this
 417.33 appropriation is \$664,000 in fiscal year 2024
 417.34 and \$681,000 in fiscal year 2025.

418.1 (e) Systemic critical incident review team.
 418.2 \$459,000 in fiscal year 2023 is to implement
 418.3 the systemic critical incident review process
 418.4 in Minnesota Statutes, section 256.01,
 418.5 subdivision 12b. The base for this
 418.6 appropriation is \$498,000 in fiscal year 2024
 418.7 and \$498,000 in fiscal year 2025.

418.8 (f) Base Level Adjustment. The general fund
 418.9 base is increased \$9,908,000 in fiscal year
 418.10 2024 and \$8,210,000 in fiscal year 2025. The
 418.11 opiate epidemic response base is increased
 418.12 \$790,000 in fiscal year 2024 and \$790,000 in
 418.13 fiscal year 2025.

418.14 **Subd. 7. Forecasted Programs; MFIP/DWP**

418.15	<u>Appropriations by Fund</u>		
418.16	<u>General</u>	<u>-0-</u>	<u>4,000</u>
418.17	<u>Federal TANF</u>	<u>-0-</u>	<u>7,000</u>

418.18	<u>Subd. 8. Forecasted Programs; MFIP Child Care</u>		
418.19	<u>Assistance</u>	<u>-0-</u>	<u>1,000</u>

418.20	<u>Subd. 9. Forecasted Programs; Minnesota</u>		
418.21	<u>Supplemental Aid</u>	<u>-0-</u>	<u>1,000</u>

418.22	<u>Subd. 10. Forecasted Programs; Housing</u>		
418.23	<u>Supports</u>	<u>-0-</u>	<u>4,304,000</u>

418.24 **Subd. 11. Forecasted Programs; MinnesotaCare**

418.25	<u>Appropriations by Fund</u>		
418.26	<u>General</u>	<u>-0-</u>	<u>(17,943,000)</u>
418.27	<u>Health Care Access</u>	<u>-0-</u>	<u>28,724,000</u>

418.28 This appropriation is from the health care
 418.29 access fund.

418.30 **Subd. 12. Forecasted Programs; Medical**
 418.31 **Assistance**

418.32	<u>Appropriations by Fund</u>		
418.33	<u>General</u>	<u>-0-</u>	<u>(56,518,000)</u>
418.34	<u>Health Care Access</u>	<u>-0-</u>	<u>(136,906,000)</u>

419.1	<u>Subd. 13. Forecasted Programs; Alternative</u>		
419.2	<u>Care</u>	-0-	<u>530,000</u>
419.3	<u>Subd. 14. Grant Programs; BSF Child Care</u>		
419.4	<u>Grants</u>	-0-	<u>6,000</u>
419.5	<u>Base Level Adjustment. The general fund</u>		
419.6	<u>base is increased \$29,000 in fiscal year 2024</u>		
419.7	<u>and \$248,000 in fiscal year 2025.</u>		
419.8	<u>Subd. 15. Grant Programs; Child Care</u>		
419.9	<u>Development Grants</u>	-0-	<u>-0-</u>
419.10	<u>Subd. 16. Grant Programs; Children's Services</u>		
419.11	<u>Grants</u>	-0-	<u>8,984,000</u>
419.12	<u>(a) American Indian Child Welfare</u>		
419.13	<u>Initiative; Mille Lacs Band of Ojibwe</u>		
419.14	<u>Planning. \$1,263,000 in fiscal year 2023 is</u>		
419.15	<u>to support activities necessary for the Mille</u>		
419.16	<u>Lacs Band of Ojibwe to join the American</u>		
419.17	<u>Indian child welfare initiative.</u>		
419.18	<u>(b) Expand Parent Support Outreach</u>		
419.19	<u>Program. The base shall include \$7,000,000</u>		
419.20	<u>in fiscal year 2024 and \$7,000,000 in fiscal</u>		
419.21	<u>year 2025 to expand the parent support</u>		
419.22	<u>outreach program to community-based</u>		
419.23	<u>agencies, public health agencies, and schools</u>		
419.24	<u>to prevent reporting of and entry into the child</u>		
419.25	<u>welfare system.</u>		
419.26	<u>(c) Thriving Families Safer Children. The</u>		
419.27	<u>base shall include \$30,000 in fiscal year 2024</u>		
419.28	<u>to plan for an education attendance support</u>		
419.29	<u>diversionary program to prevent entry into the</u>		
419.30	<u>child welfare system. The commissioner shall</u>		
419.31	<u>report back to the chairs and ranking minority</u>		
419.32	<u>members of the legislative committees that</u>		
419.33	<u>oversee child welfare by January 1, 2025, on</u>		
419.34	<u>the plan for this program. This is a onetime</u>		
419.35	<u>appropriation.</u>		

420.1 **(d) Family Group Decision Making.** The
420.2 base shall include \$5,000,000 in fiscal year
420.3 2024 and \$5,000,000 in fiscal year 2025 to
420.4 expand the use of family group decision
420.5 making to provide opportunity for family
420.6 voices concerning critical decisions in child
420.7 safety and prevent entry into the child welfare
420.8 system.

420.9 **(e) Child Welfare Promising Practices.** The
420.10 base shall include \$5,000,000 in fiscal year
420.11 2024 and \$5,000,000 in fiscal year 2025 to
420.12 develop promising practices for prevention of
420.13 out-of-home placement of children and youth.

420.14 **(f) Family Assessment Response.** The base
420.15 shall include \$23,550,000 in fiscal year 2024
420.16 and \$23,550,000 in fiscal year 2025 to support
420.17 counties and Tribes that are members of the
420.18 American Indian child welfare initiative in
420.19 providing case management services and
420.20 support for families being served under family
420.21 assessment response and to prevent entry into
420.22 the child welfare system.

420.23 **(g) Extend Support for Youth Leaving**
420.24 **Foster Care.** \$600,000 in fiscal year 2023 is
420.25 to extend financial supports for young adults
420.26 aging out of foster care to age 22.

420.27 **(h) Grants to Counties for Child Protection**
420.28 **Staff.** \$1,000,000 in fiscal year 2023 is to
420.29 provide grants to counties and American
420.30 Indian child welfare initiative Tribes to be
420.31 used to reduce extended foster care caseload
420.32 sizes to ten cases per worker.

420.33 **(i) Statewide Pool of Qualified Individuals.**
420.34 \$1,177,400 in fiscal year 2023 is for grants to

421.1 one or more grantees to establish and manage
421.2 a pool of state-funded qualified individuals to
421.3 assess potential out-of-home placement of a
421.4 child in a qualified residential treatment
421.5 program. Up to \$200,000 of the grants each
421.6 fiscal year is available for grantee contracts to
421.7 manage the state-funded pool of qualified
421.8 individuals. This amount shall also pay for
421.9 qualified individual training, certification, and
421.10 background studies. Remaining grant money
421.11 shall be available until expended to provide
421.12 qualified individual services to counties and
421.13 Tribes that have joined the American Indian
421.14 child welfare initiative pursuant to Minnesota
421.15 Statutes, section 256.01, subdivision 14b, to
421.16 provide qualified residential treatment
421.17 program assessments at no cost to the county
421.18 or Tribal agency.

421.19 **(j) Quality Parenting Initiative Grant.**
421.20 \$100,000 in fiscal year 2023 is for a grant to
421.21 the Quality Parenting Initiative Minnesota, to
421.22 implement Quality Parenting Initiative
421.23 principles and practices and support children
421.24 and families experiencing foster care
421.25 placements. The grantee shall use grant funds
421.26 to provide training and technical assistance to
421.27 county and Tribal agencies, community-based
421.28 agencies, and other stakeholders on conducting
421.29 initial foster care phone calls under Minnesota
421.30 Statutes, section 260C.219, subdivision 6;
421.31 supporting practices that create partnerships
421.32 between birth and foster families; and
421.33 informing child welfare practices by
421.34 supporting youth leadership and the
421.35 participation of individuals with experience
421.36 in the foster care system. Upon request, the

422.1 commissioner shall make information
422.2 regarding the use of this grant funding
422.3 available to the chairs and ranking minority
422.4 members of the legislative committees with
422.5 jurisdiction over human services. This is a
422.6 onetime appropriation.

422.7 **(k) Costs of Foster Care or Care,**
422.8 **Examination, or Treatment. \$5,000,000 in**
422.9 **fiscal year 2023 is for grants to counties and**
422.10 **Tribes, to reimburse counties and Tribes for**
422.11 **the costs of foster care or care, examination,**
422.12 **or treatment that would previously have been**
422.13 **paid by the parents or custodians of a child in**
422.14 **foster care using parental income and**
422.15 **resources, child support payments, or income**
422.16 **and resources attributable to a child under**
422.17 **Minnesota Statutes, sections 242.19, 256N.26,**
422.18 **260B.331, and 260C.331. Counties and Tribes**
422.19 **must apply for grant funds in a form**
422.20 **prescribed by the commissioner, and must**
422.21 **provide the information and data necessary to**
422.22 **calculate grant fund allocations accurately and**
422.23 **equitably, as determined by the commissioner.**

422.24 **(l) Grants to Counties; Foster Care Federal**
422.25 **Cash Assistance Benefits Plan. \$50,000 in**
422.26 **fiscal year 2023 is for the commissioner to**
422.27 **provide grants to counties to assist counties**
422.28 **with gathering and reporting the county data**
422.29 **required for the commissioner to develop the**
422.30 **foster care federal cash assistance benefits**
422.31 **plan.**

422.32 **(m) Base Level Adjustment. The general fund**
422.33 **base is increased \$52,386,000 in fiscal year**
422.34 **2024 and \$49,715,000 in fiscal year 2025.**

423.1	<u>Subd. 17. Grant Programs; Children and</u>		
423.2	<u>Community Service Grants</u>	<u>-0-</u>	<u>-0-</u>
423.3	<u>Base Level Adjustment. The opiate epidemic</u>		
423.4	<u>response base is increased \$100,000 in fiscal</u>		
423.5	<u>year 2025.</u>		
423.6	<u>Subd. 18. Grant Programs; Children and</u>		
423.7	<u>Economic Support Grants</u>	<u>14,000,000</u>	<u>145,931,000</u>
423.8	<u>(a) Family and Community Resource Hubs.</u>		
423.9	<u>\$2,550,000 in fiscal year 2023 is to implement</u>		
423.10	<u>a sustainable family and community resource</u>		
423.11	<u>hub model through the community action</u>		
423.12	<u>agencies under Minnesota Statutes, section</u>		
423.13	<u>256E.31, and federally recognized Tribes. The</u>		
423.14	<u>community resource hubs must offer</u>		
423.15	<u>navigation to several supports and services,</u>		
423.16	<u>including but not limited to basic needs and</u>		
423.17	<u>economic assistance, disability services,</u>		
423.18	<u>healthy development and screening,</u>		
423.19	<u>developmental and behavioral concerns,</u>		
423.20	<u>family well-being and mental health, early</u>		
423.21	<u>learning and child care, dental care, legal</u>		
423.22	<u>services, and culturally specific services for</u>		
423.23	<u>American Indian families.</u>		
423.24	<u>(b) Tribal Food Sovereignty Infrastructure</u>		
423.25	<u>Grants. \$4,000,000 in fiscal year 2023 is for</u>		
423.26	<u>capital and infrastructure development to</u>		
423.27	<u>support food system changes and provide</u>		
423.28	<u>equitable access to existing and new methods</u>		
423.29	<u>of food support for American Indian</u>		
423.30	<u>communities, including federally recognized</u>		
423.31	<u>Tribes and American Indian nonprofit</u>		
423.32	<u>organizations. This is a onetime appropriation</u>		
423.33	<u>and is available until June 30, 2025.</u>		
423.34	<u>(c) Tribal Food Security. \$2,836,000 in fiscal</u>		
423.35	<u>year 2023 is to promote food security for</u>		

424.1 American Indian communities, including
424.2 federally recognized Tribes and American
424.3 Indian nonprofit organizations. This includes
424.4 hiring staff, providing culturally relevant
424.5 training for building food access, purchasing
424.6 technical assistance materials and supplies,
424.7 and planning for sustainable food systems.

424.8 **(d) Capital for Emergency Food**
424.9 **Distribution Facilities.** \$14,931,000 in fiscal
424.10 year 2023 is for improving and expanding the
424.11 infrastructure of food shelf facilities across
424.12 the state, including adding freezer or cooler
424.13 space and dry storage space, improving the
424.14 safety and sanitation of existing food shelves,
424.15 and addressing deferred maintenance or other
424.16 facility needs of existing food shelves. Grant
424.17 money shall be made available to nonprofit
424.18 organizations, federally recognized Tribes,
424.19 and local units of government. This is a
424.20 onetime appropriation and is available until
424.21 June 30, 2025.

424.22 **(e) Food Support Grants.** \$5,000,000 in
424.23 fiscal year 2023 is to provide additional
424.24 resources to a diverse food support network
424.25 that includes food shelves, food banks, and
424.26 meal and food outreach programs. Grant
424.27 money shall be made available to nonprofit
424.28 organizations, federally recognized Tribes,
424.29 and local units of government.

424.30 **(f) Transitional Housing.** \$2,500,000 in fiscal
424.31 year 2023 is for transitional housing programs
424.32 under Minnesota Statutes, section 256E.33.

424.33 **(g) Shelter-Linked Youth Mental Health**
424.34 **Grants.** \$1,650,000 in fiscal year 2023 is for

425.1 shelter-linked youth mental health grants under
425.2 Minnesota Statutes, section 256K.46.

425.3 **(h) Emergency Services Grants. \$35,000,000**
425.4 in fiscal year 2023 is for emergency services
425.5 under Minnesota Statutes, section 256E.36.
425.6 The base for this appropriation is \$25,000,000
425.7 in fiscal year 2024 and \$25,000,000 in fiscal
425.8 year 2025. Grant allocation balances in the
425.9 first year do not cancel but are available in the
425.10 second year.

425.11 **(i) Homeless Youth Act. \$10,000,000 in fiscal**
425.12 year 2023 is for homeless youth act grants
425.13 under Minnesota Statutes, section 256K.45,
425.14 subdivision 1. Grant allocation balances in the
425.15 first year do not cancel but are available in the
425.16 second year.

425.17 **(j) Pregnant and Parenting Homeless Youth**
425.18 **Study. \$300,000 in fiscal year 2023 is to fund**
425.19 a study of the prevalence of pregnancy and
425.20 parenting among homeless youths and youths
425.21 who are at risk of homelessness. This is a
425.22 onetime appropriation and is available until
425.23 June 30, 2024.

425.24 **(k) Safe Harbor Grants. \$5,500,000 in fiscal**
425.25 year 2023 is for safe harbor grants to fund
425.26 street outreach, emergency shelter, and
425.27 transitional and long-term housing beds for
425.28 sexually exploited youth and youth at risk of
425.29 exploitation.

425.30 **(l) Emergency Shelter Facilities. \$75,000,000**
425.31 in fiscal year 2023 is for grants to eligible
425.32 applicants for the acquisition of property; site
425.33 preparation, including demolition; predesign;
425.34 design; construction; renovation; furnishing;

426.1 and equipping of emergency shelter facilities
426.2 in accordance with emergency shelter facilities
426.3 project criteria in this act. This is a onetime
426.4 appropriation and is available until June 30,
426.5 2025.

426.6 **(m) Heading Home Ramsey Continuum of**
426.7 **Care. (1) \$8,000,000 in fiscal year 2022 is for**
426.8 **a grant to fund and support Heading Home**
426.9 **Ramsey Continuum of Care. This is a onetime**
426.10 **appropriation. The grant shall be used for:**

426.11 **(i) maintaining funding for a 100-bed family**
426.12 **shelter that had been funded by CARES Act**
426.13 **money;**

426.14 **(ii) maintaining funding for an existing**
426.15 **100-bed single room occupancy shelter and**
426.16 **developing a replacement single-room**
426.17 **occupancy shelter for housing up to 100 single**
426.18 **adults; and**

426.19 **(iii) maintaining current day shelter**
426.20 **programming that had been funded with**
426.21 **CARES Act money and developing a**
426.22 **replacement for current day shelter facilities.**

426.23 **(2) Ramsey County may use up to ten percent**
426.24 **of this appropriation for administrative**
426.25 **expenses. This appropriation is available until**
426.26 **June 30, 2025.**

426.27 **(n) Hennepin County Funding for Serving**
426.28 **Homeless Persons. (1) \$6,000,000 in fiscal**
426.29 **year 2022 is for a grant to fund and support**
426.30 **Hennepin County shelters and services for**
426.31 **persons experiencing homelessness. This is a**
426.32 **onetime appropriation. Of this appropriation:**

426.33 **(i) up to \$4,000,000 in matching grant funding**
426.34 **is to design, construct, equip, and furnish the**

427.1 Simpson Housing Services shelter facility in
427.2 the city of Minneapolis; and
427.3 (ii) up to \$2,000,000 is to maintain current
427.4 shelter and homeless response programming
427.5 that had been funded with federal funding
427.6 from the CARES Act of the American Rescue
427.7 Plan Act, including:
427.8 (A) shelter operations and services to maintain
427.9 services at Avivo Village, including a shelter
427.10 comprised of 100 private dwellings and the
427.11 American Indian Community Development
427.12 Corporation Homeward Bound 50-bed shelter;
427.13 (B) shelter operations and services to maintain
427.14 shelter services 24 hours per day, seven days
427.15 per week;
427.16 (C) housing-focused case management; and
427.17 (D) shelter diversion services.
427.18 (2) Hennepin County may contract with
427.19 eligible nonprofit organizations and local and
427.20 Tribal governmental units to provide services
427.21 under the grant program. This appropriation
427.22 is available until June 30, 2025.
427.23 **(o) Chosen Family Hosting to Prevent**
427.24 **Youth Homelessness Pilot Program.**
427.25 \$1,000,000 in fiscal year 2023 is for the
427.26 chosen family hosting to prevent youth
427.27 homelessness pilot program to provide funds
427.28 to providers serving homeless youth. Of this
427.29 amount, \$218,000 is for a contract with a
427.30 technical assistance provider to: (1) provide
427.31 technical assistance to funding recipients; (2)
427.32 facilitate a monthly learning cohort for funding
427.33 recipients; (3) evaluate the efficacy and
427.34 cost-effectiveness of the pilot program; and

428.1 (4) submit annual updates and a final report
428.2 to the commissioner. This is a onetime
428.3 appropriation and is available until June 30,
428.4 2027.

428.5 (p) **Minnesota Association for Volunteer**
428.6 **Administration.** \$1,000,000 in fiscal year
428.7 2023 is for a grant to the Minnesota
428.8 Association for Volunteer Administration to
428.9 administer needs-based volunteerism subgrants
428.10 targeting underresourced nonprofit
428.11 organizations in greater Minnesota to support
428.12 selected organizations' ongoing efforts to
428.13 address and minimize disparities in access to
428.14 human services through increased
428.15 volunteerism. Successful subgrant applicants
428.16 must demonstrate that the populations to be
428.17 served by the subgrantee are considered
428.18 underserved or suffer from or are at risk of
428.19 homelessness, hunger, poverty, lack of access
428.20 to health care, or deficits in education. The
428.21 Minnesota Association for Volunteer
428.22 Administration must give priority to
428.23 organizations that are serving the needs of
428.24 vulnerable populations. By December 15,
428.25 2023, the Minnesota Association for Volunteer
428.26 Administration must report data on outcomes
428.27 from the subgrants and recommendations for
428.28 improving and sustaining volunteer efforts
428.29 statewide to the chairs and ranking minority
428.30 members of the legislative committees and
428.31 divisions with jurisdiction over human
428.32 services. This is a onetime appropriation and
428.33 is available until June 30, 2024.

429.1 (q) Base Level Adjustment. The general fund
 429.2 base is increased \$63,104,000 in fiscal year
 429.3 2024 and \$66,754,000 in fiscal year 2025.

429.4 **Subd. 19. Grant Programs; Health Care Grants**

429.5	<u>Appropriations by Fund</u>		
429.6		<u>2022</u>	<u>2023</u>
429.7	<u>General Fund</u>	<u>-0-</u>	<u>2,500,000</u>
429.8	<u>Health Care Access</u>	<u>(1,936,000)</u>	<u>3,936,000</u>

429.9 **(a) Grant Funding to Support Urban**
 429.10 **American Indians in Minnesota Health**
 429.11 **Care Programs. \$2,500,000 in fiscal year**
 429.12 2023 is from the general fund for funding to
 429.13 the Indian Health Board of Minneapolis to
 429.14 support continued access to health care
 429.15 coverage through Minnesota health care
 429.16 programs, improve access to quality care, and
 429.17 increase vaccination rates among urban
 429.18 American Indians.

429.19 **(b) Grants for Navigator Organizations.**
 429.20 (1) \$1,936,000 in fiscal year 2023 is from the
 429.21 health care access fund for grants to
 429.22 organizations with a MNsure grant services
 429.23 navigator assister contract in good standing
 429.24 as of July 1, 2022. The grants to each
 429.25 organization must be in proportion to the
 429.26 number of medical assistance and
 429.27 MinnesotaCare enrollees each organization
 429.28 assisted that resulted in a successful
 429.29 enrollment in the second quarter of fiscal year
 429.30 2022, as determined by MNsure's navigator
 429.31 payment process. This is a onetime
 429.32 appropriation and is available until June 30,
 429.33 2025.

430.1 (2) \$2,000,000 in fiscal year 2023 is from the
 430.2 health care access fund for incentive payments
 430.3 as defined in Minnesota Statutes, section
 430.4 256.962, subdivision 5. This appropriation is
 430.5 available until June 30, 2025. The health care
 430.6 access fund base for this appropriation is
 430.7 \$1,000,000 in fiscal year 2024 and \$0 in fiscal
 430.8 year 2025.

430.9 (c) **Base Level Adjustment.** The general fund
 430.10 base is increased \$3,750,000 in fiscal year
 430.11 2024 and \$1,250,000 in fiscal year 2025. The
 430.12 health care access fund base is increased
 430.13 \$1,000,000 in fiscal year 2024, and \$0 in fiscal
 430.14 year 2025.

430.15 Subd. 20. **Grant Programs; Other Long-Term**
 430.16 **Care Grants**

-0-

119,336,000

430.17 (a) **Workforce Incentive Fund Grant**
 430.18 **Program.** \$118,000,000 in fiscal year 2023
 430.19 is to assist disability, housing, substance use,
 430.20 and older adult service providers of public
 430.21 programs to pay for incentive benefits to
 430.22 current and new workers. This is a onetime
 430.23 appropriation and is available until June 30,
 430.24 2025. Three percent of the total amount of the
 430.25 appropriation may be used to administer the
 430.26 program, which may include contracting with
 430.27 a third-party administrator.

430.28 (b) **Supported Decision Making.** \$600,000
 430.29 in fiscal year 2023 is for a grant to Volunteers
 430.30 for America for the Centers for Excellence in
 430.31 Supported Decision Making to assist older
 430.32 adults and people with disabilities in avoiding
 430.33 unnecessary guardianships through using less
 430.34 restrictive alternatives, such as supported
 430.35 decision making. The base for this

431.1 appropriation is \$600,000 in fiscal year 2024,
431.2 \$600,000 in fiscal year 2025, and \$0 in fiscal
431.3 year 2026.

431.4 **(c) Support Coordination Training.**

431.5 \$736,000 in fiscal year 2023 is to develop and
431.6 implement a curriculum and training plan for
431.7 case managers to ensure all case managers
431.8 have the knowledge and skills necessary to
431.9 fulfill support planning and coordination
431.10 responsibilities for people who use home and
431.11 community-based disability services waivers
431.12 authorized under Minnesota Statutes, sections
431.13 256B.0913, 256B.092, and 256B.49, and
431.14 chapter 256S, and live in own-home settings.
431.15 Case manager support planning and
431.16 coordination responsibilities to be addressed
431.17 in the training include developing a plan with
431.18 the participant and their family to address
431.19 urgent staffing changes or unavailability and
431.20 other support coordination issues that may
431.21 arise for a participant. The commissioner shall
431.22 work with lead agencies, advocacy
431.23 organizations, and other stakeholders to
431.24 develop the training. An initial support
431.25 coordination training and competency
431.26 evaluation must be completed by all staff
431.27 responsible for case management, and the
431.28 support coordination training and competency
431.29 evaluation must be available to all staff
431.30 responsible for case management following
431.31 the initial training. The base for this
431.32 appropriation is \$377,000 in fiscal year 2024,
431.33 \$377,000 in fiscal year 2025, and \$0 in fiscal
431.34 year 2026.

432.1 (d) Base Level Adjustment. The general fund
 432.2 base is increased \$977,000 in fiscal year 2024
 432.3 and \$977,000 in fiscal year 2025.

432.4 Subd. 21. Grant Programs; Disabilities Grants -0- 8,950,000

432.5 (a) Electronic Visit Verification (EVV)

432.6 Stipends. \$6,440,000 in fiscal year 2023 is
 432.7 for onetime stipends of \$200 to bargaining
 432.8 members to offset the potential costs related
 432.9 to people using individual devices to access
 432.10 EVV. \$5,600,000 of the appropriation is for
 432.11 stipends and the remaining 15 percent is for
 432.12 administration of these stipends. This is a
 432.13 onetime appropriation.

432.14 (b) Self-Directed Collective Bargaining

432.15 Agreement; Temporary Rate Increase

432.16 Memorandum of Understanding. \$1,610,000
 432.17 in fiscal year 2023 is for onetime stipends for
 432.18 individual providers covered by the SEIU
 432.19 collective bargaining agreement based on the
 432.20 memorandum of understanding related to the
 432.21 temporary rate increase in effect between
 432.22 December 1, 2020, and February 7, 2021.
 432.23 \$1,400,000 of the appropriation is for stipends
 432.24 and the remaining 15 percent is for
 432.25 administration of the stipends. This is a
 432.26 onetime appropriation.

432.27 (c) Service Employees International Union

432.28 Memorandums. The memorandums of
 432.29 understanding submitted by the commissioner
 432.30 of management and budget to the Legislative
 432.31 Coordinating Commission Subcommittee on
 432.32 Employee Relations on March 17, 2022, are
 432.33 ratified.

433.1 **(d) Direct Care Service Corps Pilot Project.**
 433.2 \$500,000 in fiscal year 2023 is for a grant to
 433.3 HealthForce Minnesota at Winona State
 433.4 University for purposes of the direct care
 433.5 service corps pilot project in this act. Up to
 433.6 \$25,000 may be used by HealthForce
 433.7 Minnesota for administrative costs. This is a
 433.8 onetime appropriation.

433.9 **(e) Task Force on Disability Services**
 433.10 **Accessibility.** \$250,000 in fiscal year 2023 is
 433.11 for the Task Force on Disability Services
 433.12 Accessibility. Of this amount, \$..... must be
 433.13 used to provide pilot project grants. This is a
 433.14 onetime appropriation and is available until
 433.15 March 31, 2026.

433.16 **(f) Base Level Adjustment.** The general fund
 433.17 base is increased \$805,000 in fiscal year 2024
 433.18 and \$2,420,000 in fiscal year 2025.

433.19	<u>Subd. 22. Grant Programs; Adult Mental Health</u>		
433.20	<u>Grants</u>	<u>20,000,000</u>	<u>31,076,000</u>

433.21 **(a) Inpatient Psychiatric and Psychiatric**
 433.22 **Residential Treatment Facilities.**
 433.23 \$10,000,000 in fiscal year 2023 is for
 433.24 competitive grants to hospitals or mental
 433.25 health providers to retain, build, or expand
 433.26 children's inpatient psychiatric beds for
 433.27 children in need of acute high-level psychiatric
 433.28 care or psychiatric residential treatment facility
 433.29 beds as described in Minnesota Statutes,
 433.30 section 256B.0941. In order to be eligible for
 433.31 a grant, a hospital or mental health provider
 433.32 must serve individuals covered by medical
 433.33 assistance under Minnesota Statutes, section
 433.34 256B.0625.

- 434.1 **(b) Expanding Support for Psychiatric**
434.2 **Residential Treatment Facilities. \$800,000**
434.3 in fiscal year 2023 is for start-up grants to
434.4 psychiatric residential treatment facilities as
434.5 described in Minnesota Statutes, section
434.6 256B.0941. Grantees may use grant money
434.7 for emergency workforce shortage uses.
434.8 Allowable grant uses related to emergency
434.9 workforce shortages may include but are not
434.10 limited to hiring and retention bonuses,
434.11 recruitment of a culturally responsive
434.12 workforce, and allowing providers to increase
434.13 the hourly rate in order to be competitive in
434.14 the market.
- 434.15 **(c) Workforce Incentive Fund Grant**
434.16 **Program. \$20,000,000 in fiscal year 2022 is**
434.17 to provide mental health public program
434.18 providers the ability to pay for incentive
434.19 benefits to current and new workers. This is
434.20 a onetime appropriation and is available until
434.21 June 30, 2025. Three percent of the total
434.22 amount of the appropriation may be used to
434.23 administer the program, which may include
434.24 contracting with a third-party administrator.
- 434.25 **(d) Cultural and Ethnic Infrastructure**
434.26 **Grant Funding. \$10,000,000 in fiscal year**
434.27 2023 is for increasing cultural and ethnic
434.28 infrastructure grant funding under Minnesota
434.29 Statutes, section 245.4903. The base for this
434.30 appropriation is \$5,000,000 in fiscal year 2024
434.31 and \$5,000,000 in fiscal year 2025.
- 434.32 **(e) Culturally Specific Grants. \$2,000,000**
434.33 in fiscal year 2023 is for grants for small to
434.34 midsize nonprofit organizations who represent
434.35 and support American Indian, Indigenous, and

435.1 other communities disproportionately affected
435.2 by the opiate crisis. These grants utilize
435.3 traditional healing practices and other
435.4 culturally congruent and relevant supports to
435.5 prevent and curb opiate use disorders through
435.6 housing, treatment, education, aftercare, and
435.7 other activities as determined by the
435.8 commissioner. The base for this appropriation
435.9 is \$2,000,000 in fiscal year 2024 and \$0 in
435.10 fiscal year 2025.

435.11 **(f) African American Community Mental**
435.12 **Health Center Grant. \$1,000,000 in fiscal**
435.13 **year 2023 is for a grant to an African**
435.14 **American mental health service provider that**
435.15 **is a licensed community mental health center**
435.16 **specializing in services for African American**
435.17 **children and families. The center must offer**
435.18 **culturally specific, comprehensive,**
435.19 **trauma-informed, practice- and**
435.20 **evidence-based, person- and family-centered**
435.21 **mental health and substance use disorder**
435.22 **services; supervision and training; and care**
435.23 **coordination to all ages, regardless of ability**
435.24 **to pay or place of residence. Upon request, the**
435.25 **commissioner shall make information**
435.26 **regarding the use of this grant funding**
435.27 **available to the chairs and ranking minority**
435.28 **members of the legislative committees with**
435.29 **jurisdiction over human services. This is a**
435.30 **onetime appropriation.**

435.31 **(g) Behavioral Health Peer Training.**
435.32 **\$1,000,000 in fiscal year 2023 is for training**
435.33 **and development for mental health certified**
435.34 **peer specialists, mental health certified family**
435.35 **peer specialists, and recovery peer specialists.**

436.1 Training and development may include but is
 436.2 not limited to initial training and certification.

436.3 **(h) Intensive Residential Treatment Services**

436.4 **Locked Facilities.** \$2,796,000 in fiscal year
 436.5 2023 is for start-up funds to intensive
 436.6 residential treatment service providers to
 436.7 provide treatment in locked facilities for
 436.8 patients who have been transferred from a jail
 436.9 or who have been deemed incompetent to
 436.10 stand trial and a judge has determined that the
 436.11 patient needs to be in a secure facility. This is
 436.12 a onetime appropriation.

436.13 **(i) Base Level Adjustment.** The general fund
 436.14 base is increased \$27,092,000 in fiscal year
 436.15 2024 and \$34,216,000 in fiscal year 2025. The
 436.16 opiate epidemic response base is increased
 436.17 \$2,000,000 in fiscal year 2025.

436.18 **Subd. 23. Grant Programs; Child Mental Health**
 436.19 **Grants**

-0-

13,660,000

436.20 **(a) First Episode of Psychosis Grants.**
 436.21 \$300,000 in fiscal year 2023 is for first
 436.22 episode of psychosis grants under Minnesota
 436.23 Statutes, section 245.4905.

436.24 **(b) Children's Residential Treatment**
 436.25 **Services Emergency Funding.** \$2,500,000
 436.26 in fiscal year 2023 is from the general fund to
 436.27 provide licensed children's residential
 436.28 treatment facilities with emergency funding
 436.29 for staff overtime, one-to-one staffing as
 436.30 needed, staff recruitment and retention, and
 436.31 training and related costs to maintain quality
 436.32 staff. Up to \$500,000 of this appropriation
 436.33 may be allocated to support group home
 436.34 organizations supporting children transitioning

437.1 to lower levels of care. This is a onetime
 437.2 appropriation.

437.3 **(c) Children's Residential Facility Crisis**
 437.4 **Stabilization.** \$3,000,000 in fiscal year 2023
 437.5 is for implementing children's residential
 437.6 facility crisis stabilization services licensing
 437.7 requirements and reimbursing county costs
 437.8 for children's residential crisis stabilization
 437.9 services as required under Minnesota Statutes,
 437.10 section 245.4882, subdivision 6.

437.11 **(d) Base Level Adjustment.** The general fund
 437.12 base is increased \$16,100,000 in fiscal year
 437.13 2024 and \$1,100,000 in fiscal year 2025.

437.14	<u>Subd. 24. Grant Programs; Chemical</u>		
437.15	<u>Dependency Treatment Support Grants</u>	-0-	<u>2,000,000</u>

437.16 **(a) Emerging Mood Disorder Grant**
 437.17 **Program.** \$1,000,000 in fiscal year 2023 is
 437.18 for emerging mood disorder grants under
 437.19 Minnesota Statutes, section 245.4904.
 437.20 Grantees must use grant money as required in
 437.21 Minnesota Statutes, section 245.4904,
 437.22 subdivision 2.

437.23 **(b) Substance Use Disorder Treatment and**
 437.24 **Prevention Grants.** The base shall include
 437.25 \$4,000,000 in fiscal year 2024 and \$4,000,000
 437.26 in fiscal year 2025 for substance use disorder
 437.27 treatment and prevention grants recommended
 437.28 by the substance use disorder advisory council.

437.29 **(c) Traditional Healing Grants.** The base
 437.30 shall include \$2,000,000 in fiscal year 2025
 437.31 to extend the traditional healing grant funding
 437.32 appropriated in Laws 2019, chapter 63, article
 437.33 3, section 1, paragraph (h), from the opiate
 437.34 epidemic response account to the

438.1 commissioner of human services. This funding
 438.2 is awarded to all Tribal nations and to five
 438.3 urban Indian communities for traditional
 438.4 healing practices to American Indians and to
 438.5 increase the capacity of culturally specific
 438.6 providers in the behavioral health workforce.

438.7 (d) **Base Level Adjustment.** The general fund
 438.8 base is increased \$2,000,000 in fiscal year
 438.9 2024 and \$2,000,000 in fiscal year 2025.

438.10 Subd. 25. **Direct Care and Treatment -**
 438.11 **Operations** -0- 6,501,000

438.12 **Base Level Adjustment.** The general fund
 438.13 base is increased \$5,267,000 in fiscal year
 438.14 2024 and \$0 in fiscal year 2025.

438.15 Subd. 26. **Technical Activities** -0- -0-

438.16 (a) **Transfers; Child Care and Development**
 438.17 **Fund.** For fiscal years 2024 and 2025, the base
 438.18 shall include a transfer of \$23,500,000 in fiscal
 438.19 year 2024 and \$23,500,000 in fiscal year 2025
 438.20 from the TANF fund to the child care and
 438.21 development fund. These are onetime
 438.22 transfers.

438.23 (b) **Base Level Adjustment.** The TANF base
 438.24 is increased \$23,500,000 in fiscal year 2024,
 438.25 \$23,500,000 in fiscal year 2025, and \$0 in
 438.26 fiscal year 2026.

438.27 Sec. 3. **COMMISSIONER OF HEALTH**

438.28 Subdivision 1. **Total Appropriation** \$ -0- \$ 266,507,000

438.29 Appropriations by Fund

	<u>2022</u>	<u>2023</u>
438.30		
438.31 <u>General</u>	<u>-0-</u>	<u>258,888,000</u>
438.32 <u>State Government</u>		
438.33 <u>Special Revenue</u>	<u>-0-</u>	<u>6,044,000</u>
438.34 <u>Health Care Access</u>	<u>-0-</u>	<u>21,575,000</u>

439.1 **Subd. 2. Health Improvement**

439.2 Appropriations by Fund

439.3 General -0- 222,757,000

439.4 State Government

439.5 Special Revenue -0- 509,000

439.6 Health Care Access -0- 21,575,000

439.7 **(a) 988 National Suicide Prevention Lifeline.**

439.8 \$8,671,000 in fiscal year 2023 is from the
 439.9 general fund for the 988 suicide prevention
 439.10 lifeline in Minnesota Statutes, section 145.56.

439.11 Of this appropriation, \$455,000 is for
 439.12 administration and \$7,890,000 is for grants.

439.13 The general fund base for this appropriation
 439.14 is \$8,671,000 in fiscal year 2024, of which
 439.15 \$455,000 is for administration and \$7,890,000
 439.16 is for grants, and \$8,671,000 in fiscal year
 439.17 2025, of which \$455,000 is for administration
 439.18 and \$7,890,000 is for grants.

439.19 **(b) Address Growing Health Care Costs.**

439.20 \$2,476,000 in fiscal year 2023 is from the
 439.21 general fund for initiatives aimed at addressing
 439.22 growth in health care spending while ensuring
 439.23 stability in rural health care programs. The
 439.24 general fund base for this appropriation is
 439.25 \$3,057,000 in fiscal year 2024 and \$3,057,000
 439.26 in fiscal year 2025.

439.27 **(c) Community Health Workers. \$1,462,000**

439.28 in fiscal year 2023 is from the general fund
 439.29 for a public health approach to developing
 439.30 community health workers across Minnesota
 439.31 under Minnesota Statutes, section 145.9282.

439.32 Of this appropriation, \$462,000 is for
 439.33 administration and \$1,000,000 is for grants.

439.34 The general fund base for this appropriation
 439.35 is \$1,097,000 in fiscal year 2024, of which

440.1 \$337,000 is for administration and \$760,000
440.2 is for grants, and \$1,098,000 in fiscal year
440.3 2025, of which \$338,000 is for administration
440.4 and \$760,000 is for grants.

440.5 **(d) Community Solutions for Healthy Child**
440.6 **Development.** \$10,000,000 in fiscal year 2023
440.7 is from the general fund for the community
440.8 solutions for the healthy child development
440.9 grant program under Minnesota Statutes,
440.10 section 145.9271. Of this appropriation,
440.11 \$1,250,000 is for administration and
440.12 \$8,750,000 is for grants. The general fund base
440.13 appropriation is \$10,000,000 in fiscal year
440.14 2024 and \$10,000,000 in fiscal year 2025, of
440.15 which \$1,250,000 is for administration and
440.16 \$8,750,000 is for grants in each fiscal year.

440.17 **(e) Disability as a Health Equity Issue.**
440.18 \$1,575,000 in fiscal year 2023 is from the
440.19 general fund to reduce disability-related health
440.20 disparities through collaboration and
440.21 coordination between state and community
440.22 partners under Minnesota Statutes, section
440.23 145.9283. Of this appropriation, \$1,130,000
440.24 is for administration and \$445,000 is for
440.25 grants. The general fund base for this
440.26 appropriation is \$1,585,000 in fiscal year 2024
440.27 and \$1,585,000 in fiscal year 2025, of which
440.28 \$1,140,000 is for administration and \$445,000
440.29 is for grants.

440.30 **(f) Drug Overdose and Substance Abuse**
440.31 **Prevention.** \$5,042,000 in fiscal year 2023 is
440.32 from the general fund for a public health
440.33 prevention approach to drug overdose and
440.34 substance use disorder in Minnesota Statutes,
440.35 section 144.8611. Of this appropriation,

441.1 \$921,000 is for administration and \$4,121,000
441.2 is for grants.

441.3 **(g) Healthy Beginnings, Healthy Families.**
441.4 \$11,700,000 in fiscal year 2023 is from the
441.5 general fund for Healthy Beginnings, Healthy
441.6 Families services under Minnesota Statutes,
441.7 section 145.987. The general fund base for
441.8 this appropriation is \$11,818,000 in fiscal year
441.9 2024 and \$11,763,000 in fiscal year 2025. Of
441.10 this appropriation:

441.11 (1) \$7,510,000 in fiscal year 2023 is for the
441.12 Minnesota Collaborative to Prevent Infant
441.13 Mortality under Minnesota Statutes, section
441.14 145.987, subdivisions 2, 3, and 4, of which
441.15 \$1,535,000 is for administration and
441.16 \$5,975,000 is for grants. The general fund base
441.17 for this appropriation is \$7,501,000 in fiscal
441.18 year 2024, of which \$1,526,000 is for
441.19 administration and \$5,975,000 is for grants,
441.20 and \$7,501,000 in fiscal year 2025, of which
441.21 \$1,526,000 is for administration and
441.22 \$5,975,000 is for grants.

441.23 (2) \$340,000 in fiscal year 2023 is for Help
441.24 Me Connect under Minnesota Statutes, section
441.25 145.987, subdivisions 5 and 6. The general
441.26 fund base for this appropriation is \$663,000
441.27 in fiscal year 2024 and \$663,000 in fiscal year
441.28 2025.

441.29 (3) \$1,940,000 in fiscal year 2023 is for
441.30 voluntary developmental and social-emotional
441.31 screening and follow-up under Minnesota
441.32 Statutes, section 145.987, subdivisions 7 and
441.33 8, of which \$1,190,000 is for administration
441.34 and \$750,000 is for grants. The general fund
441.35 base for this appropriation is \$1,764,000 in

442.1 fiscal year 2024, of which \$1,014,000 is for
442.2 administration and \$750,000 is for grants, and
442.3 \$1,764,000 in fiscal year 2025, of which
442.4 \$1,014,000 is for administration and \$750,000
442.5 is for grants.

442.6 (4) \$1,910,000 in fiscal year 2023 is for model
442.7 jail practices for incarcerated parents under
442.8 Minnesota Statutes, section 145.987,
442.9 subdivisions 9, 10, and 11, of which \$485,000
442.10 is for administration and \$1,425,000 is for
442.11 grants. The general fund base for this
442.12 appropriation is \$1,890,000 in fiscal year
442.13 2024, of which \$465,000 is for administration
442.14 and \$1,425,000 is for grants, and \$1,835,000
442.15 in fiscal year 2025, of which \$410,000 is for
442.16 administration and \$1,425,000 is for grants.

442.17 (h) **Home Visiting.** \$62,386,000 in fiscal year
442.18 2023 is from the general fund for universal,
442.19 voluntary home visiting services under
442.20 Minnesota Statutes, section 145.871. Of this
442.21 appropriation, ten percent is for administration
442.22 and 90 percent is for implementation grants
442.23 of home visiting services to families. The
442.24 general fund base for this appropriation is
442.25 \$63,386,000 in fiscal year 2024 and
442.26 \$63,386,000 in fiscal year 2025.

442.27 (i) **Long COVID.** \$2,669,000 in fiscal year
442.28 2023 is from the general fund for a public
442.29 health approach to supporting long COVID
442.30 survivors under Minnesota Statutes, section
442.31 145.361. Of this appropriation, \$2,119,000 is
442.32 for administration and \$550,000 is for grants.
442.33 The base for this appropriation is \$3,706,000
442.34 in fiscal year 2024 and \$3,706,000 in fiscal
442.35 year 2025, of which \$3,156,000 is for

443.1 administration and \$550,000 is for grants in
443.2 each fiscal year.

443.3 **(j) Medical Education Research Cost**
443.4 **(MERC).** Of the amount previously
443.5 appropriated in the general fund by Laws
443.6 2015, chapter 71, article 3, section 2, for the
443.7 MERC program, \$150,000 in fiscal year 2023
443.8 and each year thereafter is for the
443.9 administration of grants under Minnesota
443.10 Statutes, section 62J.692.

443.11 **(k) No Surprises Act Enforcement. \$964,000**
443.12 **in fiscal year 2023 is from the general fund**
443.13 **for implementation of the federal No Surprises**
443.14 **Act portion of the Consolidated**
443.15 **Appropriations Act, 2021, under Minnesota**
443.16 **Statutes, section 62Q.021, subdivision 3. The**
443.17 **general fund base for this appropriation is**
443.18 **\$763,000 in fiscal year 2024 and \$757,000 in**
443.19 **fiscal year 2025.**

443.20 **(l) Public Health System Transformation.**
443.21 **\$23,531,000 in fiscal year 2023 is from the**
443.22 **general fund for public health system**
443.23 **transformation. Of this appropriation:**

443.24 **(1) \$20,000,000 is for grants to community**
443.25 **health boards under Minnesota Statutes,**
443.26 **section 145A.131, subdivision 1, paragraph**
443.27 **(f).**

443.28 **(2) \$1,000,000 is for grants to Tribal**
443.29 **governments under Minnesota Statutes, section**
443.30 **145A.14, subdivision 2b.**

443.31 **(3) \$1,000,000 is for a public health**
443.32 **AmeriCorps program grant under Minnesota**
443.33 **Statutes, section 145.9292.**

444.1 (4) \$1,531,000 is for the commissioner to
444.2 oversee and administer activities under this
444.3 paragraph.

444.4 **(m) Revitalize Health Care Workforce.**
444.5 \$21,575,000 in fiscal year 2023 is from the
444.6 health care access fund to address challenges
444.7 of Minnesota's health care workforce. Of this
444.8 appropriation:

444.9 (1) \$2,073,000 in fiscal year 2023 is for the
444.10 health professionals clinical training expansion
444.11 and rural and underserved clinical rotations
444.12 grant programs under Minnesota Statutes,
444.13 section 144.1505, of which \$423,000 is for
444.14 administration and \$1,650,000 is for grants.
444.15 Grant appropriations are available until
444.16 expended under Minnesota Statutes, section
444.17 144.1505, subdivision 2.

444.18 (2) \$4,507,000 in fiscal year 2023 is for the
444.19 primary care rural residency training grant
444.20 program under Minnesota Statutes, section
444.21 144.1507, of which \$207,000 is for
444.22 administration and \$4,300,000 is for grants.
444.23 Grant appropriations are available until
444.24 expended under Minnesota Statutes, section
444.25 144.1507, subdivision 2.

444.26 (3) \$430,000 in fiscal year 2023 is for the
444.27 international medical graduates assistance
444.28 program under Minnesota Statutes, section
444.29 144.1911, for international immigrant medical
444.30 graduates to fill a gap in their preparedness
444.31 for medical residencies or transition to a new
444.32 career making use of their medical degrees.
444.33 Of this appropriation, \$55,000 is for
444.34 administration and \$375,000 is for grants.

445.1 (4) \$12,565,000 in fiscal year 2023 is for a
445.2 grant program to health care systems,
445.3 hospitals, clinics, and other providers to ensure
445.4 the availability of clinical training for students,
445.5 residents, and graduate students to meet health
445.6 professions educational requirements under
445.7 Minnesota Statutes, section 144.1511, of
445.8 which \$565,000 is for administration and
445.9 \$12,000,000 is for grants.

445.10 (5) \$2,000,000 in fiscal year 2023 is for the
445.11 mental health cultural community continuing
445.12 education grant program, of which \$460,000
445.13 is for administration and \$1,540,000 is for
445.14 grants.

445.15 (n) **School Health.** \$837,000 in fiscal year
445.16 2023 is from the general fund for the School
445.17 Health Initiative under Minnesota Statutes,
445.18 section 145.988. The general fund base for
445.19 this appropriation is \$3,462,000 in fiscal year
445.20 2024, of which \$1,212,000 is for
445.21 administration and \$2,250,000 is for grants
445.22 and \$3,287,000 in fiscal year 2025, of which
445.23 \$1,037,000 is for administration and
445.24 \$2,250,000 is for grants.

445.25 (o) **Trauma System.** \$61,000 in fiscal year
445.26 2023 is from the general fund to administer
445.27 the trauma care system throughout the state
445.28 under Minnesota Statutes, sections 144.602,
445.29 144.603, 144.604, 144.606, and 144.608.
445.30 \$430,000 in fiscal year 2023 is from the state
445.31 government special revenue fund for trauma
445.32 designations according to Minnesota Statutes,
445.33 sections 144.122, paragraph (g), 144.605, and
445.34 144.6071.

446.1 (p) Mental Health Providers; Loan
446.2 Forgiveness, Grants, Information
446.3 Clearinghouse. \$4,275,000 in fiscal year 2023
446.4 is from the general fund for activities to
446.5 increase the number of mental health
446.6 professionals in the state. Of this
446.7 appropriation:

446.8 (1) \$1,000,000 is for loan forgiveness under
446.9 the health professional education loan
446.10 forgiveness program under Minnesota Statutes,
446.11 section 144.1501, notwithstanding the
446.12 priorities and distribution requirements in that
446.13 section, for eligible mental health
446.14 professionals who provide clinical supervision
446.15 in their designated field;

446.16 (2) \$3,000,000 is for the mental health
446.17 provider supervision grant program under
446.18 Minnesota Statutes, section 144.1508;

446.19 (3) \$250,000 is for the mental health
446.20 professional scholarship grant program under
446.21 Minnesota Statutes, section 144.1509; and

446.22 (4) \$25,000 is for the commissioner to
446.23 establish and maintain a website to serve as
446.24 an information clearinghouse for mental health
446.25 professionals and individuals seeking to
446.26 qualify as a mental health professional. The
446.27 website must contain information on the
446.28 various master's level programs to become a
446.29 mental health professional, requirements for
446.30 supervision, where to find supervision, how
446.31 to access tools to study for the applicable
446.32 licensing examination, links to loan
446.33 forgiveness programs and tuition
446.34 reimbursement programs, and other topics of
446.35 use to individuals seeking to become a mental

447.1 health professional. This is a onetime
447.2 appropriation.

447.3 **(q) Palliative Care Advisory Council.**
447.4 \$44,000 in fiscal year 2023 is from the general
447.5 fund for the Palliative Care Advisory Council
447.6 under Minnesota Statutes, section 144.059.

447.7 **(r) Emmett Louis Till Victims Recovery**
447.8 **Program. \$500,000 in fiscal year 2023 is from**
447.9 **the general fund for the Emmett Louis Till**
447.10 **Victims Recovery Program. This is a onetime**
447.11 **appropriation and is available until June 30,**
447.12 **2024.**

447.13 **(s) Changes to Birth Certificates. \$75,000**
447.14 **in fiscal year 2023 is from the state**
447.15 **government special revenue fund for**
447.16 **implementation of Minnesota Statutes, section**
447.17 **144.2182. The state government special**
447.18 **revenue fund base for this appropriation is**
447.19 **\$7,000 in fiscal year 2024 and \$7,000 in fiscal**
447.20 **year 2025.**

447.21 **(t) Study; POLST Forms. \$292,000 in fiscal**
447.22 **year 2023 is from the general fund for the**
447.23 **commissioner to study the creation of a**
447.24 **statewide registry of provider orders for**
447.25 **life-sustaining treatment and issue a report and**
447.26 **recommendations.**

447.27 **(u) Benefit and Cost Analysis of Universal**
447.28 **Health Reform Proposal. \$461,000 in fiscal**
447.29 **year 2023 is from the general fund for an**
447.30 **analysis of the benefits and costs of a universal**
447.31 **health care financing system and a similar**
447.32 **analysis of the current health care financing**
447.33 **system. Of this appropriation, \$250,000 is for**
447.34 **a contract with the University of Minnesota**

448.1 School of Public Health and the Carlson
448.2 School of Management. The general fund base
448.3 for this appropriation is \$288,000 in fiscal year
448.4 2024, of which \$250,000 is for a contract with
448.5 the University of Minnesota School of Public
448.6 Health and the Carlson School of
448.7 Management, and \$0 in fiscal year 2025.

448.8 **(v) Technical Assistance; Health Care**
448.9 **Trends and Costs.** \$5,000,000 in fiscal year
448.10 2023 is from the general fund for technical
448.11 assistance to the Health Care Affordability
448.12 Board in analyzing health care trends and costs
448.13 and setting health care spending growth
448.14 targets.

448.15 **(w) Sexual Exploitation and Trafficking**
448.16 **Study.** \$300,000 in fiscal year 2023 is to fund
448.17 a prevalence study on youth and adult victim
448.18 survivors of sexual exploitation and
448.19 trafficking. This is a onetime appropriation
448.20 and is available until June 30, 2024.

448.21 **(x) Local and Tribal Public Health**
448.22 **Emergency Preparedness and Response.**
448.23 \$9,000,000 in fiscal year 2023 is from the
448.24 general fund for distribution to local and Tribal
448.25 public health organizations for emergency
448.26 preparedness and response capabilities. At
448.27 least 90 percent of this appropriation must be
448.28 distributed to local and Tribal public health
448.29 organizations, and up to ten percent of this
448.30 appropriation may be used by the
448.31 commissioner for administrative costs. Use of
448.32 this appropriation must align with the Centers
448.33 for Disease Control and Prevention's issued
448.34 report: Public Health Emergency Preparedness
448.35 and Response Capabilities: National Standards

449.1 for State, Local, Tribal, and Territorial Public
449.2 Health.

449.3 **(y) Grants to Local Public Health**

449.4 **Departments.** \$16,172,000 in fiscal year 2023
449.5 is from the general fund for grants to local
449.6 public health departments for public health
449.7 response related to defining elevated blood
449.8 lead level as 3.5 micrograms of lead or greater
449.9 per deciliter of whole blood. Of this amount,
449.10 \$172,000 is available to the commissioner for
449.11 administrative costs. This appropriation is
449.12 available until June 30, 2025. The general fund
449.13 base for this appropriation is \$5,000,000 in
449.14 fiscal year 2024 and \$5,000,000 in fiscal year
449.15 2025.

449.16 **(z) Loan Forgiveness for Nursing**

449.17 **Instructors.** Notwithstanding the priorities
449.18 and distribution requirements in Minnesota
449.19 Statutes, section 144.1501, \$50,000 in fiscal
449.20 year 2023 is from the general fund for loan
449.21 forgiveness under the health professional
449.22 education loan forgiveness program under
449.23 Minnesota Statutes, section 144.1501, for
449.24 eligible nurses who agree to teach.

449.25 **(aa) Mental Health of Health Care Workers.**

449.26 \$1,000,000 in fiscal year 2023 is from the
449.27 general fund for competitive grants to
449.28 hospitals, community health centers, rural
449.29 health clinics, and medical professional
449.30 associations to establish or enhance
449.31 evidence-based or evidence-informed
449.32 programs dedicated to improving the mental
449.33 health of health care professionals.

449.34 **(bb) Prevention of Violence in Health Care.**

449.35 \$50,000 in fiscal year 2023 is from the general

450.1 fund to continue the prevention of violence in
450.2 health care programs and to create violence
450.3 prevention resources for hospitals and other
450.4 health care providers to use to train their staff
450.5 on violence prevention.

450.6 **(cc) Hospital Nursing Loan Forgiveness.**
450.7 \$5,000,000 in fiscal year 2023 is from the
450.8 general fund for the hospital nursing loan
450.9 forgiveness program under Minnesota Statutes,
450.10 section 144.1501.

450.11 **(dd) Program to Distribute COVID-19**
450.12 **Tests, Masks, and Respirators. \$15,000,000**
450.13 in fiscal year 2023 is from the general fund
450.14 for a program to distribute COVID-19 tests,
450.15 masks, and respirators to individuals in the
450.16 state. This is a onetime appropriation.

450.17 **(ee) Safe Harbor Grants. \$1,000,000 in fiscal**
450.18 year 2023 is for grants to fund supportive
450.19 services, including but not limited to legal
450.20 services, mental health therapy, substance use
450.21 disorder counseling, and case management for
450.22 sexually exploited youth or youth at risk of
450.23 sexual exploitation under Minnesota Statutes,
450.24 section 145.4716.

450.25 **(ff) Safe Harbor Regional Navigators.**
450.26 \$700,000 in fiscal year 2023 is for safe harbor
450.27 regional navigators under Minnesota Statutes,
450.28 section 145.4717.

450.29 **(gg) Base Level Adjustments.** The general
450.30 fund base is increased \$195,645,000 in fiscal
450.31 year 2024 and \$195,063,000 in fiscal year
450.32 2025. The health care access fund base is
450.33 increased \$21,575,000 in fiscal year 2024 and
450.34 \$21,575,000 in fiscal year 2025. The state

451.1 government special revenue fund base is
 451.2 increased \$437,000 in fiscal year 2024 and
 451.3 \$437,000 in fiscal year 2025.

451.4 **Subd. 3. Health Protection**

451.5	<u>Appropriations by Fund</u>		
451.6	<u>General</u>	<u>-0-</u>	<u>36,131,000</u>
451.7	<u>State Government</u>		
451.8	<u>Special Revenue</u>	<u>-0-</u>	<u>5,535,000</u>

451.9 **(a) Climate Resiliency.** \$1,977,000 in fiscal
 451.10 year 2023 is from the general fund for climate
 451.11 resiliency actions under Minnesota Statutes,
 451.12 section 144.9981. Of this appropriation,
 451.13 \$977,000 is for administration and \$1,000,000
 451.14 is for grants. The general fund base for this
 451.15 appropriation is \$988,000 in fiscal year 2024,
 451.16 of which \$888,000 is for administration and
 451.17 \$100,000 is for grants, and \$989,000 in fiscal
 451.18 year 2025, of which \$889,000 is for
 451.19 administration and \$100,000 is for grants.

451.20 **(b) Lead Remediation in Schools and Child**
 451.21 **Care Settings.** \$2,054,000 in fiscal year 2023
 451.22 is from the general fund for a lead in drinking
 451.23 water remediation in schools and child care
 451.24 settings grant program under Minnesota
 451.25 Statutes, section 145.9272. Of this
 451.26 appropriation, \$454,000 is for administration
 451.27 and \$1,600,000 is for grants. The general fund
 451.28 base for this appropriation is \$1,540,000 in
 451.29 fiscal year 2024, of which \$370,000 is for
 451.30 administration and \$1,170,000 is for grants,
 451.31 and \$1,541,000 in fiscal year 2025, of which
 451.32 \$371,000 is for administration and \$1,170,000
 451.33 is for grants.

451.34 **(c) Lead Service Line Inventory.** \$4,029,000
 451.35 in fiscal year 2023 is from the general fund

452.1 for grants to public water suppliers to complete
452.2 a lead service line inventory of their
452.3 distribution systems under Minnesota Statutes,
452.4 section 144.383, clause (6). Of this
452.5 appropriation, \$279,000 is for administration
452.6 and \$3,750,000 is for grants. The general fund
452.7 base for this appropriation is \$4,029,000 in
452.8 fiscal year 2024, of which \$279,000 is for
452.9 administration and \$3,750,000 is for grants,
452.10 and \$140,000 in fiscal year 2025, which is for
452.11 administration.

452.12 **(d) Lead Service Line Replacement.**
452.13 \$5,000,000 in fiscal year 2023 is from the
452.14 general fund for administrative costs related
452.15 to the replacement of lead service lines in the
452.16 state.

452.17 **(e) Mercury in Skin-Lightening Products**
452.18 **Grants.** \$100,000 in fiscal year 2023 is from
452.19 the general fund for a skin-lightening products
452.20 public awareness and education grant program
452.21 under Minnesota Statutes, section 145.9275.

452.22 **(f) HIV Prevention for People Experiencing**
452.23 **Homelessness.** \$1,129,000 in fiscal year 2023
452.24 is from the general fund for expanding access
452.25 to harm reduction services and improving
452.26 linkages to care to prevent HIV/AIDS,
452.27 hepatitis, and other infectious diseases for
452.28 those experiencing homelessness or housing
452.29 instability under Minnesota Statutes, section
452.30 145.924, paragraph (d). Of this appropriation,
452.31 \$169,000 is for administration and \$960,000
452.32 is for grants.

452.33 **(g) Safety Improvements for State-Licensed**
452.34 **Long-Term Care Facilities.** \$5,500,000 in
452.35 fiscal year 2023 is from the general fund for

- 453.1 a temporary grant program for safety
453.2 improvements for state-licensed long-term
453.3 care facilities. Of this appropriation, \$500,000
453.4 is for administration and \$5,000,000 is for
453.5 grants. The general fund base for this
453.6 appropriation is \$8,200,000 in fiscal year 2024
453.7 and \$0 in fiscal year 2025. Of this
453.8 appropriation in fiscal year 2024, \$700,000 is
453.9 for administration and \$7,500,000 is for
453.10 grants. This appropriation is available until
453.11 June 30, 2025.
- 453.12 **(h) Mortuary Science.** \$219,000 in fiscal year
453.13 2023 is from the state government special
453.14 revenue fund for regulation of transfer care
453.15 specialists under Minnesota Statutes, chapter
453.16 149A, and for additional reporting
453.17 requirements under Minnesota Statutes,
453.18 section 149A.94. The state government special
453.19 revenue fund base for this appropriation is
453.20 \$132,000 in fiscal year 2024 and \$61,000 in
453.21 fiscal year 2025.
- 453.22 **(i) Drinking Water Lead Testing and**
453.23 **Remediation; Day Care Facilities.**
453.24 \$1,000,000 in fiscal year 2023 is from the
453.25 general fund for statewide testing of day care
453.26 facilities for the presence of lead in drinking
453.27 water and for remediation of contamination
453.28 where found.
- 453.29 **(j) Public Health Response Contingency**
453.30 **Account.** \$20,000,000 in fiscal year 2023 is
453.31 from the general fund for transfer to the public
453.32 health response contingency account under
453.33 Minnesota Statutes, section 144.4199.
- 453.34 **(k) Base Level Adjustments.** The general
453.35 fund base is increased \$17,269,000 in fiscal

454.1 year 2024 and \$5,065,000 in fiscal year 2025.

454.2 The state government special revenue fund

454.3 base is increased \$5,242,000 in fiscal year

454.4 2024 and \$5,171,000 in fiscal year 2025.

454.5 **Sec. 4. HEALTH-RELATED BOARDS**

454.6	<u>Subdivision 1. Total Appropriation</u>	<u>\$</u>	<u>-0-</u>	<u>\$</u>	<u>203,000</u>
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454.7 Appropriations by Fund

454.8	<u>General Fund</u>	<u>-0-</u>		<u>175,000</u>
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454.9 State Government

454.10	<u>Special Revenue</u>	<u>-0-</u>		<u>28,000</u>
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454.11 This appropriation is from the state
 454.12 government special revenue fund unless
 454.13 specified otherwise. The amounts that may be
 454.14 spent for each purpose are specified in the
 454.15 following subdivisions.

454.16	<u>Subd. 2. Board of Dentistry</u>	<u>-0-</u>	<u>3,000</u>
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454.17 **Subd. 3. Board of Dietetics and Nutrition**
 454.18 **Practice**

<u>-0-</u>	<u>25,000</u>
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454.19 **Subd. 4. Board of Pharmacy**

<u>-0-</u>	<u>175,000</u>
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454.20 This appropriation is from the general fund.
 454.21 **Medication repository program. \$175,000**
 454.22 in fiscal year 2023 is from the general fund
 454.23 for transfer by the Board of Pharmacy to the
 454.24 central repository to be used to administer the
 454.25 medication repository program according to
 454.26 the contract between the central repository and
 454.27 the Board of Pharmacy.

454.28	Sec. 5. <u>COUNCIL ON DISABILITY</u>	<u>\$</u>	<u>-0-</u>	<u>\$</u>	<u>375,000</u>
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454.29 **Sec. 6. EMERGENCY MEDICAL SERVICES**
 454.30 **REGULATORY BOARD**

<u>-0-</u>	<u>\$</u>	<u>200,000</u>
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454.31 This is a onetime appropriation.

454.32	Sec. 7. <u>BOARD OF DIRECTORS OF MNSURE</u>	<u>\$</u>	<u>-0-</u>	<u>\$</u>	<u>7,775,000</u>
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455.1 This appropriation may be transferred to the
 455.2 MNsure account established in Minnesota
 455.3 Statutes, section 62V.07.

455.4 **Base Adjustment.** The general fund base for
 455.5 this appropriation is \$10,982,000 in fiscal year
 455.6 2024, \$6,450,000 in fiscal year 2025, and \$0
 455.7 in fiscal year 2026.

455.8 **Sec. 8. HEALTH CARE AFFORDABILITY**
 455.9 **BOARD.** **\$** **-0-** **\$** **1,070,000**

455.10 **(a) Health Care Affordability Board.**
 455.11 \$1,070,000 in fiscal year 2023 is from the
 455.12 general fund for the Health Care Affordability
 455.13 Board to implement Minnesota Statutes,
 455.14 sections 62J.86 to 62J.72.

455.15 **(b) Base Level Adjustment.** The general fund
 455.16 base is increased \$347,000 in fiscal year 2024
 455.17 and \$415,000 in fiscal year 2025.

455.18 **Sec. 9. COMMISSIONER OF COMMERCE** **\$** **-0-** **\$** **251,000**

455.19 **(a) Prescription Drug Affordability Board.**
 455.20 \$197,000 in fiscal year 2023 is from the
 455.21 general fund for the commissioner of
 455.22 commerce to establish the Prescription Drug
 455.23 Affordability Board under Minnesota Statutes,
 455.24 section 62J.87, and for the Prescription Drug
 455.25 Affordability Board to implement the
 455.26 Prescription Drug Affordability Act.
 455.27 Following the first meeting of the board and
 455.28 prior to June 30, 2023, the commissioner of
 455.29 commerce shall transfer any funds remaining
 455.30 from this appropriation to the board. The
 455.31 general fund base for this appropriation is
 455.32 \$357,000 in fiscal year 2024 and \$357,000 in
 455.33 fiscal year 2025.

456.1 (b) Ectodermal Dysplasias. \$54,000 in fiscal
 456.2 year 2023 is from the general fund for costs
 456.3 related to insurance coverage of ectodermal
 456.4 dysplasias. The general fund base for this
 456.5 appropriation is \$58,000 in fiscal year 2024
 456.6 and \$62,000 in fiscal year 2025.

456.7	Sec. 10. <u>COMMISSIONER OF LABOR AND</u>				
456.8	<u>INDUSTRY</u>	\$	-0-	\$	<u>641,000</u>

456.9 **Nursing Home Workforce Standards**
 456.10 **Board. \$641,000 in fiscal year 2023 is for**
 456.11 **establishment and operation of the Nursing**
 456.12 **Home Workforce Standards Board in**
 456.13 **Minnesota Statutes, sections 181.211 to**
 456.14 **181.217. The general fund base for this**
 456.15 **appropriation is \$322,000 in fiscal year 2024**
 456.16 **and \$368,000 in fiscal year 2025.**

456.17	Sec. 11. <u>ATTORNEY GENERAL</u>				
		\$	-0-	\$	<u>456,000</u>

456.18 **(a) Expert Witnesses. \$200,000 in fiscal year**
 456.19 **2023 is for expert witnesses and investigations**
 456.20 **under Minnesota Statutes, section 62J.844.**
 456.21 **This is a onetime appropriation.**

456.22 **(b) Prescription Drug Enforcement.**
 456.23 **\$256,000 in fiscal year 2023 is for prescription**
 456.24 **drug enforcement. This is a onetime**
 456.25 **appropriation.**

456.26 Sec. 12. Laws 2021, First Special Session chapter 2, article 1, section 4, subdivision 2, is
 456.27 amended to read:

456.28	Subd. 2. <u>Operations and Maintenance</u>	621,968,000		621,968,000
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456.29 (a) \$15,000,000 in fiscal year 2022 and
 456.30 \$15,000,000 in fiscal year 2023 are to: (1)
 456.31 increase the medical school's research
 456.32 capacity; (2) improve the medical school's
 456.33 ranking in National Institutes of Health

457.1 funding; (3) ensure the medical school's
457.2 national prominence by attracting and
457.3 retaining world-class faculty, staff, and
457.4 students; (4) invest in physician training
457.5 programs in rural and underserved
457.6 communities; and (5) translate the medical
457.7 school's research discoveries into new
457.8 treatments and cures to improve the health of
457.9 Minnesotans.

457.10 (b) \$7,800,000 in fiscal year 2022 and
457.11 \$7,800,000 in fiscal year 2023 are for health
457.12 training restoration. This appropriation must
457.13 be used to support all of the following: (1)
457.14 faculty physicians who teach at eight residency
457.15 program sites, including medical resident and
457.16 student training programs in the Department
457.17 of Family Medicine; (2) the Mobile Dental
457.18 Clinic; and (3) expansion of geriatric
457.19 education and family programs.

457.20 (c) \$4,000,000 in fiscal year 2022 and
457.21 \$4,000,000 in fiscal year 2023 are for the
457.22 Minnesota Discovery, Research, and
457.23 InnoVation Economy funding program for
457.24 cancer care research.

457.25 (d) \$500,000 in fiscal year 2022 and \$500,000
457.26 in fiscal year 2023 are for the University of
457.27 Minnesota, Morris branch, to cover the costs
457.28 of tuition waivers under Minnesota Statutes,
457.29 section 137.16.

457.30 (e) \$150,000 in fiscal year 2022 and \$150,000
457.31 in fiscal year 2023 are for the Chloe Barnes
457.32 Advisory Council on Rare Diseases under
457.33 Minnesota Statutes, section 137.68. The fiscal
457.34 year 2023 appropriation shall be transferred
457.35 to the Council on Disability. The base for this

458.1 appropriation is \$0 in fiscal year 2024 and
 458.2 later.

458.3 (f) The total operations and maintenance base
 458.4 for fiscal year 2024 and later is \$620,818,000.

458.5 Sec. 13. Laws 2021, First Special Session chapter 7, article 16, section 2, subdivision 29,
 458.6 is amended to read:

458.7 Subd. 29. Grant Programs; Disabilities Grants	31,398,000	31,010,000
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458.8 **(a) Training Stipends for Direct Support**
 458.9 **Services Providers.** \$1,000,000 in fiscal year
 458.10 2022 is from the general fund for stipends for
 458.11 individual providers of direct support services
 458.12 as defined in Minnesota Statutes, section
 458.13 256B.0711, subdivision 1. These stipends are
 458.14 available to individual providers who have
 458.15 completed designated voluntary trainings
 458.16 made available through the State-Provider
 458.17 Cooperation Committee formed by the State
 458.18 of Minnesota and the Service Employees
 458.19 International Union Healthcare Minnesota.
 458.20 Any unspent appropriation in fiscal year 2022
 458.21 is available in fiscal year 2023. This is a
 458.22 onetime appropriation. This appropriation is
 458.23 available only if the labor agreement between
 458.24 the state of Minnesota and the Service
 458.25 Employees International Union Healthcare
 458.26 Minnesota under Minnesota Statutes, section
 458.27 179A.54, is approved under Minnesota
 458.28 Statutes, section 3.855.

458.29 **(b) Parent-to-Parent Peer Support.** \$125,000
 458.30 in fiscal year 2022 and \$125,000 in fiscal year
 458.31 2023 are from the general fund for a grant to
 458.32 an alliance member of Parent to Parent USA
 458.33 to support the alliance member's
 458.34 parent-to-parent peer support program for

459.1 families of children with a disability or special
459.2 health care need.

459.3 **(c) Self-Advocacy Grants.** (1) \$143,000 in
459.4 fiscal year 2022 and \$143,000 in fiscal year
459.5 2023 are from the general fund for a grant
459.6 under Minnesota Statutes, section 256.477,
459.7 subdivision 1.

459.8 (2) \$105,000 in fiscal year 2022 and \$105,000
459.9 in fiscal year 2023 are from the general fund
459.10 for subgrants under Minnesota Statutes,
459.11 section 256.477, subdivision 2.

459.12 **(d) Minnesota Inclusion Initiative Grants.**
459.13 \$150,000 in fiscal year 2022 and \$150,000 in
459.14 fiscal year 2023 are from the general fund for
459.15 grants under Minnesota Statutes, section
459.16 256.4772.

459.17 **(e) Grants to Expand Access to Child Care**
459.18 **for Children with Disabilities.** \$250,000 in
459.19 fiscal year 2022 and \$250,000 in fiscal year
459.20 2023 are from the general fund for grants to
459.21 expand access to child care for children with
459.22 disabilities. Any unspent amount in fiscal year
459.23 2022 is available through June 30, 2023. This
459.24 is a onetime appropriation.

459.25 **(f) Parenting with a Disability Pilot Project.**
459.26 The general fund base includes \$1,000,000 in
459.27 fiscal year 2024 and \$0 in fiscal year 2025 to
459.28 implement the parenting with a disability pilot
459.29 project.

459.30 **(g) Base Level Adjustment.** The general fund
459.31 base is \$29,260,000 in fiscal year 2024 and
459.32 \$22,260,000 in fiscal year 2025.

460.1 Sec. 14. Laws 2021, First Special Session chapter 7, article 16, section 2, subdivision 31,
 460.2 is amended to read:

460.3 **Subd. 31. Grant Programs; Adult Mental Health**
 460.4 **Grants**

460.5	Appropriations by Fund		
460.6	General	98,772,000	98,703,000
460.7	Opiate Epidemic		
460.8	Response	2,000,000	2,000,000

460.9 **(a) Culturally and Linguistically**
 460.10 **Appropriate Services Implementation**
 460.11 **Grants.** \$2,275,000 in fiscal year 2022 and
 460.12 \$2,206,000 in fiscal year 2023 are from the
 460.13 general fund for grants to disability services,
 460.14 mental health, and substance use disorder
 460.15 treatment providers to implement culturally
 460.16 and linguistically appropriate services
 460.17 standards, according to the implementation
 460.18 and transition plan developed by the
 460.19 commissioner. Any unspent amount in fiscal
 460.20 year 2022 is available through June 30, 2023.
 460.21 The general fund base for this appropriation
 460.22 is \$1,655,000 in fiscal year 2024 and \$0 in
 460.23 fiscal year 2025.

460.24 **(b) Base Level Adjustment.** The general fund
 460.25 base is \$93,295,000 in fiscal year 2024 and
 460.26 \$83,324,000 in fiscal year 2025. The opiate
 460.27 epidemic response fund base is \$2,000,000 in
 460.28 fiscal year 2024 and \$0 in fiscal year 2025.

460.29 Sec. 15. Laws 2021, First Special Session chapter 7, article 16, section 2, subdivision 33,
 460.30 is amended to read:

460.31 **Subd. 33. Grant Programs; Chemical**
 460.32 **Dependency Treatment Support Grants**

460.33	Appropriations by Fund		
460.34	General	4,273,000	4,274,000

461.1	Lottery Prize	1,733,000	1,733,000
461.2	Opiate Epidemic		
461.3	Response	500,000	500,000

461.4 **(a) Problem Gambling.** \$225,000 in fiscal
 461.5 year 2022 and \$225,000 in fiscal year 2023
 461.6 are from the lottery prize fund for a grant to
 461.7 the state affiliate recognized by the National
 461.8 Council on Problem Gambling. The affiliate
 461.9 must provide services to increase public
 461.10 awareness of problem gambling, education,
 461.11 training for individuals and organizations
 461.12 providing effective treatment services to
 461.13 problem gamblers and their families, and
 461.14 research related to problem gambling.

461.15 **(b) Recovery Community Organization**
 461.16 **Grants.** \$2,000,000 in fiscal year 2022 and
 461.17 \$2,000,000 in fiscal year 2023 are from the
 461.18 general fund for grants to recovery community
 461.19 organizations, as defined in Minnesota
 461.20 Statutes, section 254B.01, subdivision 8, to
 461.21 provide for costs and community-based peer
 461.22 recovery support services that are not
 461.23 otherwise eligible for reimbursement under
 461.24 Minnesota Statutes, section 254B.05, as part
 461.25 of the continuum of care for substance use
 461.26 disorders. Any unspent amount in fiscal year
 461.27 2022 is available through June 30, 2023. The
 461.28 general fund base for this appropriation is
 461.29 \$2,000,000 in fiscal year 2024 and \$0 in fiscal
 461.30 year 2025

461.31 **(c) Base Level Adjustment.** The general fund
 461.32 base is \$4,636,000 in fiscal year 2024 and
 461.33 \$2,636,000 in fiscal year 2025. The opiate
 461.34 epidemic response fund base is \$500,000 in
 461.35 fiscal year 2024 and \$0 in fiscal year 2025.

462.1 Sec. 16. Laws 2021, First Special Session chapter 7, article 17, section 3, is amended to
462.2 read:

462.3 **Sec. 3. GRANTS FOR TECHNOLOGY FOR HCBS RECIPIENTS.**

462.4 (a) This act includes \$500,000 in fiscal year 2022 and \$2,000,000 in fiscal year 2023
462.5 for the commissioner of human services to issue competitive grants to home and
462.6 community-based service providers. Grants must be used to provide technology assistance,
462.7 including but not limited to Internet services, to older adults and people with disabilities
462.8 who do not have access to technology resources necessary to use remote service delivery
462.9 and telehealth. Any unspent amount in fiscal year 2022 is available through June 30, 2023.
462.10 The general fund base included in this act for this purpose is \$1,500,000 in fiscal year 2024
462.11 and \$0 in fiscal year 2025.

462.12 (b) All grant activities must be completed by March 31, 2024.

462.13 (c) This section expires June 30, 2024.

462.14 Sec. 17. Laws 2021, First Special Session chapter 7, article 17, section 6, is amended to
462.15 read:

462.16 **Sec. 6. TRANSITION TO COMMUNITY INITIATIVE.**

462.17 (a) This act includes \$5,500,000 in fiscal year 2022 and \$5,500,000 in fiscal year 2023
462.18 for additional funding for grants awarded under the transition to community initiative
462.19 described in Minnesota Statutes, section 256.478. Any unspent amount in fiscal year 2022
462.20 is available through June 30, 2023. The general fund base in this act for this purpose is
462.21 \$4,125,000 in fiscal year 2024 and \$0 in fiscal year 2025.

462.22 (b) All grant activities must be completed by March 31, 2024.

462.23 (c) This section expires June 30, 2024.

462.24 Sec. 18. Laws 2021, First Special Session chapter 7, article 17, section 10, is amended to
462.25 read:

462.26 **Sec. 10. PROVIDER CAPACITY GRANTS FOR RURAL AND UNDERSERVED**
462.27 **COMMUNITIES.**

462.28 (a) This act includes \$6,000,000 in fiscal year 2022 and \$8,000,000 in fiscal year 2023
462.29 for the commissioner to establish a grant program for small provider organizations that
462.30 provide services to rural or underserved communities with limited home and

463.1 community-based services provider capacity. The grants are available to build organizational
463.2 capacity to provide home and community-based services in Minnesota and to build new or
463.3 expanded infrastructure to access medical assistance reimbursement. Any unspent amount
463.4 in fiscal year 2022 is available through June 30, 2023. The general fund base in this act for
463.5 this purpose is \$8,000,000 in fiscal year 2024 and \$0 in fiscal year 2025.

463.6 (b) The commissioner shall conduct community engagement, provide technical assistance,
463.7 and establish a collaborative learning community related to the grants available under this
463.8 section and work with the commissioner of management and budget and the commissioner
463.9 of the Department of Administration to mitigate barriers in accessing grant funds. Funding
463.10 awarded for the community engagement activities described in this paragraph is exempt
463.11 from state solicitation requirements under Minnesota Statutes, section 16B.97, for activities
463.12 that occur in fiscal year 2022.

463.13 (c) All grant activities must be completed by March 31, 2024.

463.14 (d) This section expires June 30, 2024.

463.15 Sec. 19. Laws 2021, First Special Session chapter 7, article 17, section 11, is amended to
463.16 read:

463.17 Sec. 11. **EXPAND MOBILE CRISIS.**

463.18 (a) This act includes \$8,000,000 in fiscal year 2022 and \$8,000,000 in fiscal year 2023
463.19 for additional funding for grants for adult mobile crisis services under Minnesota Statutes,
463.20 section 245.4661, subdivision 9, paragraph (b), clause (15). Any unspent amount in fiscal
463.21 year 2022 is available through June 30, 2023. The general fund base in this act for this
463.22 purpose is \$4,000,000 in fiscal year 2024 and \$0 in fiscal year 2025.

463.23 (b) Beginning April 1, 2024, counties may fund and continue conducting activities
463.24 funded under this section.

463.25 (c) All grant activities must be completed by March 31, 2024.

463.26 (d) This section expires June 30, 2024.

464.1 Sec. 20. Laws 2021, First Special Session chapter 7, article 17, section 12, is amended to
464.2 read:

464.3 **Sec. 12. PSYCHIATRIC RESIDENTIAL TREATMENT FACILITY AND CHILD**
464.4 **AND ADOLESCENT MOBILE TRANSITION UNIT.**

464.5 (a) This act includes \$2,500,000 in fiscal year 2022 and \$2,500,000 in fiscal year 2023
464.6 for the commissioner of human services to create children's mental health transition and
464.7 support teams to facilitate transition back to the community of children from psychiatric
464.8 residential treatment facilities, and child and adolescent behavioral health hospitals. Any
464.9 unspent amount in fiscal year 2022 is available through June 30, 2023. The general fund
464.10 base included in this act for this purpose is \$1,875,000 in fiscal year 2024 and \$0 in fiscal
464.11 year 2025.

464.12 (b) Beginning April 1, 2024, counties may fund and continue conducting activities
464.13 funded under this section.

464.14 (c) This section expires March 31, 2024.

464.15 Sec. 21. Laws 2021, First Special Session chapter 7, article 17, section 17, subdivision 3,
464.16 is amended to read:

464.17 **Subd. 3. Respite services for older adults grants.** (a) This act includes \$2,000,000 in
464.18 fiscal year 2022 and \$2,000,000 in fiscal year 2023 for the commissioner of human services
464.19 to establish a grant program for respite services for older adults. The commissioner must
464.20 award grants on a competitive basis to respite service providers. Any unspent amount in
464.21 fiscal year 2022 is available through June 30, 2023. The general fund base included in this
464.22 act for this purpose is \$2,000,000 in fiscal year 2024 and \$0 in fiscal year 2025.

464.23 (b) All grant activities must be completed by March 31, 2024.

464.24 (c) This subdivision expires June 30, 2024.

464.25 **Sec. 22. APPROPRIATIONS FOR ADVISORY COUNCIL ON RARE DISEASES.**

464.26 In accordance with Minnesota Statutes, section 15.039, subdivision 6, the unexpended
464.27 balance of money appropriated from the general fund to the Board of Regents of the
464.28 University of Minnesota for purposes of the advisory council on rare diseases under
464.29 Minnesota Statutes, section 137.68, shall be under control of the Minnesota Rare Disease
464.30 Advisory Council and the Council on Disability.

465.1 Sec. 23. **APPROPRIATION ENACTED MORE THAN ONCE.**

465.2 If an appropriation is enacted more than once in the 2022 legislative session, the
465.3 appropriation must be given effect only once.

465.4 Sec. 24. **SUNSET OF UNCODIFIED LANGUAGE.**

465.5 All uncodified language contained in this article expires on June 30, 2023, unless a
465.6 different effective date is explicit.

465.7 Sec. 25. **EFFECTIVE DATE.**

465.8 This article is effective the day following final enactment.

144G.07 RETALIATION PROHIBITED.

Subd. 6. **Other laws.** Nothing in this section affects the rights and remedies available under section 626.557, subdivisions 10, 17, and 20.

150A.091 FEES.

Subd. 3. **Initial license or permit fees.** Along with the application fee, each of the following applicants shall submit a separate initial license or permit fee. The initial fee shall be established by the board not to exceed the following nonrefundable fee amounts:

- (1) dentist or full faculty dentist, \$168;
- (2) dental therapist, \$120;
- (3) dental hygienist, \$60;
- (4) licensed dental assistant, \$36; and
- (5) dental assistant with a permit as described in Minnesota Rules, part 3100.8500, subpart 3, \$12.

Subd. 15. **Verification of licensure.** Each institution or corporation shall submit with a request for verification of a license a fee in the amount of \$5 for each license to be verified.

Subd. 17. **Advanced dental therapy examination fee.** Any dental therapist eligible to sit for the advanced dental therapy certification examination must submit with the application a fee as established by the board, not to exceed \$250.

256B.057 ELIGIBILITY REQUIREMENTS FOR SPECIAL CATEGORIES.

Subd. 7. **Waiver of maintenance of effort requirement.** Unless a federal waiver of the maintenance of effort requirement of section 2105(d) of title XXI of the Balanced Budget Act of 1997, Public Law 105-33, Statutes at Large, volume 111, page 251, is granted by the federal Department of Health and Human Services by September 30, 1998, eligibility for children under age 21 must be determined without regard to asset standards established in section 256B.056, subdivision 3c. The commissioner of human services shall publish a notice in the State Register upon receipt of a federal waiver.

256B.063 COST SHARING.

Notwithstanding the provisions of section 256B.05, subdivision 2, the commissioner is authorized to promulgate rules pursuant to the Administrative Procedure Act, and to require a nominal enrollment fee, premium, or similar charge for recipients of medical assistance, if and to the extent required by applicable federal regulation.

256B.69 PREPAID HEALTH PLANS.

Subd. 20. **Ombudsperson.** The commissioner shall designate an ombudsperson to advocate for persons required to enroll in prepaid health plans under this section. The ombudsperson shall advocate for recipients enrolled in prepaid health plans through complaint and appeal procedures and ensure that necessary medical services are provided either by the prepaid health plan directly or by referral to appropriate social services. At the time of enrollment in a prepaid health plan, the local agency shall inform recipients about the ombudsperson program and their right to a resolution of a complaint by the prepaid health plan if they experience a problem with the plan or its providers.

501C.0408 TRUST FOR CARE OF ANIMAL.

Subd. 4. **Public health programs and trusts.** An irrevocable inter vivos trust created under this section is subject to section 501C.1206.

501C.1206 PUBLIC HEALTH CARE PROGRAMS AND CERTAIN TRUSTS.

(a) It is the public policy of this state that individuals use all available resources to pay for the cost of long-term care services, as defined in section 256B.0595, before turning to Minnesota health care program funds, and that trust instruments should not be permitted to shield available resources of an individual or an individual's spouse from such use.

(b) When a state or local agency makes a determination on an application by the individual or the individual's spouse for payment of long-term care services through a Minnesota public health care program pursuant to chapter 256B, any irrevocable inter vivos trust or any legal instrument, device, or arrangement similar to an irrevocable inter vivos trust created on or after July 1, 2005,

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containing assets or income of an individual or an individual's spouse, including those created by a person, court, or administrative body with legal authority to act in place of, at the direction of, upon the request of, or on behalf of the individual or individual's spouse, becomes revocable for the sole purpose of that determination. For purposes of this section, any inter vivos trust and any legal instrument, device, or arrangement similar to an inter vivos trust:

(1) shall be deemed to be located in and subject to the laws of this state; and

(2) is created as of the date it is fully executed by or on behalf of all of the settlors or others.

(c) For purposes of this section, a legal instrument, device, or arrangement similar to an irrevocable inter vivos trust means any instrument, device, or arrangement which involves a settlor who transfers or whose property is transferred by another including, but not limited to, any court, administrative body, or anyone else with authority to act on their behalf or at their direction, to an individual or entity with fiduciary, contractual, or legal obligations to the settlor or others to be held, managed, or administered by the individual or entity for the benefit of the settlor or others. These legal instruments, devices, or other arrangements are irrevocable inter vivos trusts for purposes of this section.

(d) In the event of a conflict between this section and the provisions of an irrevocable trust created on or after July 1, 2005, this section shall control.

(e) This section does not apply to trusts that qualify as supplemental needs trusts under section 501C.1205 or to trusts meeting the criteria of United States Code, title 42, section 1396p (d)(4)(a) and (c) for purposes of eligibility for medical assistance.

(f) This section applies to all trusts first created on or after July 1, 2005, as permitted under United States Code, title 42, section 1396p, and to all interests in real or personal property regardless of the date on which the interest was created, reserved, or acquired.